AGENDA AND SUPPORTING PAPERS FOR THE MEETING OF THE GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST MAIN BOARD TO BE HELD AT 12:30 IN THE LECTURE HALL, SANDFORD EDUCATION CENTRE, CHELTENHAM GENERAL HOSPITAL ON THURSDAY 14 FEBRUARY 2019

(PLEASE NOTE: Date and venue for this meeting.

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

The next meeting of the Gloucestershire Hospitals NHS Foundation Trust Main Board will be held on **Thursday 14 February 2019** in the **Lecture Hall, Sandford Education Centre, Cheltenham General Hospital** commencing at 12:30

(PLEASE NOTE DATE AND VENUE FOR THIS MEETING)

Peter Lachecki
Chair

10 January 2019

AGENDA

	Item	Paper	Purpose	Approximate Timings
1.	Welcome and Apologies			12:30
2.	Declarations of Interest			
3.	Patient Story			12:31
4.	Minutes of the meeting held on 10 January 2019	**PAPER**	**For Approval**	13:01
5.	Matters Arising	**PAPER**	**For assurance**	13:03
6.	Chief Executive's Report	**PAPER** (Deborah Lee)	**For information**	13:05
7.	Board Assurance Framework	**PAPER** (Lukasz Bohdan)	**For assurance**	13:15
8.	Trust Risk Register	**PAPER** (Lukasz Bohdan)	**For assurance**	13:20
9.	Quality and Performance:			13:25
	- Assurance Report of the Chair of the Quality and Performance Committee - meeting held on 30 January 2019	**PAPER** (Claire Feehily)	**For assurance**	
	- Quality and Performance Report	**PAPER** (Carole Webster, Sean Elyan, Caroline Landon)	**For assurance**	
	- Guardian report on Safe Working Hours for Doctors and Dentists in Training	**PAPER** (Sean Elyan)	**For assurance**	
10.	Finance and Digital:			13:40
	- Assurance Report of the Chair of the Finance Committee - meeting held on 31 January 2019	**PAPER** (Keith Norton)	**For assurance**	
	- Financial Performance Report	**PAPER** (Sarah Stansfield)	**For assurance**	
	- SmartCare Progress Report	**PAPER** (Mark Hutchinson)	**For assurance**	
11.	Audit and Assurance:		**For assurance**	13:55
	- Assurance Report of the Chair of the Audit and Assurance Committee meeting held on 8 January 2019	**PAPER** (Rob Graves)		

12.	Gloucestershire Managed Services (GMS):			14:00
	- Assurance Report of the Chair of the GMS Committee meeting held on 14 January 2019	**PAPER** (Mike Napier)	**For assurance**	
	- Finance Director Board Approval	**PAPER** (Lukasz Bohdan)	**For approval**	
13.	Revised Governance Documents: - Board Standing Orders - Standing Financial Instructions - Scheme of Delegation - Committee and Trust Leadership Team Terms of Reference	**PAPER** (Lukasz Bohdan)		14:10
14.	Brexit Risk and Planning	**PAPER** (Lukasz Bohdan)	**For assurance**	14:20
	Governor Questions			
15.	Governors' Questions – A period of 10 minutes will be permitted for Governors to ask questions			14:30
	Staff Questions			
16.	A period of 10 minutes will be provided to respond to questions submitted by members of staff			14:40
	Public Questions			
17.	A period of 10 minutes will be provided for members of the public to ask questions submitted in accordance with the Board's procedure.			14:50
	Any Other Business			
18.	Any Other Business			
	Close			**15:00**

COMPLETED PAPERS FOR THE BOARD ARE TO BE SENT TO THE CORPORATE GOVERNANCE TEAM NO LATER THAN 17:00 ON TUESDAY 5 FEBRUARY 2019

Date of the next meeting: The next meeting of the Main Board will take place at on **Thursday 14 March 2019** in the **Lecture Hall, Sandford Education Centre, Cheltenham General Hospital** at **12:30**

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

Board Members

Peter Lachecki, Chair

Non-Executive Directors	**Executive Directors**
Dr Claire Feehily	Deborah Lee, Chief Executive
Rob Graves	Lukasz Bohdan, Director of Corporate Governance
Alison Moon	Dr Sean Elyan, Medical Director
Mike Napier	Steve Hams, Director of Quality and Chief Nurse
Keith Norton	Mark Hutchinson, Chief Digital and Information Officer
	Caroline Landon, Chief Operating Officer
	Simon Lanceley, Director of Strategy and Transformation
	Sarah Stansfield, Director of Finance
	Emma Wood, Director of People and Deputy Chief Executive

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE TRUST BOARD
HELD IN THE LECTURE HALL, REDWOOD EDUCATION CENTRE,
GLOUCESTERSHIRE ROYAL HOSPITAL ON THURSDAY 10 JANUARY 2019 AT 12:30

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	PL	Chair
	Deborah Lee	DL	Chief Executive
	Lukasz Bohdan	LB	Director of Corporate Governance
	Sean Elyan	SE	Medical Director
	Steve Hams	SH	Director of Quality and Chief Nurse
	Mark Hutchinson	MH	Chief Digital & Information Officer
	Simon Lanceley	SL	Director of Strategy and Transformation
	Caroline Landon	CL	Chief Operating Officer
	Sarah Stansfield	SS	Director of Finance
	Rob Graves	RG	Non-Executive Director
	Alison Moon	AM	Non-Executive Director
	Mike Napier	MN	Non-Executive Director
	Keith Norton	KN	Non-Executive Director
APOLOGIES	Claire Feehily	CF	Non-Executive Director
	Emma Wood	EW	Director of People and Organisational Development and Deputy Chief Executive
IN ATTENDANCE	Suzie Cro	SC	Deputy Director of Quality
	Julie Hapeshi	JH	Associate Director of Research and Development *(for item 024/19 only)*
	Natashia Judge	NJ	Corporate Governance Manager
	Alison Koeltgen	AK	Deputy Director of People and Organisational Development
	Craig Macfarlane	CM	Head of Communications

PUBLIC & PRESS No governors, one member of staff, four members of the public.

The Chair welcomed all to the meeting. He noted the change of start time, explaining that this had been moved to support better public attendance. Meetings would now be held on a monthly basis.

012/19 DECLARATIONS OF INTEREST **ACTIONS**

The following interests were declared:
- LB declared an interest, noting that he was a GMS Director.
- DL declared an interest in the Research paper, noting that she was Chair of the Clinical Research Network.

013/19 PATIENT STORY

SC gave a presentation on equality and diversity inclusion within patient stories and described some of the improvement work in this area.

SC then played a recording of a patient story narrated by a mother whose daughter attempted suicide and was subsequently admitted into the emergency department (ED). The story touched on:

- The kind care received from a staff nurse and junior doctor.
- The Mental Health Liaison Team (MHLT) and the fact that they refused to see the patient as she was already under the psychiatrist's care.
- Access to the ED and the lack of direction and supervision of visitors.

- Ligature risks in the single room her daughter was in.
- Lack of checks by nursing staff and healthcare assistants.
- How the doctors on the ward round spoke *about* her daughter (in her presence), not *to* her daughter.
- The unsympathetic demeanour of one the nurses on the Acute Medical Unit (AMU) and the attitude of some agency staff.

In response:

- DL noted that the story dated back to October 2018 and asked how the learning had been taken forward since then. SH felt the story highlighted a multitude of layers, including how the Trust cares for mental health patients and the transition of patients from children's to adult services. He described the enhanced care work, to address care of mental health patients, plans for a liaison service to support transition patients, patient safety alerts, work to address ligature risks and the development of the AMY leadership model. He reflected on the importance and value of increasing substantive staff.
- DL felt the shortcomings in care highlighted in the story were unrelated to the patient's mental health presentation and were about the fundamentals of care. AM agreed and said that hearing such stories was crucial; while she noted SH points on mental health, she felt the story stressed the importance of personalised care and looking after a patient's physical and mental health. SH agreed but felt that mental health training for adult nurses was still important.
- SE expressed disappointment with the medical care; he felt it was important, however, to acknowledge the two gems of excellent care from the staff nurse and junior doctor in ED who were under incredible pressure. He reflected on how this could be carried through to the AMU.
- KN asked how the patient was doing now. SC explained that her recovery was going well.
- RG asked how information regarding patients' mental health was communicated on admission to ED. SH explained that this was captured during triage and diagnosis and would follow the patient through their care. DL also highlighted that the Joining Up Your Information (JUYI) project would soon be going live in the A&E which would give Trust staff access to records in other providers such as 2Gether and GP practices.
- PL acknowledged that while work was underway to reduce reliance on agency staff, some agency staff would be needed for the foreseeable future and asked how the quality of these nurses was assured and how the adverse impact of this could be reduced. SH answered that on AMU specifically high quality agency staff were being block booked and taken through the Trust induction. PL asked if agency staff performance was monitored. SH answered that there was a process of excluding individuals if feedback was poor but there was no routine monitoring due to the very short nature of some staff's tenure.
- MN suggested the audio of recording be used as part of training.
- LB noted that when patients attended to tell their story, the Board were able to ask what they would like to see change. SC gave assurance that this conversation was taking place..
- DL requested that the patient story be further discussed outside of Board, in particular at Quality and Performance Committee, to ensure no other patient has a similar experience. She felt all nurses on AMU should hear the audio of the story and consideration should be given to its wider use in training of Trust staff. SH and SC would ensure this happens. **SH/SC**

014/19 MINUTES OF THE MEETING HELD ON 8 NOVEMBER 2018

RESOLVED: The minutes of the meeting held on 8 November 2018 were agreed as a correct record and signed by the Chair.

015/19 MATTERS ARISING

NOVEMBER 2018 217/18 CHIEF EXECUTIVE'S REPORT – SL SAID HE WOULD BE ATTENDING A KING'S FUND SESSION WHERE WAVE 1 INTEGRATED CARE SYSTEMS (ICS) WOULD BE FEEDING BACK THEIR EXPERIENCES AND WHAT THEY WERE ABLE TO ACHIEVE AS AN ICS AS OPPOSED TO AN SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP (STP)
He would feedback to the Board.
Completed: SL detailed the King's Fund session held and a summary paper was shared with the Board.

NOVEMBER 2018 223/18 GOVERNANCE DOCUMENTS – TERMS OF REFERENCE - THE DIRECTOR OF CORPORATE GOVERNANCE PROVIDED A VERBAL UPDATE ON THE TRUST TERMS OF REFERENCE REVIEW, NOTING THAT THESE WERE BEING UPDATED ALONGSIDE THE STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS
The full suite of documents would return to the Board in January. Corporate Governance Manager to add to work plan.
Completed: Being reviewed by January Audit and Assurance Committee prior to review at Board.

LB updated that this would be at February Board.

NOVEMBER 2018 222/18 GLOUCESTERSHIRE MANAGED SERVICES – ASSURANCE REPORT - KEITH NORTON FELT IT ODD TO RECEIVE A CHAIR'S REPORT WITHOUT A SUPPORTING SUBSTANTIVE REPORT. THE BOARD DISCUSSED THE BEST APPROACH TO OVERSIGHT AND THE CHIEF EXECUTIVE FELT THAT EACH COMMITTEE REPORT SHOULD INCLUDING A DIMENSION ON GMS
This would be further discussed at the next Executive Meeting.
Completed: Executives agreed that each domain report would address any matters of significant relating to GMS as opposed to producing a standalone GMS report.

AM asked if reports would include GMS explicitly in the future. PL responded that they should.

016/19 CHAIR'S UPDATE

The Chair presented the report detailing his activities since 2 November 2018.

017/19 CHIEF EXECUTIVE'S REPORT

DL presented her report to the Board. In response:

- AM acknowledged the phenomenal effort required to achieve 90% for the Four Hour Accident & Emergency (A&E) Standard for quarter 3. She also noted that the Trust had called for a review of all investments and services aimed at reducing demand and asked whether DL had confidence that the system would cease any initiatives which were not working. DL responded that she had confidence that if a review was undertaken which demonstrated that services were not adding value

that they would be changed or withdrawn. She cautioned that it would take time and resources to address demand. SE added that a recent meeting was held with CCG partners to discuss delivery of services to patients in ED. This was described as productive and encouraging.

- DL praised the impact of the social media campaign on 2 January 2019 highlighting demand within A&E. She described how this had resulted in a reduction in minors attendances. MN asked whether repeating the campaign every Monday would be helpful. DL cautioned that should this become a regular occurrence the impact might be reduced but noted that the ICS communication leads would be reviewing the impact and the duration of the affect, alongside the investment to consider future approaches.
- MN asked about the impact of changes to the emergency care tariff. DL said that the changes to tariff would benefit Trust, but how agreement is reached on what fixed costs should be would be more challenging. SS said that detailed work was underway as there was a difference in interpretation between providers and commissioners on aspects of the tariff.
- The Board expressed their thanks to staff working over Christmas and New Year.

018/19 TRUST RISK REGISTER

LB presented the Trust Risk Register, highlighting that this had been reissued following changes made at the Trust Leadership Team meeting held the previous day.

RG added that the Trust Risk Register was reviewed in detail at Audit and Assurance Committee.

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..

019/19 QUALITY AND PERFORMANCE:

ASSURANCE REPORTS OF THE CHAIR OF THE QUALITY AND PERFORMANCE COMMITTEE - MEETINGS HELD ON 29 NOVEMBER 2018 AND 20 DECEMBER 2018

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

QUALITY AND PERFORMANCE REPORT

SH and CL presented the Quality and Performance Report, highlighting the improved position in relation to Clostridium Difficile and MRSA, delivery of the two week cancer wait in December, and shadow reporting for Referral to Treatment (RTT) reporting.

PL asked how the RTT reporting was progressing. MH answered that this was going well with issues addressed between each test cycle. Live reporting would commence in March, for February's performance as per the original plan subject to cycles 2 and 3 not revealing any new concerns.

Concern was expressed at the number of 52 week breaches which continued and DL explained the work to address and also the link to the recovery work and RTT test cycles.

AM said that at the last Quality and Performance Committee the Director of Planned Care shared the improvement plan for Urology, highlighting risks around workforce and referral rate. AM praised the plan and acknowledged the national risks around Urology. CL described challenges around workforce and said that this was an ongoing piece of work with new consultants in place.

RESOLVED: That the Board receive the report as source of assurance.

LEARNING FROM DEATHS

SE presented the Learning from Deaths Report, noting that this was reviewed on a quarterly basis by the Quality and Performance Committee.

In response:

- PL noted that the Trust's approach was being rolled out nationally and praised the team. CM would highlight the Trust's achievement through comms. **CM**
- SE said that he had discussed with SC the possibility of the Bereavement Team attending Board as part of the patient story item.
- PL observed the comment within the report regarding areas of excellent care and asked how their approach could be embedded across the Trust. SE explained that the Director of Safety had done some work on this such as kitchen table events and the development of the Learning From Excellence module within Datix which captured good practice but acknowledged that learning needed to be shared wider and further.
- RG asked which data table would highlight an issue within the Trust. SE said that individual cases were reviewed for specific issues and cautioned against using deaths as an indicator of poor care, as deaths were an unusual event. He reinforced that the Trust wanted to support staff in learning when things went wrong and did not wish to discourage reporting.
- SL asked about the ability to benchmark against other providers. SE cautioned that there was a lack of consistency as some Trusts did not use Structured Judgement Reviews and therefore currently these comparisons were not being published. He stressed the importance of cultural change around learning.

RESOLVED: That the Board accept the Learning from Deaths report as a source of assurance.

020/19 FINANCIAL PERFORMANCE

ASSURANCE REPORTS OF THE CHAIR OF THE FINANCE COMMITTEE - MEETINGS HELD ON 28 NOVEMBER 2018 AND 19 DECEMBER 2018

KN reported the key messages from the November and December Finance and Digital Committee Chair's reports.

PL highlighted that the NHS Long Term Plan recommended each Trust recruit a Chief Digital and Information Officer which we had already done and become fully digitised by 2023/24 which was again consistent with our vision.

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

FINANCIAL PERFORMANCE REPORT

SS presented the Financial Performance Report to provide an overview of the financial performance of the Trust as at the end of Month 8.

RG observed that receivables had increased between the start of the year and the current period of reporting, and asked if this related to phasing. SS confirmed that this was the case and largely related to the income position and accruing of over and underperformance. This was noted not to be indicative of a deteriorating cash position.

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

NHS IMPROVEMENT LETTERS: EXIT FROM FINANCIAL SPECIAL MEASURES AND ENFORCEMENT UNDERTAKINGS

DL presented the paper formally advising the Board of the recent NHS Improvement (NHS) decision to release the Trust from the Financial Special Measures (FSM) regime and to lift the majority of the Enforcement Undertakings.

As a result of the lifting of FSM, the NHSI regulatory team has reviewed the Trust's compliance with the Enforcement Undertakings issued in parallel to the Trust being placed in FSM and decided to issue the Trust with a Compliance Certificate against a of the majority of undertakings. As a result, only enforcement undertakings relating to medium-term financial recovery plan remained in place and these would be reviewed ahead of the 2019/20 year commencing.

RESOLVED: That the Board note the decision by NHSI to remove the Trust from Financial Special Measures, the revised segmentation within the Single Oversight Framework, the residual undertakings and note the likelihood of further undertakings being issued for the period financial year 2020.

SMARTCARE PROGRESS REPORT

MH presented the SmartCare Progress Report to provide assurance on the current position of the recovery programme and return to RTT reporting.

MN highlighted the reduction in the volume of data quality issues and felt that inevitably over time these would become harder to address as only the complicated would remain. He was asked whether it was worth projecting an estimate or setting an acceptable level. MH responded that conversations were underway on how to tackle data quality issues on an ongoing basis which would inform a trajectory but he noted all Trusts will have a level of data quality issues which was why validation is a fundamental part of the approach to reporting.

RG noted the risks outlined within the report and the reference to resource and adequate deployment. He sought assurance that adequate funding and resource was available. MH answered that conversations were continuing at the Finance and Digital Committee and at Trust Leadership Team. The process would take some time, but investment in the data validation team had been agreed which he confirmed was sufficient to support the reliable reporting of RTT.

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

021/19 PEOPLE AND ORGANISATIONAL DEVELOPMENT

ASSURANCE REPORT OF THE CHAIR OF THE PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE - MEETING HELD ON 7 DECEMBER 2018

AM reported the key messages from the December People and Organisational Development (OD) Committee Chair's report.

MN reminded the Board that in the next year the People and OD Strategy would be developed and requested explicit inclusion of the Trust's approach to violence and aggression, bullying and harassment. DL explained that the staff survey had highlighted a reduction in the number of staff likely to report such incidents which required further investigation and would drive the Trust's approach. AM explained that the discussions in the Committee at present were tactical and operational, but would play into strategic intent.

PL briefed that as part of the Long Term Plan there was some short term national work underway around culture and leadership and questioned whether the Trust should get involved. DL would give thought and discuss with him outside the meeting and she was not yet familiar with the work in question.

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

PEOPLE AND ORGANISATIONAL DEVELOPMENT REPORT

AK presented the report and highlighted the key points including increases in recruitment numbers, the forthcoming Health and Wellbeing Hub, the Staff Experience and Improvement Group, the Health Care Assistants' (HCAs') turnover plan and improvements to appraisal and mandatory training.

In response:

- PL asked if the Trust had identified what was driving the HCAs turnover. AK answered that work was underway to understand this more fully, with an On-boarding Co-Ordinator looking at HCA experience post-induction. SH said that the HCAs recruitment approach had been modified and it now used focus groups involving current HCA staff rather than one to one interviews with line managers, which had proven much more realistic and effective. AM praised this approach and said that more detailed information was being sought from exit interviews – this would return to the next Committee.
- MN said that he struggled to see the numbers for HCA positions as they were categorised under additional clinical services. He asked for the exact figures for HCAs. AK agreed provide the figures and amend the format of future reports. **AK**
- PL reflected on new investment into the NHS and whether the promise to put more money into the NHS workforce was stimulating demand with local educators more so than normal. SH answered that the University of Gloucestershire were ahead of the national trend with good fill rates on undergraduate nurse programmes; he did not think, however that this was related to the promise of more workforce funding. SH said that the Allied Health Professionals market was more difficult, as was the market for other smaller therapy groups. SE said that discussions around taking additional medical students from Bristol and creating a medical school in Worcestershire were underway. Workforce planning for doctors post-graduation was noted to leave much to be desired..

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

EQUALITY REPORT

AK presented the Equality Report to the Board noting that this had been reviewed and scrutinised by the People and OD Committee and focused on 2017/18 data. The next annual report would be received earlier than planned in July 2019.

RESOLVED: That the Board note the publication of the Equality Report 2017/18.

022/19 AUDIT AND ASSURANCE

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

RG reported the key messages from the November Audit and Assurance Committee Chair's report.

KN asked if RG was comfortable with the work being undertaken around cyber security. RG answered that he was much more comfortable than a few months ago but stressed this was an area where the Trust could not afford to be complacent as it would continue to face cyber threats. MH concurred, noting that while significant progress had been made the challenge was continuing. Further review supported by NHS Digital was underway.

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

023/19 GLOUCESTERSHIRE MANAGED SERVICES (GMS)

ASSURANCE REPORTS OF THE CHAIR OF THE GMS COMMITTEE MEETINGS HELD ON 21 NOVEMBER 2018 AND 10 DECEMBER 2018

MN reported the key messages from the November and December GMS Chair's report.

In response:

- KN reflected that in the commercial sector there was a focus on the intelligent supplier and intelligent customer actively managing one another. He asked MN for his assessment of how this was progressing at the Trust. MN said that this had been little weak at first however he had raised this with DL outside of the Committee. He acknowledged that plans were in place to address this. DL reflected on the need to potentially deploy resource differently, as well as the need for a contract management function and external strategic estates advice. She highlighted that SL was investigating this and the Trust were considering how to develop the role of the Chief Operating Officer to become an effective client of soft facilities management (FM) services.
- AM noted that cleaning and national standards would be reviewed at the next meeting and asked whether this would explore whether the Trust aimed to comply with the national standards. MN responded that a remediation plan had previously been created to bring performance up to local standards. It has been agreed that there is now no reason the Trust should not comply with national standards and therefore the next Committee would seek to understand how much of a change this would represent and what the cost implications would be. CL added that the

Managing Director of GMS was undertaking work to assess whether or not there was a funding gap in this respect, which the Trust has challenged.

- DL said that she would expect any additional resources associated with meeting minimum national standards to come from the transformation and productivity increases promised as part of the GMS offer. MN answered that in GRH in particular a real step change was apparent in regards to Interserve influence there.
- PL reminded the Board that there would be a review of strategy around GMS and that this should return to the Board in May or June. **NJ** (for work plan)
- SS noted that GMS would have to produce their annual report and accounts. She also said that she observed greater accountability within GMS but not transformation as yet.

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

024/19 SIX MONTHLY RESEARCH REPORT

SL presented the six monthly research report to provide an update to the Board on the current status of research activity within the Trust. He highlighted that JH would soon be retiring and thanked her on behalf of the Board for the effort and impact she has had on research.

DL noted her interest in this item as Chair of the West of England Local Clinical Research Network (LCRN)

In response:

- SE asked JH which areas of the Trust required further focus in terms of research. JH highlighted diabetes and cardiology.
- AM said that she had attended the recent Research Forum and praised the commitment and passion of the team and welcomed the new strategy. She questioned whether the Trust should highlight this was part of the tripartite mission and link to university status at the beginning of the strategy. AM also stressed the importance of clinical staff utilising a good evidence base and critically appraising good research and welcomed inclusion of this also.
- MN said that he was interested in target numbers, their driver and the Trust's response. SL answered that this was established by the Clinical Research Network and was devolved from a national target; however there was nothing stopping the Trust from being more ambitious.
- SE highlighted the information gathering service offered by the Trust Library and felt the natural link could be better highlighted. **NJ** (for work plan)
- DL suggested the report return to Board in three months setting out the opportunities and plans for increasing recruitment into trials both commercial and non-commercial. She also informed that nationally the region was not performing well and was in the lower quartile in respect of patient recruitment, and said that the Clinical Research Network was investigating why this was and developing plans to address.

RESOLVED: That the Board accept the report as assurance of the performance and governance of research within the Trust.

025/19 MINUTES OF THE MEETING OF THE COUNCIL OF GOVERNORS HELD ON 17 OCTOBER 2018

RESOLVED: That the minutes be noted.

026/19 GOVERNORS' QUESTIONS

There were none.

027/19 STAFF QUESTIONS

There were none.

028/19 PUBLIC QUESTIONS

"Does Gloucestershire Hospitals NHS Foundation Trust have a clear narrative of diversity and inclusion that is agreed by the Board and effectively communicated to staff, and which staff at every level can have confidence in?"

The Board have approved a number of action plans which link to diversity and inclusion. Our Trust have provided the following narrative on diversity and inclusion:

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

The value of diversity is integrated in our training programmes from induction to people management courses and in the networks and working groups the Trust support. All staff undertake equality, diversity and inclusion training as part of their induction initially and every 3 years thereafter.

The Trust has developed a Diversity Network which is open to all staff to join. The network collaborates with the Trust to eliminate unlawful discrimination experienced by staff and is well supported by the Trust Leadership Team and 100 leaders network. It also provides a signposting and support function where issues can be discussed in a safe and confidential environment. Network members are also trained to assist in bullying and harassment cases and advise on policy decisions. Throughout the year the network celebrates the diversity of our Trust by promoting and participating in local and national events which recognise and champion characteristics which can be more vulnerable to discrimination. Board Champions for protected characteristics have been agreed for 2019 and will be reverse mentored by members of the Diversity Network. Regular updates on Equality and Diversity activities are provided in a quarterly Trust wide newsletter, posters and flyers are visible to promote the diversity network and its events, alongside promotion within the weekly Blog.

Last financial year (2017/18) the Equality, Diversity and Inclusion (EDI) Steering Group continued to promote and embed our principles of equality, diversity and inclusion into all policy decisions and service delivery within our Trust. Details of some of our achievements and progress can be found in our recently published Equality report (see link) which meets the requirements of the Public Sector Equality Duty (PSED) and the Equality Delivery System (EDS2). https://www.gloshospitals.nhs.uk/about-us/our-trust/equality-diversity/

During 2018/19 our main priority will be to develop in consultation with staff and patients new 4-year Equality Objectives. These will also incorporate Human Rights principles.

In terms of 'staff at every level having confidence in the Trusts narrative' we can measure this in a number of ways:

- Diversity network membership (which has grown over the last year) and participation in network events (starting to increase);
- WRES report (which highlights the differences in experience between white and BAME staff and is analysed for inclusion in the equality of opportunity plan);
- Feedback from the staff survey and Freedom to Speak up guardian on our processes and successes in tackling issues such as discrimination.
- The 2017 results show that the vast majority of staff do perceive the Trust as fair and have a good experience with us, but there is a portion who do not share these perceptions and our equality of opportunity plan looks to actively address these;
    - Key finding 21 – 86 % of staff believe the organisation provides equal opportunities for career progression/promotion (14% disagree)
    - Key Finding 30 – 3.61 (engagement score and has a maximum value of 5) regard fairness and effectiveness of procedures for reporting errors, near misses and incidents
    - Key Finding 31 – 3.54 (engagement score) staff confidence and security in reporting unsafe clinical practice
    - Key Finding 19 – 3.5 (engagement score) organisation/management taking interest in and action on health/wellbeing
    - Key Finding 25 - 26% of staff experience harassment, bullying or abuse from staff

<u>What joined up plan does Gloucestershire Hospitals NHS Foundation Trust have to address health inequalities within the Trust.</u>

Please take a look at two documents published on our Trust website: https://www.gloshospitals.nhs.uk/about-us/reports-and-publications/

- Equality Report 2017-18
- Quality Account 2017-18

If you need more detail, there are also a number of enabling strategies (that will be incorporated into the Trust's new Quality Strategy due to be published in June 2019):

- Improving Patient & Carer Experience
- Dementia Strategy
- Patient Health and Wellbeing

<u>What joined up plan does Gloucestershire Hospitals NHS Foundation Trust have for addressing health inequalities with their partner organisations covering the whole of Gloucestershire?"</u>

Please take a look at the Sustainability and Transformation Plan (STP), which is designed to close the Health and Wellbeing Gap; Care and Quality Gap and Finance and Efficiency Gap: https://www.gloucestershireccg.nhs.uk/stp-documents/

029/19 ANY OTHER BUSINESS

There was none.

030/19 DATE OF NEXT MEETING

The next **Public** meeting of the **Main Board** will take place at 12:30 **Thursday 14 February 2019** in **Lecture Hall, Sandford Education Centre, Cheltenham General Hospital**

031/19 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 14:50

Chair
14 February 2019

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

TRUST BOARD – FEBRUARY 2019

MATTERS ARISING

CURRENT TARGETS

Target Date	Month/Minute/Item	Action with	Issue	Action	Update
February 2019	January 2019 021/19 People and Organisational Development – People and Organisational Development Report	**AK**	MN said that he struggled to see the numbers for Health Care Assistant (HCA) positions as they were categorised under additional clinical services. He asked for the exact figures for HCAs.	AK agreed provide the figures and amend the format of future reports.	*Ongoing* *The extrapolation of HCA data will be available with the next set of data reported at the People and OD committee of 4 March.* *Assurance on progress of the HCA retention programme will also be provided.*
February 2019	January 2019 013/19 Patient Story	**SH/ SC**	DL requested that the patient story be further discussed outside of Board, in particular at Quality and Performance Committee, to ensure no other patient has a similar experience. She felt all nurses on AMU should hear the audio of the story and consideration should be given to its wider use in training of Trust staff.	SH and SC would ensure this happens.	*Completed:* *The patient story has been shared with the Divisional Leadership Team, the Acute Medical Unit senior nursing team and will be shared and discussed at the Senior Nursing and Midwifery Committee in March.* *The patient story has been discussed by the Quality and Performance Committee along with an update on immediate actions taken as a result of the story.* *The mother of the patient has agreed to meet with the Director of Quality and Chief Nurse who will work to involve the family in our improvements.*

February 2019	January 2019 019/19 Quality and Performance – Learning from Deaths	**CM**	PL noted that the Trust's approach was being rolled out nationally and praised the team.	CM would highlight the Trust's achievement through comms.	*Completed:* *To be highlighted via the "Messages from the Board" section within the latest newsletter.*

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

TRUST BOARD – FEBRUARY 2019

REPORT OF THE CHIEF EXECUTIVE

1. Our Trust

1.1 I am absolutely delighted to open this month's report with the news that the Trust has been rated as GOOD by the Care Quality Commission following their recent inspection of our services. The Trust joins a group of around one third of acute hospital trusts who are rated good or better and this achievement completes the 'hat-trick' of all three NHS providers in the county being rated good by the CQC – we believe we are the only STP that can claim this accolade! As a result of this most recent inspection, 90.5 % of the Trust's services are now rated Good or Outstanding compared to 72.5% two years ago. Whilst the improvements since our last inspection have been plain for all to see, this is a very welcome endorsement by the CQC. The response from staff has been phenomenal and this rating marks an important milestone in our *Journey To Outstanding.* In their press release, the CQC commented "Since their first comprehensive inspection in March 2015, Gloucestershire Hospitals NHS Foundation Trust has implemented and thoroughly embedded improvements and I am pleased to congratulate the trust in reaching an overall rating of good. Patients we met on inspection were entirely positive about their care. We found staff to be dedicated, kind, caring and patient focused. We found clear evidence of leaders who were visible and committed to continual improvement and instilling a shared vision of high quality care". A fitting endorsement for our staff, who have worked tirelessly to deliver this result and assurance for our patients that they are officially in 'Good' hands.

1.2 Areas of outstanding practice featured in the report included a culture in which quality improvement and innovation was embedded and special praise was given to the quality of care to patients with a Learning Disability. Recent changes to service provision between GRH and CGH, such as the trauma and orthopaedic pilot, was commended, as were this year's winter plans and changes to urgent and unscheduled care services (A&E) at GRH.

1.3 The CQC rated the responsiveness of services as Requires Improvement, reflecting the long waiting times experienced by too many of our patients. This is an area that is achieving huge focus in the Trust and I am confident that our plans to improve waiting times will significantly impact in this area, as has already recently been demonstrated with the achievement of the two week cancer waiting time standard for the first time in more than two years.

1.4 The Well-led Review also resulted in a 'good' rating, demonstrating the quality of leadership across all levels of the Trust. Unsurprisingly given the recent financial status, the Trust was rated as 'requires improvement' for Use of Resources, however, the positive progress being made in managing the Trust's finances was also recognised.

1.5 Following on from December's pattern, operational pressures continued into January with some of the most challenging periods experienced so far this winter. Compounding high attendance levels at A&E and the acuity of many patients presenting has resulted in high levels of admission and bed occupancy rates. A late peak of Influenza A has further contributed to these pressures. The most significant constraint to flow and achievement of national waiting standards has been the high level of patients who are considered Medically Stable For Discharge (MSFD) but whose discharge is delayed; levels have exceeded those planned for by 50-100% across the month. Partners continue to work hard to support our aim of <50 patients in the MSFD and we are grateful for their focus.

1.6 As ever, the response from staff throughout our hospitals has been phenomenal and patients have remained safe and well cared for, albeit with waits in excess of those which we strive for. There is evidence that a number of our new services and pathways such as the AMIA (Acute Medical Initial Assessment Unit) and SAU (Surgical Assessment Unit) have contributed significantly to what would otherwise have been an even more challenging picture. With several months of winter ahead, the focus will remain on working with system partners to try and reduce reliance on hospital based care whilst supporting staff to remain resilient in the face of current demand. Despite this backdrop, the Trust has achieved the 90% A&E trajectory for quarter 3, thus securing the Provider Sustainability Funding (PSF); performance for January fell short of this standard, at 89.2% although this remains strong performance relative to the sector position.

1.7 We have now received the final planning guidance and work is well underway to ensure we achieve the requirements. The January activity submission was made on time and we are on track to submit the first draft of our Annual Operational Plan 2019/12 on the 12th February 2019. Unlike previous years, the guidance is silent on performance trajectories beyond restating the importance of the NHS Constitutional Standards. The Trust has been issued with its Financial Control Total year – this is the financial plan which our regulators expect us to deliver in 2019/20 – and the expectation is a balanced financial plan. Whilst this will feel like some way off our current financial performance, the acute sector has done well out of this year's settlement and there are a number of allocations.

1.8 On Monday 4th February, I joined staff, patients and supporters of Maggie's Centre, Cheltenham to take part in their celebrations for World Cancer Day. Under the leadership of Sally Hayes, the Centre is going from strength to strength with more than 1800 patients per month accessing support from the centre and with increasingly close working between the Centre and our own staff. I was especially heartened to hear about the focus on support to men suffering from cancer, as we know this is an area of health inequality; this has resulted in almost 25% of those using the centre being male.

1.9 A busy month on Board recruitment and I am pleased to confirm the appointment of two new Executive Directors to the organisation. Professor Mark Pietroni has been appointed as our next Medical Director: Mark's career path has been unconventional with 15 years in Bangladesh and, more recently, as Director of Public Health for South Gloucestershire. Alongside this latter role Mark has worked as an Acute Physician and most recently also as Specialty Director for Unscheduled Care, here at GHFT. Mark will take up his post on the 1st March 2019 and will continue one day of clinical practice in the Trust. Rachael De Caux has been appointed as Chief Operating Officer. Rachael is currently Regional Medical Director for NHSI South and brings with her a wealth of operational and quality improvement experience; she too has experience of both NHS and non-NHS sectors. An A&E consultant by background, Rachael was fortunate to be selected to attend the prestigious NHS Leadership Academy programme at Harvard Business School in 2014, aimed at supporting to clinicians to enter senior management positions in the NHS.

2. National and Regional

2.1 The much awaited NHS Long Term Plan has now been published and commentators are busily analysing the key messages and implications for the NHS. This was rapidly followed by publication of the guidance on tariff setting and further detail on the operational planning guidance and requirements there in.

2.2 NHS Providers, the representative voice of NHS Trusts, has produced a summary of the headlines but also their own analysis and views on the plan. They rightly observe that the plan's success will ride on the effectiveness of the 'ruthless prioritisation of key investment areas'. In the words of NHS Providers, CEO Chris Hopson 'to plan is to choose'. Alongside the yet to be published national workforce implementation plan, clarity on training and education funding, capital investment and a sustainable solution for social care funding, one cannot help but wonder whether, given these key interdependencies, we have been provided with a vision as opposed to a plan – time will tell but I wholeheartedly applaud its ambition.

2.3 Whether vision, strategy or plan the direction set out in the Long Term Plan (LTP) is useful context for our own work to develop our Trust strategy for the next five year period (2019-2024). The focus on out of hospital care, with the explicit aim of reducing pressure on emergency hospital services, alongside the intention to address the top five causes of premature death is very welcome, as is the commitment to tackle this through the lens of the inequalities that characterise early death. Given our own very significant ambitions in this space, the focus on digitally-enabled care is also music to my ears and it was good to read that we are ahead of the game in having achieved the 2021/22 milestone of every local NHS organisation having a Chief Information Officer on their Board with our recent appointment of Mark Hutchinson.

2.4 Nationally and regionally, there remains much focus on the reorganisation of roles within NHS England and NHS Improvement. Following the recent announcement that the South West Regional Director will be Elizabeth O'Mahony, currently the Chief Financial Officer for NHS Improvement and a former regional finance director in the South West, we have been informed that Elizabeth's start will be delayed to enable her to conclude some key pieces of national work. Adam Sewell-Jones, former Director of improvement at NHSI, is acting in the interim period.

3. Our System and Community

3.1 On the 18th January, Will Smart, Chief Information Officer for NHS England visited the health system and spent a day with colleagues from primary, community and secondary care hearing about vision for 'digital care'' and also seeing some of the very positive progress made in areas such as the JUYI (Joining Up Your Information) which is already enabling professionals from primary care and community services to access the records of patients and service users that they are also supporting; from the end of February, our staff will also have access to this information and, based on a recent day when I had the opportunity to shadow one of our senior registrars, it was very evident that the benefit derived from accessing the patient's GP record would be enormous. I was also able to spend some private time, describing some of the challenges associated with our own 'digital journey' and make my very best pitch (!) for Gloucestershire Hospitals to be invited to join the Global Digital Exemplar programme, as a 'fast follower' and in doing so secure additional funding to enable the acceleration of the next phase of our digital journey.

3.2 Work continues in developing the *One System* business case and notably our own contribution in respect of our vision for *Centres of Excellence (CE).* John Abercrombie, national lead for the Surgical Getting It Right First Programme (GIRFT) will be working with the Trust over a series of meetings in March and April to help us refine our vision for the CE programme through exposure to emerging national thinking and models of best practice from across the Country. Not unexpectedly, whilst the detail is being developed, some stakeholders are anxious about what this means for them and/or their patients; the Board is committed to working with staff, local communities and their representatives to ensure their views are heard and taken into consideration as we progress our work in this area. Importantly, our vision remains a strong and vibrant future for both of our main hospital sites.

Deborah Lee
Chief Executive Officer
February 2019

TRUST BOARD – FEBRUARY 2019
Lecture Hall, Sandford Education Centre commencing at 12:30

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

Purpose

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

Key issues to note

Assurance

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

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

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

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

- Since the BAF report was last presented to the Board in November, the lead Executive Directors have reviewed, and, where appropriate, revised the controls and assurances for their respective Objectives.
- Board Committees continue to undertake a detailed, quarterly scrutiny of component 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. The Audit an Assurance Committee reviews the BAF as a whole.
- The Quality and Performance Committee and the Finance and Digital Committee reviewed their respective components of the BAF at their January meetings. The People and OD Committee is due to review its component of the BAF at the next meeting (March). The Committee reviews focus on gaps in controls and assurance and the Committers, through their work programmes, ensure appropriate scrutiny of performance and risk

- An update of progress in the achievement of the Strategic Objectives is included in Appendix 1 demonstrating that:
  - 9 Strategic Objectives are rated **GREEN** and have either been delivered or are on target to be delivered by April 2019 (no change compared to Quarter 2 2018/19 – the previous reporting period)
  - 6 Strategic Objectives are rated **AMBER** (i.e. delivery at risk; previously ten).
  - 5 Strategic Objectives are rated **RED** (i.e. 'not on track to be achieved; previously one). Strategic Objective 4.2 is not RAG-rated; this reflects the fact that there is no agreed measure of progress against this objective (previously one objective – SO4.6 research) was not rated as, at the time, it was a new objective)
- The Board should also note that the research Strategic Objective (4.6) has previously not had an oversight committee. With the remit of the Quality and Performance Committee now proposed to expand to cover research, the Board is asked to assign SO 4.6 to the Quality and Performance Committee.

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

BAF ref./ SO RAG	1.1	1.2	1.3	1.4	1.5	1.6	2.1	2.2	2.3	2.4	2.5	3.1	3.2	3.3	3.4	4.1	4.2	4.3	4.6
RR entries	5	6	3	3	7	1	1	2	0	0	0	2	2	1	0	4	4	1	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.

Development of the new BAF in support of the new Trust strategy.

Recommendations

To receive the report for assurance that the risks to the Strategic Objectives are controlled effectively. To assign SO 4.6 to the Quality and Performance Committee as the oversight committee.

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 and/or TLT							
Audit and Assurance Committee	**Finance and Digital Committee**	**GMS Committee**	**People and OD Committee**	**Quality and Performance Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
	January 2019			January 2019			

Outcome of discussion when presented to previous Committees/TLT
The Committees received assurances that the risks to the strategic objectives were controlled effectively. The Committees reviewed gaps and requested management action to address. The Committees used the BAF to inform agenda/work plan 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 2	Qtr 3				
1.1			Director of Quality & Chief Nurse	Quality and Performance *and*: People and OD *(Well-led component)* Finance and Digital *(Sustainable use of resources component)*	Be rated good overall by the CQC	February 2019: Trust rated Good overall by the CQC. Objective achieved.
1.2			Director of Quality & Chief Nurse	Quality and Performance	Be rated outstanding in the domain of 'Caring' by the CQC	February 2019: Trust rated Good n the domain of 'Caring' by the CQC. Objective will not be achieved by April 2019
1.3			Chief Operating Officer	Quality and Performance	Meet all national access standards	Objective will not be achieved by April 2019 See Quality and Performance Report
1.4			Medical Director	Quality and Performance	Have a hospital standardised mortality ratio of below 100	Objective achieved
1.5			Director of Quality & Chief Nurse	Quality and Performance	Have more than 35% of our patients sending us a family friendly test response, and of those 93% would recommend us to their family and friends	
1.6			Director of Quality & Chief Nurse	Quality and Performance	Have improved the experience in our outpatient departments, reducing complaints to less than 30 per month	
2.1			Director of People	People and OD	Have an Engagement Score in the Staff Survey of at least 3.9	
2.2			Director of People	People and OD	Have a 'Staff Turnover Rate' of Less Than 11%	
2.3			Director of People	People and OD	Have a Minimum of 65% of 'Our Staff Recommending Us as a Place to Work' through the Staff Survey	RAG rating changed to amber to reflect the delays in progressing the activity of the Staff Experience Improvement Group, delayed implementation of the Accelerated

BAF code	RAG rating		Executive Lead	Oversight Committee	Objective to be achieved by 31 March 2019	Comments
	Qtr 2	Qtr 3				
						Development Pool scheme, and the need to finalise the technological approach we will adopt for online staff engagement.
2.4			Medical Director	Quality and Performance People and OD	Have trained a further 900 bronze, 70 silver and 45 gold quality improvement coaches	
2.5			Director of People	People and OD	Be recognised as taking positive action on health and wellbeing, by 95% of our staff (responding definitely or to some extent in staff survey)	
3.1			Director of Strategy and Transformation	Board	Have implemented a model for urgent care that ensures people are treated in centres with the very best expertise and facilities to maximise their chances of survival and recovery	The ICS Programme Board agreed to pause the timeline to allow for further development of the model, and additional public engagement on the care in hospital components. A Programme Director is in place in the Trust to co-ordinate wider engagement on the options for change, and modelling and testing of the operational impact of the proposals to support the next draft of the Outline Business Case. This work is overseen by GHFT's Centres of Excellence Delivery Group. Meanwhile key elements of the model of care are being delivered as 'Test and Learn' projects including trauma & orthopaedics, gastroenterology and urgent treatment centre pathways.
3.2			Chief Executive	SmartCare Programme Board reporting to Board	To complete TrakCare recovery work to enable the Trust to	

BAF code	RAG rating		Executive Lead	Oversight Committee	Objective to be achieved by 31 March 2019	Comments
	Qtr 2	Qtr 3				
					resume national RTT reporting by February 2019 (amended)	
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 and Digital	Show an improved financial position	The overall Income and Expenditure position to end December is showing a £0.7m adverse variance to plan. The forecast outturn is currently £11.0m adverse to planned control total, driven by loss of agenda for change funding within GMS, cost pressures, income under-recovery, CIP under-delivery and associated loss of PSF.
4.2		N/A	Chief Operating Officer	Finance and Digital	Be among the top 25% of trusts for efficiency	The RAG rating has been left blank due to the lack of an agreed method for measuring efficiency. That said, the identified additional CIPs and further measures have begun to be delivered. Weekly deep dives with divisions, COO (Chief Operating

BAF code	RAG rating		Executive Lead	Oversight Committee	Objective to be achieved by 31 March 2019	Comments
	Qtr 2	Qtr 3				
						Officer), Chief Nurse, Medical Director and Director of Programme Management have been established to increase pace to year end. Detailed project plans and associated quantified benefits for implementation in 2018/19 are in development, stretching to Q1 2019/20.
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	As reported to the Board in January, given the Trust remains subject to Enforcement Undertakings it will now move from Segment 4 to Segment 3 of the Single Oversight Framework; lifting of all Undertakings would most likely result in further progress to Segment 2.
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	Research & Innovation (R&I) Forum, reporting to Trust Leadership Team	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

(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.	**Unannounced core services Inspection** **Director of Quality & Chief Nurse** **Quality and Performance Committee** (Responsive/ Effective/ Safe/ Caring) **In addition** **Well-led** **Director of Corporate Governance and Director of People and Organisational Development** **People and OD Committee** **Sustainable use of resources** **Director of Finance** **Finance and Digital Committee**	**External** 1. Improvement plan in response to last CQC inspection monitored by regulatory bodies. 2. CQC Provider Inspection Review data. **Internal** 3. Board overview of sub board committee activity. 4. Board review of plans Quality and Performance Report. 5. Board review of CQC improvement plan and Quality and Performance Report, Risk Register. 6. Sub board committee review of Improvement plan in response to last CQC inspection (closely monitored by Quality Delivery Group and Quality and Performance Committee) 7. Development of a Quality Improvement Strategy.	**External** 1. Improvement plan monitored by Gloucestershire CCG (Clinical Commissioning Group) Clinical Quality Review Group (CGRG), Health Overview and Scrutiny Committee (HOSC), CQC provider engagement meeting. **Internal** 2. Division/Executive presentation and papers to the Executive Review meeting. 3. Quality monitoring at Trust Leadership Team. 4. Annual Reports from key Committees 5. Chief Executive Officer led quarterly Executive Review meetings	1. GCCG CQRG meeting and GHT reports. 2. Quality reports to Q&P. 3. CQC Provider meeting. 4. Executive review meetings for Divisions. 5. Quality Account indicators analysis. 6. Q&P Committee reports. 7. Exception reports from Divisions to QDG. 8. Exception Reports from Delivery Groups to Q&P (Cancer Services Delivery Group, Planned Care Delivery Group, Emergency	↔

		8. Benchmarking assessments by Divisions at QDG. 9. Divisional operating plans. 10. Executive Reviews of Divisions. 11. J2O visits to service e areas. 12. CQC Responsive Improvement Plan 13. Review of risk Registers. 14. Audit plan.	6. Monthly Executive Review meetings with Divisions. 7. Quality and Performance Committee (Sub-Board Committees of (Key Committees - Infection Control Committee, Hospital Mortality Indicator Group, Safeguarding Adults and Children Committee, Clinical Systems Safety Group). 8. Council of Governors meeting and Governors' Quality and Performance meeting 9. Trust Leadership Team (TLT) 10. Risk Management Group 11. Audit Committee 12. Quality and Delivery Group (CQC review Group) 13. Divisional Board Meetings (Quality Boards/ Speciality Governance meetings).	Care Delivery Group, Quality Care Delivery Group). 9. Divisional Reports and minutes to TLT. 10. Freedom to Speak Up Reports and returns. 11. Governor review of papers at CoG meeting 12. Audit and Assurance Committee meeting. 13. Internal Audit reports	

			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. 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 Divisional/Trust Risk Register		Score
C2768NIC There is a risk of avoidable infections, arising from a failure to meet some national cleaning standards and effectively manage anti-microbial prescribing in some areas.			3 x 4 = 12 (Safety)
C2667NIC The risk of poor patient experience and/or outcomes as a result of hospital acquired C.Diff infection.			5 x 2 = 10 (Quality)
C1945NTVN The risk of moderate to severe harm due to insufficient pressure ulcer prevention controls			3 x 4 = 12

C2619MDEOLThe risk of not meeting our statutory requirements due to inadequate improvement for next CQC EOL assessment. **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 year presenting with self harming behaviour who require a place of safety but do not require medical care.			(Safety) 2 x 5 = 10 (Statutory) 3 x 3 = 9 (Statutory)
Actions Agreed for any gaps	**By Whom**	**By When**	**Update**
1. Overall assurance assessment of CQC standards on wards using NAAS	Director of Quality/ Chief Nurse, Medical Director, Director for Safety	March 2019	NAAS implemented in July with ward to Board reporting.
2. Develop QDG Division exception reporting so that Issues within Divisions are monitored (enhanced surveillance) and risks that are either across Divisions or are not resolving are put into the Quality Summit process.	Director of Quality/ Chief Nurse, Medical Director, Director for Safety Deputy Director of Quality	Feb 2019	Exception reports reviewed and improved at every meeting.
3. Review of our quality measures (Ward to Board systems).	Director of Quality/ Chief Nurse, Medical Director, Director for Safety	March 2019	Quality system measurements being reviewed and agreed.
Enabling Strategies	**Oversight Group**	**Executive Committee**	
Risk Management Strategy/ risk register procedure	Risk Management Group	Trust Leadership Team	
Dementia Improvement Strategy	Quality Delivery Group	Quality & Performance Committee	
Staff Health and Wellbeing Strategy	H&W Committee	Quality & Performance Committee	
Improving Patient and Carer Strategy	Quality Delivery Group	Quality & Performance Committee	

Quarterly Progress Report Against Delivery	RAG Rating
Baseline assessment July 2017 1. 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). 2. 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). 3. Overall 73% of ratings were Good or Outstanding (an improvement from 68% in 2015). **October 2018 Update** • CQC inspected 4 core services (Medical, Urgent and Emergency Care, Surgery and OPA). • The Responsive Plan responding to our last inspection had no “red” outstanding actions and all the actions that are outstanding are moving to key committees to monitor their improvement as part of their business as usual. • The CQC Provider Information Return in July enabled us to carry out a self-assessment and we rated ourselves as Good overall after reviewing all key current data and information. • The use of resources inspection was the 18th October 2018 and it is likely that we will be rated “Good”. • The “well led” inspection is the 13-15 November 2018 and it is likely that we will be rated “Good” for that Domain. **Jan 2019 Update** • CQC will finalise their inspection findings and a validated report will be due in early February 2019. • The Quality Improvement Strategy is being tested with key staff groups and will be finalised in May 2019 after the strategic priorities are finalised. • The Quality Delivery Group is key to improving the delivery of our quality regulatory standards. **8th February 2019 Update** Trust rated Good overall. Objective achieved.	(Green)

(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	**Director of Quality and Chief Nurse** **Quality and Performance Committee (Q&P)**	Improve and sustain staff behaviours so that they meet outstanding characteristics by peer observation, role modelling, feedback and staff reward/recognition schemes which reward staff who are "going the extra mile". Implementation of Nursing Accreditation and Assessment Scheme (NAAS) for wards Improve staff engagement with patient experience data and QI work. Liaison with CQC and other trusts rated as outstanding to learn of improvement work undertaken and methodologies adopted and then implement. Implementation of GSQIA work to providing training to staff and mentoring/ coaching of projects to	1. Monitoring of responsive action plan by CQC/QDG group. 2. Improvement projects supported by Patient Experience Improvement Team and GSQIA. 3. Receipt of reports and presentations by Q&P, Governors and Divisional Boards, Divisional Quality Groups on patient experience indicators. 4. Divisional presentations and reports to Executive Reviews (monthly). 5. Matron audit reports to their Divisional Boards and quality Committees 6. Regular monitoring and analysis of key patient experience data (surveys, complaints etc).	**External** – feedback on services/patient experience provided by • National Survey Programme by CQC Patient-led Assessments of the Care Environment inspections with patient representatives **Internal** – feedback obtained from patients/ carers to 1. Board - patient experience stories 2. Quality Delivery Group 3. Governor Q&P meetings. 4. Internal Audit reports	↔

characteristics of the outstanding domain. 1.2.4 Risk that environment and use of corridors in situations of overcrowding does not support staff to maintain privacy and dignity.		improve patient experience 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.	7. Feedback obtained from patients/ carers to Board (patient experience stories), Quality Delivery Group, Governors, Q&P Committee meetings and Internal Audit report.		
			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**
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 **C2734NPatExp** The risk of reduced quality for patients approaching PALs with issues/concerns about provision hospital services.					2 x 4 = 8 (Safety) 3 x 4 = 12 (Quality)

C2619MDEOL The risk of not meeting our statutory requirements due to inadequate improvement for next CQC EOL assessment. **M2484Emer** The risk of poor patient quality due to lack of visibility of Decision to Admit times on Trakcare **M2473Emer** The risk of poor quality patient experience during periods of overcrowding in the Emergency Department **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	2 x 5 = 10 (Statutory) 3 x 3 = 9 (Quality) 3 x 4 = 12 (Quality) 3 x 3 = 9 (Safety)

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 May 2019	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 Chief Nursing Directors	End of July 2018	Complete.
PLACE inspection report action plan developed.	Deputy Director Estates/ PESG	May 2018	Complete.
Completion of compliance inspections NAAS Audits	Divisional Chief Nurses and Chief of Service NAAS Team	Continuous Continuous	Stopped due to operational pressures. Continue on a rolling programme.
Enabling Strategy	**Oversight Committee**	**Executive Group**	
Patient Experience and Carer Strategy 2015-2017.	Patient Experience Strategic Group	Quality & Performance Committee	Patient Experience Improvement Strategy updated and within Quality Improvement Strategy which in draft.

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

October 2018

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

Self assessment rating (highlighted are the areas inspected

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

Current position Jan 2019

- We are waiting for the final validated CQC inspection report which is due in Feb 2019. It is likely that we will be rated overall as good as per our self-assessment.

Update 8th February 2019
February 2019: Trust rated Good n the domain of 'Caring' by the CQC. Objective will not be achieved by April 2019

(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 This is caused by increased system demand and high medically stable for discharge.	**Chief Operating Officer (COO)** **Quality and Performance Committee**	Bi-weekly hospital-wide Task and Finish Group chaired by Medicine COS (Chief of Service) Bi-weekly Unscheduled Care operational meeting chaired by Unscheduled Care Specialty Director Monthly Emergency Care Delivery Group chaired by Director of Unscheduled Care Creation of Director of Unscheduled Care/Deputy COO role to provide focus and direction across Unscheduled Care agenda Creation of Director of System Flow role, overlapping GHT and system partners Creation of system-wide discharge team staffed by senior	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 schemes at front door led by system partners Right sized capacity allocation cross site	None	

		managers from all providers across health economy System-wide A&E Delivery Board. A hospital-wide Unscheduled care delivery plan involving all internal stakeholders to review process and patient pathways through Unscheduled Care hospital-wide System-wide discharge plan signed up to by all providers across health economy System-wide A&E Delivery action plan.			
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 & Cancer (Referral to Treatment) and Cancer.	**Chief Operating Officer (COO)** **Quality and Performance Committee (Q&P)**	RTT PTL (Patient Tracking List) (accuracy related to Trak Recovery Programme)	• Cancer capacity and recovery plans in place to forecast required capacity	Performance reports to the Q&P Committee.	↔

		PTL (Patient Tracking List) Cancer 2ww PTL daily in place; 62 d PTL in development Monthly Planned Care Delivery Group Monthly Cancer Delivery Group Creation of Director of Scheduled Care/Deputy COO role to provide focus and direction across the Scheduled Care agenda. RTT Trak Recovery Group focused on support for re-reporting of RTT Cancer capacity and recovery plans in place – providing forecast to Service lines Referral to Treatment recovery plan by speciality and aligned to Trak Recovery for re-reporting	• Work with CCG partner through Cancer Clinical Programme Group • Planned Care Delivery Group (monthly) • Check and Challenge (weekly)		
			Gaps in Control	**Gaps in Assurance**	
			• Demand outstrips capacity plans – work with system partners to support appropriate referrals • Lack of accurate patient tracking lists • Lack of demand and capacity plans for RTT (that includes the historical position)	RTT reporting.	
Potential Risk Exposure – Confirmed Risks on Trust / Divisional Risk Registers					**Mitigation**
C1748COO – The risk of statutory intervention for failing national access standards in relation to cancer.				4 x 3 = 12 (Statutory) 4 x 4 = 16 (Statutory)	

<table>
<tr><td colspan="3">C2628COO – The risk of non-delivery of appointments within 18 weeks within the NHS Constitutional standards for treatment times.

C1798COO - The risk of delayed follow up care due outpatient capacity constraints in a number of specialties including neurology, cardiology, rheumatology,ophthalmology, general surgery, urology, vascular, T&O and ENT. Risk to both quality of care through patient experience impact(15)and safety risk associated with delays to treatment(4).</td><td>3 x 5 = 15 (Quality)</td><td></td></tr>
<tr><td>Actions Agreed for any gaps</td><td>By Whom</td><td colspan="2">By When</td><td>Update</td></tr>
<tr><td>Review of system-wide demand management including review of 2ww referrals received in to the organisation.</td><td>COO</td><td colspan="2">Provided every quarter to CCG</td><td>In collaboration with CCG</td></tr>
<tr><td>Review of capacity allocation cross site.</td><td>COO</td><td colspan="2">Links in to One Place business case as part of Capital programme during 2018/19</td><td>Outpatient Programme Board STP</td></tr>
<tr><td>Validation of all PTLs, establish RTT reporting, complete demand and capacity modelling and recovery plans for delivering 18w RTT.</td><td>COO</td><td colspan="2">Links in to Trak recovery plan – cross reference with other BAF criteria/ SmartCare Q4 18/19 re-reporting of RTT</td><td>On-going validation of PTLs continues</td></tr>
<tr><td>Enabling Strategy</td><td>Oversight Group</td><td colspan="2">Executive Committee</td><td></td></tr>
<tr><td>STP (Sustainability and Transformation Plan)
Cancer Strategy</td><td>Planned Care Delivery Group
Unscheduled Care Delivery Group / ED Task and Finish</td><td colspan="2">Q&P Committee</td><td></td></tr>
<tr><td colspan="4">Quarterly Progress Report Against Delivery</td><td>RAG Rating</td></tr>
<tr><td colspan="4">See the Trust Board Quality and Performance report for comprehensive update on performance but in summary Emergency Department performance for Q3 FY18/19 was 90% – strongest performance continuing in many years and ahead of NHSE (NHS England) trajectory. Trajectory has been set for the year at 90% for the 4 hour standard.

Referral to Treatment (RTT) reporting has been suspended – see Trak Recovery Plan with re-reporting planned for Q4 18/19. Significant validation work continues and identification of key metrics to support reporting. Key information from front line validation tool which has been developed and is in use to enable reporting of RTT is being reviewed.

Cancer Delivery plan presented and endorsed by Q&P committee with planned recovery for 2ww by December 2018 and 62 days by March 2019. Significant progress to date is noted in the Q&P exception report which continues to be monitored closely for delivery. Specific actions by tumour site are detailed in the Cancer Delivery Plan.</td><td></td></tr>
</table>

(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** **Hospital Mortality Group**	1. Regular monitoring of mortality indicators though Hospital Mortality Group (HMG) 2. Agreed areas of clinical pathway work to identify improvements in care, coding and pathways 3. Neck of femur group monitoring action plan for improved care. Similar model to be applied for other care pathways as appropriate 4. Mortality database and initiation of mortality reviews though Bereavement Office. 5. Revised learning from deaths policy published in line with national guidance.	Divisional reporting to hospital Mortality summarising outcomes of Mortality/ morbidity reviews Medical Examiner (Histo-pathologist) review of all deaths reported via Bereavement Mortality Exception Report from Quality Delivery Group to Q&P Committee. Internal Audit review of PwC of mortality Review process authorised via Audit and assurance committee Close working with Dr Foster to report on HSMR, identify factors driving high rates and investigate the drivers behind these Regular reporting by division to the HMG	Monthly reporting to the Q&P Committee. Annual internal audit report presented to Audit and Assurance Committee March 2018 Dr Foster data now show HSMR within expected range and below 100 Continued reporting shows HSMR now 95.5 in the latest report and both weekend and weekday mortality are below 100.	↔

			Mortality dashboard reporting to divisional and speciality level Monitoring through Quality Delivery Group and with partners through CCG (Clinical Commissioning Group) quality monitoring group and through the joint NHSI (NHS Improvement) and NHSE (NHS England) Quality Improvement Group Mortality/ Morbidity reviews held in all clinical specialties contributing to Hospital Mortality Group Collective analysis of mortality reviews reported now performed Trauma mortality review through trauma lead Meeting of all families by the bereavement team and recording of their comments		

			Medical Examiner cohort now extended to range of specialties following interviews.		
			Gaps in Control	**Gaps in Assurance**	
			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.	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)
C2768NIC - The risk of poor patient experience and/or outcomes as a result of hospital acquired C.Diff infection.	5 x 2 = 10 (Quality)
C2768NIC – There is a risk of avoidable infections, arising from a failure to meet some national cleaning standards and effectively manage anti-microbial prescribing in some areas.	3 x 4 = 12 (Safety)
C2333MD - The risk of failure to learn from deaths as a results 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 and Quality Delivery Group	Quality and Performance Committee

Quarterly Progress Report Against Delivery	RAG Rating
• Current Dr Foster data shows a HSMR of 95.5 (Oct 2018) • Mortality dashboard now in use for learning from deaths report to the Board • The 2019 objective has been achieved • Enhanced input of Bereavement Team into death review process and recognition of Medical Examiner in national guidance • Continued consistent delivery under 100 as per target.	

(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

<table>
<tr><th>Principal Risks to Achievement of the Objective</th><th>Risk Owner (Executive Director & Committee)</th><th>Key Controls</th><th>Assurance on Controls</th><th>Current Assurances</th><th>Direction of Travel</th></tr>
<tr><td rowspan="3">1.5.1 Risk that the trust does not achieve a 35% feedback response to the Friend and Family test in following depts.

• Emergency Dept.
• Maternity
• Inpatients (inc Day Surgery)
• Outpatients

The risk is caused by patients not responding to the request from the Trust’s supplier to complete the survey and results in a decreased response rate and this would result in reduced data leading to possible gaps in the experience data.</td><td rowspan="3">Director of Quality and Chief Nurse

Quality and Performance Committee</td><td rowspan="3">1. National initiative by NHS England
Responses collated by external company prior to internal review and uploading to NHSE.</td><td>• Local review of response rate and variations noted/ acted upon
• Feedback uploaded to national website and results published monthly
• Response rate automation of requests to patients to participate
○ Text (SMS)
○ Phone call
○ On line
• Cards calculated locally
• Benchmarking with other trusts available on NHSI website of response rates</td><td>• Review of national data and benchmarking with other trusts available on NHSI website of response rates</td><td rowspan="3">↔</td></tr>
<tr><td>Gaps in controls</td><td>Gaps in Assurances</td></tr>
<tr><td>• Lack of control over response rate</td><td>• Response rate no longer monitored by NHSE</td></tr>
</table>

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

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

				2. Sentiment analysis produces unreliable data source for improvement	

Potential Risk Exposure	Related Risks on Trust Risk Register	Score
C1945NTVN – The risk of moderate to severe harm due to insufficient pressure ulcer prevention controls		3 x 4 = 12 (Safety)
C2619MDEOLThe risk of not meeting our statutory requirements due to inadequate improvement for next CQC 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)
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)
M2484Emer The risk of poor patient quality due to lack of visibility of Decision to Admit times on Trakcare		3 x 3 = 9 (Quality)
M2473Emer The risk of poor quality patient experience during periods of overcrowding in the Emergency Department		3 x 4 = 12 (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)

Actions Agreed for any gaps	By Whom	By When	Update
Reports are sent regularly to Divisional Chief Nurses and clinical areas to ensure continual focus is given.	Patient Experience Improvement Managers	Provided monthly	Divisions to act on findings
The patient experience improvement team have moved to be part of the Academy to support patient experience improvement projects.	Patient Experience Improvement Managers	Dec 2018	Complete

Sentiment analysis produces unreliable data source for improvement and so real time surveys will be introduced.	Patient Experience Improvement Managers	Jan 2019	Complete
Enabling Strategy	**Oversight Committee**	**Executive Group**	
Patient Experience and Carer Strategy 2015-2017. Patient Experience quality improvement strategy draft being reviewed.	Quality Delivery Group	Quality & Performance Committee	

Quarterly Progress Report Against Delivery	RAG Rating
Current position The current, December 2018, combined (maternity, ED, inpatient and OPA) FFT score is **91%.** In quarter 1 we met our strategic objective for FFT of 93% positive score in 1 out of 4 areas, In quarter 2 this increased to 2 out of 4 areas but the Trust overall did not meet this objective. Jan 2019 Update **1.** In quarter 3 the combined (maternity, ED, inpatient and OPA) FFT score continues to be **91%.** 2. Our strategic objective of 35% of patients responding to the FFT was not met in any area and the target set for the Trust is 10% above the national average. We also have no control over whether a patient chooses to respond to us or not. However, we do perform positively against the national average for response rate in all three domains. 3. Table 1 shows the breakdown, by quarter, of each area against the Trust targets and the national averages for quarter 1 and 2 2018/19. Please note response rates are not reported for outpatients. 4. Measurement is a critical part of testing and implementing changes; measures tell a team whether the changes they are making actually lead to improvement. The FFT question alone is not sensitive enough to assist staff with knowing where to improve services as they need to read all the comments and use the sentiment analysis tools. 5. The FFT score continues to be a balancing measure for some of our patient experience improvement projects across the services. 6. To improve the position real time surveys are being piloted and will give staff more contemporaneous insight data about what it is like to experience care in that area.	

	Strategic Objective: Have more than 35% of our patients sending us a friends and family test response, and of those, 93% would recommend us to their family and friends				
	Target 2018/19	Quarter 1 2018/19	Quarter 2 2018/19	Quarter 3 2018/19	National Average (quarter 2 2018/19 available only)
Trust positive score	93%	91%	91%	91%	N/A
Inpatient FFT positive score *(includes day case)*	93%	91%	87%	91%	95%
Emergency Department FFT positive score	93%	84%	84%	82%	84%
Outpatient FFT positive score	93%	92%	93%	93%	94%
Maternity (Birth) FFT positive score	93%	96%	94%	99%	97%
Trust response rate	35%	24%	14%	14%	N/A
Inpatient FFT response rate *(includes day case)*	35%	27%	25%	23%	26%
Emergency Department FFT response rate	35%	20%	17%	18%	14%
Maternity (Birth) FFT response rate	35%	25%	21%	24%	23%

(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

<table>
<tr><th>Principal Risks to Achievement of the Objective</th><th>Risk Owner (Executive Director & Committee)</th><th>Key Controls</th><th>Assurance on Controls</th><th>Current Assurances</th><th>Direction of Travel</th></tr>
<tr>
<td rowspan="3">1.6.1 Risk that causes of complaints relating to patients Outpatient experience are not fully understood or acted upon. This is caused by lack of resources to do regular thematic reviews and would results in a continued trend or theme being repeated leading to an impact on Trust reputation and continued poor experience.</td>
<td rowspan="3">Director of Quality and Chief Nurse

Quality and Performance Committee</td>
<td rowspan="3">External –
1. Data - we are using nationally agreed codes submitted to Department of Health

Internal -
2. Complaints Policy

3. The Outpatient Transformation Strategy ‘Journey to Outstanding - Right Patient, Right Appointment, Right Place, First Time’

4. Digital Recovery Plan for Trakcare.

5. Outpatient Department metrics and generic competencies for outpatients.

6. Analysis of themes from complaints by Patient Experience sent to Division/Executive

7. Outpatient Improvement Group</td>
<td>1. Reports to Quality & Performance Committee every quarter
2. Quality Delivery Group and Safety & Experience Review Group bi monthly.
3. CBO (Central Booking Office) operational report monthly
4. Outpatient appointments complaints review and Outpatient Improvement Group.</td>
<td>1. Reports show that number of complaints that have an outpatient experience element to them have declined.
2. Review of complaints data on a regular basis.</td>
<td rowspan="3">↔</td>
</tr>
<tr><th>Gaps in Controls</th><th>Gaps in Assurance</th></tr>
<tr><td>Challenges by external stakeholders about actions implemented as a result of complaints or Trust volunteering information</td><td>Detailed diagnosis of issues within the OPA complaints from Datix as each complaint letter needs to be read.</td></tr>
</table>

		8. Outpatient Senior Nurse Forum 9. Complaints Report with themes / serious complaints through Q&P			
Principal Risks to Achievement of the Objective	**Risk Owner (Executive Director & Committee)**	**Key Controls**	**Assurance on Controls**	**Current Assurances**	**Direction of Travel**
1.6.2 Impact of changes implemented in out-patients not reflected by reduction in complaints as 200,000 outpatient appointments every quarter	**Director of Quality & Chief Nurse** **Quality & Performance Committee**	Quality Improvement project being led by the Outpatient Matrons and Deputy Head of Patient Experience	Every outpatient complaint for 1 month reviewed by the Deputy Head of Patient Experience to see themes and trends.	Report demonstrates number of complaints has declined.	↑
			Gaps in Controls	**Gaps in Assurance**	
			Each complaint has to be reviewed to see if it has an outpatient element to it and then marked for review.	The Nursing Assessment and Accreditation Assessment system not yet rolled out to Outpatients Department	
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	1. Review of complaints data on a regular basis.	↑
			Gaps in Controls	**Gaps in Assurance**	

Potential Risk Exposure	Related risks on Trust Risk Register		**Score**
D&S2556OPD - Risk of poor patient experience and outcomes due to patient unknowingly being transferred to hold file and not being actioned			2 x 3 = 6 (Quality)
Actions Agreed for any gaps	**By Whom**	**By When**	**Update**
Data presented to Operational Delivery Committees so that reports can be produced.	Deputy Head of Patient Experience Improvement	Monthly	
Enabling Strategy	**Oversight Committee**	**Executive Group**	
Outpatient Transformation Strategy	Planned Care Board / D&S Board	Quality & Performance Committee	

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

Baseline information

- Across the organisation, approximately 200,000 outpatient episodes provided every quarter.
- Prior to the implementation of the IT system Trakcare the number of complaints for outpatients' episodes of care was approximately 30 per month (as reported to PESG in November 2016).
- In April 2017, Outpatient complaints rose to 96 for that month and peaked at 120 in July 2017.
- The Trust received **91** outpatient related complaints in Q1 and so we have now achieved the objective which is an average of 30 complaints per month (these are complaints that have an issue assigned as Service Area – Outpatients).

Current position

The Trust has set a target of 35 working days for response times and so only Q2 data is complete.

The Trust received **81** outpatient related complaints in July August September Q2 data. We have now achieved the objective which is an average of 30 complaints per month (these are complaints that have an issue assigned as Service

Area – Outpatients). **Jan 2019 Update** • The Outpatient Transformation Strategy is being delivered and this is being monitored through the OPA Improvement Group ***'Journey to Outstanding - Right Patient, Right Appointment, Right Place, First Time'***. • The Central Booking Office (CBO) continues to see significant improvement its KPIs. • The new telephone system has now embedded and there has now been a reduction in the complaints received to 30/month.	

(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.	**Director of People and Organisational Development (OD)** **People and OD Committee**	• Engagement events such as: – 100 Leaders – Extended Leader Network – Divisional/ Local initiatives and management forums – Medical Education Board – Diversity Network – Executive walkabouts – 'Back to the floor' – Involve – Weekly CEO Blog – Freedom to Speak Up promotion. • Staff survey action plan process informing action planning at a Divisional level and trust wide priorities. • Triangulation of in-patient and staff survey	1. People and OD (POD) Delivery Group and POD Committee 2. Freedom to Speak up annual report to People and OD Committee 3. Staff Experience improvement Group, inc. Staff survey reports and updates. 4. Executive Review 5. Escalation of issue through Health and Safety Committee to Executive Colleagues. 6. Escalation of issues to Executive Colleagues via a range of communication methods (i.e. open door policy)	1. Regular report to People and OD committee via. Update on priorities and staff survey reports. 2. Annual Staff Survey Report cascaded at all levels across the organisation. 3. Freedom to Speak up annual report to People and OD Committee.	↑

		• Staff engagement and formal consultation and working groups such as: – Local Negotiating Committee (medical staff) – JSCNC (TU) – Divisional and Trust Health and Safety Forums.	**Gaps in Control** Lack of triangulation of staff data relevant to engagement, whilst we recruit to the post of staff experience co-ordinator. Management of low level/ informal operational change (as opposed to change requiring formal consultation and stakeholder engagement).	**Gaps in Assurance** Gap in reporting triangulation of data (whilst we develop this role) means reporting to People and OD Committee is limited to staff experience reporting and doesn't currently triangulate patient experience data	

Potential Risk Exposure – Confirmed risks on Trust / Divisional Risk Registers	Score
C2803P&OD – The risk of continued poor levels of staff engagement is that our staff experience will impact negatively on retention, recruitment and patient experience.	3 x 3 = 9 (Workforce)

Actions Agreed for any gaps	By Whom	By When	Update
Development of 'Staff Experience Improvement Group' to implement a range of staff engagement, health and wellbeing actions and begin triangulation of data relating to staff experience. The group replaces the former Staff Health and Wellbeing Group and Staff Engagement Steering Group.	Head of Leadership and OD	September 2018 (met May 2018)	Complete
Development of informal change toolkit for managers and leadership support. Present draft concept and leaders checklist at 100 Leaders and Extended Leader Network Jan 2019	Deputy Director of People and OD	January 2019	Complete
Enabling Strategy	**Oversight Group**	**Executive Committee**	
Workforce Strategy	People and OD Group	People and OD Committee	

Quarterly Progress Report Against Delivery	RAG rating
• We reduced delivery progress to 'amber' in July 2018 as the Staff Engagement score for 2017 reduced from 3.71 to 3.67. (Nationally the average engagement score for acute trusts also dropped from 3.81 in 2016 to **3.79** in 2017) • Key Staff Survey themes and actions reported to the People and OD Committee, Oct 2018. • Risk updated and added to Datix, Oct 2018. • The 'Staff Experience Improvement Group' are overseeing key work such as: HCA retention plan, whilst developing capability to triangulate data. HCA Turnover project which convened focus groups to seek feedback, which in turn has made recommendations. Feedback to HCA groups planned for 25/10/18. • Staff Survey launched with additional questions relating to Health and Wellbeing Oct 2018. • Established new Extended Leadership Network aimed at mid-level managers (Network met in August and November 2018) • Established GM/AGM Forum and Operational Matrons Group • Monthly Diversity Network coffee socials and bimonthly meetings • Promotion of Freedom to Speak Up Friday and FTSU week, develop the role of FTSU ambassador • Relaunch of Schwartz rounds • Launch of Nurse Accreditation and Assessment Scheme (NAAS) • Engagement at all levels of Trust to seek feedback on Journey to Outstanding #J2O and ideas for new trust strategic objectives • Increased usage of social media to promote and celebrate great work in Trust using #J20 • Jan SEIG 2019 reviewed Nurse exit study findings, incorporating lessons learnt into redesign of exit interviews. • Organisational change toolkit developed, however not yet rolled out (100 leaders agenda revised due to operational pressures).	

(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.	**Director of People and OD** **People and OD Committee**	1. Multiple daily operational safer staffing calls with escalation process to Chief Nurse. 2. Two yearly review of safe HCA and nursing levels via national models of safety 3. NAAS strategy 4. Vacancy Control Panel (VCP) process enabling speedier fill to post process 5. VCP cost control, agency & bank 6. Investment into recruitment team 7. Recruitment & Selection Policy and Task Group. 8. Exit Interviews 9. Sustainable Workforce and ELD Priorities 10. Recruitment Strategy Group - **linked** to demand and supply routes, student attraction n and increased HE engagement. 11. Dedicated HRBP resource leading on strategic development of sustainable workforce (ACPs, TNAs, Apprentices) 12. New Talent Development System	1. Workforce Sustainability & ELD group priorities 2. Divisional workforce plans include action plans for hard to fill roles & forward planning 3. Human Resources Business Partner and Finance Business Partners involvement in vacancy projection 4. Workforce plans to be aligned to operational capacity and demand work within divisions 5. Education work strands to improve career planning & career routes/pathways 6. Bespoke retention projects and listening events (i.e. band 5 nurses) 7. STP work to reduce competitive recruitment between STP partners 8. Robust Training plans for all staff grades and provision for staff to develop themselves	1. Operational dashboard published with trends and future projection at People and OD committee 2. Bi-annual Education, learning and development report to People and OD Committee 3. Sustainable workforce report to People and OD Committee 4. STP update & impact included in People and OD report to Board 5. Escalation to People and OD Delivery Group, TLT. 6. Executive Review Challenge re: recruitment and retention priority plans.	↑

		13. Defined development / career pathway support through professional education 14. Focused workstreams supporting reduction in turnover – such as HCA turnover project, medical secretary support.	15. Coaching offer STP leadership behaviour definition		
			Gaps in Controls	**Gaps in Assurance**
			1. Talent Management 2. Limited compliance with exit interviews 3. Integrated Workforce Plans	1. **One version of data** – Finance and HR records on establishment do not accurately match impacting on vacancy data transparency. 2. Review of HCA terms and conditions 3. Review of Exit Interview Process 4. Streamlined Junior Doctor onboarding process.

Potential Risk Exposure – confirmed risk entries on Trust Divisional Risk Registers	Score
C1437P&OD – The risk of being unable to match recruitment needs with suitably qualified clinical staff (including: AHP's, Nursing and Medical), impacting on the delivery of the Trusts strategic objectives.	2 x 4 = 8 (Workforce)
S2275 - The risk of workforce issues with staff well-being arising from an on-going lack of staff able to deliver the emergency general surgery rota due to reducing staffing numbers and vacancies.	4 x 4 = 16 (Workforce)

Actions Agreed for any gaps	By Whom	By When	Update
1. Robust talent management system to link development opportunities with succession planning and career management	Head of Organisational Development	July 2018	Complete.

2. One version of data – Finance and HR records on establishment do not match	Deputy Director of People and OD	September 2018	Organising data via professional group. Delayed launch to April 2019.
3. To continue to develop Nurse Associate roles, Nurse apprenticeships and advanced clinical practice	Chief Nurse /Director of Quality	August 2018	First cohort due to complete April 2019.
4. Doctors in Training Streamlining Programme, to ensure new starters & potential joiners have the best experience within the Trust	Medical Staffing Manager	August 2018	National pilot postponed, however key principles adopted by GHT. Awaiting national system update, expected Jan 2019.
5. Review of HCA terms and conditions	Deputy Director of People and OD	August 2018	Presented to TLT, and Business Development Process. Now subject to cost pressure discussion.
6. Review of Exit Interview Process	HR Advisory Team	December 2018	Complete – lessons learnt shared with SEIG , Jan 2019.
7. Mentorship Programme Launch	Head of Organisational Development	April 2019	Toolkit complete – launch pending (100 leaders event reprioritised)
8. Development of informal change toolkit for managers and leadership support. Present draft concept and leaders checklist at 100 Leaders and Extended Leader Network Jan 2019	Deputy Director of People and OD	January 2019	Staff Experience Co-ordinator and Onboarding Co-ordinator recruited to (start dates Jan/ Feb 2019).
9. Recruitment to key posts : Staff Experience Co-ordinator, Onboarding Co-ordinator and Recruitment Manager	Head of Workforce Resourcing and Head of Organisational Development	December 2018	Recruitment Manager post remains vacant, interim search underway.
10. Develop workforce plans, aligned to operational planning round – upload into centralised NHSi workforce plan, which links to ICS plan.	Deputy Director of People and OD	February 2019	Draft plans scheduled for review 30 Jan 2019 (on track)
Enabling Strategy	**Oversight Committee**	**Executive Group**	
Workforce Strategy	People and OD Committee	People and OD Delivery Group TLT Executive Review	
Quarterly Progress Report Against Delivery			**RAG Rating**
Recruitment Improvements • The recruitment steering group is now well established.			

- Recruitment activity has increased phenomenally, including bank recruits and internal moves. Substantive recruitment to hard to fill posts remains a significant challenge.
- Marketing campaigns are being finalised, with improvements now made to JD's and adverts and divisions supporting with job biographies and increased engagement with teams.
- Exploring cross STP DBS portability and pre-hire IAT with 2G and GC
- Re-write of DBS policy and guidance (key principles agreed, policy draft in progress)
- Onboarding co-ordinator post being advertised, to support increase new starter care and engagement.
- NQN Open Day (End of Sept), offers made to 38 NQNs to start Spring 2019.
- HCA assessment day review has supported increased volumes of new recruits, especially to our Bank.
- Career Fair plans are in progress – the Trust visited Dublin in October 2018 and is scheduling 2019 events, to include events in Australia aimed at Nurse Recruitment.
- Recruitment Newsletter produced and launched Oct 2018
- We are participating in national workshops via NHSi sharing best practice on recruitment and retention and continue to share best practice across the ICS.
- Operational workforce plans developed with Divisions for 2019/20 to include local risks and mitigation, linking to Trust wide and ICS workforce plans.

ACP

- A number of pockets of work around the development of ACPs have already taken place; this project has focused on pulling this work together into a strategy for the development of ACPs which helps to mitigate the risk articulated above.
- The ACP role has now been defined with an emergent 'advanced practice' map, which clarifies the characteristics belonging to the different roles falling under the umbrella of advanced practice, such as: ACP, Nurse Practitioner, Clinical Nurse Specialist, Consultant Nurse.
- The organisational 'heat map' has been outlined, indicating where we need ACP roles and which areas take priority for the development of ACPs.
- We have engaged with a number of other acute Trusts and Gloucestershire ICS. Specifically collaborating with Derby (who now have 77 ACPs in post) we have visited site and met with service leads to understand their lessons learnt so far.
- Routes to entry have been identified : Including internal development and external recruitment pathways (Qualified/ Part Qualified/ Unqualified)
- We have begun to compile the 3 year training programme and engage with UoG, UWE and other HEIs to explore how we can make this programme work in practise. Some modules will be funded through the HEES ICS transformation funding; others may be achieved through a Masters level Apprenticeship.

Trainee Nurse Associates • First "Fast-Follower" cohort of 11 Trainee Nursing Associates due to complete in GHT in April 2019 • Shared Countywide procurement exercise appointed University of Gloucestershire as the apprenticeship provider • Second "legacy" cohort of 19 commenced Apprenticeship programme on 24th September. (42 across the ICS footprint) **Clinical Nurse Fellows** • Established new Clinical Nurse Fellows programme to both attract new first/2:1 degree band 5 nurses and retain/develop existing Band 5 nurses. • Day 1 of programme commenced on 20th September to include in-house induction and enrolment on to the Level 3 Leadership Apprenticeship. Only 3 started, but very high quality individuals with good quality improvement projects proposed. **Apprenticeships** • Continual development of new apprenticeships to "grow our own" and increase access to qualifications as Healthcare standards emerge nationally • Some - slow progress made with developing an ICS approach to apprenticeships (shared procurement, documentation, leadership programmes) **Numbers of Nurse Degree Students on placements** • Expansion of nurse student placements and partnerships with Worcester, Oxford Brookes as well as involvement in the National HEE RePAIR project to reduce Student Nurse attrition and transition shock to NQ nurse. **Joint People and OD , Q&P Committee** Meeting held to review safe staffing levels, further work underway to ensure compliance with NHSi guidance from April 2019 re: triangulating safer staffing across professional groups.	

(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 – Extended Leader Network – Divisional/ Local initiatives and management forums – 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	1. People and OD (POD) Delivery Group and POD Committee 2. Workforce Sustainability & ELD (Education Learning and Development) group 3. Divisional plans for hard to fill roles & forward planning 4. HRBP (Human Resources Business Partners) & FBP (Finance Business Partners) involvement in vacancy projection 5. Education work strands to improve career planning & career routes/pathways 6. Robust training plans for all staff grades and provision for staff to develop themselves 7. Coaching offer 8. STP (Sustainability and Transformation Plans) leadership behaviour definition	1. Annual staff survey report to workforce Committee 2. Scrutiny of employee issues at People and OD (POD) Delivery Group 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	→

		Monitoring and intervention/ action relating to exit interviews, grievances and turnover data.	9. Leadership development programmes to improve management skills and approach 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 19. TLT (Trust Leadership Team) and DOG (Directors Operational Group) process 20. Back to floor days 21. Datix review & feedback	6. Monitored through Executive Divisional Reviews/Divisional Board structure.	

			22. Internal Comms agenda and intranet use for key messages & blogs. 23. Listening events 24. Involve 25. SD Forum 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
Recruitment of a coordinator to support collation and analysis of staff experience data, and help drive forward the Staff Experience Improvement Group activity and effectiveness. Also to support implementation of Accelerated Development Pool scheme.	Head of Leadership & OD	January 2019	Complete Recruited to, start by Feb 2019.
Finalise approach to supporting online staff engagement with app/electronic opportunities in liaison with Comms & IT	Head of Leadership & OD	January 2019	
Development of the Staff Experience Improvement Group, in order to triangulate themes and ensure appropriate intervention	Chaired by Deputy Director of People and OD	First meeting June 2018	Completed

Enabling Strategy	Oversight Committee	Executive Group	
Workforce	People and OD Committee	Trust Leadership Team	
Quarterly Progress Report Against Delivery			**RAG Rating**
Staff Experience Improvement Group meetings have continued. Whilst we await for our new coordinator to start the group has reframed as a steering group (like the V&A steering group operates) – with task & finish groups beneath it which focus on specific projects and initiatives. The group will consider the experience of staff in terms of: entry/beginning; middle; end/departure. Jan 2019, the group reviewed lessons learnt from Nurse Exit review. Additional events launched in 2018 include: Diversity Network (bimonthly network meetings and monthly informal coffee socials); Extended Leadership Network; General Manager/AGM Forum; Focus groups with HCAs to seek feedback on their experiences; Gem Monthly staff/quarterly team awards; Promotion and embedding of Freedom to Speak Up Guardian; Relaunch of Schwarz Rounds; Nurse Accreditation & Assessment Scheme (NAAS); Trust-wide engagement on J2O and ideas for new Trust strategic objectives; Increased use of social media to promote and celebrate great work: #J2O; New approach to appraisals (paperwork) and talent development (Accelerated Development Pool Scheme); Launched Staff Experience Improvement Group to review data and identify themes for action RAG rating changed to amber, to reflect the delays in progressing the activity of the Staff Experience Improvement Group, delayed implementation of the Accelerated Development Pool scheme, and the need to finalise the technological approach we will adopt for online staff engagement.			

(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. Performance against programme monitored for reasons of non-attendance.	Feedback to GSQIA members/ divisions by quarterly newsletters of numbers attending and progress of projects 6 monthly reports of GSQIA progress to QPC Monitoring of numbers trained through the GSQIA (Gloucestershire Safety and Quality Improvement Academy) Approval of Quality Framework to include plans for training for staff at TLT	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 GSQIA New date for six month report to be added to work plan	Medical Director Medical Director\Director of Corporate Governance	September 2019 December 2018	Report removed from Sept 18 agenda to reduce size of agenda new date to be agreed 6 month report to QDG
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 has been agreed at TLT. Staff in that role will then engage with the programme. Numbers of staff completing courses (excluding Non GHT staff): Bronze = 1768 (up from 1670 last quarter) Silver = 113 (up from 86 last quarter) Gold = 8 (up from 6 last quarter, and 18 people recently recruited)	

(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 OD** **People and OD Committee**	1. Workforce Strategy 2. Health & Wellbeing strategy 3. Health promotion programmes 4. Provision of staff support programmes 5. Catering 'healthy options' on site 6. Health and Wellbeing web resource 7. Sickness management policies. 8. Health and Safety policies 9. Access to occupational health services.	1. Monitoring and control of sickness absence. 2. Reprioritised work programme for 2018 to simplify employee Support Services 3. Diversity network 4. Staff Health and Wellbeing Steering Group 5. Bespoke questions on this year's staff survey to get views on health-wellbeing services currently offered to staff	1. Annual staff survey report to People and OD Committee 2. Monthly data on absence reviewed by HR Advisory Team and included in People and OD Dashboard. 3. Annual health & wellbeing report to People and OD committee 4. Sickness absence levels/ reasons for absence monitored through Executive Divisional Reviews/Divisional Board structure	↔
			Gaps in Control	**Gaps in Assurance**	
			Inability to track sickness cases effectively with 'triggers' to expedite and monitor casework compliance, ensuring staff access timely support.	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 on P&OD risk register or Trust risk register			
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	High level concept of health-wellbeing "one stop shop" developed and being shared with stakeholders to get feedback. This includes exploring options for provision of an Employee Assistance Programme. Draft Business Plan due Feb 2019 (on track)
Launch "Staff Experience Improvement Group"	Head of Organisational Development	September 2018	Complete
Improve the triangulation of data relating to staff experience, to enable in depth analysis and targeted intervention.	Head of Organisational Development	October 2018	Recruited to Co-ordinator role due to start by Feb 19.
Secure HR case management system to support improved tracking of casework, ensuring timely intervention.	Deputy Director of People and OD	Business case to PODG – Dec 18. (within existing budget)	Completion of business case delayed until March 2019 PODG
Enabling Strategy	**Oversight Committee**	**Executive Group**	
Staff Health and Wellbeing Strategy/Workforce Strategy	People and OD Committee		
Quarterly Progress Report Against Delivery			**RAG Rating**
• Project plan for the Health and Wellbeing One Stop shop has been launched, with a dedicated task and finish group. Work to scope the re-provision of Occupational Health services has commenced, involving key stakeholders and our internal infection control lead. • Reasonable adjustments guidance has now been developed, with staff side and HR Advisors, to support both staff and managers with adjustments in the workplace for staff with disabilities. • H&WB pathway development is underway, with key elements of the H&WB offer (such as Occupational Health provision) under scrutiny and redevelopment. • Coordinator role for the staff experience improvement group has been recruited to (start date pending).			

(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

<table>
<tr><th>Principal Risks to Achievement of the Objective</th><th>Risk Owner (Executive Director& Committee)</th><th>Key Controls and Mitigation</th><th>Assurance on Controls</th><th>Current Assurances</th><th>Direction of Travel</th></tr>
<tr><td rowspan="3">Risk of stakeholder opposition to future system reconfiguration proposals as part of the STP One Place Programme, due to a lack of information/ clarity on the proposed risks and benefits of the model (case for change) and/or poor stakeholder engagement, that could result in a delay to implementation and realisation of benefits to patients and staff.</td><td rowspan="3">Director of Strategy and Transformation

Main Board</td><td rowspan="3">1. Detailed implementation plan with modelling of impact of service changes (to patients, partners and staff) as part of the STP One Place Programme
2. Increased staff, patient and public involvement in the model design
3. Impact Assessment and Quality Impact Assessment of all proposals
4. Risk assessments of operational processes
5. Outline Business Case & Full Business Case through Trust Board (and ICS Delivery Board)
6. NHSE (NHS England) stage 2 Assurance Process</td><td>Full Business Case including impact assessments.</td><td>Strategic Outline Case June 2017 Output from NHSE (NHS England) stage 1 assurance.</td><td rowspan="3">↑</td></tr>
<tr><th>Gaps in Control</th><th>Gaps in Assurance</th></tr>
<tr><td>None</td><td>None</td></tr>
<tr><th colspan="4">Potential Risk Exposure – confirmed risks on Trust / Divisional Risk Registers</th><th colspan="2">Risk score</th></tr>
<tr><td colspan="6">National political processes could introduce delays into the proposed timetable.
Unexpected increase in demand for services.</td></tr>
<tr><td colspan="4">• C1748COO - The risk of statutory intervention for failing national access standards in relation to cancer.</td><td colspan="2">4 x 3 = 12 (Statutory)

3 x 4 = 12 (Quality)</td></tr>
</table>

- **M2473EMER -** The risk of poor quality patient experience during periods of overcrowding in the ED (Emergency Department).

Enabling Strategy	Oversight Committee	Executive Group	
GHFT Trust Strategy GHFT Clinical Strategy (under review) One Gloucestershire STP (Sustainability and Transformation Plan)	Centres of Excellence Delivery Group reporting to Trust Leadership Team [ICS New Models of Care Board + ICS Delivery Board]	Main Board	

Quarterly Progress Report Against Delivery	RAG Rating
Outline Business Case for new system wide clinical model for urgent care completed in draft form in August. The ICS Programme Board agreed to pause the timeline to allow for further development of the model, and additional public engagement on the care in hospital components. A Programme Director is in place in the Trust to co-ordinate wider engagement on the options for change, and modelling and testing of the operational impact of the proposals to support the next draft of the Outline Business Case. This work is overseen by GHFT's Centres of Excellence Delivery Group. Meanwhile key elements of the model of care are being delivered as 'Test and Learn' projects including trauma & orthopaedics, gastroenterology and urgent treatment centre pathways.	

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

Principal Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls and Mitigations	Assurance on Controls	Current Board Assurances	Direction of Travel
3.2.1 Risk that the data quality improvements necessary to support a return to reporting are not achieved	**CEO (Chief Executive Officer) as SRO (Senior Responsible Owner) of SmartCare Programme** **SmartCare Programme Board reporting to Finance and Digital Committee**	1. Comprehensive data quality cleansing programme in place 2. Development of SOPs and training of all staff inputting data affecting RTT reporting 3. Tracking of progress through Trakcare Operational Recovery Group 4. Working with Yeovil who have commenced reporting from TrakCare. 5. Oversight by Trust leadership Team and Finance & Digital Committee	Weekly TrakCare Operational recovery Group Recovery Progress Report to SmartCare Programme Board	Monthly reports to Main Board on programme performance and future reporting to Finance and Digital Committee	↑
			Gaps in Control	**Gaps in Assurance**	
			Limited influence over supplier actions and decisions which impact on objective	None	

Principal Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls and Mitigations	Assurance on Controls	Current Assurances	Direction of Travel
3.2.2 Risk that necessary system configuration and work is not completed to proposed timeline	**CEO as SRO of SmartCare Programme**	1. Recruitment to system configuration team 2. Working with other TrakCare users who are reporting RTT e.g. Yeovil	Weekly Trakcare Operational recovery Group Recovery Progress	**Monthly reports to Main Board on programme performance.** and future reporting to Digital Committee	↑

	SmartCare Programme Board reporting to Finance and Digital Committee	3. Two planned 'test cycles' to identify any issues in advance of returning to reporting.	Report to SmartCare Programme Board		
			Gaps in Control	**Gaps in Assurance**	
			Limited influence over supplier actions and decisions which impact on objective	None	

Potential Risk Exposure – confirmed risks on Trust/ Divisional Risk Registers	Score
F2723 Risk that FY19 income recovery will be reduced as a result of being unable to submit accurate data to commissioner to support payment, arising from current issues associated with TrakCare implementation **C2628COO** The risk of regulatory intervention (including fines) and poor patient experience resulting from the non-delivery of appointments within 18 weeks within the NHS Constitutional standards.	**4 x 3 =12 (Finance)** **4x4=16 (Statutory)**

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

Quarterly Progress Report Against Delivery	RAG Rating
• Detailed project plan developed and presented to SmartCare Programme Board. • First test cycle complete resulting in changes to RTT scripts • First cycle of operational validation completed and shadow RTT performance produced	

(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

<table>
<tr><th>Principal Risks to Achievement of the Objective</th><th>Risk Owner (Executive Director & Committee)</th><th>Key Controls and Mitigation</th><th>Assurance on Controls</th><th>Current Assurances</th><th>Direction of Travel</th></tr>
<tr><td rowspan="3">3.3.1 Risk that resources are not available to achieve compliance. (themes, coding and failure to comply with specialty national data reporting)</td><td rowspan="3">Director of Strategy and Transformation

Quality and Performance Committee</td><td rowspan="3">1. GIRFT reports for T&O, Vascular, Urology, OMF, Urology, Vascular, Paediatric Surgery, General Surgery and ENT have had reports and have action plans in place.
2. Renal, Dermatology, Breast, Endocrinology, ED, Anaesthetics and Diabetics have received a visit to report but await an action plan from the national GIRFT Team.
3. Cardiology, Radiology, Rheumatology and Respiratory have received a questionnaire to complete so that the national team can prepare a report.
4. Any required business cases to deliver compliance to be considered through Planning Cycle.
5. The two services most likely to reach completion of actions are T&O and Paediatric Surgery</td><td>• GIRFT (Getting It Right First Time) Governance Framework has been revised to provide a Clinical Lead into which all specialties report with an annual meeting with the executive team.
• A report should be shared at Q&P Committee.</td><td>Governance Framework review to be endorsed at Q&P in February 2019 (Quality & Performance) Committee

GIRFT standing agenda item on Divisional Reviews.</td><td rowspan="3">↑</td></tr>
<tr><th>Gaps in Control</th><th>Gaps in Assurance</th></tr>
<tr><td>• The new governance framework should address any gaps in control</td><td>• Work to be undertaken to enhance engagement with communications teams and Divisional Boards</td></tr>
</table>

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 consultation material 5. Clinical leadership of engagement activities.	• NHSE (NHS England) Assurance Process • SW Clinical Senate Assurance process.	• Strategic Outline Case June 2017 • Output from NHSE stage 1 assurance.	↔
			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 to be regular reporting item on Q&P committee	Director of Clinical Strategy	July 2017 meeting cycle	Completed
Review of governance process undertaken with recommendations	Medical Director & CEO	December 2018	Approved and Completed
Interviews to appoint a GIRFT Clinical Lead	Medical Director, deputy medical Director & PMO	January 2019	Completed
Formal reporting timetable to be set up	GIRFT Clinical Lead & PMO	February 2019	In progress
Gap analysis of actions plans to determine priority services to secure compliance	GIRFT Clinical Lead & PMO	March 2019	Being progressed through Quarterly reviews
Escalation Reports from Quarterly meetings to Divisional Boards	Clinical GIRFT Lead & PMO	March 2019	Quarterly EDR minutes to be presented to TLT; TLT minutes received by Board

Enabling Strategy	Oversight Group	Executive Committee	
Centres of Excellence Strategic Outline Case Divisional Business Plans 2018/19 & 19/20	New Quarterly meeting with GIRFT Clinical Lead and annual executive review	Quality and Performance Committee	
Quarterly Progress Report Against Delivery			**RAG Rating**
Action plans following each review developed within specialties who have received a report. Progress reviewed in Quarterly Reviews and Annual Executive Reviews			
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. Reconfiguration of General Surgery in progress with proposed start date October 2019. Reconfiguration of estate for Urology Team enabling completion of several actions. All other GIRFT schemes where recommendations have been submitted to the Trust are being reviewed by the PMO to ensure progress against the recommendations are achieved and captured.			

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

<table>
<tr><th>Principal Risks to Achievement of the Objective</th><th>Risk Owner (Executive Director & Committee)</th><th>Key Controls and Mitigation</th><th>Assurance on Controls</th><th>Current Assurances</th><th>Direction of Travel</th></tr>
<tr><td rowspan="3">Risk that staff will not be able to access training due to lack of availability or difficulty being released from roles.</td><td rowspan="3">Director of Strategy and Transformation

Health and Wellbeing Group</td><td rowspan="3">1. Identification of target staff in all clinical areas
2. Training offer clarified with HLSGlos
3. Training programme agreed</td><td>Number of sessions held and uptake reports to H&W Group</td><td>High-level reports to Health and Wellbeing Group.</td><td rowspan="3">↔</td></tr>
<tr><td>Gaps in Control</td><td>Gaps in Assurance</td></tr>
<tr><td>None</td><td>None</td></tr>
<tr><th>Potential Risk Exposure</th><th colspan="3">Related risks on Trust Risk Register</th><th></th><th></th></tr>
<tr><td>None</td><td colspan="3">None</td><td></td><td></td></tr>
</table>

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

Quarterly Progress Report Against Delivery	RAG Rating
• Reporting schedule to Health and Wellbeing Group established • 26 more staff have undergone face to face Make Every Contact Count (MECC) training since the last report – further sessions due to take place (including for members of the Trust H&WB Group). Increased publicity for the sessions. • E-learning training is also available on Trust training platform.	

(4.1) Strategic Objective – Show an improved financial position

<table>
<tr><th>Principal Risks to Achievement of the Objective</th><th>Risk Owner (Executive Director & Committee)</th><th>Key Controls</th><th>Assurance on Controls</th><th>Current Assurances</th><th>Direction of Travel</th></tr>
<tr><td rowspan="3">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 Plan.</td><td rowspan="3">Director of Finance

Finance and Digital Committee</td><td rowspan="3">1. Regular (twice weekly) conference calls with NHSI (NHS Improvement)
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 FY19 programme (including monitoring and reporting of performance against target)
4. Turnaround Implementation Board scrutiny of CIP 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</td><td>1. Finance Report
2. Audit reports
3. CIP (Cost Improvement Plan) Report
4. Performance reporting.</td><td>1. NHSI agreement to Financial Recovery Plan
2. Initial Deloitte review and implemented actions.</td><td rowspan="3">↓</td></tr>
<tr><th>Gaps in Controls</th><th>Gaps in Assurance</th></tr>
<tr><td></td><td>Reliable data for activity impacting billing and income recovery.</td></tr>
</table>

		7. SmartCare Programme Board overseeing Trak 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 9. Year end position reforecast and Board Assurance process undertaken – ongoing monitoring and recovery plan in place			

Potential Risk Exposure	Related risks on Trust Risk Register	**Risk score** *(all for finance domain)*
• **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 4 = 20 (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		4 x 4 = 16 (Finance)
• **F2335** - The risk of agency spend in clinical and non-clinical areas exceeding planned levels due to ongoing high vacancy levels, with resulting impact of delivery of FY19 CIP programme		4 x 4 = 16 (Finance)

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 favourable variance to plan for period to end December – forecast to under-deliver by M12..
Progress/slippage is tracked and reported weekly to Executives (through the dashboard) and monthly via other forums including to the Finance Committee.	Director of CIP PMO	Ongoing	
TIB chaired by the CEO (Chief Executive Officer) to reiterate the importance of CIP delivery and to support the resolution of any escalated issues.	Director of CIP PMO	Ongoing	
Finance business partners work with divisions to recover slippage and identify mitigating actions Escalation to Director of Finance where Executive intervention required (part of Executive reviews).	Director of Operational Finance	Ongoing	Overall I&E (Income & Expenditure) performance is reporting an adverse variance of £0.7m to plan
Financial recovery plan to minimise the forecast outturn variance.	Director of CIP (Cost Improvement Plan) PMO (Programme Management Office)	Ongoing	
Enabling Strategy	**Oversight Committee**	**Executive Group**	
	Finance and Digital Committee	Turnaround Improvement Board and Trust Leadership Team	

Quarterly Progress Report Against Delivery	RAG Rating
The overall Income and Expenditure position to end December is showing a £0.7m adverse variance to plan. The forecast outturn is currently £11.0m adverse to planned control total, driven by loss of agenda for change funding within GMS, cost pressures, income under-recovery, CIP under-delivery and associated loss of PSF.	

(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.	**Chief Operating Officer** **Finance and Digital Committee**	1. Monitoring at the CIP (Cost Improvement Plan)/Transformation Board 2. Monitoring at the Emergency Care Delivery Group and the Planned Care Delivery Group 3. Theatres Transformation Plan 4. Getting it Right First Time reviews	1. Opportunities for improvement have been evaluated 2. Progress reports to the Finance and Digital 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
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 4 = 20 (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)
C2628COO - The risk of non-delivery of appointments within 18 weeks within the NHS Constitutional standards for treatment times.	4 x 4 = 12 (Statutory)

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. Phase 1 Theatres Plan completed (increased session utilisation). Theatres Transformation Plan reviewed to support Phase 2.	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 STP (Sustainability and Transformation Plans)	Transformation Board and the Trust Leadership Team. Planned Care Delivery Group Theatres Collaborative Group	Finance and Digital Committee	

Quarterly Progress Report Against Delivery	RAG Rating N/A
The Trust benchmark favourably for efficiency on Model Hospitals, hence RAG status shown as Green The identified additional CIPs and further measures have begun to be delivered. Weekly deep dives with divisions, COO (Chief Operating Officer), Chief Nurse, Medical Director and Director of Programme Management have been established to increase pace to year end. Detailed project plans and associated quantified benefits for implementation in 2018/19 are in development, stretching to Q1 2019/20.	

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, due to stranded costs associated with providing 7-day acute services.	**Director of Strategy and Transformation** **Trust Leadership Team**	1. Oversight from Clinical Programme Board of STP (Sustainability and Transformation Programme) 2. Adherence to “design” and “design for delivery” stages of programme change 3. Open book costing of model 4. Endorsement by Resources Steering Group of STP prior to implementation 5. System-wide approach to risk sharing.	Business case endorsed through Resources Steering Group.	1. STP Memorandum of Understanding (MOU) 2. Risk sharing agreement as part of MOU.	↔
			Gaps in Control	**Gaps in Assurance**	
			None	None	
Principal Risks to Achievement of the Objective	**Risk Owner (Executive Director & Committee)**	**Key Controls**	**Assurance on Controls**	**Current Assurances**	**Direction of Travel)**
4.3.2 Risk of failure to recruit to staffing model for integrated service.	**Director of Strategy and Transformation** **Trust Leadership Team**	Oversight from Clinical Programme Board of STP Adherence to “design” and “design for delivery “stages of programme change Oversight from STP workforce group.	STP workforce strategy.	Principles of integrated working endorsed by Clinical Programmes Board.	↔
			Gaps in Control	**Gaps in Assurance**	
			None	None	

Potential Risk Exposure – confirmed risks on Trust and Divisional Risk Register			Score (CxL)	
F2335 - The risk of agency spend in clinical and non-clinical areas exceeding planned levels due to ongoing high vacancy levels, with resulting impact of delivery of FY19 CIP programme.			4 x 4 = 16 (Finance)	
Enabling Strategy	**Oversight Group**	**Executive Committee**		
One Gloucestershire, Transforming Care, Transforming Communities	STP Delivery Board	Trust Leadership Team		

Quarterly Progress Report Against Delivery

RAG Rating

Respiratory

- Lead for Integrated Respiratory Team appointed.
- Staff consultation (GCS) & engagement (GHFT) on 7-day working and service specification to commenced in September 2018
- Phased implementation of the integrated team started on 27th September
- GHFT respiratory consultants have begun pilot for respiratory advice and guidance service within the Gloucester locality
- Progress to date and ambition for 2019/20 to be reviewed at February's Respiratory CPG.

Diabetes

- Model for integrated leg ulcer service agreed.
- Awaiting funding for implementation of community clinics from CCG.

Musculo Skeletal (MSK) conditions

- The significant progress made to reduce the fractured neck of femur mortality rate by 37% (20 lives saved this year) with GHFT being been shortlisted for a HSJ award
- MSK Foot and ankle triage now live
- Full Business Case for MSK specialised triage being approved by the CCG Priorities committee.
- eRS and booking processes have been configured, with joint training being organised. The referral form has been tested within Primary Care, in conjunction with Cancer 2WW form.

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

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

Potential Risk Exposure – confirmed risks on Trust/ Divisional Risk Registers	Score
D&S2837PATH - The risk of not maintaining the quality management system due to resource issues which could result in loss of UKAS ISO 15189 Accreditation in Histopathology.	4 x 3 = 12 (Statutory)

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

Quarterly Progress Report Against Delivery	RAG Rating
• The performance in initiating and delivery reports to the Department of Health show an improving picture; now 75% and 60% of studies, respectively reaching the target of 80%. • GHFT is on target to recruit 1600 patients in 2019/20 against an initial CRN target of 1000 and a stretch target of 2300	

TRUST BOARD – FEBRUARY 2019
Lecture Hall, Sandford Education Centre commencing at 12:30

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

Purpose

To provide the Board with oversight of the key risks within the organisation and to provide the Board with assurance that the Executive Directors are 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.
- All risk on the Trust Risk Register are within their review dates.

Changes in the reporting period:

The Trust Leadership Team met on 6 February 2019 and agreed the following **five** changes to the Trust Risk Register:

Two risks have been approved by TLT for addition to the Trust Risk Register:

> **F2722** Risk that the Trust's expenditure exceeds the budgets set resulting in failure to deliver the Financial Recovery Plan for FY19 Score 4x 4 =16 for Finance. Executive Lead: Director of Finance
>
> **F2522** Risk that available capital is insufficient to support requirements associated with buildings maintenance, equipment renewal and backlog maintenance resulting in major operational impacts and increased costs. Score is 4x4 =16 for Business. Executive Lead: Chief Operating Officer.

Both of the above risks and their controls were discussed at the January Finance and Digital Committee.

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

C2667NIC The risk of poor patient experience and/or outcomes as a result of hospital acquired C.Diff infection. Executive lead: Steve Hams. Downgrade from 5x2 to a 4x3 Following implementation of the Trust's C. difficile action plan and the GMS cleaning turnaround plan the rate of C. difficile cases has seen a sustained fall. The catastrophic risk in quality has therefore been mitigated; however a risk of major potential impact still exists. Executive Lead: Director of Quality and Chief Nurse

No risks have been **upgraded** in this period.

One risks have been **closed**

C2768NIC There is a risk of avoidable infections, arising from a failure to meet some national cleaning standards and effectively manage anti-microbial prescribing in some areas. Executive Lead: Director of Quality and Chief Nurse

This risk has been successfully mitigated by a rapid improvement plan within GMS. (The risk of poor patient experience and/or outcomes as a result of hospital-acquired C.Diff infection (Ref C2667NIC) remains on the risk register).

One risk has had the wording changed:

C2628COO Wording of the risk changed from 'The risk of non-delivery of appointments within 18 weeks within the NHS Constitutional standards for treatment times.' To: 'The risk of regulatory intervention (including fines) and poor patient experience resulting from the non-delivery of appointments within 18 weeks within the NHS Constitutional standards.' Executive Lead: Chief Operating Officer

All new risk scoring 12+ for safety and 15+ in other domains have been escalated to the Trust Leadership Team (TLT) for consideration of inclusion on the Trust Risk Register.

Three risks with catastrophic consequences are currently being reviewed by the Divisions and Executive Leads; a recommendation will be made to TLT in the March reporting cycle as to whether those risks should be escalated to the Trust Risk Register (i.e. whether they meet the criteria for inclusion in the context of their impact on the Strategic Objectives).

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

Ongoing compliance with the agreed processes.

Recommendations

To receive the report as assurance that the Executive Directors are actively controlling and pro-actively mitigating risks so far as is possible and to note 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 and/or TLT

Audit and Assurance Committee	Finance and Digital Committee	GMS Committee	People and OD Committee	Quality and Performance Committee	Remuneration Committee	Trust Leadership Team	Other (specify)
						6th February 2019	

Outcome of discussion when presented to previous Committees/TLT

TLT recommended that the Board endorse the above changes to the TRR.

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

Ref	Inherent Risk	Controls in place	Action / Mitigation	How would you assess the status of the controls?	Consequence	Likelihood	Risk rating	Division	Highest Scoring Domain	Executive Lead Title	Title of Assurance / Monitoring Committee
F2724	Risk that the Trust does not achieve the required cost improvement resulting in failure to deliver the Financial Recovery Plan for FY19	1. PMO in place to record and monitor the FY19 programme 2. Finance Business Partners to assist budget holders 3. Fortnightly CIP Deep Dives 4. Monthly monitoring and reporting of performance against target 5. Monthly Turnaround Implementation Board 6. Monthly Finance and Digital Committee scrutiny 7. Quarterly executive reviews 8. NHSI monitoring through monthly Finance reporting	1. Identification of further opportunities from the Model Hospital, Carter Review etc. 2. Identification of further schemes at fortnightly CIP Deep Dives	Complete	Catastrophic (5)	Likely - Weekly (4)	20	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Finance	Director of Finance	Finance and Digital Committee
F2522	Risk that available capital is insufficient to support requirements associated with buildings maintenance, equipment renewal and backlog maintenance resulting in major operational impacts and increased costs	1. Board approved, risk assessed capital plan including backlog maintenance 2. MEF and Capital Control Group 3. Capital funding issue and maintenance backlog escalated to NHSI 4. All opportunities to apply for capital made 5. Finance and Digital Committee oversight 6. GMS Committee and Board oversight	1. Prioritisation of capital managed through the intolerable risks process for 19/20 2. Ongoing escalation to NHSI and system	Complete	Major (4)	Likely - Weekly (4)	16	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Business	Chief Operating Officer	Finance and Digital Committee
F2722	Risk that the Trust's expenditure exceeds the budgets set resulting in failure to deliver the Financial Recovery Plan for FY19	1.Monthly monitoring, forecasting and reporting of performance against budget by finance business partners 2. Monthly executive reviews 3. Performance management framework 4. Quarterly Executive Reviews 5. Purchase and procurement SOPs to ensure control 6. Executive ownership of some expenditure items, which form part of the budget such as nurse agency, with escalation to CCG to fund additional pressures	1. Budget setting for 19/20 underway with review of expenditure to ensure budget is set to match demand and activity forecasts	Complete	Major (4)	Likely - Weekly (4)	16	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Finance	Director of Finance	Finance and Digital Committee
S2275	The risk of workforce issues with staff well-being arising from an on-going lack of staff able to deliver the emergency general surgery rota due to reducing staffing numbers and vacancies.	1. Guardian of Safe working Hours. 2. Junior doctors support 3. Staff support services available to staff 4. Mental health first aid services available to trainees in ED	1. Agency/locum cover for on call rota 2. Nursing staff clerking patients 3. Prioritisation of workload 4. Existing junior doctors covering gaps where possible 5. Consultants acting down 6. Ongoing recruitment for substantive and locum surgeons for rota including international opportunities 8. Health and well being hub will offer greater emotional well being services	Partially complete	Major (4)	Likely - Weekly (4)	16	Surgical	Workforce	Medical Director	Trust Leadership Team, People and OD Committee
F2335	The risk of agency spend in clinical and non-clinical areas exceeding planned levels due to ongoing high vacancy levels, with resulting impact of delivery of FY19 CIP programme	1. Challenge to agency requests via VCP 2. Agency Programme Board receiving detailed plans from nursing medical workforce and operations working groups 3. Finance agency report review on a 6 monthly basis 4. Turnaround Implementation Board 5. Quarterly Executive Reviews	1. Convert locum/agency posts to substantive 2. Promote higher utilisation of internal nurse and medical bank 3. Implementation of Health Roster for roster and Bank management 4. Implementation of Master Vendor Agreement for Nursing Agency - improving the control of medical agency spend and authorisation 5. Finalise job planning 6. Ongoing recruitment processes including international recruitment 7. Creation of new medical roles such as Associate specialists 8. Creation of a health and wellbeing hub aimed at reducing absence and reliance on costly temporary solutions	Partially complete	Major (4)	Likely - Weekly (4)	16	Corporate, Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Finance	Chief Nurse	Finance and Digital Committee, People and OD Committee

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

Ref	Inherent Risk	Controls in place	Action / Mitigation	How would you assess the status of the controls?	Consequence	Likelihood	Risk rating	Division	Highest Scoring Domain	Executive Lead Title	Title of Assurance / Monitoring Committee
C2628COO	The risk of regulatory intervention (including fines) and poor patient experience resulting from the non-delivery of appointments within 18 weeks within the NHS Constitutional standards.	The standard is not being met and reporting is planned for March 2019 (February data). This risk is aligned with the recovery of Trak. Controls in place from an operational perspective are: 1.The daily review of existing patient tracking list 2. Additional resource to support central and divisional validation of the patient tracking list. 3.Review of all patients at 45 weeks for action e.g. removal from list (DNA / Duplicates) or 1st OPA, investigations or TCI. 4. A delivery plan for the delivery to standard across specialities is in place 5. Additional PTLs - inpatient PTL to support management of this issue	1.RTT and TrakCare plans monitored through the delivery and assurance structures	Partially complete	Major (4)	Likely - Weekly (4)	16	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Statutory	Chief Operating Officer	Quality and Performance Committee
C1798COO	The risk of delayed follow up care due outpatient capacity constraints all specialities. (Orthodontics; ENT; Urology; Oral Surgery; Diabetic Medicine; Paediatric Urology; Endocrinology; Cardiology; Paediatric Surgery; Neurology; Colorectal and GI Surgery) Risk to both quality of care through patient experience impact (15) and safety risk associated with delays to treatment (4).	1. Speciality-specific review administratively of patients (i.e. clearance of duplicates) (administrative validation) 2. Speciality-specific clinical review of patients 3. Utilisation of existing capacity to support long waiting follow up patients 4.Weekly review at Check and Challenge meeting with each service line 5. Specialities to have seen (review or outpatient) all patients overdue a follow up in 2016 by the end of March 2019. 6.Do Not Breach DNB (or DNC) functionality within the report for clinical colleagues to use with 'urgent' patients. 7. Use of telephone follow up for patients - where clinically appropriate	1. Revise systems for reviewing patients waiting over time 2. Assurance from specialities through the delivery and assurance structures to complete the follow-up plan 3. Additional provision for capacity in key specialities to support f/u clearance of backlog	Partially complete	Moderate (3)	Almost certain - Daily (5)	15	Medical, Surgical	Quality	Chief Operating Officer	Quality and Performance Committee
C2667NIC	The risk of poor patient experience and/or outcomes as a result of hospital acquired C.Diff infection.	1. Strengthened infection control team. 2. Deputy Director of Infection control in post 3. New cleaning regime introduced	1. Delivery of the detailed action plan, developed and reviewed by the Infection Control Committee. The plan focusses 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	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Director of Quality and Chief Nurse	Infection Control Committee, Quality and Performance Committee
C2669N	The risk of harm to patients as a results of falls	1. Patient Falls Policy 2. Falls Care Plan 3. Post falls protocol 4. Equipment to support falls prevention and post falls management 5. Acute Specialist Falls Nurse in post 6.Falls link persons on wards 7. Falls monitored and reported at the Health and Safety Committee and the Quality and Performance Committee	1. Falls training 2. HCA specialist training 3. #Little things matter campaign 4. Discussion with matrons on 2 wards to trial process	Partially complete	Major (4)	Possible - Monthly (3)	12	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Chief Nurse/ Quality Lead	Quality and Performance Committee, Trust Leadership Team

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

Ref	Inherent Risk	Controls in place	Action / Mitigation	How would you assess the status of the controls?	Consequence	Likelihood	Risk rating	Division	Highest Scoring Domain	Executive Lead Title	Title of Assurance / Monitoring Committee
C1945NTVN	The risk of moderate to severe harm due to insufficient pressure ulcer prevention controls	1. Evidence-based working practices including, but not limited to: nursing pathway, documentation and training including assessment of MUST score, Waterlow (risk) score, Anderson score (in ED), SSKIN bundle (assessment of at risk patients and prevention management), care rounding and first hour priorities. 2. Tissue Viability Nurse team cover both sites in Mon-Fri providing advice and training. 3. Nutritional assistants on several wards where patients are at higher risk (COTE and T&O) and dietician review available for all at risk of poor nutrition. 4. Pressure relieving equipment in place Trust wide throughout the patients journey - from ED to DWA once assessment suggests patient's skin may be at risk.	1. Create a rolling action plan to reduce pressure ulcers 2. Amend RCSA for pressure ulcers to obtain learning and facilitate sharing across divisions 3. Sharing of learning from incidents via matrons meetings, governance and quality meetings, Trust wide pressure ulcer group, ward dashboards and metric reporting. 4. NHS collaborative work in 2018 to support evidence based care provision and idea sharing	Incomplete	Moderate (3)	Likely - Weekly (4)	12	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Director of Quality and Chief Nurse	Quality and Performance Committee
S2568Anaes	The risk to patient safety of failure of anaesthetic equipment during an operation with currently very few spares to provide a reliable back up.	1. Prioritisation of operations 2. Maintenance by own medical engineering service	1. Application to MEF 2. Loan request	Partially complete	Catastrophic (5)	Rare - Less than annually (1)	5	Surgical	Safety	Medical Director	Divisional Board, Medical Devices Committee, Quality and Performance Committee
GMS2378Est	Risk of electrocuting personnel due to the deterioration of existing aluminium cables supplying electrical circuits throughout the Tower block basement	1. Electrical contractor to provide quote for complete rewire of aluminium cables. Checked every five yearly under the five yearly installation check.	1. Carry out rewire of Aluminium Cables - Tower Block (due 1/04/2019)	Complete	Catastrophic (5)	Rare - Less than annually (1)	5	Gloucestershire Managed Services	Safety	Chief Operating Officer	GMS Committee

REPORT TO MAIN BOARD – FEBRUARY 2019

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

This report describes the business conducted at the Quality and Performance Committee on 11 February 2019, 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
Patient Experience Report	Comprehensive report received on patient feedback in Quarter 3 (Oct-Dec 2018). Highlights included progress on 15 quality improvement projects that have arisen from information received from patients. 8 teams are participating in the Sweeney Programme. There are plans to introduce real-time patient feedback. The report identified service improvements to PALS. Internal audit report confirmed need for improved divisional engagement with inpatient survey data.	The Committee commended the team on the range and depth of improvement projects being undertaken and the value ascribed to patient experience data underpinning such work. • How can we strengthen and demonstrate the connections between the improvement activity and improved levels of patient satisfaction demonstrated by future in-patient and cancer surveys? • How will we know we are investing in the optimum improvement activities to improve overall scores and narrow the difference	Connections to be made between this report and the data derived from bereaved families within the Learning from Deaths arrangements.	Future reports to focus on the issue of connecting inputs to evidence of improvement.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
		between Cheltenham and Gloucester sites?		
Patient Story from last Board meeting	The Committee was briefed about actions taken since the last Board when a patient's mother's story had described experiences in the Acute Medical Unit following the patient's admission after attempted suicide.	The discussion focussed on what immediate steps had been taken and what dimensions would be addressed through longer-term improvement actions.	The communication of the story to relevant staff was confirmed. Work concerning relevant risk assessments was underway. Possibility of some aspects being addressed via a quality summit was described.	
Serious Incident Report	The discussion focussed on issues raised by two cases. The first concerned a patient's death following bilateral pneumonia and septicaemia. The second concerned the circumstances of a patient lost to follow up appointments within Opthalmology and the impact for them.	The actions that had been taken in response and the ways in which the patient's parents had been communicated with and supported in terms of their understanding of the outcome. Significant progress to identify and improve the accuracy of lists, booking of follow up patient appointments within Opthalmology were described, together with clinical oversight of cases.		Further report to next Cttee re specific circumstances re scale of backlogs in Opthalmology, together with report back on investigation of cluster of gynaecological incidents.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Quality Delivery Group	Comprehensive report demonstrating range of work undertaken in this group was commended as providing steadily improved assurance to the Cttee.	Discussion included: • Actions to deal with out of date policies not yet achieving improved position. Why? • Focus on current incidence and risk rating of violence and aggression towards staff • Confidence that backlogs in Histology will be resolved • Specific concerns re rough sleeping in the Orchard Centre	• Improved individual accountability for tackling the backlog was described • Will be the subject of a deep dive at People and OD Cttee • Histology workload issues are being managed although timeline for clearance of backlog not yet available • Orchard Centre security being addressed with GMS	
Cancer Delivery Group	Highlights included achievement of 2-week cancer standard for December.	Discussion included staffing availability for the weekend theatre lists and the importance of the Trust maintaining the willingness of colleagues to support the additional capacity. National discussions to examine pension arrangements were described.		

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Planned Care	Comprehensive report on progress towards RTT reporting.	Discussion included: • The level of confidence that current numbers of patients waiting for at least 52 weeks could reduce to a maximum of 48 within 9 weeks as externally required. • Further discussion about Opthalmology patients and the likely timeframe / resource requirements associated with backlog of patients to be seen. What is the likely longest timeframe for appointments for those affected?	• Efforts to achieve 52 week improvement trajectory were described but it is known to be very challenging and dependent on impact of winter demand. • The progress in Opthalmology was described with scrutiny of lists, additional clinics etc. Further modelling of future options underway.	Plan to be reported to next Cttee Further analysis to next Cttee
Emergency Care	Extensive pressures were described with attendances 11% higher than in January 2018. Performance for December was 87.5%. This was placed in the very difficult national context.	Discussion focussed on the range of further measures that are being developed, including an action plan for ambulance handovers; piloting revised triage arrangements. The workforce challenges in community-based provision		

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
		were discussed, notably within commissioned home care. The Cttee reflected on whether the planning assumptions of 45 medically stable patients were ever realistic. This will be addressed when the Winter Plan is formally reviewed. What has the impact been on the Trust having to cancel elective work?	 There have been consequential elective cancellations, although not for cancer operations.	 More data about cancellations to be included in future Committee reports.

Claire Feehily
Chair of Quality and Performance Committee
8 February 2019

TRUST BOARD – FEBRUARY 2019
Lecture Hall, Sandford Education Centre commencing at 12:30

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

Purpose

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

Safe
Never Events
There were no new never events reported for December. There is an action plan in place within the surgical Division for a cluster of never events and this continues to be monitored via the Quality Delivery Group (QDG).

The Care Quality Commission (CQC) has reviewed Never Events nationally and has produced a report called **Opening the door to change** – *NHS safety culture and the need for transformation* (December 2018). The report was reviewed at QDG and the planned action agreed was that all the Divisions will review this report and make comment on how they will implement the relevant recommendations within their Divisions with the intention to report back at the next meeting (Feb 2019). The Theatre Improvement plan will also be reviewed in light of these recommendations to check whether any additional actions need to be added.

C.Diff Cases – Cumulative Totals
The trust have a comprehensive action plan to bring about improvements for this indicator which is being monitored by the Infection Prevention and Control Committee. Each identified case is robustly reviewed internally and then also presented to the CCG. There was 1 case of trust-apportioned C. difficile during December 2018 (the case rate is within the expected limits for the month). Across all the investigations of individual cases we have identified antimicrobials as a leading risk factor and this will be an area of focused improvement
% of Adult Inpatients who have Received a VTE Risk Assessment

Venous Thrombo embolus (VTE)
Performance of risk assessment for VTE continues to be delivered at 93-94% through Clinical Audit data collection. Data collection remains a challenge via TRAK with a new pathway being designed using a wider Multidisciplinary Approach Team approach.

Dementia

- **% of patients who have been screened for Dementia (within 72 hours)**
- **% of patients who have received a dementia diagnostic assessment with positive or inconclusive results that were then referred for further diagnostic advice/FU (within 72 hours)**

Improvements have been made to the current documentation and now weekly manual audits are taking place as with VTE data collection remains a challenge via TRAK. Clinical audit are now supporting the work and an electronic solution in an EPR still needs to be developed.

Caring
Friends and Family Test (FFT)
The Friends and Family Test positive response rate for Maternity and Outpatients are within nationally reported averages. The ED score was just below national average and work is being done locally to review comments and act on the results. The ED score at CGH is 10% higher for their positive score and so the focus of the improvement work will be focused in GRH. The Inpatient score is below national average and again CGH site have a 10% higher positive score. Ward managers need to remain focused on the comments and continue with improvements that will impact on the results. The overall score for the Trust remains at 91% which is 2% below the strategic objective target.

Effective
% of fracture neck of Femur patients treated within 36 Hours
The improvement plan was due to be reviewed at December's Divisional surgical Board, however this was cancelled due to operational pressures therefore the plan will be reviewed at next Board in January.

Ambulance Handovers – Over 30 Mins
There were 63 ambulance handover delays for December 2018. This increase is in line with the drop in triage performance and increase in E.D attendances.

Ambulance Handovers – Over 60 Minutes
1 > 60 minute ambulance handover delay for December 2018 = same performance as November 2018 but 1 greater than the previous year. This increase is in line with increased E.D attendances and a drop in triage performance.

Performance

During December, the Trust met the national standard for 2 week wait cancer standards and diagnostics. The Trust did not meet the national standards or Trust trajectories for; A&E 4 hour standard 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 December 2018, the trust performance against the 4hr A&E standard was 87.02% with an average of 408 attendances per day. Attendances year to date are 6% above last year's levels.

In respect of RTT, we have started reporting the RTT position in shadow form internally and have planned to re-report by March 2019 (February data). Operational teams continue to monitor and manage the long waiting patients on the Referral to Treatment pathways; however, as reported previously to the Board we will continue to see 52 week breaches whilst we are seeing our longest waiting patients and until full data cleansing exercise is completed and our patient tracking list is accurate.

Our performance against the cancer standard saw delivery for the 2 week standard in December at 94.3%, there continues to be significant referrals not resulting in cancer conversion which is being addressed with system partners.

The existing Cancer Delivery Plan which identifies specific actions by tumour site to deliver recovery has been developed and reviewed on a fortnightly basis. One tumour site (urology) continues to demonstrably impact the aggregate position with significant number of 62day breaches and this has continued into the November position. Positively the Trust is planning to address the backlog to enable delivery of 62 day by March 2019.

Cancer 62 day Referral to Treatment (GP referral) performance for November (un-validated) was 79.7%, this was an increase in performance, but it is recognised that this is not a stable position as we treat the urology backlog piece.

As last month, we are addressing our longest waiting patients and reviewing the opportunities for how we can support a reduction in the 104 patient cohort. We are working to reduce our long waiters with our tertiary centres.

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

Conclusions

Cancer delivery, with a particular focus on Urology recovery and backlog clearance during January, and sustaining A&E performance is the priority for the operational teams to continue the positive performance improvement, this is delivered through transformational change to patient pathways now robust operating models are developed.

Quality delivery (with the exception of those areas previously discussed) remain stable, further work is being completed to identify a refreshed quality and performance dashboard to widen our understanding of quality and performance delivery.
Work to review the statutory returns and key indicators is being led through our information team to support our recovery programme through Trak Recovery.

Recommendations

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

Impact Upon Strategic Objectives

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

Impact Upon Corporate Risks

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

Regulatory and/or Legal Implications

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

Equality & Patient Impact

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

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	
No change.			

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

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

Outcome of discussion when presented to previous Committees/TLT

Quality and Performance Report

Reporting period December 2019

to be presented at January 2019 Quality and Performance Committee

Executive Summary

Delivery of agreed action plans remains critical to restore operational performance to the expected levels. During November the Trust did not meet the national standards or Trust trajectories for 62 day cancer standard and the 4 hour standard in month performance for December and suspended reporting of the 18 week referral to treatment (RTT) standard continues.

The Trust did not meet the 4 hour standard in December 87.02% against the STP trajectory at 90% against a backdrop of significant attendances. The Trust has met the 4 hour standard for Quarter Three performance of 90%.

The Trust has met the diagnostics standard for December at 0.20%, this is as yet un-validated performance at the time of the report.

The Trust has met the standard for 2 week wait cancer at 94.3% in December.

The Key areas of focus remain for delivery of Cancer quality and performance against speciality level trajectories. The Cancer Delivery plan is reviewed monthly 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 62 day pathway, specifically with latter urology remaining the speciality with the greatest under-delivery.

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

Strengths

4 hour performance continues to perform well in comparison to other Trusts, despite average attendances of 408 per day.

The national standard for % of patients seen within 6 weeks for Diagnostic tests continues to be met.

Operational oversight of cancellations, which is now back to pre-trak cancellation levels. Outcome recording and clinic typing through the development of a suite of Business Intelligence reports has been helpful to support operational colleagues. The next stage is to take this through to weekly email issuing, this is now being manually undertaken. There are still data quality errors with reports across operational areas, resulting in a large degree of validation and / or manual counting and review. This remains business as usual and will be monitored through the Planned Care Delivery Group.

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

MRSA Blood stream cumulative totals
There have been no further cases.

C Difficile
There was 1 case of trust-apportioned C. difficile during December 2018. Investigations of individual cases have focussed on antimicrobials as a leading risk factor; this case rate is within the expected limits for the month. The trust has a comprehensive action plan to bring about improvements. All cases are reviewed internally and presented to the CCG.

Weaknesses

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

VTE

The improvement programme continues with the Director of Safety visiting ward areas to review systems and processes locally. Currently there is variation within current systems and so standardization needs to happen. Performance of risk assessment for VTE continues to be delivered at 93-94% through Clinical Audit data collection. Data collection remains a challenge via TRAK with a new pathway being designed using a wider MDT approach

Dementia

Elderly patients admitted on a non-elective basis should be screened for dementia using a screening question and / or a simple cognitive test. Performance shown in this report reflects figures submitted monthly to NHS England. The figures reported in the QPR are from Trakcare. An audit is being finalised that has reviewed our current performance within the medical records and will be reported to QDG next month. A rolling programme of audits has been developed.

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

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

Opportunities

Divisional Reports

The Divisions have requested a specific report that breaks down all the QPR metrics into Divisional reports this is planned to support the refreshed QPR that will be presented to Committee in April / May 2019.

Friends and Family Test

There is a 10% difference in positive scores between the CGH and GRH sites for the inpatient and ED positive scores with CGH receiving more positive responses. In order to meet the Trust target of 93% positive response rate the improvement work needs to be focused at GRH. The Medical and Surgical Divisions have received reports by ward.

Risks & Threats

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

Cancer performance remains a significant risk for the Trust. The Trust is continuing to work with the Clinical Commissioning Group on a joint project that is working with Primary Care to address the quality of referrals received into the two week wait team and to audit the patient information leaflets. Patient choice levels are being benchmarked (and case stories provided) as the Trust needs to ensure we are offering reasonable notice of appointments. Patient choice for January has already impacted the 2ww pathways. 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. The changes to the 'letter format' for patients has commenced in January as reported at last committee.

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

Current reports do not differentiate between non-admitted and admitted patients and as we move forward with re-reporting a review of the RTT reporting scripts and internal PTLs are identifying errors, this requires time and support for validation of these lists.
The validation volumes for the PTL (new and follow up patients) and incorrect processes remain a risk, as does any change to the existing PTLs or change in practice, aligned with the recovery pace for Trak Recovery. Significant validation has been undertaken on the Outpatient Waiting List and a draft Inpatient Waiting List from both the central and speciality teams, the latter has not been able to be produced until the work of the external validation can be completed in the new year. Operational colleagues are represented at the Governance structure relating to the Trak Deep Dive Recovery programme. This will remain a risk for 2018, with the appropriate mitigations in place to support operational delivery. Progress to reporting RTT has been positive within month and as yet no identified issues with reporting as planned.

Performance Against STP Trajectories

* = unvalidated data

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

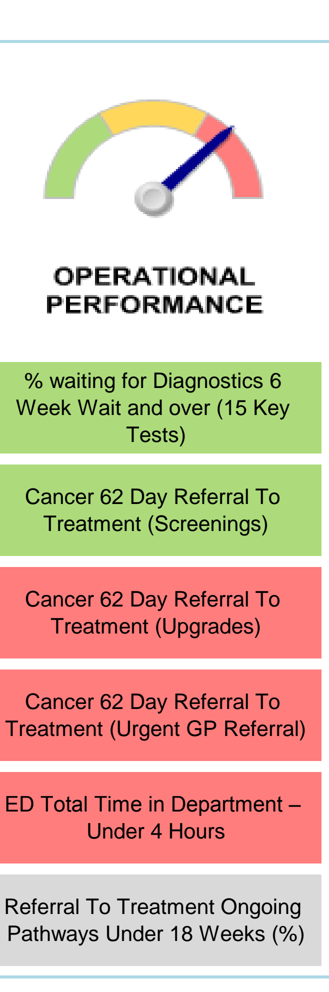
RAG Rating: The STP indicators are assessed against the monthly trajectories agreed with NHS Improvement.

Indicator		Month												
		Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
ED Total Time in Department – Under 4 Hours	Trajectory	77.40%	80.00%	80.00%	83.50%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
	Actual	90.76%	89.73%	88.46%	86.94%	91.98%	91.58%	93.33%	91.34%	90.26%	89.01%	90.54%	91.59%*	87.55%
Referral To Treatment Ongoing Pathways Under 18 Weeks (%)	Trajectory	82.90%	84.00%	85.20%	86.30%									
	Actual													
% waiting for Diagnostics 6 Week Wait and over (15 Key Tests)	Trajectory	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%
	Actual	0.75%	0.64%	0.49%*	0.26%	0.56%	1.26%	0.52%	0.55%	1.27%*	0.63%	0.03%	0.42%*	0.20%*
Cancer - Urgent Referrals Seen in Under 2 Weeks from GP	Trajectory	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.10%	93.00%	93.10%	93.00%	93.00%
	Actual	81.20%	86.40%	90.60%	90.50%	86.60%	86.30%	88.60%	90.40%	88.90%	82.80%	91.80%*	90.60%*	94.00%*
2 week wait Breast Symptomatic referrals	Trajectory	93.30%	93.20%	93.20%	93.30%	93.20%	93.30%	93.40%	93.40%	93.30%	93.20%	93.40%	93.40%	93.10%
	Actual	96.30%	92.40%	97.60%	94.50%	91.30%	91.90%	95.10%	96.00%	97.80%	98.90%	99.20%*	94.50%*	97.60%*
Cancer – 31 Day Diagnosis To Treatment (First Treatments)	Trajectory	96.10%	96.30%	96.10%	96.30%	96.10%	96.30%	96.10%	96.20%	96.30%	96.20%	96.20%	96.30%	96.20%
	Actual	97.30%	96.00%	97.60%	97.90%	96.70%	96.90%	97.10%	96.80%	96.90%	93.50%	93.20%*	94.00%*	93.60%*
Cancer – 31 Day Diagnosis To Treatment (Subsequent – Drug)	Trajectory	100.00%	100.00%	100.00%	98.40%	98.50%	100.00%	98.80%	98.10%	100.00%	98.40%	98.00%	98.10%	100.00%
	Actual	100.00%	98.90%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	98.80%	100.00%*	100.00%*	100.00%*
Cancer – 31 Day Diagnosis To Treatment (Subsequent – Radiotherapy)	Trajectory	94.40%	94.40%	94.10%	94.20%	95.50%	95.80%	94.60%	95.10%	94.60%	95.00%	94.30%	94.70%	94.50%
	Actual	98.10%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	98.70%	100.00%	100.00%	98.60%*	98.60%*	98.60%*
Cancer – 31 Day Diagnosis To Treatment (Subsequent – Surgery)	Trajectory	94.70%	94.10%	94.50%	94.10%	95.10%	95.00%	94.20%	95.90%	94.60%	95.30%	94.30%	95.00%	94.80%
	Actual	94.90%	93.00%	95.50%	98.00%	94.90%	96.60%	94.50%	96.00%	95.70%	94.30%	98.30%*	96.60%*	93.90%*
Cancer 62 Day Referral To Treatment (Screenings)	Trajectory	90.50%	92.90%	92.90%	90.50%	92.00%	94.70%	90.50%	90.00%	91.20%	92.10%	92.90%	92.90%	90.90%
	Actual	95.50%	98.00%	95.90%	95.90%	100.00%	94.10%	100.00%	100.00%	100.00%	85.50%	93.50%*	93.50%*	100.00%*
Cancer 62 Day Referral To Treatment (Upgrades)	Trajectory	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Actual	100.00%	0.00%	80.00%	94.10%	76.50%	100.00%	84.60%	53.30%	100.00%	75.00%	77.80%*	58.80%*	66.70%*
Cancer 62 Day Referral To Treatment (Urgent GP Referral)	Trajectory	85.30%	85.40%	85.40%	85.20%	82.80%	84.40%	85.30%	79.70%	77.10%	81.70%	82.00%	83.70%	82.80%
	Actual	73.40%	69.70%	79.10%	78.10%	80.30%	79.90%	66.90%	74.70%	76.30%	69.00%	68.00%*	78.40%*	68.00%*

Summary Scorecard

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

<u>RAG Rating</u> : Overall RAG rating for a domain is an average performance of lead indicators against national standards. Where data is not available the lead indicator is treated as Red.



Trust Scorecard

* = unvalidated data

Category	Indicator	Standard 2017/18	Month Dec-17	Jan-18	Feb-18	Mar-18	Standard 2018/19	Month Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Quarter 18/19 Q3	Annual 18/19
Quality	**Key Indicators - Quality**																	
Friends & Family Test	ED % Positive	>=86%	85.9%	85.6%	82.7%	83.7% *	R<81% A81-83% G>=84%	83.1%	83.2%	84.6%	83.6%	82.0%	85.9%	82.7%	82.7%	81.0% *	82.1%	83.4% *
	Inpatients % Positive	>=95%	91.6%	91.5%	92.0%	89.7% *	R<93% A93-95% G>=96%	90.2%	91.4%	91.7%	91.7%	90.7%	91.9%	92.2%	90.9%	91.5% *	91.5%	91.3% *
	Maternity % Positive	>=97%	90.3%	100.0%	88.9%	93.6% *	R<94% A94-96% G>=97%	97.4%	94.0%	95.6%	93.3%	94.7%	0.0%	100.0%	98.2%	100.0% *	99.4%	95.8% *
	Outpatients % Positive	>=93%	92.4%	93.3%	93.1%	92.3% *	R<91% A91-93% G>=94%	92.0%	92.3%	92.3%	93.3%	91.9%	92.3%	93.0%	92.5%	92.9% *	92.8%	92.5% *
	Total % Positive		91.0%	92.2%	91.9%	90.9%	R<90% A90-92% G>=93%	90.6%	91.2%	91.3%	91.6%	90.3%	91.6%	91.8%	91.2%	90.9% *	91.3%	91.1% *
Infection Control	MRSA Bloodstream Cases – Cumulative Totals	0	0	0 *	0 *	0 *	0	1	1	1	2 *	3	5	5	5	5	5	5 *
Mortality	Hospital Standardised Mortality Ratio (HSMR)	Dr Foster confidence level	93.4	93.1	95	96	Dr Foster confidence level	98.3	95.2	96	96.4	98.1	99.8					99.8 *
	Hospital Standardised Mortality Ratio (HSMR) – Weekend	Dr Foster confidence level	97.1	95	97.7	98.4	Dr Foster confidence level	101.1	97.3	97.1	97.9	96.6	98.4					98.4 *
	Summary Hospital Mortality Indicator (SHMI) – National Data	Dr Foster confidence level	107			107.2	Dr Foster confidence level			103.3								103.3 *
MSA	Number of Breaches of Mixed Sex Accommodation	0	11	5	7	6	R>=20 A11-19 G<=10	8	8	20	5	6	0	7	2	6	15	62 *
Readmissions	Emergency re-admissions within 30 days following an elective or emergency spell	Q1<6% Q2<5.8% Q3<5.6% Q4<5.4%	7.6% *	6.3% *	7.9% *	7.2% *	R>6.8% G<6.8%	7.4% *	7.1% *	7.5% *	7.5% *	7.9% *	7.6% *	7.8% *	7.1% *			7.5% *
VTE Prevention	% of Adult Inpatients who have Received a VTE Risk Assessment	>95%		78.5% *	76.8% *	79.3% *	R<=95% A96% G>97%	79.9% *	96.6% *	91.7% *	94.8% *	94.6% *	93.8% *	94.8% *	95.4% *	90.7% *	93.7% *	92.5% *
	Detailed Indicators - Quality																	
Dementia Screening	% of patients who have been screened for Dementia (within 72 hours)	>=90%	1.1%	0.7% *	0.7%	0.8%	R<70% A70-89% G>=90%	0.7%	1.6%	1.6%	1.7%	3.5%	2.3%	1.8%	2.6%	3.4% *	2.6%	2.0% *
	% of patients who have received a dementia diagnostic assessment with positive or inconclusive results that were then referred for further diagnostic advice/FU (within 72 hours)	>=90%	0.0%	50.0% *	0.0%	0.0%	R<70% A70-89% G>=90%	0.0%	0.0%	0.0%	0.0%	12.5%	0.0%	0.0%	0.0%	0.0% *	0.0%	8.0% *
	% of patients who have scored positively on dementia screening tool that then received a dementia diagnostic assessment (within 72 hours)	>=90%	57.1%	100.0% *	33.3%	66.7%	R<70% A70-89% G>=90%	50.0%	16.7%	33.3%	11.1%	41.2%	18.2%	33.3%	22.2%	26.3% *	26.1%	35.3% *
ED Checklist	ED Safety checklist compliance CGH	R<50% A50-79% G>=80%	92%	86% *	83% *	82% *	R<50% A50-79% G>=80%	82% *	89% *	84% *	88% *	90% *	89% *	90% *	93% *	93% *		
	ED Safety checklist compliance GRH	R<50% A50-79% G>=80%	67%	72% *	81% *	81% *	R<50% A50-79% G>=80%	85% *	73% *	73% *	75% *	85% *	90% *	90% *	91%	93% *	87%	
Emergency Department	ED: % of time to initial assessment – Under 15 minutes	>=99%	89.9%	91.9%	88.2%	89.5%	R<92% A92-94% G>=95%	90.5%	90.3%	90.8%	88.6%	90.7%	87.3%	88.8%	89.6%	85.4%	87.9%	89.1% *
	ED: % of time to start of treatment – Under 60 minutes	>=90%	40.7%	43.3%	32.7%	35.2%	R<87% A87-89% G>=90%	36.8%	33.6%	34.1%	31.4%	34.3%	29.0%	36.7%	34.5%	32.1%	34.4%	33.6% *
Infection Control	C.Diff Cases – Cumulative Totals	18/19 = 36	41	45	49	56	R>3 G<=3	5	14	16	40	29	32	36	40	41	41	41 *
	Ecoli – Cumulative Totals		200	222 *	240 *	258 *	TBC	17	32	56	79 *	107	139	164	168	171	171	171 *
	Klebsiella – Cumulative Totals						TBC	6	12	13	22 *	29	39	46	49	51	51	51 *
	MSSA Cases – Cumulative Totals	No target	78	89 *	93 *	100 *	TBC	9	18	28	41	49	63	72	76	2 *	8 *	76 *
	Pseudomonas – Cumulative Totals						TBC	2	3	6	14 *	17	20	23	24	24	24	24 *
Maternity	Percentage of Spontaneous Vaginal Deliveries		60.9% *	57.0% *	63.4% *	61.8% *	0	57.5% *	61.4% *	60.0% *	64.3% *		63.1% *	59.2% *	59.4% *	59.3% *	59.2% *	61.3% *
	Percentage of Women Seen by Midwife by 12 Weeks	>90%	86.6% *	88.7% *	89.2% *	89.9% *	>90%	92.7% *	90.1% *	90.5% *	89.8% *	87.4% *	89.6% *	89.5% *	92.0% *	89.7% *	90.9% *	89.8% *

Category		Indicator	Standard 2017/18	Month				Standard 2018/19	Month									Quarter 18/19 Q3	Annual 18/19
				Dec-17	Jan-18	Feb-18	Mar-18		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18		
	Medicines	Rate of Medication Incidents per 1,000 Beddays	Current mean	3.4 *	4.1 *	3.5 *	3.6 *	Current mean	3.6 *	4.6 *	4.4 *	4.3 *	4 *	3.8 *	4.3 *	4.6 *	3.8 *		
	Patient Safety Incidents	Number of falls per 1,000 bed days	Current mean	8.2 *	7.8 *	7.3 *	7.7 *	TBC	8.3 *	7.6 *	8.3 *	6.9 *	6.3 *	7.5 *	7.3 *	6.8 *	7.2 *		
		Number of falls resulting in harm (moderate/severe)		13 *	18 *	10 *	8 *	TBC	10 *	8 *	7 *	11 *	6 *	9 *	8 *	6 *	8 *		8 *
		Number of Patient Safety Incidents - severe harm (major/death)		1 *	3 *	1 *	1 *	TBC	2 *	1 *	1 *	1 *	1 *	2 *	1 *	0 *	1 *		1 *
		Number of Patient Safety Incidents Reported		1,025 *	1,260 *	1,139 *	1,229 *	0	1,192 *	1,210 *	1,199 *	1,206 *	1,142 *	1,202 *	1,228 *	1,249 *	1,153 *		
		Pressure Ulcers – Category 2	R=1% G<1%	0.54% *	1.30% *	1.63% *	0.48% *	R=1% G<1%	0.39% *	0.39% *	0.90% *	0.25% *	0.57% *	0.68% *	0.13% *	0.27% *	0.93% *		
		Pressure Ulcers – Category 3	R=0.3 G<0.3%	0.14% *	0.47% *	0.63% *	0.24% *	R=0.3 G<0.3%	0.00% *	0.00% *	0.00% *	0.13% *	0.14% *	0.00% *	0.00% *	0.27% *	0.13% *		
		Pressure Ulcers – Category 4	R=0.2% G<0.2%	0.00% *	0.00% *	0.00% *	0.00% *	R=0.2% G<0.2%	0.00% *	0.00% *	0.00% *	0.00% *	0.14% *	0.00% *	0.00% *	0.00% *	0.00% *		
	Research	Research Accruals	17/18 = >1100	29 *	80 *	61 *	112 *	TBC	42 *	54 *	16 *								19 *
	RIDDOR	Number of RIDDOR	Current mean	7 *	1 *	1 *	1 *	Current mean	4 *	0 *	1 *	2 *	2 *	5 *	4 *	1 *	4 *		
	Safe nurse staffing	Care Hours per Patient Day total		7	7	7	7	0	7	7	8	7	7	7	7	7	7 *	7 *	7 *
	Safety Thermometer	Safety Thermometer – Harm Free	R<88% A89-91% G>92%	93.1% *	90.1% *	91.8% *	91.5% *	R<88% A89-91% G>92%	92.8% *	93.8% *		92.2% *	94.2% *	93.4% *	94.2% *	93.1% *	94.3% *		
		Safety Thermometer – New Harm Free	R<93% A94%-95% G>96%	96.9% *	96.0% *	96.4% *	97.6% *	R<93% A94%-95% G>96%	98.0% *	97.8% *		98.4% *	97.7% *	98.6% *	98.5% *	97.9% *	97.3% *		
	Sepsis Identification and Treatment	% of patients screened in ED for Sepsis	>90%	98.0% *	98.0% *	98.0% *	100.0% *	R<50% A50-89% G>=90%	98.0% *	98.0% *	100.0% *	98.0% *	98.0% *	98.0% *					
		% of patients who were administered IVABs with 1 hour of arriving to ED	>50%	83.0% *	89.0% *	84.0% *	78.0% *	R<50% A50-89% G>=90%	82.0% *	88.0% *	88.0% *	72.0% *	79.0% *	79.0% *					
	Serious Incidents	Number of Never Events reported	0	1 *	0 *	0 *	1 *	0	1 *	0 *	0 *	0 *	0 *	0 *	0 *	0 *	0 *		1 *
		Number of Serious Incidents Reported		1 *	3 *	10 *	2 *	0	3 *	10 *	5 *	0 *	4 *	4 *	2 *	1 *	1 *		
		Percentage of Serious Incident Investigations Completed Within Contract Timescale		100% *	100% *	100% *	100% *	>80%	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% *	G>90%	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	1.9 *	2.6 *	2.4 *	2.8 *	Current mean	1.4 *	2.8 *	1.7 *	2.5 *	2.3 *	2.2 *	3.9 *	3 *	.5 *		
		Rate of Physically Violent and Aggressive Incidents Occurring per 1,000 Staff	Current mean	1.5 *	1.4 *	2.6 *	2.8 *	Current mean	4 *	2.8 *	2.5 *	3.3 *	2.1 *	2.9 *	2.8 *	1.6 *	2.3 *		
	Stroke Care	High Risk TIA Patients Starting Treatment Within 24 Hours	>=60%	69.6%	67.7%	60.0%	76.0%	>=60%	69.4%	73.5%	69.6%	58.6%	70.8%	51.5%	42.6%	48.3%	61.1%	47.9%	59.3% *
		Stroke Care: Percentage of patients Receiving Brain Imaging Within 1 Hour	>=50%	33.8%	46.2%	38.2%	41.0%	R<45% A45-49% G>=50%	36.7%	50.0%	40.6%	37.8%	47.0%	41.5%	34.3%	26.6%	31.9%	31.0%	38.5% *
		Stroke Care: Percentage of patients Spending 90%+ Time on Stroke Unit	>=80%	74.0%	91.8%	94.4%	73.5%	R<70% A70-79% G>=80%	90.4%	95.1%	95.6%	94.1%	97.2%	93.4%	80.7%	87.7%			92.0% *
	Trauma & Orthopaedics	% of fracture neck of Femur patients treated within 36 Hours		81.4% *	73.9% *	83.8% *	64.4% *	R<80% A80-89% G>=90%	72.2% *	79.4% *	68.3% *	74.2% *	88.7% *	85.5% *	67.7% *	70.1% *	75.0% *	70.9% *	76.0% *
		Fracture Neck of Femur – Time To Treatment 90th Percentile (Hours)		43.1 *	45.7 *	42.3 *	64.4 *	TBC	48.1 *	42.3 *	49.8 *	51.8 *	38.4 *	38.6 *	52.2 *	60.3 *	43.9 *	50.3 *	31 *
		Fracture Neck of Femur Patients Seeing Orthogeriatrician Within 72 Hours		100.0% *	98.5% *	100.0% *	98.4% *	TBC	94.4% *	91.2% *	93.7% *	100.0% *	98.4% *	90.9% *	100.0% *	98.5% *	100.0% *	99.5% *	99.0% *
Operational Performance	**Key Indicators - Operational Performance**																		
	Cancer	Cancer 62 Day Referral To Treatment (Screenings)	>=90%	95.5%	98.0%	95.9%	95.9%	R<85% A85-89% G>=90%	100.0%	94.1%	100.0%	100.0%	100.0%	85.5%	93.5% *	93.5% *	100.0% *	95.9% *	95.4% *
		Cancer 62 Day Referral To Treatment (Upgrades)	>=90%	100.0%	0.0%	80.0%	94.1%	>=90%	76.5%	100.0%	84.6%	53.3%	100.0%	75.0%	77.8% *	58.8% *	66.7% *	66.7% *	71.3% *
		Cancer 62 Day Referral To Treatment (Urgent GP Referral)	>=85%	73.4%	69.7%	79.1%	78.1%	R<80% A80-84% G>=85%	80.3%	79.9%	66.9%	74.7%	76.3%	69.0%	68.0% *	78.4% *	68.0% *	73.0% *	73.7% *
	Diagnostics	% waiting for Diagnostics 6 Week Wait and over (15 Key Tests)	<1%	0.75%	0.64%	0.49% *	0.26%	R>2% A1.01-2% G<=1%	0.56%	1.26%	0.52%	0.55%	1.27% *	0.63%	0.03%	0.42% *	0.20% *	0.20% *	0.20% *
	Emergency Department	ED Total Time in Department – Under 4 Hours	>=95%	90.76%	89.73%	88.46%	86.94%	R<90% A90-94% G>=95%	91.98%	91.58%	93.33%	91.34%	90.26%	89.01%	90.54%	91.59% *	87.55%	90.02%	90.85 *
	RTT	Referral To Treatment Ongoing Pathways Under 18 Weeks (%)	>=92%					>=92%											

Category	Indicator	Standard 2017/18	Month				Standard 2018/19	Month									Quarter	Annual
			Dec-17	Jan-18	Feb-18	Mar-18		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	18/19 Q3	18/19
	Detailed Indicators - Operational Performance																	
Cancer	2 week wait Breast Symptomatic referrals	>=93%	96.3%	92.4%	97.6%	94.5%	R<90% A90-92% G>=93%	91.3%	91.9%	95.1%	96.0%	97.8%	98.9%	99.2% *	94.5% *	97.6% *	97.2% *	95.7% *
Cancer	Cancer – 31 Day Diagnosis To Treatment (First Treatments)	>=96%	97.3%	96.0%	97.6%	97.9%	R<94% A94-95% G>=96%	96.7%	96.9%	97.1%	96.8%	96.9%	93.5%	93.2% *	94.0% *	93.6% *	93.6% *	96.0% *
Cancer	Cancer – 31 Day Diagnosis To Treatment (Subsequent – Drug)	>=98%	100.0%	98.9%	100.0%	100.0%	R<96% A96-97% G>=98%	100.0%	100.0%	100.0%	100.0%	100.0%	98.8%	100.0% *	100.0% *	100.0% *	100.0% *	99.8% *
Cancer	Cancer – 31 Day Diagnosis To Treatment (Subsequent – Radiotherapy)	>=94%	98.1%	100.0%	100.0%	100.0%	R<92% A92-93% G>=94%	100.0%	100.0%	100.0%	98.7%	100.0%	100.0%	98.6% *	98.6% *	98.6% *	98.6% *	99.6% *
Cancer	Cancer – 31 Day Diagnosis To Treatment (Subsequent – Surgery)	>=94%	94.9%	93.0%	95.5%	98.0%	R<92% A92-93% G>=94%	94.9%	96.6%	94.5%	96.0%	95.7%	94.3%	98.3% *	96.6% *	93.9% *	96.7% *	96.0% *
Cancer	Cancer - Urgent Referrals Seen in Under 2 Weeks from GP	>=93%	81.2%	86.4%	90.6%	90.5%	R<90% A90-92% G>=93%	86.6%	86.3%	88.6%	90.4%	88.9%	82.8%	91.8% *	90.6% *	94.0% *	92.0% *	87.9% *
Cancer	Number of patients waiting over 104 days with a TCI date	0	9	10	4	6	0	9	12	6	8	22	26	7	13	8	8	13 *
Cancer	Number of Patients waiting over 104 days without a TCI date	0	34	19	14	17	TBC	18	18	22	28	24	30	39	37	27	27	37 *
Diagnostics	The number of planned / Surveillance Endoscopy Patients Waiting at Month End		733	239 *	106	123	TBC	188	223	260	311	407	576	630 *	680 *	686 *	686 *	686 *
Discharge	Number of patients delayed at the end of each month	<14	41	22	23	34	TBC	37	27	36	47	44	41	44 *	40 *	34 *	34 *	34 *
Discharge	Patient Discharge Summaries Sent to GP Within 1 Working Day	>=85%	59.9% *	56.9% *	57.7% *	59.4% *	>=85%	62.0% *	60.2% *	64.7% *	62.0% *	62.3% *	61.5% *	62.6% *				62.2% *
Emergency Department	Ambulance Handovers – Over 30 Minutes	< previous year	56	45	44	49	< previous year	30	25	44	58	68	66	74	33	61 *	168 *	459 *
Emergency Department	Ambulance Handovers – Over 60 Minutes	< previous year	0	2	3	3	< previous year	1	3	1	0	2	2	2	1	1 *	4 *	13 *
Emergency Department	ED: % total time in department - Under 4 Hours CGH	>=95%	96.60%	93.60%	95.10%	96.50%	R<90% A90-94% G>=95%	97.80%	98.10%	96.30%	96.90%	96.00%	96.40%	96.90%	96.94% *	95.47%	96.51%	96.80% *
Emergency Department	ED: % total Time in Department – Under 4 Hours GRH	>=95%	88.00%	87.90%	85.30%	82.30%	R<90% A90-94% G>=95%	89.10%	88.10%	91.80%	88.40%	87.40%	85.20%	87.30%	89.06% *	83.82%	86.89%	87.84% *
Emergency Department	ED: Number of patients experiencing a 12 Hour Trolley wait (>12hours from decision to admit to admission)	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0 *	0 *	0 *
Length of Stay	Average Length of Stay (Spell)		4.79 *	5.1 *	5.04 *	4.99 *	0	5.14 *	4.65 *	4.57 *	4.52 *	4.61 *	4.49 *	4.56 *	4.53 *	4.01 *	4.36 *	4.55 *
Operational Efficiency	Length of Stay for General and Acute Elective Spells (Occupied Bed Days)	<=3.4	2.84 *	2.91 *	2.99 *	3.03 *	R>4.5 A3.5-4.5 G<=3.4	2.82 *	2.78 *	2.52 *	2.72 *	3.01 *	2.87 *	2.6 *	2.81 *	2.25 *	2.54 *	2.7 *
Operational Efficiency	Length of Stay for General and Acute Non-Elective (Occupied Bed Days) Spells	Q1/Q2<5.4 Q3/Q4<5.8	5.28 *	5.56 *	5.53 *	5.46 *	TBC	5.68 *	5.16 *	5.15 *	4.98 *	4.96 *	4.85 *	5.01 *	4.95 *	4.45 *	4.8 *	5.01 *
Operational Efficiency	Number of LMCs Not Re–admitted Within 28 Days	0	6 *	12 *	25 *	21 *	0	12 *	23 *									
Operational Efficiency	Number of Patients Stable for Discharge	<40	64	55	65	67	TBC	67	66	71	71	75	80	75	76	69 *	69 *	72 *
Operational Efficiency	Number of stranded patients with a length of stay of greater than 7 days		446	472	464	482	TBC	384	395	369	373	382	376 *	374 *	382 *	374 *	374 *	379 *
RTT	Referral To Treatment Ongoing Pathways Over 52 Weeks (Number)	0	74 *	50 *	63	95 *	0	95	92	98	113	125	105	103	105	97	97	97 *
SUS	Percentage of Records Submitted Nationally with Valid GP Code	>=99%	100.0%	100.0%	100.0%	100.0%	>=99%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0% *	100.0% *	100.0% *	100.0% *	100.0% *
SUS	Percentage of Records Submitted Nationally with Valid NHS Number	>=99%	99.8%	99.8%	99.8%	99.8%	>=99%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8% *	99.8% *	99.8% *	99.8% *	99.8% *
Finance	**Key Indicators - Finance**																	
Finance	YTD Performance against Financial Recovery Plan		-6.4 *	-6.5 *	-10.8 *	-18.4 *	TBC	.05	.07	.09	.18 *	.2	.2	.2	.4	.04		
	Detailed Indicators - Finance																	
Finance	Agency – Performance Against NHSI Set Agency Ceiling		3 *	3 *	3 *	3 *	TBC	2	2	2	2	2	3	3	3	3		
Finance	Capital Service		4 *	4 *	4 *	4 *	TBC	4	4	4	4	4	4	4	4	4		
Finance	Cost Improvement Year to Date Variance		2,015	-4,423	-7,085	10,475	TBC	-51	121	1,116	2,365	2,342	2,975	2,994	2,013 *	1,593		
Finance	Liquidity		4 *	4 *	4 *	4 *	TBC	4	4	4	4	4	4	4	4	4		
Finance	NHSI Financial Risk Rating	3	4 *	4 *	4 *	4 *	3	4	4	4	4	4	4	4	4	4		
Finance	Total PayBill Spend		27.7 *	28.1 *	28.5 *	28.5 *	TBC	28.4	28.5	28.05	28.5	30.5	27.5	29.5	29.03	29.7		
Leadership and Development	**Key Indicators - Leadership and Development**																	
Workforce Expenditure and Efficiency	% Sickness Rate	G<3.6% R>4%	3.9%	3.9%	4.0%	3.9%	R>4% A3.6-4% G<=3.5%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9% *	3.9% *
Workforce Expenditure and Efficiency	% Turnover	G<11% R>15%	11.9%	11.6%	11.4%	12.1%	TBC	12.0%	11.8%	12.3%	12.3%	12.0%	12.1%	11.9%	11.6%	11.7% *	11.6% *	12.3% *

Category		Indicator	Standard 2017/18	Month				Standard 2018/19	Month									Quarter	Annual
				Dec-17	Jan-18	Feb-18	Mar-18		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	18/19 Q3	18/19
	Detailed Indicators - Leadership and Development																		
	Appraisal and Mandatory Training	Trust total % mandatory training compliance	>=90%	88% *	73%	79%		R<70% A70-89% G>=90%			87%	87%	88%	90%	91% *	91% *	91% *		91% *
		Trust total % overall appraisal completion	G>=90% R<70%	84.0%	83.0%	83.0%	82.0%	R<70% A70-89% G>=90%			74.0%	74.0%	75.0% *	79.0%	80.0% *	79.0% *	79.0% *		79.0% *

Exception Report

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of Adult Inpatients who have Received a VTE Risk Assessment **Standard: R<=95% A96% G>97%**		Performance of risk assessment for VTE continues to be delivered at 93-94% through Clinical Audit data collection. Data collection remains a challenge via TRAK with a new pathway being designed using a wider MDT approach	Director of Safety
% of fracture neck of Femur patients treated within 36 Hours **Standard: R<80% A80-89% G>=90%**		Action plan was due to be reviewed at December surgical Board, this was cancelled due to operational pressures therefore this will be reviewed at January Surgical Board.	Director of Operations - Surgery
% of patients who have been screened for Dementia (within 72 hours) **Standard: R<70% A70-89% G>=90%**		On-going work regarding electronic solution. Audits in place and information being shared with Commissioner,	Deputy Chief Nurse

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of patients who have received a dementia diagnostic assessment with positive or inconclusive results that were then referred for further diagnostic advice/FU (within 72 hours) Standard: R<70% A70-89% G>=90%		Weekly manual audits in place. On going work with clinical audit to support further audit work. Electronic solution in an EPR still to be developed.	Deputy Chief Nurse
% of patients who have scored positively on dementia screening tool that then received a dementia diagnostic assessment (within 72 hours) Standard: R<70% A70-89% G>=90%		Manual audits in place re medical clerking compliance.	Deputy Chief Nurse
Ambulance Handovers – Over 30 Minutes Standard: < previous year		63 ambulance handover delays for December 2018. This increase is in line with the drop in triage performance and increase in E.D attendances.	Director of Unscheduled Care and Deputy Chief Operating Officer

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Ambulance Handovers – Over 60 Minutes **Standard: < previous year**		1 > 60 minute ambulance handover delay for December 2018 = same performance as November 2018 but 1 greater than the previous year. This increase is in line with increased E.D attendances and a drop in triage performance.	Director of Unscheduled Care and Deputy Chief Operating Officer
C.Diff Cases – Cumulative Totals **Standard: R>3 G<=3**		There was 1 case of trust-apportioned C. difficile during December 2018. Investigations of individual cases have focussed on antimicrobials as a leading risk factor, this case rate is within the expected limits for the month. The trust have a comprehensive action plan to bring about improvements. All cases are reviewed internally and presented to the CCG.	Associate Chief Nurse and Deputy Director of Infection Prevention and Control
Cancer – 31 Day Diagnosis To Treatment (First Treatments) **Standard: R<94% A94-95% G>=96%**		Dec Performance = 94.1% Target = 96% National performance = 96.6% Performance affected by shared pathway between Head and Neck and Skin (OMF. Full review of breaches has shown several process issues related to booking management and tracking. Urology 31 day performance has improved from a nadir in Oct/Nov. Current performance for January is meeting the standard	Director of Planned Care and Deputy Chief Operating Officer

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Cancer 62 Day Referral To Treatment (Upgrades) **Standard: >=90%**		Dec performance - 66.7% (10.5 tx and 3.5 breaches) 2 tertiary referrals referred Day 43 and 84 1 x prostate breach 1 skin breach from input required from two specialties	Director of Planned Care and Deputy Chief Operating Officer
Cancer 62 Day Referral To Treatment (Urgent GP Referral) **Standard: R<80% A80-84% G>=85%**		Dec performance - 69% (unvalidated) Target - 85% National performance - 79.2% 150 tx 46.5 breaches Uro 21 H&N 5 LGI 4 UGI 3.5 Gynae 3 Poor month for all specialties. Breach analysis will be conducted to understand poor performance. Urology showing signs of recovery from nadir in summer 2018. January performance shows improved position.	Director of Planned Care and Deputy Chief Operating Officer
ED Total Time in Department – Under 4 Hours **Standard: R<90% A90-94% G>=95%**		Trust wide 4 hour performance was 87.5% for December 2018. Whilst this is below NHSI trajectory for the month, Quarter 3 surpassed the trajectory of 90%. Emergency department activity was 7.47% higher than December 2017 with MFFD > 90 per day for the most of the month. Same day emergency care through AMIA and SAU saw the greatest number of patients retuned home to date (720).	Director of Unscheduled Care and Deputy Chief Operating Officer

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % of time to initial assessment – Under 15 minutes **Standard: R<92% A92-94% G>=95%**		Trustwide triage performance decreased to 85.4%, the lowest level since June 2017. Due to sickness the streaming nurse has become increasingly part of the numbers reducing triage capacity at the front door.	Director of Unscheduled Care and Deputy Chief Operating Officer
ED: % of time to start of treatment – Under 60 minutes **Standard: R<87% A87-89% G>=90%**		Time to treatment was 32.1% in December 2018. Medical workforce review commencing January 2019.	Director of Unscheduled Care and Deputy Chief Operating Officer
ED: % total Time in Department – Under 4 Hours GRH **Standard: R<90% A90-94% G>=95%**		Trust wide 4 hour performance was 83.8% for December 2018. Whilst this is below NHSI trajectory for the month, Quarter 3 surpassed the trajectory of 90%. Emergency department activity was 7.31% higher than December 2017 at GRH. Same day emergency care was maximised through AMIA and SAU.	Director of Unscheduled Care and Deputy Chief Operating Officer

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Emergency re-admissions within 30 days following an elective or emergency spell **Standard: R>6.8% G<6.8%**		The current rate of readmissions runs consistently below the national average which is above 8%. Work is underway to assess if we have any specialties with excess levels and detailed analysis will then be undertaken. Once this work is complete a reset of the target will be established.	Deputy Medical Director
Inpatients % Positive **Standard: R<93% A93-95% G>=96%**		Our score remains static. Ward and service areas need to review the comments made by our patients and make improvements in response. We have shared the FFT access with all the ward managers and matrons. Staff are now reviewing comments as part of their diagnostic phase for their quality improvement work.	Deputy Director of Quality
MRSA Bloodstream Cases – Cumulative Totals **Standard: 0**		During September 2018 the trust had two cases of trust-apportioned MRSA bacteraemia in a patient with a known history of MRSA, thought to be a possible blood culture contaminant and another in a patient with a surgical site infection (associated with another trust). These cases were reviewed by the IPC team and the clinical team. There have been no further cases.	Associate Chief Nurse and Deputy Director of Infection Prevention and Control

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of patients delayed at the end of each month **Standard: TBC**	50.0 40.0 30.0 20.0 10.0 0.0 Feb-18 Mar-18 Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18	There are 33 delayed discharges reported for December 18. again collaborative working with system partners and a push on DTOC especially around 21 days has been initiated since the beginning of January. Wards report daily to the ops centre around blockages for patients and delayed discharges. These are taken back daily to system partners.	Director of Unscheduled Care and Deputy Chief Operating Officer
Number of Patients Stable for Discharge **Standard: TBC**	100.0 80.0 60.0 40.0 20.0 0.0 Feb-18 Mar-18 Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18	Average patients stable for discharge as of December 31st is showing as 58. However, it may be anticipated that this number would have been higher but due to the xmas period there may have been a delay in reporting. There has been collaborative working with system partners and the Trust in the way we are operationally working to ensure greater, earlier discharges.	Director of Unscheduled Care and Deputy Chief Operating Officer
Number of patients waiting over 104 days with a TCI date **Standard: 0**	30.0 25.0 20.0 15.0 10.0 5.0 0.0 Feb-18 Mar-18 Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18	Gynaecological 1 Lower gastrointestinal 2 Lung 1 Upper gastrointestinal 1 Urological (excl. testicular) 13 Grand Total 18	Director of Planned Care and Deputy Chief Operating Officer

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of Patients waiting over 104 days without a TCI date **Standard: TBC**		Lower gastrointestinal 6 Lung 1 Other 1 Upper gastrointestinal 3 Urological (excl. testicular) 21 Grand Total 32	Director of Planned Care and Deputy Chief Operating Officer
Percentage of Women Seen by Midwife by 12 Weeks **Standard: >90%**		It has come to light that there is an intersystems issue, in that when the ultrasound field (which is one of the fields used to calculate the gestation at booking) is updated, it makes the gestation at booking field blank, which has been affecting this metric. An urgent JIRA has been raised for this. In the meantime, the data team are going to try and do a manual work around in the background to try and produce a more accurate picture. We will endeavour to update this metric, for this month and also for previous months, with the correct figures once this has been done.	Divisional Chief Nurse and Director of Midwifery
Stroke Care: Percentage of patients Receiving Brain Imaging Within 1 Hour **Standard: R<45% A45-49% G>=50%**		Improved performance on November position by 9% There have been significant challenges faced in December but the service has improved the number of patients staying on the stroke unit by 10% on last month. Breach themes vary between patients presenting with difficult diagnosis, problems with CT scanners leading to delays and delayed assessments in ED due to demand.	Director of Unscheduled Care and Deputy Chief Operating Officer

TRUST BOARD – FEBRUARY 2019
Lecture Hall, Sandford Education Centre commencing at 12:30

Report Title
Guardian for Safe Working – Quarterly Report
Sponsor and Author(s)
Author: Dr Simon Pirie, Guardian for Safe Working Sponsor: Dr Sean Elyan, Medical Director
Executive Summary
<u>Purpose</u> This report covers the period of 1.8.18 – 31.10.18 <u>Key issues to note</u> There were 145 exception reports logged There are a total of 8 fines to the value of £741.86. No correlation with Datix clinical incident reports for this period. <u>Conclusions</u> The number of exceptions has risen slightly this quarter, as has the amount of fines levied. This is encouraging, but we need to ensure continued engagement of trainees to allow for accurate interpretation of the data. <u>Implications and Future Action Required</u> Continued support for the Guardian role and for the proposed solutions to issues that arise.
Recommendations
Continue current monitoring and engagement with teams where exception reporting is occurring.
Impact Upon Strategic Objectives
N/A
Impact Upon Corporate Risks
N/A
Regulatory and/or Legal Implications
Under the 2016 terms and conditions of service (TCS) for junior doctors, the Trust provides an exception reporting process for working hours or educational opportunities that vary from those set out in work schedules. The Guardian oversees exception reports and assures the Board of Compliance with safe working hours' limits.

Equality & Patient Impact			
N/A			
Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

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

Outcome of discussion when presented to previous Committees/TLT

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

TRUST BOARD – JANUARY 2019

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

1. Executive Summary

1.1 This report covers the period of 1.8.18 – 31.10.18. There were 145 exception reports logged; compared to 103 in the last quarter.

1.2 We have again needed to levy some fines. These are detailed below; there are a total of 4 fines to the value of £741.86. The Junior Doctor's forum is fully functioning and meets quarterly.

2. Introduction

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

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

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

High level data

Number of doctors / dentists in training (total):	473
Number of doctors / dentists in training on 2016 TCS:	473
Amount of time available in job plan for guardian:	2PA
Administrative support:	4Hrs
Amount of job-planned time for educational supervisors:	0.25/0.125 PAs

(first/additional trainees to maximum 0.5 SPA)

3. Junior Doctor Vacancies

Junior Doctor Vacancies by Department					
Department	**F1**	**F2**	**ST 1-2**	**ST3-8**	**Additional training and trust grade vacancies**
ED			2	0.2	
Oncology			1		
T&O			2		
Surgery			1	3	**1 Trust Dr/Fellow in Opthalmology** **1 Clinical fellow Urology**
General Medicine			16	8	**2 Clinical education fellows** **1 Specialty Dr Rheumatology** **1 Specialty Dr Orthogeriatrics**
Paeds				3	**1 Specialty Dr**
Obs & Gynae				1	

4. Locum Bookings

4.1 Data from finance team:

Total spend Aug-Oct 2018 on Junior Medical Locum **£800,277.42**.

5. Exception Reports (working hours)

Exception reports by Department		
Specialty	**Exceptions carried over from last report**	**Exceptions raised**
General/GI Surgery		16
Urology		
Trauma/ Ortho		3
ENT		10
Vascular Surgery		
Ophthalmology		2
Orthogeriatrics		
General/old age Medicine		16
Acute medicine/ ACUA		93
Emergency Department		5
Obstetrics and Gynaecology		0
Paediatrics		0
Total		**145**

6. Fines this Quarter

Fine by Department				
Rota cycle	**Department**	**Hours**	**Fine**	**When levied**
30.7.18-24.9.18	Renal	49.39	**£478.75**	Nov 18
30.7.18-24.9.18	Neuro	48.11	**£38.30**	Nov 18
30.7.18-17.9.18	Colorectal	48.37	£114.90	Nov 18
30.7.18-15.10.18	Upper GI	48.14	£109.91	Nov 18
Total		194.01	£741.86	

Fines (cumulative)			
Balance at end of last quarter	**Fines this quarter**	**Disbursements this quarter**	**Balance at end of this quarter**
3421.35	£741.86	0.00	4163.21

7. Issues Arising

7.1 Four reports were raised as 'immediate safety concerns'. Two did not appear to detail any immediate safety concern (? error), the other two did not identify any direct harm to patients, but outlined very high level of workloads with reduced staffing levels to deal with them.

8. Actions Taken to Resolve Issues

8.1 Discussions had with educational supervisors and plans made to reduce episodes where staffing levels reduced.

9. Qualitative Information

9.1 The Allocate software for raising exception reports came into use on the 1st October 2017. It remains challenging to retrieve and utilise data. In order to understand whether exceptions have led to fines being indicated, reports need to be reviewed manually which takes a lot of time.
Allocate have announced new system updates which will hopefully address some of these issues.

10. Correlations to Clinical Incident Reporting

10.1 We are now looking for any links between exception reports and Datix reports being submitted. There were no Datix reports correlating with dates of exception reports submitted during this quarter.

11. Summary

11.1 A total of 145 working hours exception reports have been made since the beginning of Aug 2018 – end Oct 2018. We are still trying to collect data on specific specialties so that we can better monitor performance and the effectiveness of changes when made to reporting numbers.

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

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

Date 04/02/2019

Recommendation

- To approve

Appendices

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

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

REPORT TO MAIN BOARD – FEBRUARY 2019

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

This report describes the business conducted at the Finance & Digital Committee held 31 January 2019, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Financial Performance Report	In Month 9 the Trust reported a cumulative deficit of £19.3m. This represents a £0.7m adverse position against plan, driven by the position at the time of reporting on the A&E related Provider Sustainability Funding (PSF).	Would active cash management need to be reintroduced this year?	Borrowing that the Trust had available from NHS Improvement (NHS) means that the Trust should not need to actively manage working capital for the rest of the financial year.	
Capital Programme Update	There remains no movement on the capital loan financing from NHSI – capital programme still held other than for emergency requests. Options list for future sources of capital funding discussed.	Are there any operational impacts of the slowdown in capital spend? What are the pros and cons of the possible funding sources?	A number of emergency requests have already been authorised in areas where this is a concern.	Detailed options appraisal on potential funding sources still required.

Cost Improvement Programme (CIP) Update	At Month 9 the Trust has delivered £20.2m of CIP year to date (YTD) against the YTD NHSI target of £18.6m. Within the month, the Trust has delivered £2.8m of CIP against an in-month NHSI target of £3.3m.	What is the operational engagement with the CIP programme currently?	CIP is part of business as usual activities for Divisional management and their teams.	
Electronic Patient Record (EPR) Procurement	The Trust is seeking to get the very best EPR system and wished to explore some of the options with the Finance and Digital Committee.	Have we incorporated the learning from the experience with TrakCare? How is the Procurement to be approached? How can the Trust get best value, most benefit and least disruption?	The Business case for an EPR system is strong. There are several options for how the Procurement is done in order to get the right solution, and all of the appropriate Procurement rules will be followed, using Mark's valuable previous experience elsewhere.	Confirming the detailed Business case and then the right approach to Procurement.

Risk Register (Digital)	The full inventory of risks assigned to the Digital space was presented to Committee as requested at the last meeting.	There are opportunities to improve the quality of the risk descriptions and actions (clarity, consistency, etc.). Having seen the full list, the Committee would like to focus on those most material in future meetings, using same thresholds as for Finance and other Committees.	There is a comprehensive list of Digital Risks being actively managed. Future Committee meetings will give ongoing attention to those most material in either score or RAG rating.	

Keith Norton
Chair of Finance and Digital Committee
31 January 2019

TRUST BOARD – FEBRUARY 2019
Lecture Hall, Sandford Education Centre commencing at 12:30

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

Purpose

To provide assurance to the Board with regard to the Trust's financial performance for the period ended 31st December 2018.

Key issues to note

- The Trust is reporting an actual income and expenditure deficit of £19.3m for the year to date at December 2018. This is an adverse variance of £0.7m.

  Line variances are:
  Total Income £3.4m
  Total Pay (£0.5)m
  Total Non-Pay (£5.7)m
  Non-Operating £2.3m
  Donated Assets (£0.2)m
  Total (£0.7)m

- Following a detailed review of the income and expenditure forecast, the Trust has amended the forecast deficit to £29.8m, a variance of £11.0m to the £18.8m control total.

- It should be noted that £3.8m of this variance (that driven by the GMS AfC clawback and the associated loss of the Q4 PSF) has been forecast since M6.

Conclusions

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

Recommendations
The Board are asked to note the contents of the report.
Impact Upon Strategic Objectives
Delivery of an improved financial position.
Impact Upon Corporate Risks
None.

Regulatory and/or Legal Implications			
Movement to forecast will lead to increased scrutiny.			
Equality & Patient Impact			
None.			
Resource Implications			
Finance	**X**	Information Management & Technology	
Human Resources		Buildings	

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

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

Report to the Trust Board

Financial Performance Report
Month Ended 31st December 2018

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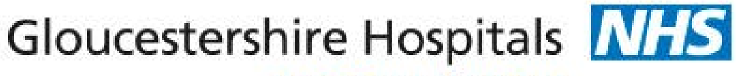
Introduction and Overview



In April the Board approved budget for the 2018/19 financial year was a deficit of £29.7m on a control total basis (after removing the impact of donated asset income and depreciation). The Board approved a revised control total of £18.8m (including PSF) on 12th June 2018. This has been reflected in Month 9 reporting.

The financial position as at the end of December 2018 reflects the Group position including Gloucestershire Hospitals NHS Foundation Trust and the newly formed Gloucestershire Managed Services Limited, the Trust's wholly-owned subsidiary company. The Group position in this report excludes the Hospital Charity.

In December the Group's consolidated position shows a year to date deficit of £19.3m. This is £0.7m adverse against plan reflecting the loss of PSF A&E income in Q3. As discussed at the Finance Committee on 31st January 2019, following discussions with NHSI it has now been confirmed that this income will be received by the Trust, which will be reported in month 10.

Statement of Comprehensive Income (Trust and GMS)

	TRUST POSITION			GMS POSITION			GROUP POSITION *		
Month 09 Cumulative Financial Position	**Budget £000s**	**Actuals £000s**	**Variance £000s**	**Budget £000s**	**Actuals £000s**	**Variance £000s**	**Budget £000s**	**Actuals £000s**	**Variance £000s**
SLA & Commissioning Income	331,806	335,067	3,260	0	0	0	331,806	335,067	3,260
PP, Overseas and RTA Income	4,275	3,860	(415)	0	0	0	4,275	3,860	(415)
Other Income from Patient Activities	4,060	3,499	(561)	0	0	0	4,060	3,499	(561)
Operating Income	50,924	52,120	1,196	33,346	33,267	(78)	54,453	55,571	1,118
Total Income	**391,065**	**394,546**	**3,480**	**33,346**	**33,267**	**(78)**	**394,594**	**397,996**	**3,402**
Pay	248,689	248,776	(87)	12,626	13,027	(401)	261,315	261,803	(488)
Non-Pay	145,989	151,173	(5,184)	19,144	19,647	(502)	135,317	141,003	(5,686)
Total Expenditure	**394,678**	**399,949**	**(5,271)**	**31,770**	**32,673**	**(904)**	**396,632**	**402,806**	**(6,175)**
EBITDA	**(3,613)**	**(5,404)**	**(1,791)**	**1,576**	**594**	**(982)**	**(2,037)**	**(4,810)**	**(2,773)**
EBITDA %age	**(0.9%)**	**(1.4%)**	**(0.4%)**	**4.7%**	**1.8%**	**(2.9%)**	**(0.5%)**	**(1.2%)**	**(0.7%)**
Non-Operating Costs	15,487	14,208	1,279	1,576	594	982	17,063	14,802	2,261
Surplus/(Deficit)	**(19,100)**	**(19,612)**	**(511)**	**0**	**0**	**0**	**(19,100)**	**(19,612)**	**(511)**
Excluding Donated Assets	450	278	(173)	0	0	0	450	278	(173)
Control Total Surplus/(Deficit)	**(18,650)**	**(19,334)**	**(684)**	**0**	**0**	**0**	**(18,650)**	**(19,334)**	**(684)**

* Group Position excludes £30.3m of intergroup transactions including dividends

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Group Statement of Comprehensive Income

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

In December, the Group’s consolidated position shows an in month deficit of £3.2m which is £1m adverse against plan.

The year to date deficit of £19.3m is an adverse variance of £0.7m against plan.

Month 09 Financial Position	Annual Budget £000s	M09 Budget £000s	M09 Actuals £000s	M09 Variance £000s	M09 Cumulative Budget £000s	M09 Cumulative Actuals £000s	M09 Cumulative Variance £000s
SLA & Commissioning Income	444,587	35,241	36,281	1,039	331,806	335,067	3,260
PP, Overseas and RTA Income	5,710	471	411	(60)	4,275	3,860	(415)
Other Income from Patient Activities	5,418	450	821	371	4,060	3,499	(561)
Operating Income	74,297	6,613	6,010	(603)	54,453	55,571	1,118
Total Income	**530,012**	**42,775**	**43,522**	**747**	**394,594**	**397,996**	**3,402**
Pay	346,990	28,298	29,711	(1,413)	261,315	261,803	(488)
Non-Pay	178,190	14,817	15,342	(525)	135,317	141,003	(5,686)
Total Expenditure	**525,180**	**43,115**	**45,053**	**(1,937)**	**396,632**	**402,806**	**(6,175)**
EBITDA	**4,832**	**(340)**	**(1,530)**	**(1,190)**	**(2,037)**	**(4,810)**	**(2,773)**
EBITDA %age	**0.9%**	**(0.8%)**	**(3.5%)**	**(2.7%)**	**(0.5%)**	**(1.2%)**	**(0.7%)**
Non-Operating Costs	22,751	1,896	1,665	231	17,063	14,802	2,261
Surplus/(Deficit)	(17,919)	(2,236)	(3,196)	(960)	(19,100)	(19,612)	(511)
Excluding Donated Assets	(902)	50	31	(19)	450	278	(173)
Control Total Surplus/(Deficit)	(18,821)	(2,186)	(3,165)	(979)	(18,650)	(19,334)	(684)

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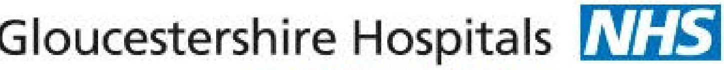
Detailed Income & Expenditure



Month 09 Financial Position	M09 Budget £000s	M09 Actuals £000s	M09 Variance £000s	M09 Cumulative Budget £000s	M09 Cumulative Actuals £000s	M09 Cumulative Variance £000s
SLA & Commissioning Income	35,241	36,281	1,039	331,806	335,067	3,260
PP, Overseas and RTA Income	471	411	(60)	4,275	3,860	(415)
Other Income from Patient Activities	450	821	371	4,060	3,499	(561)
Operating Income	6,613	6,010	(603)	54,453	55,571	1,118
Total Income	**42,775**	**43,522**	**747**	**394,594**	**397,996**	**3,402**
Pay						
Substantive	26,295	27,512	(1,217)	242,409	241,352	1,057
Bank	940	851	89	8,460	8,831	(371)
Agency	1,063	1,348	(285)	10,446	11,621	(1,175)
Total Pay	**28,298**	**29,711**	**(1,413)**	**261,315**	**261,803**	**(488)**
Non Pay						
Drugs	4,956	5,014	(58)	50,144	52,292	(2,148)
Clinical Supplies	4,021	4,422	(401)	28,897	29,870	(973)
Other Non-Pay	5,840	5,906	(66)	56,275	58,841	(2,565)
Total Non Pay	**14,817**	**15,342**	**(525)**	**135,317**	**141,003**	**(5,686)**
Total Expenditure	**43,115**	**45,053**	**(1,937)**	**396,632**	**402,806**	**(6,175)**
EBITDA	**(340)**	**(1,530)**	**(1,190)**	**(2,037)**	**(4,810)**	**(2,773)**
EBITDA %age	**(0.8%)**	**(3.5%)**	**(2.7%)**	**(0.5%)**	**(1.2%)**	**(0.7%)**
Non-Operating Costs	1,896	1,665	231	17,063	14,802	2,261
Surplus/(Deficit)	**(2,236)**	**(3,196)**	**(960)**	**(19,100)**	**(19,612)**	**(511)**
Excluding Donated Assets	50	31	(19)	450	278	(173)
Surplus/(Deficit)	**(2,186)**	**(3,165)**	**(979)**	**(18,650)**	**(19,334)**	**(684)**

Non-Pay – expenditure is showing a £5.7m overspend year to date. Of the £0.5m overspend in month, Clinical Supplies is £0.4m adverse mainly on medical and surgical equipment within Surgery – Theatres; Other Non-Pay is largely on plan in month.

SLA & Commissioning Income – is £3.3m favourable against plan. This predominantly reflects under performance against Specialised Services (£0.8m), Worcestershire and Hereford (£0.5m), offset by over performance on GCCG (£0.5m), Welsh Commissioners (£0.9m) and Other Commissioners (£3.1m).

PP / Overseas / RTA Income – performance has deteriorated slightly with a £0.4m year to date adverse variance. Oncology private patients (£0.1m) and RTA cost recovery (£0.3m) make up the adverse variance.

Other Patient Income – the year to date adverse variance largely relates to the DoH clawback of Agenda for Change funding in respect of GMS (£0.6m).

Other Operating Income – The in month under performance is driven by the loss of Q3 A&E PSF reward funding (£0.7m).

Pay – expenditure is showing a £0.5m overspend year to date reflecting an underspend on substantive staff, offset by an overspend on temporary staffing. The in month variance of £1.4m adverse is mainly driven by undelivered Pay CIPs (£0.9m), largely Diagnostic & Specialist (£0.3m), Surgery (£0.3m) and Medicine (£0.2m). Other significant in month overspends include nursing agency in Unscheduled Care (£0.2m), clinical coders and business intelligence agency staff (£0.3m) and domestic staff agency in GMS (£0.1m).

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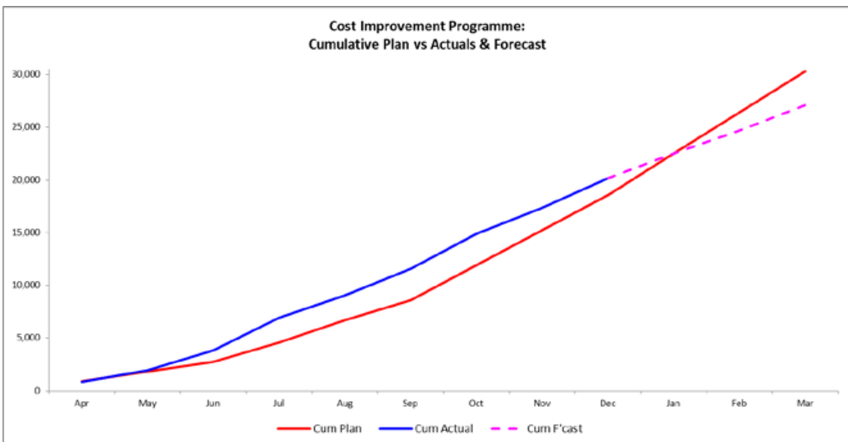
1. At Month 9 the trust has delivered £20.2m of CIP YTD against the YTD NHS Improvement target of £18.6m.
The YTD delivery splits into £15.4m recurrent and £4.7m of non-recurrent schemes. This translates into a split of 78% of recurrent delivery versus 22% of non-recurrent delivery.
Within the month, the Trust has delivered £2.8m of CIP against an in-month NHSI target of £3.3m.

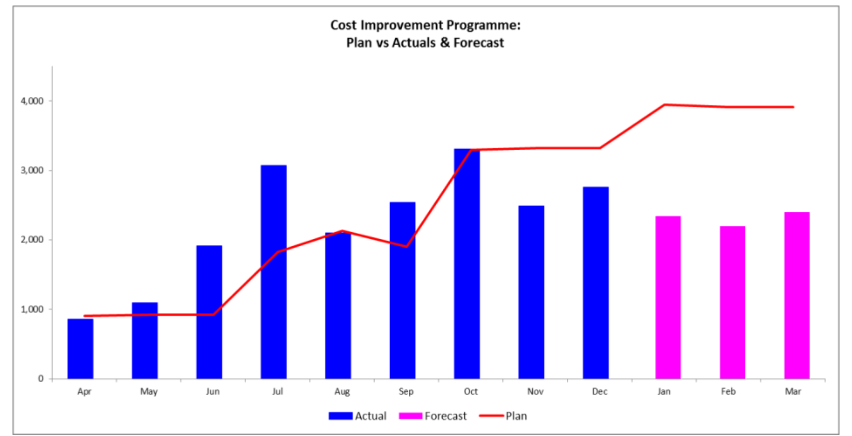
2. At Month 9, the Divisional year end forecast figures indicate delivery of £27.1m against the Trust's target of £30.3m. This is an increase against the M8 FOT of £121k. The increase in the FOT is due to movements in month mainly due to T&O GIRFT and Vacancy Factor.

3. The cumulative FOT indicates that GHFT will be reporting a negative variance against plan from January (see graph to the right). This is consistent with the projection at Month 8.

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



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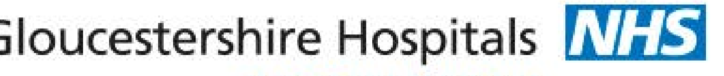
Forecast Outturn



Following a detailed review of the income and expenditure forecast, the Trust has amended the forecast deficit to £29.8m, a variance of £11.0m to the £18.8m control total. It should be noted that £3.8m of this variance (that driven by the GMS AfC clawback and the associated loss of the Q4 PSF) has been forecast since M6.

The factors driving the variance to control total are highlighted in the table opposite:

I. A shortfall in the Trust's cost improvement programme of £3.4m.
II. A shortfall of £0.9m in DoH funding for the Agenda for Change pay award for the Trust's subsidiary company, GMS.
III. An under performance (excluding the impact of pass through drugs and devices) on commissioning income of £1m.
IV. Cost pressures of £2.2m, reflecting higher agency usage than planned, and pass through drugs expenditure not offset by commissioning income.
V. The loss of Provider Sustainability Funding for Q3 A&E of £0.7m, and Q4 funding of £2.8m due to non delivery of the control total.

The following page provides an update on actions taken to secure the revised forecast outturn, and the possible risks to delivery.

Control Total	£m (18.8)
CIP Shortfall	(3.4)
GMS AfC Clawback	(0.9)
Commissioning Income	(1.0)
Cost Pressures	(0.7)
PSF Q3 A&E	(2.8)
PSF Q4	(2.2)
Forecast Outturn	**(29.8)**

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Cost Improvement Programme

- At month 7 forecast CIP delivery was £26.9m. The Month 9 forecast is £27.1m, an improvement of £0.2m.

Contract Settlement

- The Trust continues to work towards settlement of the 2018/19 contractual income position to support the forecast outturn outlined here.

Nursing Bank and Agency

- A review of nursing bank and agency usage led by the Director of Quality and Chief Nurse identified a maximum reduction in expenditure of £0.9m in the final quarter of the financial year. This opportunity was subject to review at the Turnaround Implementation Board, where the controls being implemented were discussed, with recognition of the impact of operational pressures on the Trust's use of bank and agency.

A&E 4 Hour Wait Performance PSF Funding

- It has now been confirmed that the Trust will receive the Q3 A&E PSF funding of £0.7m.

New Risks
Opening Additional Capacity

- The Trust has experienced significant operational pressures during December and January, with emergency patient activity resulting in the need to open additional inpatient beds, with expenditure being incurred above forecast. The impact of continued higher levels of emergency activity represents a risk to the delivery of the Trust's financial forecast.

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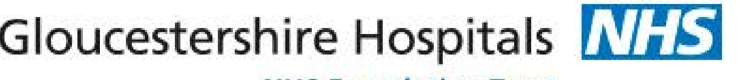

Trust Financial Position	Opening Balance 31st March 2018 £000	GROUP Balance as at M9 £000	B/S movements from 31st March 2018 £000
Non-Current Assests			
Intangible Assets	9,130	10,054	924
Property, Plant and Equipment	251,010	249,382	(1,628)
Trade and Other Receivables	4,463	4,498	35
Total Non-Current Assets	**264,603**	**263,934**	**(669)**
Current Assets			
Inventories	7,131	7,535	404
Trade and Other Receivables	19,276	28,332	9,056
Cash and Cash Equivalents	5,447	10,523	5,076
Total Current Assets	**31,854**	**46,390**	**14,536**
Current Liabilities			
Trade and Other Payables	(47,510)	(60,342)	(12,832)
Other Liabilities	(3,284)	(4,350)	(1,066)
Borrowings	(4,703)	(11,257)	(6,554)
Provisions	(160)	(160)	0
Total Current Liabilities	**(55,657)**	**(76,109)**	**(20,452)**
Net Current Assets	**(23,803)**	**(29,719)**	**(5,916)**
Non-Current Liabilities			
Other Liabilities	(7,235)	(6,954)	281
Borrowings	(111,219)	(123,227)	(12,008)
Provisions	(1,472)	(1,472)	0
Total Non-Current Liabilities	**(119,926)**	**(131,653)**	**(11,727)**
Total Assets Employed	**120,874**	**102,562**	**(18,312)**
Financed by Taxpayers Equity			
Public Dividend Capital	168,768	170,068	1,300
Reserves	43,530	43,530	0
Retained Earnings	(91,424)	(111,036)	(19,612)
Total Taxpayers' Equity	**120,874**	**102,562**	**(18,312)**

The table shows the M9 balance sheet and movements from the 2017/18 closing balance sheet, supporting narrative is on the following page.

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Balance Sheet (2)

Commentary below reflects the Month 9 balance sheet position against the 2017/18 outturn

Non-Current Assets

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

Current Assets

- Inventories show a increase of £404k.
- Trade receivables are £9.1m above the closing March 2018 level.
- Cash has increased by £5.1m since the year-end. The Group was holding cash to pay a VAT liability in early January and received payment of invoices that were not due until January.

Current Liabilities

- Current liabilities have increased by £20.5m, reflecting an increase in creditors/accruals. A loan repayment of £5m has also moved from non current liabilities to current liabilities as it now falls payable within a year.

Non-Current Liabilities

- Borrowings have increased by £12m, this reflects an in month movement of a new loan of £2.2m and the reclassification from long term borrowing to current borrowing as described above.

Retained Earnings

- The retained earnings reduction of £19.6m reflects the impact of the in year deficit.

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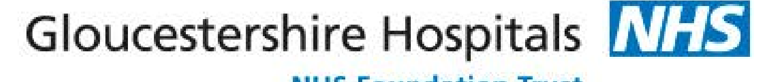
Better Payment Practice Code (BPPC)



	Cumulative for Financial Year		Current Month December	
	Number	£'000	Number	£'000
Total Bills Paid Within period	82,864	169,725	7,437	18,813
Total Bill paid within Target	62,918	134,535	5,303	13,960
Percentage of Bills paid within target	76%	79%	71%	74%

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.

Liabilities – Borrowings

Analysis of Borrowing	As at 31st December 2018 £000
<12 months	
Loans from ITFF	3,317
Distress Funding	6,055
Obligations under finance leases	1,782
Obligations under PFI contracts	103
Balance Outstanding	**11,257**
>12 months	
Loans from ITFF	22,593
Capital Loan	4,500
Distress Funding	76,163
Obligations under finance leases	1,516
Obligations under PFI contracts	18,455
Balance Outstanding	**123,227**
Total Balance Outstanding	**134,484**

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

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

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

The position reflects £20.3m of additional in-year borrowing.

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Cashflow : December

Cashflow Analysis	Apr-18 £000s	May-18 £000s	Jun-18 £000s	Jul-18 £000s	Aug-18 £000s	Sep-18 £000s	Oct-18 £000s	Nov-18 £000s	Dec-18 £000s	Jan-19 £000s	Feb-19 £000s	Mar-19 £000s	Plan Year ending 31.3.19 £000s
Surplus (Deficit) from Operations	**(4,831)**	**(2,512)**	**(1,213)**	**(1,126)**	**(2,148)**	**(272)**	**638**	**1,219**	**(2,605)**	**(1,188)**	**(3,043)**	**(2,351)**	**(19,432)**
Adjust for non-cash items:													
Depreciation	912	912	912	912	912	912	625	869	870	870	870	870	10,446
Other operating non-cash	0	0	0	0	0	0	0	0	0	0	0	(1,500)	(1,500)
Operating Cash flows before working capital	(3,919)	(1,600)	(301)	(214)	(1,236)	640	1,263	2,088	(1,735)	(318)	(2,173)	(2,981)	(10,486)
Working capital movements:													
(Inc.)/dec. in inventories	0	71	0	0	0	(330)	33	155	(333)	0	0	0	(404)
(Inc.)/dec. in trade and other receivables	(4,596)	(2,610)	(546)	2,310	(963)	3,647	(3,619)	(615)	(2,064)	(1,774)	(1,870)	2,753	(9,947)
Inc./(dec.) in current provisions	0	0	0	0	0	0	0	0	0	0	0	(79)	(79)
Inc./(dec.) in trade and other payables	7,156	1,157	1,434	(1,013)	1,222	(6)	(1,654)	(1,050)	5,586	(6,938)	4,042	5,785	15,721
Inc./(dec.) in other financial liabilities	(437)	904	0	0	0	(1,552)	(245)	(35)	2,431	0	0	0	1,066
Net cash in/(out) from working capital	2,123	(478)	888	1,297	259	1,759	(5,485)	(1,545)	5,620	(8,712)	2,172	8,459	6,357
Capital investment:													
Capital expenditure	(158)	(207)	(459)	(459)	(1,883)	(159)	(1,155)	(2,295)	(253)	(2,879)	(3,380)	(2,472)	(15,759)
Capital receipts	0	0	0	0	0	0	0	0	0	0	0	0	0
Net cash in/(out) from investment	(158)	(207)	(459)	(459)	(1,883)	(159)	(1,155)	(2,295)	(253)	(2,879)	(3,380)	(2,472)	(15,759)
Funding and debt:													
PDC Received	0	0	0	0	0	0	0	0	1,300	0	1,700	0	3,000
Interest Received	3	13	2	2	5	30	12	2	3	3	3	3	81
Interest Paid	(29)	(218)	(78)	(178)	(87)	(1,255)	(91)	(223)	(76)	(179)	(85)	(1,836)	(4,335)
DH loans - received	3,500	0	0	0	4,044	4,465	1,915	4,152	2,186	4,632	2,346	1,434	28,674
DH loans - repaid	0	0	0	0	(167)	(1,317)	0	0	0	0	(167)	(1,318)	(2,969)
Finance lease capital	(148)	(148)	(148)	(148)	(148)	(148)	(149)	(149)	(149)	(149)	(149)	(149)	(1,782)
Interest element of Finance Leases	(12)	(12)	(12)	(12)	(12)	(12)	(13)	(13)	(13)	(13)	(13)	(13)	(150)
PFI capital element	(95)	(95)	(95)	(95)	(95)	(95)	(95)	(94)	(94)	(94)	(94)	(94)	(1,135)
Interest element of PFI	(161)	(161)	(161)	(161)	(161)	(161)	(161)	(160)	(160)	(160)	(160)	(160)	(1,927)
PDC Dividend paid	0	0	0	0	0	(1,489)	0	0	0	0	0	(873)	(2,362)
Net cash in/(out) from financing	3,058	(621)	(492)	(592)	3,379	18	1,418	3,515	2,997	4,040	3,381	(3,006)	17,095
Net cash in/(out)	1,104	(2,906)	(364)	32	519	2,258	(3,959)	1,763	6,629	(7,869)	0	0	(2,793)
Cash at Bank - Opening	5,447	6,551	3,645	3,281	3,313	3,832	6,090	2,131	3,894	10,523	2,654	2,654	5,447
Closing	6,551	3,645	3,281	3,313	3,832	6,090	2,131	3,894	10,523	2,654	2,654	2,654	2,654

The cashflow for December 2018 is shown in the table:

Cashflow Key movements:

Current Assets – The increase in trade and other receivables since month 8 has reduced cash.

Other Financial Liabilities – Trade and other payables have increased in month.

The Cash Position – reflects the Group position. The Trust has drawn down loan support of £20.3m. The Trust has requested further loans in line with the forecast I&E position and working capital. The increase in cash during the month of December is offset by an increase in creditors.

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

Capital Expenditure Update

The table provides an overview of the progress of the capital programme to date and year end forecast for 2018/19.

Capital Programme Expenditure Summary position at 31st December 2018

Capital Summary	Internal YTD Plan £000's	YTD Spend £000's	YTD Var £000's	18/19 Full Year Plan £000's	FOT 18/19 Spend £000's	Forecast Variance £000's
Health & Safety Projects	2,237.5	1,455.2	-782.3	4,475.0	2,750.4	-1,724.6
Environmental Works	117.0	104.1	-12.9	200.0	117.0	-83.0
Estates Unallocated Allowances	72.0	-18.5	-90.5	125.0	38.8	-86.2
Non Health & Safety Projects	862.5	873.6	11.1	1,154.0	1,257.1	103.1
Committed Schemes	1,400.0	1,199.7	-200.4	2,679.0	2,672.8	-6.2
Service Reconfiguration	610.5	205.2	-405.3	1,221.0	209.0	-1,012.0
Major Equipment Replacement	698.8	34.0	-664.8	4,588.0	3,222.0	-1,366.0
IM&T	3,864.7	1,573.6	-2,291.1	6,100.0	3,803.5	-2,296.5
MEF	1,141.0	296.9	-844.1	2,000.0	400.1	-1,599.9
Other Schemes	0.0	49.3	49.3	1,300.0	1,399.6	99.6
Contingency	0.0	0.0	0.0	200.0	0.0	-200.0
Strategic Development	300.0	272.6	-27.4	1,975.0	786.5	-1,188.5
Overspend/(Underspend)	**11,304.0**	**6,045.8**	**-5,258.2**	**26,017.0**	**16,656.8**	**-9,360.2**

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

The Trust is still awaiting the outcome of the capital financing application, and therefore the forecast currently assumes that additional funding will not be received in 2018/19. This position reflects spend against schemes with the highest priority in terms of health and safety and contractual commitments.

Points to note:

- Work continues within the Women's Centre to replace the carbon steel piping. H&S budgets have been reprioritised to accommodate this replacement work.
- IM&T schemes have been finalised, however a halt has been placed on further capital commitments until the outcome of the capital financing application is known.
- Detailed planning and phased implementation of the £920k streaming improvements works is underway.
- The Trust has committed to funding the enabling works for the new Linac (£480k) and has recently approved the Infoflex business case (£147k).
- Enabling works for Victoria Warehouse and Pullman Court are included in the forecast position (£100k).

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Recommendations

The Board is asked to note:

- The Trust is reporting an actual income and expenditure deficit of £19.3m for the year to date at December 2018. This is an adverse variance of £0.7m.
- The forecast outturn of £29.8m, and associated actions to secure delivery.

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

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

Date: **January 2019**

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TRUST BOARD – FEBRUARY 2019
Lecture Hall, Sandford Education Centre commencing at 12:30

Report Title							
SmartCare Progress Report							
Sponsor and Author(s)							
Author: Leah Carey, Digital Transformation Lead, Trakcare Recovery, Sarah Hammond, Head of BI Felicity Taylor Drewe, Deputy COO/ Director of Planned Care Sponsor: Mark Hutchinson, Executive Chief Digital and Information Officer							
Executive Summary							
<u>Purpose</u> To provide assurance to the Board, from the Trak Care Recovery Programme, on the current position of the recovery Programme and Return to RTT plan.							
Recommendations							
The Board is asked to note this report.							
Impact Upon Strategic Objectives							
Contributing to ensuring our organisation is stable and viable with the resources to deliver its vision, through harnessing the benefits of information technology.							
Impact Upon Corporate Risks							
A number of clinical safety, operational and financial risks have been highlighted which the recovery programme is designed to mitigate.							
Regulatory and/or Legal Implications							
The Trust has been informed by NHSI that It was satisfied formal regulatory action in respect of TrakCare recovery is not appropriate at this time. We have a contractual agreement with the supplier of TrakCare (Intersystems) which we are reviewing with external advice and in conjunction with other TrakCare Trusts.							
Equality & Patient Impact							
See report.							
Resource Implications							
Finance	✓	Information Management & Technology	✓				
Human Resources	✓	Buildings					
Action/Decision Required							
For Decision		For Assurance	✓	For Approval		For Information	

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

TRUST BOARD – FEBRUARY 2019

SMARTCARE PROGRESS REPORT

1. Purpose

This report provides an update on the progress of the recovery programme following the implementation of TrakCare in December 2016. This report demonstrates an increase in the overall number of DQ issues for the first time since January 2018 but in contrast a positive report of progress made towards returning to RTT reporting.

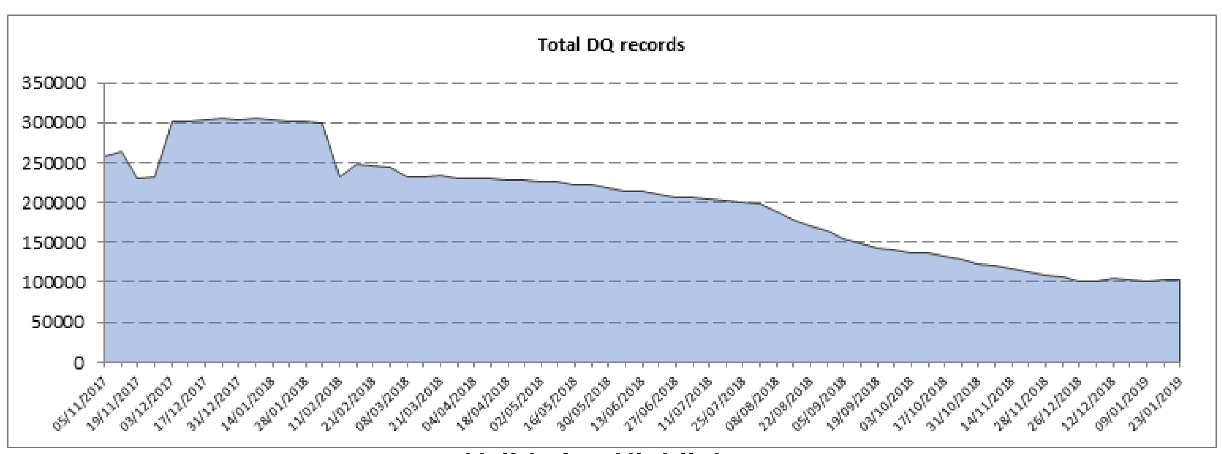
2. Data Quality Issues

RTT related data quality (DQ) issues continues to be monitored and reported to the TrakCare Recovery Board via a series of dynamic dashboard views on a weekly basis. As of the 23/01/19 the overall number of DQ issues now sits at 103,254. Prior to January 2019 third party validators were contracted to support the removal/fixing of data quality issues being created . This was in order to concentrate the efforts of the recovery team (operational and IM & T colleagues) on performance validation and stopping the creation of new issues which is a complex and multifactorial. The validation team are addressing the Primary Waiting list (relating to DQ); the 0 to 18 week cohort of patients to support correct re-reporting and the longest waiting patients to support the management of the 52 week wait position. The validation team and operational colleagues have also had to re-validate a small cohort of the work arried out by the third party that was previously undertaken. Whilst a significant number of validation has been deemed successful by the third party team (DQ2,DQ11) further validation and quality assurance has resulted in the need to validate all waiting list removals. The recovery of RTT has been set alongside a collaborative approach between informatics and operational teams. There are still fixes that are required to be applied to the logic on some of the areas highlighted by the 5 key RTT DQ metrics. There has been no change in the level of operational validation during the last period of reporting.

The work is now focused on the permanent fixes which are generating DQ issues and understanding where and whom the issues are being created by so that these can be addressed. Aligned to this an RTT training programme is being expanded at a global level for example induction, e-learning module in addition to a bespoke training when we have clarity on the issues being produced. A data quality board will be formally set up to take the wider DQ issues forward. Additional to this there is a sub-group established to support the specific RTT re-reporting and this will continue to meet fortnightly to maintain a level of oversight in this area.
Below shows the recent distribution of DQ issues by week, it should be noted that the majority of this increase has been predicted in the trajectories reviewed at the TrakCare Recovery Board.

Pattern of Overall DQ Issues since 26/12

26/12/2018	02/01/2019	09/01/2019	16/01/2019	23/01/2019
101699	101485	101921	102573	103254



Validation Highlights

Vol Change in 1 Week		Data Quality Report:	Overall Issues In This Indicator
2	1.	Elective Planned Waiting List Entry on an Open RTT Pathway	99
188	2.	Open Waiting List Entries with a Blank RTT Pathway ID	2359
46	2c.	Open Waiting List Entries with a Blank RTT Pathway ID - From Outcomes (Closed pathways) *NB known system Issue, will remain until 2017 Upgrade*	625
169	3.	Open Waiting List Entries on a Closed RTT Pathway	11096
-24	4.	Planned Elective OR Return Outpatient Waiting List Entries with No Recall Date	1594
2	5.	Open Waiting List Entries with past activity and No Future Activity Booked	6194
-7	6.	DNA Discharges	192
-16	7.	Planned Elective Waiting List Entries with No Previous Elective Admission	4211
6	8.	Open Inpatient Waiting List Entries with cancellations that should be closed	199
-9	9.	Open Outpatient Waiting List Entries that should be closed due to a Cancellation Reason	855
-10	10a.	Open Return Outpatient Waiting List Entries where the Last Activity is Inpatients - (Exact Match)	1194
-62	10b.	Open Return Outpatient Waiting List Entries where the Last Activity is Inpatients - (Potential Match)	2674
24	11.	Open RTT Pathways where the last activity was cancelled or the patient was removed from waiting list	826
331	12.	Total Duplicate RTT Pathways	2818
-165	13.	Total Duplicate Waiting List Entries	34027
33	13.1	Open new OPWL with any past Waiting List Entry Type against the same pathway with same or different Treatment Function	3106
-8	14.	Open Waiting List Entries which have multiple booked appointments or TCI's	521
1	15.	Deceased Patients with Open Waiting List Entries or on an Open RTT Pathway	13
43	16.	New Outpatient Waiting Lists with no clinician assigned	7926
36	17.	Waiting List Entries that have a vetting outcome of rejected	475
0	18.	Inpatient Waiting Lists with a blank waiting list admission type	10
43	19.	Outpatient Outcome of "Refer to different Department/Consultant- for same condition" but no new referral details added	1668
1	20.	Open Waiting Lists with a blank waiting list type	14
-40	21.	Open Waiting Lists where the activity has been booked on a previous episode	15079
102	22.	Open Waiting Lists with DQ issues that have ERS appointments	13955

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

3. Return to RTT reporting

3.1 RTT Script & Logic

The BI team in conjunction with operational colleagues continue to make progress with the review of the trust's RTT logic. During February the focus will be on amending the RTT reporting logic to use the 'primary waiting list' field within TrakCare, this has been tested and the associated impacts shared with the operational teams, This amendment will be moved into 'live' during the next monthly test run of the RTT process. To address the inclusion of Primary Waiting list the central validation team has been deployed to 'fix' this identified issue. The validation team have undertaken an initial review of the impact and the logic will be implemented into live following the 18th February 2019.

Further work is planned to review the logic for identifying completed pathways and this will be worked up during this month.

3.2 Validation Tool

The validation tool had now been incorporated into the RTT reporting so that the overall position includes corrections made by the Validation Team. This has enabled the 2nd shadow RTT reporting process to collate all validation activity into the monthly snapshot. This shadow report tested the end to end processes which were deemed successful and enabled the level of RTT performance to be produced, the team are now carrying out quality assurance work to test the reported level of performance against the validation activity that was undertaken. Following this reporting attempt technical issues were identified that have impacted on the tools use in shadow report attempt 3, however all issues have now been fixed. The next phase of work will enable the tool to be transitioned into business as usual for the reporting process within the BI team ensuring the tool is robust and all processes documented.

3.3 Reporting Process

Shadow report cycle two saw the completion of the full end to end reporting process for the first time. Following the quality assurance work described above, any edits or changes to the process or data feeds will be made. This puts the project in the promising position of shadow report cycle three being a full process that creates a trusted answer *noting that this will contain an un-validated cohort of patients until March 2019.

4. RETURN TO RTT PLAN

Task Name	Start	Finish	RAG	Owner
Interim Recruitment for Validation Tool Manager	24/09/2018	05/10/2018		SH
Completion of Validation Guide for DQ3	24/09/2018	22/10/2018		AT
ongoing DQ2 Validation to sit in Trak Support team	24/09/2018	02/11/2018		TT/SH
DQ7 Specialty Validation	04/11/2018	28/11/2018		FTD
DQ 2 Validation by Populo- 3approx. 30,000	24/09/2018	24/12/2018		ZP
RTT End to End Process Refine	28/09/2018	11/10/2018		SH/RB
Agree Return to RTT Plan at Smartcare Board	01/10/2018	01/10/2018		LP
Validation Tool Build	08/10/2018	14/11/2018		jj/SH
BI and Kayleigh to review and amend summary report	10/10/2018	02/11/2018		JG/KW/JA
Assessment of completeness	15/10/2018	02/11/2018		CMcA

Final Review of RTT Scripts	05/11/2018	05/11/2018		LP/RB/SH
TLT Update	07/11/2018	07/11/2018		FTD
SmartCare Board Update	03/12/2018	03/12/2018		LP
Shadow Report Process Attempt 1	03/12/2018	19/12/2018		SH/RB
Review SRPA 1	19/12/2018	31/12/2018		SH/RB
DQ3 Validation by Populo- 23,000	24/12/2018	04/03/2019		ZP
Shadow Report Attempt 2	02/01/2019	17/01/2019		SH/RB
SmartCare Board Update	14/01/2019	14/01/2019		LP
SRAP 2 Sign Off	18/01/2019	19/01/2019		SH/FTD/CL
Review SRPA 2	19/01/2019	31/01/2019		RTT Group
Shadow Report Attempt 3	01/02/2019	15/02/2019		SH/RB
SRAP 3 Sign Off	18/02/2019	19/02/2019		SH/FTD/CL
Review SRPA 3	19/02/2019	28/02/2019		RTT Subgroup
SmartCare Board Go/No Go	04/03/2019	04/03/2019		SmartCare Board
First Real Submission	01/03/2019	15/03/2019		SH/RB
Submission Sign Off	15/03/2019	19/03/2019		SH/FTD/CL/MH/DL
TrakCare Recovery Go/No Go	19/03/2019	19/03/2019		TBS
SmartCare Board Go/No Go- Virtual	19/03/2019	19/03/2019		TBC
Submit RTT Performance	19/03/2019	19/02/2019		SH

5. Risks

- The number of data quality issues has begun increasing for the first time since January 2018. There is a draft work plan to address the areas that have been identified as increasing and it is recognised that the number of issues need to be addressed to ensure that the return to re-reporting is sustained. It should be noted that this is the primary risk of the successful outcome of this work.
- Risk that RTT cannot be sustainably reported as a result of lower then required investment in the Trak Recovery team budget resulting in failure to measure and/or deliver performance. This has been raised as an intolerable risk.

6. Next Phase

- Discussions are ongoing as to the transition from TrakCare Recovery to a more Optimisation focus, this will include a review of the current work programme and outstanding priorities.
- Shadow attempt three of RTT cycle and production of RTT % position
- Continued efforts to stop the creation of new data quality issues, full update in all work streams at next board
- Identification of audit cycle to support assurance both internally and with regulators.
- Publication of service level waiting times in conjunction with CCG colleagues, the same format utilised both internally and externally.

Author:	Leah Carey, Digital Transformation Lead,
Presenting/ Co Author:	Sarah Hammond, Associate CIO; Head of BI, Felicity Taylor- Drewe, Deputy COO/ Director of Planned Care, Mark Hutchinson, Executive Chief Digital Information Officer
Date:	06.02.19

REPORT TO TRUST BOARD – FEBRUARY 2019

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

This report describes the business conducted at the Audit and Assurance Committee on 8 January 2019, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Counter Fraud	Update on current plan implementation – this is currently on track. Future Arrangements following resignation of the current manager. 3 options outlined.	Is the current option appraisal sufficiently objective? Can a 6-month trial with Audit South West provide interim cover and add meaningfully to the option appraisal?	A sensible interim solution.	Additional work to be undertaken.
Internal Audit	Progress report, final reports for - Patient Experience - Medication Income and Pharmacy CIP	What is the cause of limited division ownership? What is the significance of the manual system?	Recommendations to be progressed.	Lack of real time information a factor. Report to be reviewed at the Quality Committee.

	- Draft plan for 2019/20	Does the time allocated to Consultant Job Planning indicate a lack of co-ordination with other initiatives?	Executives to review and refine the plan.	
External Audit	Review of planned work for 18/219 audit.	How will the Value for Money assessment be made?	There will be continued dialogue between the Trust and Audit to address any areas of concern.	
Emergency Planning Report	General update identifying main area of focus as ensuring hot services have current business continuity plans.	Is Brexit planning under the auspices of this team? As this report is work in progress when will further assurance be provided?	Brexit currently shared between a number of Executives/initiatives.	Report to February Board Further report to the March meeting to move reassurance to assurance.
Governance Documents	Comprehensive suite of refreshed governance documents presented for scrutiny.			Detailed inputs to be gathered ahead of February Board.
Reports from the Finance Director	Losses & Compensations Single Tender Actions 19/20 Budget Setting.	What is the rejection rate of ex-gratia payment claims? What is the process to receive budge holder sign off?	All claims require FD authorisation. Rejection rate is low. Incidence rate comparable to other Trusts Budget setting process now more robust.	Budget setting and sign off process to be reviewed at May meeting.

Gloucestershire Managed Services Update	Update on internal audit reports, audit plan, capital & cash flow planning and VAT related work.	Are the yearend work programmes (GMS & Trust) aligned to ensure Trust/Group accounts can be completed to the national deadline?	Yes	

Rob Graves
Chair of Audit and Assurance Committee
February 2019

REPORT TO TRUST BOARD – FEBRUARY 2019

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

This report describes the business conducted at the GMS Committee held 14 January 2019, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Matters Arising	Cleaning is currently performed to a local standard.	Need to understand the impact of not complying with national standards, confirm whether the Trust will stay with local standards or move to national ones; if the latter, cost implications of such a move need to be understood.	Discussions are ongoing about moving to national standards.	Proposal to be developed and agreed by the Trust. Committee to receive assurance at March meeting.
GMS Report	GMS budget setting process.	Are the Trust and GMS processes/timescales aligned?	Work in progress.	Further work is required; update on the GMS budget setting process to be brought to the February Committee.

Risk and Governance	Trust-owned estates and facilities-related risks.		Chief Operating Officer and Director of Strategy and Transformation are reviewing the risks, with a specific action to assess whether the Trust should carry a strategic risk of infrastructure/facilities failure.	Results of the review of estates and facilities risks will be presented at the February GMS Committee meeting.
GMS Restructure	GMS Restructure Business Case.	Has the financial impact of the proposed restructure been considered and discussed with the Trust? Have the engagement and approval by the Trust been considered, given that it is a matter reserved for the Trust Board?	Proposed structure will not be finalised until after the staff engagement/ consultation ends.	Potential financial impact, and assumptions made, to be identified and discussed with the Trust. Case for change to be shared with the Committee members. Restructure timeline and engagement/endorsement/approval milestones to be agreed with the Trust and built into Committee/Board work plans

Mike Napier
Chair of Gloucestershire Managed Services Committee
15 January 2019

TRUST BOARD – FEBRUARY 2019
Lecture Hall, Sandford Education Centre commencing at 12:30

Report Title
Appointment of GMS director
Sponsor and Author(s)
Author: Neil Jackson, Managing Director, Gloucestershire Managed Services (GMS) Sponsor: Lukasz Bohdan, Director of Corporate Governance
Executive Summary

Purpose

To approve appointment of the GMS Finance and Commercial Director

Key issues to note

The GMS Board structure allows for a permanent full time Finance and Commercial Director, to be appointed as a member of GMS Board of Directors. This role is currently being covered by an interim.

Initial advertisement on NHS Jobs did not identify a suitable candidate from the five applications received. A subsequent head hunting process was undertaken which identified a short list of three candidates for the role.

Interviews were held on 17th of January 2019. The interview panel comprised of Kathy Headdon, interim GMS Chair; Sarah Stansfield, Trust Director of Finance, Neil Jackson, GMS Managing Director and Steve Burnside Service Lead Medical Engineering.

The candidates also attended a briefing session with Rod Anthony and a staff focus group as part of the interview day programme.

Of the three applicants interviewed on 17th January 2019 Simon Wadley was considered the best candidate offering the required level of skills and experience from:

- Current and previous public and private sector experience including GCHQ, Health/NHS and commercial businesses.
- Significant experience at a senior executive management level across a number of industries.

Key Terms and Conditions:

Term of office –	Permeant appointment on GMS terms and conditions (including 6 months probationary period)
Remuneration –	£90,000 per annum
Hours of work -	37.5 hours a week

The recruitment process and the terms and conditions were previously approved by the Remuneration Committee.

As set out in the GMS *Schedule of matters reserved and delegated* appointment of GMS Directors is a matter reserved for the Trust Board.

Implications and next steps

- Offer made to Simon Wadley
- Companies House to be notified of changes

Recommendations

The Board is asked to:

- Approve the appointment of Simon Wadley as Finance and Commercial Director of GMS

Impact Upon Strategic Objectives

Not applicable

Impact Upon Corporate Risks

Not applicable

Regulatory and/or Legal Implications

Company House records to be updated.

Equality & Patient Impact

Not applicable

Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required

For Decision		For Assurance		For Approval	X	For Information	

Date the paper was previously presented to Committees and/or TLT

Audit and Assurance Committee	Finance and Digital Committee	GMS Committee	People and OD Committee	Quality and Performance Committee	Remuneration Committee	Trust Leadership Team	Other (specify)

Outcome of discussion when presented to previous Committees/TLT

N/A

TRUST BOARD – FEBRUARY 2019
Lecture Hall, Sandford Education Centre commencing at 12:30

Report Title	
Review of Governance Documents	
Sponsor and Author(s)	
Author:	Cecilia Price, Corporate Governance Graduate Trainee & Lukasz Bohdan, Director of Corporate Governance
Sponsor:	Lukasz Bohdan, Director of Corporate Governance
Executive Summary	

<u>Purpose</u>

To present the revised governance documents to the Board for approval, including:

- Board Standing Orders (SOs)
- Standing Financial Instructions (SFIs)
- Scheme of Delegation
- Terms of Reference for Board Committees (Audit and Assurance Committee, Estates Committee, Finance and Digital Committee, People and Organisational Development Committee, Quality and Performance Committee, and Remuneration Committee) and for the Trust Leadership Team

<u>Key issues to note</u>

General

- Undertaking periodic review of governance arrangements and documents is considered good practice and ensures that the Trust's governance arrangements remain fit for purpose.
- Following the revisions to the Trust Constitution, the Trust has reviewed and aligned its SOs, SFIs and Scheme of Delegation. Terms of Reference (ToRs) of the Board Committees and the Trust Leadership Team have also been reviewed and updated.
- Relevant stakeholders (e.g. Committee Chairs, CEO, Director of Finance, Head of Shared Service) have contributed to the revisions and/or reviewed the amendments.
- The Audit and Assurance Committee have reviewed all the papers at its January 2019 meeting; feedback from the Committee have been reflected in the attached documents and the Director of Corporate Governance had undertaken a final review and edit to ensure consistency and completeness across the attached suite of governance documents.

Board Standing Orders (SOs)

- Board Standing orders have been reviewed by the Trust's legal advisors, DAC Beachcroft as part of the Constitution review.
- Changes include: general housekeeping, including alignment to the Council of Governors' SOs, where relevant; introduction of e-governance (i.e. decision making outside the Board meetings); updates to the conflicts of interest section to reflect latest NHS guidance; updates to the tendering procedure; and the development and inclusion of the sealing policy.

Standing Financial Instructions (SFIs)

- SFIs have been updated. Changes include: general housekeeping; alignment to the revised governance structure and policy landscape (e.g. control totals); revisions to the delegated authority limits associated with tendering; and revisions to the financial delegation limits.

Scheme of Delegation

- A comprehensive Scheme of Delegation has been created pulling in one document the matters reserved to the Board and the responsibilities delegated to individuals/Board Committees, as per the revised Trust Constitution, SFIs, SOs and Terms of Reference.

Terms of Reference (ToR) for Board Committees and the Trust Leadership Team

- Changes to the Terms of Reference reflect the revised governance arrangements, including the remit of the Committees, delegated responsibilities and the reporting lines; and best practice (e.g. NHS Providers' *The foundations of good governance: a compendium of best practice*, NHS Audit Committee Handbook; ICSA: The Governance Institute Guidance)
- Individual Committees and the Trust Leadership Team endorsed the proposed changes

Implications and Future Action Required

Following the Board approval the Committees and TLT will adopt the revised Terms of Reference.

Governance documents will be uploaded to the Trust's website.

The documents will be reviewed annually.

Recommendations

The Board is asked to approve the revised governance documents.

Impact Upon Strategic Objectives

Effective, fit-for-purpose governance arrangements support the delivery of the Trust's Strategic Objectives.

Impact Upon Corporate Risks

Not applicable

Regulatory and/or Legal Implications

Compliance with NHS Foundation Trust Code of Governance and best practice.

Equality & Patient Impact

Not applicable

Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required

For Decision		For Assurance		For Approval	X	For Information	

Date the paper was presented to previous Committees and/or TLT							
Audit and Assurance Committee	**Finance and Digital Committee**	**Estates Committee**	**People and OD Committee**	**Quality and Performance Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
July 2018 (SOs and SFIs) September 2018 (ToR only) January 2019 (All documents)	October 2018 (ToR only)	October 2018 (ToR only)	September 2018 (ToR only)	October 2018 (ToR only)	January 2019 (ToR only)	October 2018 (ToR only)	

Outcome of discussion when presented to previous Committees/TLT
ToRs endorsed/endorsed with amendments, now reflected in the attached documents. The Audit and Assurance Committee reviewed and commented on the documents; the requested changes have now been reflected in the attached documents.

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

STANDING ORDERS

Version Control			
Version	**Author**	**Date**	**Changes**
0.1	Lukasz Bohdan	08-01-2019	First draft
0.2	Lukasz Bohdan	08-02-2019	Edits made following Audit and Assurance Committee

Approved by the Board of Directors on [insert date]

STANDING ORDERS

Foreword

NHS Trusts are required by law to make Standing Orders (SOs), which regulate the way in which the proceedings and business of the Trust will be conducted. Standing Orders are part of its corporate governance arrangements.

The Standing Orders, Standing Financial Instructions and the "Schedule of decisions reserved to the Board and the Scheme of Delegation" provide a comprehensive business framework that can be applied to all activities. They fulfil the dual role of protecting the Trust's interests and protecting staff from possible accusation that they have acted less than properly.

Members of the Board of Directors and all members of staff should be aware of the existence of and work to these documents.

STANDING ORDERS

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STANDING ORDERS
FOR THE REGULATION OF PROCEEDINGS AND BUSINESS
OF THE BOARD OF DIRECTORS

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/or the Director of Corporate Governance).

1.2 Any expression to which a meaning is given in the Health Service Acts or in the Regulations or Orders made under the Acts or the Trust Constitution shall have the same meaning in this interpretation.

2. The Trust

2.1 The Trust has the functions conferred on it by the NHS Act 2006 and by its Authorisation.

2.2 The Trust has resolved that certain powers and decisions may only be exercised or made by the Board in formal session. These powers and decisions are set out in "Schedule of decisions reserved to the Board and the Scheme of Delegation" and have effect as if incorporated into the Standing Orders.

3. Meetings of the Board of Directors

3.1 **Admission of the Public and the Press** – subject to Standing Order (SO) 3.2 below, all meetings of the Board are to be open to members of the press and public.

3.2 The Board 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 SO 3.17) 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 Board if they are interfering with, or preventing the proper conduct of the meeting.

3.5 Nothing in these Standing Orders shall require the Board 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 Board.

3.6 **Calling Meetings** - Ordinary meetings of the Board shall be held at such times and places as the Board may determine.

3.7 Meetings of the Board may only be called in accordance with this paragraph. The Chair may call a meeting of the Board 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 Directors, 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 Directors may forthwith call a meeting.

3.8 The Board may agree that its members 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 Board shall agree a protocol to be applied in the case of such meetings.

3.9 **Notice of Meetings** - Before each meeting of the Board, 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 Director, or sent by post to the usual place of residence of such Director, so as to be available to them at least fourteen clear days before the meeting.

3.10 Subject to SO 3.12, lack of service of the notice on any Director shall not affect the validity of a meeting.

3.11 In the case of a meeting called by Directors in default of the Chair, the notice shall be signed by those Directors 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 Directors 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 **Setting the Agenda** - The Board may determine that certain matters shall appear on every agenda for a meeting of the Board 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).

3.14 A Director desiring a matter to be included on an agenda shall make their request in writing to the Chair at least ten clear days before the meeting, subject to Standing Order 3.9. Requests made less than ten days before a meeting may be included on the agenda at the discretion of the Chair.

3.15 Agendas will be sent to members six days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be despatched no later than three clear days before the meeting, save in emergency.

3.16 **Chair of Meeting** - The Chair, or in their absence, the Vice-Chair, shall preside at meetings of the Board and shall be entitled to exercise a casting vote where the number of votes for and against a motion is equal.

3.17 If the Chair and Vice-Chair are absent from a meeting of the Board, the Directors 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.

3.18 **Notices of Motion** - A Director of the Trust 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.

3.19 **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.

3.20 **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 Director(s) who gives it and also the signature of four other Directors. When any such motion has been disposed of by the Board, it shall not be competent for any Director other than the Chair to propose a motion to the same effect within six months; however the Chair may do so if they consider it appropriate.

3.21 **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.

3.22 Subject to SO 3.23, when a motion is under discussion or immediately prior to discussion it shall be open to a Director to move:

3.22.1 An amendment to the motion.
3.22.2 The adjournment of the discussion or the meeting.
3.22.3 That the meeting proceed to the next business.
3.22.4 The appointment of an ad hoc committee to deal with a specific item of business.
3.22.5 That the motion be now put.

3.22.6 A motion to exclude the public (including the press).

3.23 The motions specified in paragraphs 3.22.3 and 3.22.5 may only be put by a Director who has not previously taken part in the debate.

3.24 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.

3.25 **Chair's Ruling** - Statements of Directors made at meetings of the Board 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.

3.26 **Voting** - Every question at a meeting shall be determined by a majority of the votes of the Chair of the meeting and members present and voting on the question and, in the case of the number of votes for and against a motion being equal, the Chair of the meeting shall have a second or casting vote.

3.27 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 Directors present so request.

3.28 If at least one-third of the Directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Director present voted or abstained.

3.29 If a Director so requests, their vote shall be recorded by name upon any vote (other than by paper ballot).

3.30 In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote.

3.31 An officer who has been appointed formally by the Board to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy shall be entitled to exercise the voting rights of the Executive Director. An officer attending the Board to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An officer's status when attending a meeting shall be recorded in the minutes.

3.32 **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.

3.33 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.

3.34 Minutes shall be circulated in accordance with Directors' wishes. Where providing a record of a public meeting the minutes shall be made available to the public.

3.35 **Joint Directors** - Where the office of a member of the Board is shared jointly by more than one person:

3.35.1 either or both of those persons may attend or take part in meetings of the Board:
3.35.2 if both are present at a meeting they should cast one vote if they agree:
3.35.3 in the case of disagreements no vote should be cast;

3.35.4 the presence of either or both of those persons should count as the presence of one person for the purposes of SO 3.43 (Quorum).

3.36 **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 Board are present, including one Executive Director and one Non-Executive Director, and that a majority of those present vote in favour of suspension.

3.37 A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

3.38 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Directors.

3.39 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.

3.40 The Audit and Assurance Committee shall review every decision to suspend Standing Orders.

3.41 **Variation and Amendment of Standing Orders** - These Standing Orders shall be amended only if:

3.41.1 a notice of motion under Standing Order 3.18 has been given; and
3.41.2 no fewer than half the total of the Trust's Non-Executive Directors vote in favour of amendment; and
3.41.3 at least two-thirds of the Directors are present; and
3.41.4 the variation proposed does not contravene a statutory provision or direction made by the Secretary of State.

3.42 **Record of Attendance** - The names and job titles of the Directors present at the meeting shall be recorded in the minutes.

3.43 **Quorum** - No business shall be transacted at a meeting of the Board unless at least one-third of the whole number of the Chair and Directors appointed (including at least one Executive Director and one Non-Executive Director) are present.

3.44 An officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

3.45 If a Director 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 6 and 7) 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.

3.46 **Frequency –** The Trust shall hold meetings of the Board of Directors at least six times in each calendar year.

4. Arrangements for the Exercise of Functions by Delegation

4.1 Subject to a provision in the authorisation or the Constitution, the Board may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee, appointed by virtue of SO 5 below or by a Director or an officer of the Trust in each case subject to such restrictions and conditions as the Board thinks fit.

4.2 **Emergency Powers** - The powers which the Board has retained to itself within these Standing Orders (SO 2.2) may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and the Chair shall be reported to the next formal meeting of the Board for ratification.

4.3 **E-Governance** – Where agreed by any of the office holders described in SO 4.2 decisions may also be made by way of a written resolution. In such cases the document or issue in need of review should be sent to Directors and the Board of Directors should have a specified number of days to register their approval via email or other means to the Director of Corporate Governance. The document should not require extensive discussion, although the Board of Directors may choose to ask specific questions to the document author. The email will need to clearly specify the approval that is sought. A document or issue will be considered approved when three-quarters of the Board of Directors has approved it. As in a Board meeting, the Chair shall have the casting vote in the event of an evenly split vote. Notice of all decisions taken by written resolution will be reported to the following formal Board or Committee meeting.

4.4 **Delegation to Committees** - The Board shall agree from time to time to the delegation of executive powers to be exercised by committees or sub-committees, which it has formally constituted. The Constitution and terms of reference of the committees and their specific executive powers shall be approved by the Board.

4.5 **Delegation to Officers: Schedule of decisions reserved to the Board and the Scheme of Delegation** - Those functions of the Trust which have not been retained as reserved by the Board or delegated to a committee or sub-committee shall be exercised on behalf of the Board by the Chief Executive. The Chief Executive shall determine which functions they will perform personally and shall nominate officers to undertake the remaining functions for which they will still be accountable to the Board.

4.6 The Director of Corporate Governance shall prepare a Scheme of Delegation identifying their proposals which shall be considered and approved by the Board, subject to any amendments agreed during the discussion. The Director of Corporate Governance may periodically propose amendment to the Scheme of Delegation, which shall be considered and approved by the Board as indicated above.

4.7 Nothing in the “Reservation of decisions to be reserved to the Board and the Scheme of Delegation” shall impair the discharge of the direct accountability to the Board of the Director of Finance or other Executive Directors to provide information and advise the Board in accordance with any statutory requirements.

5. Committees

5.1 **Appointment of Committees** - Subject to such directions as may be given by NHS Improvement (Monitor), the Trust may and, if directed by NHS Improvement (Monitor), shall appoint committees of the Trust, consisting wholly or partly of Directors of the Trust or wholly of persons who are not Directors of the Trust.

5.2 A committee appointed under SO 5.1 may, subject to such directions as may be given by NHS Improvement (Monitor) or the Board, appoint sub-committees consisting wholly or partly of members of the committee (whether or not they include Directors of the Trust) or wholly of persons who are not members of the Board committee (whether or not they include Directors of the Trust).

5.3 The Standing Orders of the Board as far as they are applicable shall apply with appropriate alteration to meetings of any committees or sub-committee established by the Board.

5.4 Each Board committee shall have such terms of reference and powers and be subject to such conditions as the Board shall decide. Each sub-committee shall have such terms of reference and powers and be subject to such conditions as the appointing committee shall decide. Such terms of reference shall have effect as if incorporated into the Standing Orders.

5.5 Committees may not delegate their executive powers to a sub-committee unless expressly authorised by the Board.

5.6 The Board shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines that persons, who are neither Directors nor officers, shall be appointed to a committee, the terms of such appointment shall be determined by the Board.

5.7 Where the Trust is required to appoint persons to a committee and/or to undertake statutory functions as required by the Secretary of State or NHS Improvement (Monitor) and where such appointments are to operate independently of the Trust, such appointment shall be made in accordance with the regulations laid down by the Secretary of State.

5.8 Without prejudice to the formation of any other committees or sub-committees as the Board may see fit, the following committees shall be established by the Board:

a) Audit and Assurance Committee
b) Remuneration Committee

5.9 **Confidentiality** - A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Board or shall otherwise have concluded on that matter.

5.10 A Director of the Trust or a member of a committee shall not disclose any matter reported to the Board or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Board or committee shall resolve that it is confidential.

6. Declarations of Interests and Register of Interests

6.1 **Declaration of interests**

6.2 Each Director shall comply with paragraph 11 of the Constitution regarding conflicts of interest.

6.3 Interests that are required to be declared by a Director in accordance with paragraph 11 of the Constitution are:

6.3.1 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 SOs 6.6 and 6.10 (subject to SO 6.7);

6.3.2 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 SOs 6.8 and 6.10; and

6.3.3 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 SOs 6.9 and 6.10.

6.3.4 An interest must be declared under paragraph 11.3 of the Constitution to the Director of Corporate Governance at the time of the Director's appointment or as soon thereafter as the interest arises, and in any event within seven clear days of becoming aware of the existence of that interest.

6.3.5 If during the course of a meeting the Board, a Director has an interest of any sort in a matter which is the subject of consideration the Director concerned shall disclose the fact, and the Chair shall decide what action to take. This may include excluding the Director from the discussion of the matter in which the Director has an interest and/or prohibiting the governor from voting any such matter.

6.3.6 Subject to SO 6.3.4 if a Director has declared a financial interest in a matter (as described in SOs 6.6 and 6.7) they shall not take part in the discussion of that matter nor vote on any question with respect to that matter.

6.3.7 Any interest declared at a meeting of the Board and subsequent action taken should be recorded in the meeting minutes. Any changes in interests should be declared at the next Board meeting following the change occurring.

6.3.8 This SO 6 applies to a committee or sub-committee and to a joint committee or sub-committee as it applies to the Board and applies to a member of any such committee or sub-committee (whether or not they are also a member of the Trust) as it applies to a member of the Trust.

6.4 **Nature of interests**

6.5 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).

6.6 A financial interest is where a Director may receive direct financial benefits (by either making a gain or avoiding a loss) as a consequence of a decision that the Board makes. This could include:

6.6.1 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;

6.6.2 employment in an organisation which is doing or is likely to do business with an organisation in receipt of NHS funding; or

6.6.3 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.

6.7 A Director shall not be treated as having a financial interest in any a matter by reason only:

6.7.1 of their membership of a company or other body, if they have no beneficial interest in any securities of that company or other body;

6.7.2 of shares or securities held in collective investment or pensions funds or units of authorised unit trusts;

6.7.3 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

6.7.4 of any remuneration or allowances payable to a Director in accordance with the Constitution.

6.8 A non-financial professional interest is where a Director may receive a non-financial professional benefit as a consequence of a decision that the Board makes, such as increasing their professional reputation or status or promoting their professional career. This could include situations where a Director is:

6.8.1 an advocate for a particular group of patients;
6.8.2 a clinician with a special interest;
6.8.3 an active member of a particular specialist body; or
6.8.4 an advisor for the Care Quality Commission or National Institute of Health and Care Excellence.

6.9 A non-financial personal interest is where a Director may benefit personally as a consequence of a decision that the Board 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 Director is:

6.9.1 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
6.9.2 a member of a lobbying or pressure group with an interest in health and/or social care.

6.10 A Director 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 Director is involved in making. This includes material interests of:

6.10.1 close family members and relatives, including a spouse or partner or any parent, child, brother or sister of the Director;
6.10.2 close friends and associates; and
6.10.3 business partners.

6.11 If Directors 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.

6.12 **Register of interests**

6.13 The Director of Corporate Governance will ensure that a register of interests is established to record formally declarations of interests of Directors.

6.14 Details of the register will be kept up to date and reviewed annually.

6.15 The register will be available to the public.

7. Standards of Business Conduct

7.1 **Policy** - Staff must comply with the national guidance contained in HSG(93)5 'Standards of Business Conduct for NHS staff'. The following provisions should be read in conjunction with this document.

7.2 **Canvassing of, and Recommendations by, Directors in Relation to Appointments** - Canvassing of Directors of the Trust, directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

7.3 A Director or Governor shall not solicit for any person any appointment under the Trust or recommend any person for such appointment: but this paragraph of this Standing Order shall not preclude a Director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

7.4 Informal discussions outside appointments, panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

7.5 **Relatives of Directors, Governors or Officers** - Candidates for any staff appointment shall, when making application, disclose in writing whether they are related to any Director, Governor or the holder of any office in the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal.

7.6 The Directors, Governors and every officer of the Trust shall disclose to the Chief Executive any relationship with a candidate of whose candidature that Director or officer is aware. It shall be the duty of the Chief Executive to report to the Trust any such disclosure made.

7.7 On appointment, Directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Trust whether they are related to any other Director or holder of any office under the Trust.

7.8 Where the relationship of an officer or another Director to a Director or Governor is disclosed, the SO 6 shall apply.

8. Tendering and Contract Procedure

8.1 **Duty to comply with Standing Orders** - The procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Orders (except where SO 3.39 (Suspension of SOs) is applied).

8.2 **EU Directives Governing Public Procurement** - Directives by the Council of the European Union, as implemented in English Law, for awarding all forms of contracts shall have effect as if incorporated in these Standing Orders.

8.3 The Trust shall comply as far as is practicable with the requirements of the NHS Executive "Capital Investment Manual". In the case of management consultancy contracts the Trust shall comply as far as is practicable with NHS Improvement (Monitor) guidance on Consultancy Spending published 2 November 2016.

8.4 **Competition** - The Trust shall ensure that competitive tenders/quotations are invited, either directly or via a framework, for the supply of goods, materials and manufactured articles and for the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the Department of Health); for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and for disposals. Competitive quotations are not required for expenditure under £5,000 but expenditure must not be disaggregated to avoid a competitive procurement process. The Director of Finance or nominated officer shall maintain a list of applicable exemptions from waivering competition.

8.5 Competitive tendering/quotation procedures may be waived, subject to prior review by Procurement and by the Director of Finance only where:

8.5.1 the estimated expenditure or income is above or is reasonably expected to be above £5,000 excluding VAT and does not, or is not reasonably expected to, exceed £25,000 excluding VAT and;
8.5.2 there is an urgent requirement and/or;
8.5.3 the goods, services or works are of a special characteristic that, in the opinion of the Chief Executive or the nominated officer, it is not possible or desirable to undertake a competitive process and/or;
8.5.4 where the supply is proposed under special arrangements negotiated by the Department of Health in which event the said special arrangements must be complied with.

8.6 Formal tendering procedures over £25,000 excluding VAT and under the thresholds of the EU Procurement Directives may be waived, subject to prior review by Procurement, by the Director of Finance and the Chief Executive where:

8.6.1 the timescale genuinely precludes competitive tendering. Failure to plan the work properly is not a justification for single tender; or
8.6.2 specialist expertise is required and is available from only one source; or
8.6.3 the task is essential to complete the project, AND arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate; or
8.6.4 there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering; or
8.6.5 Where provided for in the Capital Investment Manual.

8.7 The limited application of the waivering of these competition rules should not be used to avoid competition or for administrative convenience or to award further work to a supplier originally appointed through a competitive procedure.

8.8 Where it is decided that competitive tendering is not applicable and should be waived by virtue of SO 8.6.1 to 8.6.5, the fact of the waiver and the reasons should be documented and reported to the Audit and Assurance Committee in the Single Tender Action Report.

8.9 Except where SO 8.5 to 8.8, or a requirement under SO 8.2 applies, the Board shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than three firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

8.10 The Board shall ensure that the organisations invited to tender / quote for building and engineering works shall be those on an approved list in accordance with Annex A section 5. Where, in the opinion of the Director of Finance it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Chief Executive.

8.11 Tendering procedures are set out in Annex A.

8.12 **Quotations** - are required when the intended expenditure is reasonably expected to exceed £5,000 excluding VAT but less than £25,000 excluding VAT.

8.13 Where quotations are required under SO 8.12 they should be sought from at least three firms/individuals as per Annex A based on specifications or terms of reference prepared by, or on behalf of, the Board.

8.14 Quotations should be in writing unless the Chief Executive or the nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotation should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

8.15 All quotations should be treated as confidential and should be retained for inspection for the period of the contract awarded.

8.16 The Chief Executive or the officer nominated by them should evaluate the quotations and select the one which gives the best value for money. If this is not the lowest then this fact and the reasons why the lowest quotation was not chosen should be in a permanent record.

8.17 **Where tendering or competitive quotation is not required** - Where tenders or quotations are not required, because expenditure is below £5,000, the Trust shall procure goods and services in accordance with procurement procedures approved by the Board.

8.18 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided under contract or in-house. The Board may also determine from time to time that in-house services should be market tested by competitive tendering.

8.19 **Private Finance** - When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

8.19.1 The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector. The proposal must be specifically agreed by the Trust in the light of such professional advice as should reasonably be sought in particular with regard to vires.

8.19.2 The selection of a contractor/finance company must be on the basis of competitive

tendering or quotations.

8.20 **Contracts** - The Trust may only enter into contracts within its statutory powers and shall comply with:

a. these Standing Orders;
b. the Trust's SFIs;
c. EU Directives and other statutory provisions;
d. any relevant directions including the Capital Investment Manual and guidance on the Procurement and Management of Consultants;
e. such of the NHS Standing Conditions of Contract as are applicable.
f. any framework agreement terms and conditions that apply to contracts made under frameworks, such as the Government Procurement Service.

Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

8.21 In all contracts made by the Trust, the Board shall endeavour to obtain best value for money.

8.22 **Personnel and Agency or Temporary Staff Contracts** - The Chief Executive shall nominate officers with delegated authority to enter into contracts for the employment of other officers, to authorise regrading of staff, and to enter into contracts for the employment of agency staff or temporary staff.

8.23 **Contracts for Services with Individuals or Personal Services Companies -** The Chief Executive shall nominate officers to assess the tax status on individuals/personal services companies to ensure compliance with HMRC Self-Employment/IR35 status, prior to entering into any contracts of this nature.

8.24 **Healthcare Services Contracts** - Service contracts with NHS commissioners for the supply of healthcare services shall be drawn up in accordance with the National Health Service Act 2006.

8.25 The Chief Executive shall nominate officers with power to negotiate for the provision of healthcare services with commissioners of healthcare.

8.26 **Cancellation of Contracts** - Except where specific provision is made in model Forms of Contracts or Standing Schedules of Conditions approved for use within the National Health Service and in accordance with Standing Orders 8.2 and 8.3 there shall be inserted in every written contract a clause empowering the Trust to cancel the contract and to recover from the contractor the amount of any loss resulting from such cancellation, if the contractor shall have offered, or given or agreed to give, any person any gift or consideration of any kind as an inducement or reward for doing or forbearing to do or for having done or forborne to do any action in relation to the obtaining or execution of the contract or any other contract with the Trust, or for showing or forbearing to show favour or disfavour to any person in relation to the contracts or any other contract with the Trust, or if the like acts shall have been done by any person employed by him/her or acting on his/her behalf (whether with or without the knowledge of the contractor), or if in relation to any contract with the Trust the contractor or any person employed by him/her or acting on his/her behalf shall have committed any offence under the Bribery Act 2010 and other appropriate legislation.

8.27 **Determination of Contracts for Failure to Deliver Goods or Material** - There shall be inserted in every applicable written contract for the supply of goods or materials a clause to secure that, should the contractor fail to deliver the goods or materials or any portion thereof within the time or times specified in the contract, the Trust may without prejudice determine the contract either wholly or to the extent of such default and purchase other goods, or material of similar description to make good (a) such default, or (b) in the

event of the contract being wholly determined the goods or materials remaining to be delivered. The clause shall further secure that the amount by which the cost of so purchasing other goods or materials exceeds the amount which would have been payable to the contractor in respect of the goods or materials shall be recoverable from the contractor.

8.28 **Contracts Involving Funds Held on Trust** – As management processes overlap, the preceding requirements in respect of contracts equally apply to contracts involving funds held on trust.

8.29 All personnel involved in tendering and contracting activities must be aware of the Bribery Act 2010 and must ensure that all dealings with other organisations and their staff do not bring them in breach of the Act that could leave them open to criminal proceedings being. All Trust staff involved in the tendering of a project shall complete the Conflicts of Interest Form.

8.30 **The Bribery Act (2010)** – Under the Bribery Act and the terms and conditions of an employee's contract, it is an offence for staff to accept any inducement or reward for:

8.30.1 doing, or refraining from doing anything in their official capacity; or
8.30.2 showing favour or disfavour to any person in their official capacity.

8.30.3 The Bribery Act 2010 replaces the fragmented and complex offences at common law and in the Prevention of Corruption Acts 1889-1916. This broadly defines the two sections below:

8.30.3.1 two general offences of bribery:

i. offering or giving a bribe to induce someone to behave, or to reward someone for behaving, improperly;
ii. requesting or accepting a bribe either in exchange for acting improperly or where the request or acceptance is itself improper;

8.30.3.2 the corporate offence of negligently failing by a company or limited liability partnership to prevent bribery being given or offered by an employee or agent on behalf of that organisation.

9. Disposals

9.1 Competitive Tendering or Quotation procedures shall not apply to the disposal of:

a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or their nominated officer;

b) obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;

c) items to be disposed of with an estimated sale value of less than £500, this figure to be reviewed annually; and

d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract.

10. In-House Services

10.1 In all cases where the Trust determines that in-house services should be subject to competitive tendering the following groups shall be set up:

10.1.1 Specification group, comprising the Chief Executive or nominated officer(s) and specialist(s).

10.1.2 In-house tender group, comprising representatives of the in-house team, a nominee of the Chief Executive and technical support.

10.1.3 Evaluation group, comprising normally a specialist officer, a supplies officer and a Director of Finance representative. For services having a likely annual expenditure exceeding £200,000, a Non-Executive Director should be a member of the evaluation team.

10.2 All groups should work independently of each other but individual officers may be a member of more than one group. No member of the in-house tender group may, however, participate in the evaluation of tenders.

10.3 The evaluation group shall make recommendations to the Board.

10.4 The Chief Executive shall nominate an officer to oversee and manage the contract.

11. Custody of Seal and Sealing of Documents

11.1 **Custody of Seal** - The Common Seal of the Trust shall be kept by the Director of Corporate Governance in a secure place.

11.2 **Sealing of Documents** - The Seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board or of a committee thereof, or where the Board has delegated its powers.

11.3 Before any building, engineering, property or capital document is sealed it must be approved and signed by the Director of Finance (or an officer nominated by them) and authorised and countersigned by the Chief Executive (or an officer nominated by them who shall not be within the originating Division).

11.4 Where it is necessary that a document be sealed (in accordance with SO 11.6), the seal shall be affixed in the presence of the Director of Corporate Governance and will be attested by them.

11.5 **Register of Sealing** - An entry of every sealing shall be made and numbered consecutively in a register provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. The register of sealing shall be maintained by the Director of Corporate Governance. A report of all sealing shall be made to the Trust at least quarterly. (The report shall contain details of the seal number, the description of the document and date of sealing).

11.6 **Sealing Policy** - The following contracts should have the seal applied:

11.6.1 All contracts for the purchase/lease of land and/or building;
11.6.2 All contracts for capital works exceeding £1,000,000;
11.6.3 Any contract or agreement with organisations other than NHS or other government bodies including local authorities where the whole-life value exceeds or is expected to exceed £10,000,000, except for contracts within the Group; and
11.6.4 Any contract where the other party requests a seal.

12. Signature of Documents

12.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board shall have given the necessary authority to some other person for the purpose of such proceedings.

12.2 The Chief Executive or nominated officers shall be authorised, by resolution of the Board, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed), the subject matter of which has been approved by the Board or committee or sub-committee to which the Board has delegated appropriate authority.

13. Miscellaneous

13.1 **Directors acting as a corporate trustee** All funds received in trust shall be in the name of the Trust as corporate trustee. In relation to funds held on trust, powers exercised by the Trust as corporate trustee shall be exercised separately and distinctly from those powers exercised as a Trust. Directors acting on behalf of the Trust as a corporate trustee are acting as a quasi-trustee. Full recognition must be given to the guidance and regulation as determined by the Charity Commission Accountability for charitable funds held on trust is to the Charity Commission and to Monitor. Accountability for non-charitable funds held on trust is only NHS Improvement (Monitor).

13.2 **Standing Orders to be given to Directors and Officers** - It is the duty of the Chief Executive to ensure that existing Directors and officers and all new appointees are notified of and understand their responsibilities within Standing Orders and Standing Financial Instructions. Updated copies shall be issued to staff designated by the Chief Executive. New designated officers shall be informed in writing and shall receive copies where appropriate of Standing Orders.

13.3 **Documents having the standing of Standing Orders** - Standing Financial Instructions, “Schedule of decisions reserved to the Board and the Scheme of Delegation” and Board committee and sub-committee Terms of Reference shall have the effect as if incorporated into Standing Orders.

13.4 **Review of Standing Orders** - Standing Orders shall be reviewed annually by the Trust. The requirement for review extends to all documents having the effect as if incorporated in Standing Orders.

Annex A: Tendering Procedure

1 Invitation to Tender

1.1 All invitations to tender on a formal competitive basis shall state that no tender will be considered for acceptance unless submitted electronically, via the Trust E-Tendering system. Approval from the Head of Procurement must be obtained for exceptional circumstances where the E-Tendering system cannot be used. Where tenders are not submitted through the E-Tendering system, they must be submitted in a plain, sealed package bearing the word 'Tender' followed by the Tender Reference Number and the latest date and time for the receipt of such tender. A minimum of two people must open tenders. At least one person must not be involved in the tender process. Neither must be from the originating department.

1.2 Every tender for goods, materials, manufactured articles supplied as part of a works contract and services shall embody such of the main contract conditions as may be appropriate in accordance with the contract forms described in Section 1.3 and 1.4 below.

1.3 Every tender for building and engineering works, except for maintenance work only where Estmancode guidance should be followed, shall embody or be in the terms of the current edition of the appropriate Joint Contracts Tribunal (JCT) or NEC terms amended to comply with Concode. When the content of the works is primarily engineering, tenders shall embody or be in the terms of the General Conditions of Contract recommended by the Institutions of Mechanical Engineers and the Association of Consulting Engineers (Form A) or, in the case of civil engineering work, the General Conditions of Contract recommended by the Institution of Civil Engineers. The Standing documents should be amended to comply with Concode and, in minor respects, to cover special features of individual projects. Tendering based on other forms of contract may be used only after prior consultation with the Department of Health.

1.4 Every tender for goods, materials, services (including consultancy services) or disposals shall embody such of the NHS Standard Conditions of Contract, or other appropriate public sector Conditions that may apply. Every tenderer must have given or give a written undertaking not to engage in collusive tendering or other restrictive practice.

2 Receipt, Safe Custody and Record of Formal Tenders

2.1 Formal competitive tenders shall be submitted on the Trust's E-Tendering system or addressed to the Head of Procurement, Victoria Warehouse where approved in accordance with 1.1 above.

2.2 The date and time of receipt of each tender together with the details of the date, time and persons opening the documents will be recorded in the E-Tendering system.

2.3 Where tenders are received outside the E-Tendering system in accordance with 1.1, the Chief Executive shall designate an officer or officers, not from the originating department, to receive tenders on his/her behalf and to be responsible for their endorsement and safe custody until the time appointed for their opening, and for the records maintained in accordance with Section 3.

3 Opening Formal Tenders

3.1 As soon as practicable after the date and time stated as being the latest time for the receipt of tenders they shall be opened in the presence of two senior officers designated by the Chief Executive and not from the originating department.

3.2 A permanent record shall be maintained to show for each set of competitive tender

invitations despatched:

a) the names of firms/individuals invited;
b) the names of and the number of firms/individuals from which tenders have been received;
c) the total price(s) tendered;
d) closing date and time;
e) date and time of opening;
f) and the record shall be signed by the persons present at the opening, or recorded electronically in an E-Tendering system.

3.3 Where an electronic tendering package is used all actions by both procurement staff and suppliers are recorded within the system audit reports

3.4 Except as in Section 3.5 below, a record shall be maintained of all price alterations on tenders, i.e. where a price has apparently been altered, and the final price shown shall be recorded. Every price alteration appearing on a tender and the record should be initialled by two of those present at the opening.

3.5 A report shall be made in the record if, on any one tender, price alterations are so numerous as to render the procedure Section 3.4 unreasonable.

4 Admissibility and Acceptance of Formal Tenders

4.1 In considering which tender to accept, if any, the designated officers shall have regard to whether value for money will be obtained by the Trust and whether the number of tenders received provides adequate competition. In cases of doubt they shall consult the Chief Executive.

4.2 Tenders received after the due date and time (whether hard copy or via electronic means) may be considered only if the Chief Executive or nominated officer decides that there are exceptional circumstances, e.g. where significant financial, technical or delivery advantages would accrue, and is satisfied that there is no reason to doubt the bona fides of the tenders concerned. The Chief Executive or nominated officer shall decide whether such tenders are admissible and whether re-tendering is desirable. Re-tendering may be limited to those tenders reasonably in the field of consideration in the original competition. If the tender is accepted the late arrival of the tender should be reported to the Board at its next meeting.

4.3 Technically late tenders (i.e. those despatched in good time but delayed through no fault of the tenderer) may at the discretion of the Chief Executive be regarded as having arrived in due time.

4.4 Incomplete tenders (i.e. those from which information necessary for the adjudication of the tender is missing) and amended tenders (i.e. those amended by the tenderer upon his/her own initiative either orally or in writing after the due time for receipt) should be dealt with in the same way as late tenders under Section 4.2.

4.5 Where examination of tenders reveals errors which would affect the tender figure, the tenderer is to be given details of such errors and afforded the opportunity of confirming or withdrawing his/her offer.

4.6 Necessary discussions with a tenderer of the contents of his/her tender, in order to elucidate technical points etc, before the award of a contract, need not disqualify the tender.

4.7 While decisions as to the admissibility of late, incomplete, or amended tenders are under

consideration and while the tenders are being obtained, the tender documents shall remain strictly confidential and kept in safekeeping by an officer designated by the Chief Executive.

4.8 Where only one tender/quotation is received the Trust shall, as far as practicable, ensure that the price to be paid is fair and reasonable.

4.9 Should a request be made to the Board for acceptance of a tender that has not offered the most economically advantageous tender then the Board shall investigate and consider whether the request can be accepted or whether the tendering exercise should be completed again. Where the Board accepts that the reasons for accepting a tender that is not the most advantageous it shall document these reasons, together with any reference to risks to the Trust in accepting or rejecting the initial request.

4.10 Where the form of contract includes a fluctuation clause all applications for price variations must be submitted in writing by the tenderer and shall be approved by the Chief Executive or nominated officer.

4.11 All Tenders should be treated as confidential and should be retained for inspection for the period of the contract awarded. Successful tenders should be retained for six years after the expiry of the contract awarded.

5 **Lists of Approved Firms**

5.1 The Trust shall use the Constructionline as its list of approved firms for Building and Engineering works, from whom tenders and quotations may be invited. For other services where tenders or quotations are required the Trust will use the processes established by the countywide Procurement Shared Service.

5.2 The Chief Executive's prior approval shall be obtained where a firm not on an approved list is asked to tender and a report shall be submitted to the Audit and Assurance Committee on the reasons why the firm has been chosen.

5.3 Any Director may request a report on the financial standing of the favoured tenderer which will be carried out by an independent firm of financial advisers.

6 **Conflicts of Interest**

6.1 All Trust staff that are involved in a formal tender process shall sign a declaration of Conflict of Interest. Declarations should be retained with Tender records.

GLOUCESTERSHIRE HOSPITALS

NHS FOUNDATION TRUST

Standing Financial Instructions (SFIs)

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Foreword

1. The Gloucestershire Hospitals NHS Foundation Trust is a public benefit corporation which was established on 1st July 2004 under the Health & Social Care (Community Health & Standards) Act 2003 (subsequently consolidated into Chapter 5 of the National Health Service Act 2006). NHS Foundation Trusts are governed by a range of statutes, including the National Health Service and Community Care Act 1990 (NHS & CC Act 1990) and the National Health Service Act 1977 (NHS Act 1977). The statutory functions conferred on the Trust are set out in the NHS & CC Act 1990 (Schedule 2), Chapter 5 of the National Health Service Act 2006 and the Trust's constitution.

2. As a public benefit corporation, the Trust has specific powers to do anything which appears to be necessary or desirable for the purposes of, or in connection with, its functions. In this respect it is accountable to the Charity Commission for those funds deemed to be charitable. The Trust also has a common law duty as a bailee for patients' property held by the Trust on behalf of patients.

3. The Membership and Procedure Regulations 1990 (SI (1990)2024) require Trusts to adopt Standing Orders (SOs) for the regulation of their procedures and business whilst the "Directions on Financial Management in England" issued under HSG (96)12 in 1996, require Health Authorities to adopt Standing Financial Instructions (SFIs) setting out the responsibilities of individuals. These Directions are not mandatory on NHS Foundation Trusts but are being observed, as far as they are relevant, as a matter of good practice.

4. In addition the Code of Accountability for NHS Boards (published by the Department of Health in April 1994, EL(94)40) requires Boards to draw up Standing Orders, a Schedule of Decisions reserved to the Board and Standing Financial Instructions. The Code also requires Boards to ensure that there are management arrangements in place to enable responsibility to be clearly delegated to senior executives. Additionally, Boards will have drawn up locally generated rules and instructions, including financial procedural notes, for use within their organisation. Collectively these must comprehensively cover all aspects of (financial) management and control. In effect, they set the business rules which directors and employees (including employees of third parties contracted to the Trust) must follow when taking action on behalf of the Board.

1. Introduction

1.1 General

1.1.1 These SFIs detail the financial responsibilities, policies and procedures to be adopted by the Trust and shall have effect as if incorporated in the Standing Orders (SOs) of the Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board and the Scheme of Delegation adopted by the Trust.

1.1.2 These SFIs identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations including Trading Units. They do not provide detailed procedural advice. These statements should therefore be read in conjunction with the Trust's detailed corporate policy documents, financial procedures and any departmental procedure notes. All financial procedures must be approved by the Director of Finance.

1.1.3 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Director of Finance or delegated officer must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's SOs.

1.1.4 The National Health Service Act 2006, The Health Act 2009 and the Foundation Trust's Constitution require that all the powers of the Foundation Trust are exercisable by the Board of Directors on its behalf. Standing Orders and the Reservation of Powers to the Board and Scheme of Delegation together with these Standing Financial Instructions and such other locally generated rules and instructions, including financial procedure notes, as may exist for use within the Foundation Trust provide a regulatory and business framework for the conduct of the Board of Directors. Collectively these documents must comprehensively cover all aspects of financial management and control. In effect, they set the business rules which Board members and officers must follow when taking action on behalf of the Board.

1.2 Terminology

1.2.1 Any expression to which a meaning is given in Health Service Acts, or in the Financial Directions made under the Acts, shall have the same meaning in these instructions; and

a. "Trust" means the Gloucestershire Hospitals NHS Foundation Trust;
b. "Board" means the Board of Directors of the Trust as set out in the Constitution;
c. "Committee" means any committee established by the Council of Governors or the Board of Directors for the purposes of fulfilling its functions;
d. "Council of Governors" means the body of elected and appointed governors, authorised to be members of the Council of Governors and to act in accordance with the Constitution;
e. "Constitution" means the constitution, approved by the Independent Regulator, and which describes the operation of the Foundation Trust;
f. "Chief Executive" means the chief officer of the Trust;
g. "Director of Finance" means the chief financial officer of the Trust;
h. "2006 Act" refers to the National Health Service Act 2006;
i. "Authorisation agreement" refers to the document issued by the Regulator at the inception of the Trust authorising it to operate as a Foundation Trust in accordance with Chapter 5 of the National Health Service Act 2006;

j. "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;

k. "Budget Holder" means the director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation;

l. “Funds held on trust” shall mean those funds which the Trust holds at the date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under the NHS Act 2006, as amended. Such funds may or may not be charitable;

m. "Legal Adviser" means the properly qualified person appointed by the Trust to provide legal advice;

n. “Mandatory services” are those services which the Regulator has deemed it compulsory that the Trust provides, as listed in the Authorisation agreement;

o. “Protected assets” refers to those assets of the Trust deemed by the Regulator to be essential to the provision of mandatory services (see above) and listed as such in the Authorisation agreement;

p. “Regulator” means the Independent Regulator for the purposes of the 2006 Act;

q. “Shared Services” means the Shared Services for Finance and Procurement, hosted by the Gloucestershire Hospitals NHS Foundation Trust;

r. "SFIs" means Standing Financial Instructions;

s. “SOs” means Standing Orders; and

t. “Virement” means the transfer of budgetary provision from one budget head to another.

1.2.2 Wherever the title Chief Executive, Director of Finance, or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them.

1.2.3 Wherever the term "employee" is used and where the context permits it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

1.3 Responsibilities and Delegation

1.3.1 The Board exercises financial supervision and control by:

a. formulating the financial strategy;

b. requiring the submission and approval of budgets;

c. defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); and

d. defining specific responsibilities placed on directors and employees as indicated in the Scheme of Delegation document.

1.3.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the ’Reservation of Powers to the Board’ document.

1.3.3 The Board will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation document adopted by the Trust.

1.3.4 Within the SFIs, it is acknowledged that the Chief Executive is accountable to the Board for ensuring that the Trust fulfils the functions and responsibilities set out in the Authorisation agreement within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities, is responsible to the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust’s system of internal control.

1.3.5 The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities but they remain accountable for financial control.

1.3.6 It is a duty of the Chief Executive to ensure that existing directors and employees and all new appointees are notified of and understand their responsibilities within these Instructions.

1.3.7 The Director of Finance is responsible for:

a. implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;
b. maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;
c. ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time; and
d. ensuring that good financial practice is followed in accordance with accepted professional standards and advice received from internal and external auditors.

And, without prejudice to any other functions of Directors and employees to the Trust, the duties of the Director of Finance include:

e. the provision of financial advice to the Trust and its Directors and employees;
f. the design, implementation and supervision of systems of internal financial control; and
g. the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

1.3.8 All directors and employees, singularly and collectively, are responsible for:

a. the security of the property of the Trust;
b. avoiding loss;
c. exercising economy and efficiency in the use of resources;
d. conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation; and
e. reporting suspected theft or fraud to the Director of Finance and/or Local Counter Fraud Service.

1.3.9 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

1.3.10 For any and all Directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the Director of Finance.

2. Audit

2.1 Audit and Assurance Committee

2.1.1 In accordance with Schedule 7 (paragraph 23) of the 2006 Act and both the Trust's Constitution and Standing Orders, the Board shall formally establish an Audit and Assurance Committee of Non-Executive Directors to perform such monitoring, review and other functions as are appropriate. In particular the Audit and Assurance Committee will provide an independent and objective view of internal control by:

a. overseeing Internal and External Audit services;

b. review systems of internal control and ensure they are fit for purpose;

c. monitoring compliance with Standing Orders and Standing Financial Instructions; and

d. reviewing schedules of losses and compensations

2.1.2 Where the Audit and Assurance Committee feels there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chair of the Audit and Assurance Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be brought to the attention of the Council of Governors and the Regulator.

2.1.3 It is the responsibility of the Director of Finance to ensure that an adequate internal audit service is provided and the Audit and Assurance Committee shall be involved in the selection process when an internal audit service provider is changed. This will likely involve a nominated member of the Audit and Assurance Committee being the Trust's representative on the Countywide selection panel (where the service is countywide).

2.1.4 The Audit and Assurance Committee is responsible for making a recommendation to the Council of Governors to the appointment of external auditors. The Committee has a responsibility for assessing the external (financial) auditors on an annual basis, in terms of the quality of their work.

2.2 Fraud and Corruption

2.2.1 In line with their responsibilities, the Chief Executive and Director of Finance shall monitor and ensure compliance with directions issued by the Secretary of State for Health and/or NHS Counter Fraud Authority on fraud, bribery and corruption.

2.2.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the NHS Fraud and Corruption Manual and guidance.

2.2.3 The Local Counter Fraud Specialist shall report to the Trust Director of Finance and shall work with staff within the NHS Counter Fraud Authority in accordance with the NHS Counter Fraud Manual.

2.2.4 The local counter Fraud Specialist will provide a written report, at least annually on counter fraud work within the Trust.

2.2.5 Any employee discovering or suspecting a loss of any kind must either immediately inform the Finance Director, or inform the Local Counter Fraud Specialist who will then appropriately inform the Finance Director and/or Chief Executive.

2.3 Director of Finance

2.3.1 The Director of Finance is responsible for:

a. ensuring that there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function;

b. ensuring that the internal audit is adequate and meets the NHS mandatory audit standards;

c. in conjunction with the Counter Fraud and Security Management Service, deciding at what stage to involve the police in cases of misappropriation, and other irregularities;

d. ensuring that an annual Internal Audit Report is prepared for the consideration of the Audit and Assurance Committee and the Board. The report must cover:

   i. a clear statement on the effectiveness of internal control, in accordance with current controls assurance guidance issued by the Department of Health including for example compliance with control criteria and standards,

   ii. major internal control weaknesses discovered,

   iii. progress on the implementation of internal audit recommendations,

   iv. progress against plan over the previous year;

e. ensuring that a three year strategic Internal Audit Plan is prepared for the consideration of the Audit and Assurance Committee and the Board; and

f. ensuring that an annual Internal Audit Plan is produced for consideration by the Audit and Assurance Committee and the Board, which sets out the proposed activities for the function for the forthcoming financial year.

2.3.2 The Director of Finance or designated auditors are entitled without necessarily giving prior notice to require and receive:

a. access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

b. access at all reasonable times to any land, premises or employee of the Trust;

c. the production of any cash, stores or other property of the Trust under an employee's control; and

d. explanations concerning any matter under investigation.

2.3.3 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance or Local Counter Fraud Service must be notified immediately.

2.4 Role of Internal Audit

2.4.1 In accordance with the requirements of the Accounting Officer Memorandum issued by the Regulator, the Trust is required to establish an Internal Audit function. It is the responsibility of the Director of Finance to ensure that this function is in place and operates efficiently and effectively.

2.4.2 Internal Audit will provide assurances about the effectiveness of controls in place across all of the Trust's activities. To fulfill this function, Internal Audit will review the overall arrangements the Board itself has in place for securing adequate assurances and provide an opinion on those arrangements to support the Statement on Internal Control (see Section 5.2). This will entail reviewing the way in which the Board has identified objectives, risks, controls and sources of assurance on these controls, and assessed the value of assurances obtained.

2.4.3 In addition Internal Audit will provide specific assurances on the areas covered in the Internal Audit Plan as approved by the Audit and Assurance Committee (see 2.3.1), and will work alongside other professionals wherever possible to advise on systems of control and assurance arrangements. This is a distinct role, which is quite different to

reviewing and commenting on the reliance of the assurances themselves, which is the responsibility of the Board.

2.4.4 The Head of Internal Audit will normally attend Audit and Assurance Committee meetings and has a right of access to all Audit and Assurance Committee members, the Chair and Chief Executive of the Trust.

2.4.5 The Head of Internal Audit shall be accountable to the Director of Finance. The reporting system for Internal Audit shall be agreed between the Director of Finance, the Audit and Assurance Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Manual. The reporting system shall be reviewed at least every 3 years.

2.5 External Audit

2.5.1 The Trust is required to have an external (financial) auditor and is to provide such information and facilities as are necessary for the auditor to fulfil their responsibilities under Chapter 5 of the 2006 Act.

2.5.2 Under Schedule 7 (paragraph 23) of the 2006 Act and the Trust's Constitution, it is the responsibility of the Council of Governors at a General Meeting to appoint (or remove) the external (financial) auditor on behalf of the Trust. As part of the appointment process, the Trust must ensure that the auditors meet the selection criteria set out in Appendix B of the Audit Code for NHS Foundation Trusts.

2.5.3 In accordance with the Audit Code for NHS Foundation Trusts, a market testing exercise will be undertaken as a minimum every 5 years.

2.5.4 The Council of Governors also has the power to appoint (and remove) any external auditor appointed to review and report on any other aspect of the Trust's affairs.

2.6 Audit Code

2.6.1 The Trust has a responsibility, under the terms of its Authorisation agreement, to comply with the Audit Code for NHS Foundation Trusts as approved by the Regulator. The Chief Executive has overall responsibility for ensuring compliance with the Code.

3. Financial Targets

3.1 The Trust is required to meet such financial targets as are specified by the Regulator, either under the terms of the initial Authorisation agreement or subsequently.

3.2 Whilst there is no specific target regulating overall revenue performance in Foundation Trusts (e.g. a requirement to break-even year on year), the Regulator has the power to intervene in the Trust's affairs and potentially to revoke its Authorisation agreement where financial viability is seriously compromised.

3.3 The Chief Executive has overall executive responsibility for the Trust's activities and in this capacity is responsible for ensuring that the Trust aims to maintain its financial viability and meets any specific financial targets set by the Regulator. In this capacity the Chief Executive is responsible for setting appropriate internal targets in order to ensure financial viability and for signalling to the Finance and Digital Committee and the Board where the Trust's financial viability or key targets are at risk.

3.4 The Director of Finance is responsible for:

a. advising the Board and Chief Executive on progress in meeting these targets, recommending corrective action as appropriate;

b. ensuring that adequate systems exist internally to monitor financial performance ;

c. managing the cashflow and external borrowings of the Trust; and

d. providing the Regulator with such financial information as is necessary to monitor the financial viability of the Trust.

4. Business Planning, Budgets and Budgetary Control

4.1 Preparation and Approval of Business Plans and Budgets

4.1.1 Under the terms of Schedule 7 (paragraph 26) of the 2006 Act and its Constitution, the Trust is required to provide the Regulator with information concerning its forward plans for each financial year. In this respect, the Council of Governors is responsible for providing the Board with its views on those forward plans when they are being prepared and the Board correspondingly has a duty to consult them.

4.1.2 The Chief Executive will therefore compile and submit to the Board and the Council of Governors, an annual business plan which takes into account financial targets and forecast limits of available resources. The annual business plan will contain:

a. a statement of the significant assumptions on which the plan is based; and

b. details of major changes in workload, delivery of services or resources required to achieve the plan.

4.1.3 Once approved, the Chief Executive will be responsible for submitting the Business Plan as required to the Regulator.

4.1.4 The Chief Executive is also responsible for ensuring on behalf of the Board that the Council of Governors is consulted on any significant changes to the Business Plan in year.

4.1.5 At the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit revenue and capital budgets for approval by the Board. Such budgets will:

a. be in accordance with the aims and objectives set out in the annual business plan;

b. accord with workload and manpower plans;

c. be produced following discussion with appropriate budget holders/managers;

d. be prepared within the limits of available and identified funds;

e. identify all sources of those funds; and

f. identify potential risks.

4.1.6 The Director of Finance shall monitor financial performance against budget and business plan, periodically review them, and report to the Board.

4.1.7 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled and to explain variances.

4.1.8 The Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage their budgets successfully.

4.2 Budgetary Delegation

4.2.1 The Director of Finance (on behalf of the Chief Executive) may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

a. the amount of the budget;

b. the staffing levels associated with that budget;

c. the purpose(s) of each budget heading;

d. individual and group responsibilities;

e. authority to exercise virement;

f. achievement of planned levels of service; and

g. the provision of regular reports.

4.2.2 Expenditure authorised by the Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

4.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

4.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Director of Finance (on behalf of the Chief Executive).

4.2.5 The agreed budgetary delegation limits for the Trust are detailed in Appendix 1.

4.3 Budgetary Control and Reporting

4.3.1 The Director of Finance will devise and maintain systems of budgetary control. These will include:

a. monthly financial reports to the Board in a form approved by the Board containing:
   i. income and expenditure to date showing trends and forecast year-end position;
   ii. explanations of any material variances from plan;
   iii. details of any corrective action where necessary and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation;
   iv. approved use of Reserves, both by the Chief Executive under delegated powers and via specific Board decisions; and
   v. capital expenditure to date versus plan.
   vi. projected outturn capital expenditure against plan;
   vii. explanations of any material variances from plan;
   viii. details of any corrective action where necessary and the Chief Executive’s and/or Director of Finance’s view of whether such actions are sufficient to correct the situation;
b. the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;
c. investigation and reporting of variances from financial, workload and manpower budgets;
d. monitoring of management action to correct variances; and
e. arrangements for the authorisation of budget transfers.

4.3.2 Each Budget Holder is responsible for ensuring that:

a. any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board;
b. the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement; and
c. no permanent employees are appointed without the approval of an Executive Director other than those provided for in the authorised budgeted establishment.

4.3.3 The Chief Executive is responsible for ensuring the identification and implementation of cost improvements and income generation initiatives in accordance with the requirements of the annual Business Plan and agreed Control Total.

4.3.4 The Director of Finance is responsible for advising the Chief Executive and the Board on the financial consequences of any changes in policy, pay awards and other events impacting on budgets and will also advise on the financial implications of future plans

and developments proposed by the Trust.

4.4 Capital Expenditure

4.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure (the particular applications relating to capital are contained in section 12 of these SFIs). The delegation limits for capital expenditure are detailed in Appendix 1.

4.5 Performance Information and Monitoring Returns

4.5.1 The Chief Executive, on behalf of the Trust, is responsible for providing the Regulator with such information as is necessary to monitor compliance with the terms of the Authorisation agreement.

4.5.2 The Chief Executive, on behalf of the Trust, is also responsible for ensuring that the Trust contributes to standard national NHS data flows which are required for NHS policy development/ funding decisions as well as performance assessment by the Healthcare Commission.

5. Annual Accounts and Reports

5.1 In accordance with Schedule 7 (paragraph 25) of the 2006 Act and the Trust's Constitution, the Trust must keep accounts, and in respect of each financial year must prepare annual accounts, in such form as the Regulator may, with the approval of the Treasury, direct. These responsibilities will be carried out by the Director of Finance who, on behalf of the Trust, will:-

a. prepare annual accounts in accordance with the Regulator's Manual of Accounts and any other guidance from the same, the Trust's accounting policies and generally accepted accounting practice;

b. prepare and submit annual accounts to the Board and an audited summary of the Main Financial Statements to an Annual Members' Meeting convened by the Council of Governors, certified in accordance with current guidelines;

c. lay a copy of the annual accounts, and any report of the external (financial) auditor thereon, before Parliament and subsequently send them to the Regulator.

5.2 The annual accounts should, in accordance with the requirements set out in the Accounts Direction, include a Statement on Internal Control within the financial statements.

5.3 The Trust's annual accounts must be audited by the external (financial) auditor appointed by the Council of Governors and be presented at the Annual Members' Meeting referred to in 1 (b) above.

5.4 In accordance with Schedule 7 (paragraph 26) of the 2006 Act, the Trust will also prepare an annual report which, after approval by the Board, will be presented to the Council of Governors. It will then be published and made available to the public and also submitted to the Regulator. The annual report will comply with the Regulator's Annual Report Guidance for NHS Foundation Trusts and will include, inter alia:

a. information on the steps taken by the Trust to ensure that the actual membership of the various constituencies (public ,patients and staff) is representative of those eligible for such membership;

b. the Annual Accounts of the Trust in full or summary form;

c. details of relevant directorships and other significant interests held by Board members;

d. composition of the Audit and Assurance Committee and of the Remuneration Committee;

e. remuneration of the Chair, the Non-Executive Directors and Executive Directors, on the same basis as those specified in the Companies Act;

f. a statement of assurance by the Chief Executive in respect of organisational controls and risk management within the Trust (as per HSC 1999/123;

g. any other information required by the Regulator.

5.4.1 These responsibilities will be carried out by the Director of Corporate Governance who, on behalf of the Trust, will prepare and submit annual reports to the Board and an audited summary to an Annual Members' Meeting convened by the Council of Governors.

5.5 The Trust is to comply with any decision that the Regulator may make as to the form of the annual report, the timing of its submission and the period to which it relates.

6. Bank Accounts

6.1 General

6.1.1 The Director of Finance is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance/directions issued by the Regulator.

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6.2 Bank Accounts

6.2.1 The Director of Finance is responsible for:

a. bank accounts

b. establishing separate bank accounts for the Trust's charitable funds;

c. ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made; and

d. reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.

6.2.2 No officer other than the Director of Finance will open any bank account in the name of the Trust (or constituent hospitals) or relating to any activities of the Trust/hospital, or issue instructions to the Trust’s bankers.

6.2.3 No officer should disclose details of the Trust’s bank accounts without the approval of the Director of Finance. This is to ensure that the risk of fraud and money laundering to the Trust’s accounts is minimised

6.3 Banking Procedures

6.3.1 The Director of Finance will prepare detailed instructions on the operation of bank accounts which must include:

a. the conditions under which each bank account is to be operated;

b. the limit to be applied to any overdraft; and

c. those authorised to sign cheques or other orders drawn on the Trust's accounts.

6.3.2 The Director of Finance must advise the Trust's bankers in writing of the conditions under which each account will be operated.

6.4 Tendering and Review

6.4.1 The Director of Finance will review the banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's banking business. Where appropriate the Trust will conduct such reviews/tendering exercises in conjunction with other NHS organisations in Gloucestershire.

6.4.2 Competitive tenders should be sought at least every 5 years for any commercial banking arrangements. The results of the tendering exercise should be reported to the Board. The requirement to seek competitive tenders does not extend to any national initiative / direction re banking facilities, i.e. the Government Banking Service – GBS.

7. Income, Fees and Charges and Security of Cash, Cheques and Other Negotiable Instruments

7.1 Income Systems

7.1.1 The Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

7.1.2 In this capacity, the Director of Finance will establish systems in order to ensure that timely and appropriate invoices are raised for income due under the terms of contracts with NHS commissioners (see Section 8).

7.1.3 The Director of Finance is also responsible for the prompt banking of all monies received.

7.2 Fees and Charges

7.2.1 The Trust will price its service contracts with NHS healthcare commissioners according to national tariffs published by the Department of Health. In areas where national tariff arrangements do not apply, the Trust will follow the Department of Health's guidance in the "Costing Manual" in costing/pricing NHS service contracts.

7.2.2 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

7.3 Debt Recovery

7.3.1 The Director of Finance is responsible for the appropriate recovery action on all outstanding debts and in this capacity is responsible for providing the Finance and Digital Committee with a monthly analysis of debtors profiled by age and actions to recover.

7.3.2 Income not received should be dealt with in accordance with losses procedures.

7.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated.

7.4 Security of Cash, Cheques and Other Negotiable Instruments

7.4.1 The Director of Finance is responsible for:

a. approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;
b. ordering and securely controlling any such stationery;
c. the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and
d. prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

7.4.2 Official money shall not under any circumstances be used for the encashment of private cheques.

7.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance.

7.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

8. NHS Contracts for the Provision of Services

8.1 The Chief Executive, as the accountable officer, is responsible for ensuring that the Trust enters into suitable legally binding contracts with NHS commissioners both for the mandatory healthcare services specified in the Trust's Authorisation agreement with the Regulator and also other healthcare services. In discharging this responsibility, the Chief Executive should ensure that these contracts take account of:-

a. the standards of healthcare quality expected, including those published by the Secretary of State under Section 46 of the Act and the Health Act 2006. ;
b. relevant National Service Frameworks and guidelines published by the National Institute for Health and Clinical Excellence;
c. service priorities contained within the Trust's Business Plan and agreed with healthcare commissioners;
d. national tariffs published by the Department of Health (see 7.2.1) or other agreed local pricing mechanisms where national tariffs do not (yet) apply;
e. the need to provide ancillary and other supporting services essential to the delivery of the healthcare involved;
f. the need to ensure the provision of reliable and on-going information on service cost, volume and quality;
g. previously agreed developments or investment plans.

8.2 A good contract for health care services will result from a dialogue between clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The contract will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

8.3 The Director of Finance will need to ensure that regular reports are provided to the Finance and Digital Committee and the Board detailing forecast/ budgeted and actual income from contracts with NHS commissioners. This analysis will particularly highlight the impact of differences between planned and actual numbers of patients treated and outline any action required to address such variances. Periodically, at intervals to be agreed with the Board, the Chief Executive will also provide information on the impact of differences between the actual cost to the Trust of treating patients in individual service lines and the relevant national tariff.

8.4 Where the Trust participates in a tendering exercise (whether in competition with others or not) for a health related or non-clinical service, approval must be sought according to the delegated authority limits.

8.5 Delegated authority limits associated with tendering:

	Director of Finance (in consultation with Chief Executive)	Trust Leadership Team	Trust Board
Decision not to bid	No limit	Not applicable	Not applicable

Total or annual value range where services are provided by the Trust and tender is to retain the current provision	0 - £10m	>£10m - £50m	>£50m
Total or annual value range where services are not currently provided by the Trust and tender is to acquire provision	0 - £5m	>£5m - £25m	>£25m

8.6 No tender must be submitted without sign-off from the relevant authority.

9. Terms of Service and Payment of Directors and Employees

9.1 Remuneration Committee

9.1.1 In accordance with the requirements of the 2006 Act and Standing Orders, the Trust shall establish a Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

9.1.2 The Committee will:

a. Periodically review the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board, making use of the output of the board evaluation process as appropriate, and make recommendations to the Board, and Governance and Nominations Committee of the Council of Governors, as applicable, with regard to any changes;
b. Give full consideration to and make plans for succession planning for the chief executive taking into account the challenges and opportunities facing the trust and the skills and expertise needed on the Board in the future;
c. Appoint candidates to fill all the executive director positions on the Board;
d. Consider any matter relating to the continuation in office of any board executive director including the suspension or termination of service of an individual as an employee of the trust, subject to the provisions of the law and their service contract;
e. Monitor and evaluate the performance of the Chief Executive through the Chair's appraisal process;
f. Determine the remuneration and terms of service of Executive Directors;
g. Discuss and, if appropriate, confirm the assessments made of performance related pay by the Chair for the Chief Executive the Chief Executive for the other Executive Directors;
h. Determine pay rises and review the need for any other adjustments. If a performance related pay scheme is in operation then a meeting of the Committee will review the performance of individual directors prior to the award of any bonus payments. (If a group PRP scheme is in place covering the most senior managers as well as Executive Directors then the Committee will determine membership of the scheme and payments for the scheme as a whole); and
i. Advise on and oversee appropriate contractual arrangements for Executive Directors, including any termination payments.

9.1.3 The Committee shall advise the Board in writing as to the basis for its recommendations. The Board shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of executive directors. Minutes of the Board's meetings should record such decisions.

9.1.4 The Board will after due consideration and amendment if appropriate approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees not covered by the Committee.

9.1.5 The Trust will remunerate the Chair and Non Executive Directors as determined by the Council of Governors.

9.2 Funded Establishment

9.2.1 The manpower plans incorporated within the annual budget will form the funded establishment.

9.2.2 The funded establishment of any department may not be varied without the approval of the Vacancy Control Panel.

9.3 Staff Appointments

9.3.1 No director or employee may engage, re-engage, or regrade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

a. unless authorised to do so by the Vacancy Control Panel; and

b. within the limit of their approved budget and funded establishment.

9.3.2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc., for employees.

9.4 Processing of Payroll

9.4.1 The Director of Finance is responsible for:

a. specifying timetables for submission of properly authorised time records and other notifications;

b. the final determination of pay;

c. making payment on agreed dates; and

d. agreeing method of payment.

9.4.2 The Director of Finance will issue instructions regarding:

a. verification and documentation of data;

b. the timetable for receipt and preparation of payroll data and the payment of employees;

c. maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

d. security and confidentiality of payroll information;

e. checks to be applied to completed payroll before and after payment;

f. authority to release payroll data under the provisions of the Data Protection Act;

g. methods of payment available to various categories of employee;

h. procedures for payment by cheque, bank credit, or cash to employees;

i. procedures for the recall of cheques and bank credits;

j. pay advances and their recovery;

k. maintenance of regular and independent reconciliation of pay control accounts;

l. separation of duties of preparing records and handling cash; and

m. a system to ensure the recovery from leavers of sums of money and property due by them to the Trust.

9.4.3 Appropriately nominated managers have delegated responsibility for:

a. submitting time records, and other notifications in accordance with agreed timetables;

b. completing time records and other notifications in accordance with the Director of Finance's instructions and in the form prescribed by the Director of Finance; and

c. submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination or retirement. Where an employee fails to report for duty in circumstances that suggest they have left without notice, the Director of Finance must be informed immediately.

9.4.4 Regardless of the arrangements for providing the payroll service, the Director of Finance shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

9.5 Contracts of Employment

9.5.1 The Board shall delegate responsibility to the Director People and OD for:

a. ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and dealing with variations to, or termination of, contracts of employment.

10. Non-pay Expenditure

10.1 Delegation of Authority

10.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers (including the level of virement between one budget holder and another). The financial limits are laid out in the Scheme of Delegation.

10.1.2 The Director of Finance will set out:

a. the list of managers who are authorised to place requisitions for the supply of goods and services; and

b. the maximum level of each requisition and the system for authorisation above that level.

10.1.3 The Director of Finance will also be responsible for ensuring that the Trust has clearly established arrangements for the purchase of goods and services.

10.1.4 The Director of Finance will also be responsible for ensuring that the Trust makes optimum use of corporate, national or regional contracts for the acquisition of goods and services, in order to ensure best value for money.

10.2 Choice, Requisitioning, Ordering, Receipt and Payments for Goods and Services

10.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust, i.e consideration of whole life costs and contribution to the achievement of other Trust objectives (e.g. safety, sustainability). In so doing, the advice of the Procurement Shared Service shall be sought. Requisitions must therefore be directed through the Trust's official contracts negotiated by or on behalf of the Trust, where available. Where such official contracts are not available, quotations or tenders must be obtained through the Procurement Shared Service via local, regional or national contracts, in accordance with Standing Orders. Only for exempt goods and services should a good or service be obtained without a purchase order.

10.2.2 The Director of Finance shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms or otherwise in accordance with national guidance.

10.2.3 The Director of Finance will:

a. advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed;

b. prepare procedural instructions on the obtaining of goods, works and services incorporating the thresholds;

c. be responsible for the prompt payment of all properly authorised accounts and claims and for advising the Board on a monthly basis of performance against targets set under the Government's Better Payments Practice Code;

d. be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

   i. A list of directors/employees (including specimens of their signatures) authorised to requisition, receipt and certify invoices for payment in respect of goods/services provided to the Trust where those goods or services are exempt from the P2P system of Procurement.

   ii. Certification that:

      - goods have been duly received, examined and are in accordance with specification and the prices are correct;

- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined and are reasonable
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct;
- the account is in order for payment;
- correct treatment for VAT purposes.

iii. A timetable and system for submission to the Finance Shared Services Paymaster Services Manager of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

iv. Instructions to employees regarding the handling and payment of accounts within the Finance Shared Services.

e. be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as below).

10.2.4 Prepayments are only permitted where exceptional circumstances apply. In such instances:

a. the financial advantages outweigh the disadvantages (i.e., cashflows must be discounted to Net Present Value) and the intention is not to circumvent cash management arrangements;

b. the appropriate Director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments;

c. the Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed; and

d. the budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate manager if problems are encountered.

10.2.5 Official Orders must:

a. be consecutively numbered;

b. be in a form approved by the Director of Finance;

c. state the Trust's terms and conditions of trade; and

d. only be issued to, and used by, the Procurement Shared Service.

10.2.6 Managers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and that:

a. all contracts (other than for a simple purchase permitted within the Scheme of Delegation or delegated budget), leases, tenancy agreements and other commitments which may result in a liability are notified to the Procurement Shared Service and the Director of Finance in advance of any commitment being made;

b. any contracts above specified thresholds are advertised, procured and awarded by the Procurement Shared Service in accordance with UK procurement legislation as amended and the principles of EU and WTO and GPA guidelines on public

procurement and comply with current public procurement best practice and guidance;

c. where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health and Social Care and relevant regulatory bodies;

d. no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

    i. isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

    ii. conventional hospitality, such as lunches in the course of working visits;

e. any gift, reward or benefit is recorded on the Trust's Hospitality Register;

f. no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;

g. all goods, services, or works are ordered on an official order except for purchases from petty cash and exempt expenditure agreed by the Director of Finance;

h. verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";

i. orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

j. goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

k. changes to the list of directors/employees authorised to certify invoices are notified to the Director of Finance;

l. purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance; and

m. petty cash records are maintained in a form as determined by the Director of Finance.

10.2.7 The Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the appropriate guidance. The technical audit of these contracts shall be the responsibility of the relevant Director.

10.3 Grants to Local Authorities and Voluntary Bodies

10.3.1 Grants to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act 2006 or section 64 of the Health Service and Public Health Act 1968 shall comply with procedures laid down by the Director of Finance which shall be in accordance with these Acts.

11. Treasury Management

11.1 External Borrowing

11.1.1 As a Foundation Trust, the Trust has freedom to access capital (i.e. borrow externally) subject to the following:-

a. prohibition on the use of protected assets as security for borrowing; and

b. any additional degree of scrutiny required by financial institutions

11.1.2 The Director of Finance will advise the Board concerning the Trust's ability to pay a dividend on, and repay Public Dividend Capital (PDC) and any proposed new borrowing, within the limits set by the Department of Health. The Director of Finance is also responsible for reporting periodically to the Board concerning the PDC debt and all loans financing facilities and overdrafts.

11.1.3 The Director of Finance will advise the Board concerning the Trust's ability to pay a dividend on, and repay Public Dividend Capital (PDC) and any proposed new borrowing, within the limits set by the Department of Health. The Director of Finance is also responsible for reporting periodically to the Board concerning the PDC debt and all loans financing facilities and overdrafts

11.1.4 Any application for a loan, financing facility or overdraft will only be made by the Director of Finance or by an employee so delegated.

11.1.5 The Director of Finance must prepare detailed procedural instructions concerning applications for loans, financing facilities and overdrafts.

11.1.6 All short term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position. Any short term borrowing requirement must be authorised by the Director of Finance.

11.1.7 All long term borrowing must be consistent with the plans outlined in the current financial plan as reported to the Regulator.

11.2 Investments

11.2.1 Under the terms of the 2006 Act and its Constitution, the Trust may invest money (other than money held by it as a Trustee) for the purposes of or in connection with its functions. This may include investment by forming or participating in forming bodies corporate or by otherwise acquiring membership of bodies corporate.

11.2.2 The Director of Finance is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held, other than short term temporary cash surpluses.

11.2.3 The Director of Finance will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

11.2.4 In the case of temporary cash surpluses, these may only be held in such form and with such public or private sector organisations as are approved by the Board. In giving approval to the mechanisms for short term investment, the Board will take account of instructions or guidelines issued by the Regulator to Foundation Trusts.

11.2.5 For other longer term forms of investment, including those referred to in 11.2, the approval of the Board will be obtained before proceeding.

11.3 Cash Flow Monitoring

11.3.1 The Director of Finance is responsible for managing and monitoring the overall cash flow of the Trust and for providing reports thereon to the Finance and Digital Committee and the Board. These reports will include:-

a. a comparison of month end outturn with the plan (monthly); and

b. a rolling 12 month projection of month end cash balances (quarterly)

12. Capital Investment, Private Financing, Fixed Asset Registers and Security of Assets

12.1 Capital Investment

12.1.1 The Chief Executive:

a. shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

b. is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost ; and

c. shall ensure that the capital investment is not undertaken without consideration of the availability of resources to finance all revenue consequences, including capital charges.

12.1.2 For every capital expenditure proposal the Chief Executive shall ensure:

a. that a business case (in accordance with Monitor's guidance contained within Risk Evaluation for investment decisions by NHS Foundation Trusts) is produced setting out:

   i. an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

   ii. appropriate project management and control arrangements.

b. that the Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case which is approved by the Board subject to agreed delegated limits.

12.1.3 For capital schemes where the contracts stipulate stage payments, the Director of Finance will issue procedures for their management, incorporating the recommendations of "Estatecode" and procedures for the regular reporting of expenditure and commitment against authorised expenditure.

12.1.4 The approval of a capital programme shall not constitute approval for the expenditure on any scheme. The Chief Executive shall issue to the manager responsible for any scheme:

a. specific authority to commit expenditure;

b. authority to proceed to tender; and

c. approval to accept a successful tender.

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with "Estatecode" guidance and the Trust's Standing Orders.

12.1.5 The Director of Finance shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

12.2 Private Finance

12.2.1 When the Trust proposes to access finance under the Private Finance Initiative, the following procedures shall apply:

a. The Director of Finance shall demonstrate that the use of private finance represents value for money and appropriately transfers significant risk to the private sector;

b. Where the sum involved exceeds delegated limits, the business case must be referred to the Regulator; and

c. The proposal must be specifically agreed by the Board.

12.3 Asset Registers

12.3.1 The Responsible Officer is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Finance concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once every two years.

12.3.2 The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be consistent with best practice.

12.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

a. properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

b. stores, requisitions and wages records for own materials and labour including appropriate overheads; and

c. lease agreements in respect of assets held under a finance lease and capitalised.

12.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

12.3.5 The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

12.3.6 The value of each asset shall be indexed to current values in accordance with best practice.

12.3.7 The value of each asset shall be depreciated using methods and rates as determined by the Director of Finance.

12.4 Security of Assets

12.4.1 The overall control of fixed assets is the responsibility of the Chief Executive.

12.4.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance. This procedure shall make provision for:

a. recording managerial responsibility for each asset;

b. identification of additions and disposals;

c. identification of all repairs and maintenance expenses;

d. physical security of assets;

e. periodic verification of the existence of, condition of, and title to, assets recorded;

f. identification and reporting of all costs associated with the retention of an asset; and

g. reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

12.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance.

12.4.4 Whilst each employee has a responsibility for the security of property of the Trust, it is the responsibility of directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with instructions.

12.4.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by directors and employees in accordance with the procedure for reporting losses.

12.4.6 Where practical, assets should be marked as Trust property.

13. Stores and Receipt of Goods

13.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

a. kept to a minimum;

b. subjected to annual stocktake; and

c. valued at the lower of cost and net realisable value.

13.2 Subject to the responsibility of the Director of Finance for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of fuel oil and coal of a designated estates manager.

13.3 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.

13.4 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

13.5 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year.

13.6 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.

13.7 The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also 14, Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

13.8 For goods supplied via the NHS Supply Chain central warehouses, the Director of Finance shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note.

14. Disposals and Condemnations, Losses and Special Payments

14.1 Disposals and Condemnations

14.1.1 Under the terms of the Authorisation agreement, the approval of the Regulator is required prior to the disposal of any protected assets (above any "de minimis" limit where specified). There are no external restrictions on the disposal of other assets provided that the proceeds are used to further the Trust's public interest objectives.

14.1.2 The Director of Finance must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers. These procedures should take account of the requirements set out in (1) above.

14.1.3 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

14.1.4 All unserviceable articles shall be:

a. condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Finance; and
b. recorded in a form approved by the Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance.

14.1.5 The Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

14.2 Losses and Special Payments

14.2.1 The Director of Finance shall prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

14.2.2 Any employee discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Director of Finance or inform an officer charged with responsibility for responding to concerns involving loss or fraud confidentially. This officer will then appropriately inform the Director of Finance and/or Chief Executive. Where a criminal offence is suspected, the Director of Finance must immediately inform the police. The Director of Finance should comply with any requirements to report fraud as determined by the Regulator/Secretary of State.

14.2.3 For losses apparently caused by theft, fraud, arson, neglect of duty or gross carelessness, except if trivial, the Director of Finance (or the Local Counter Fraud Specialist on the Director's behalf) must notify the Audit and Assurance Committee which will consider approval of write off on behalf of the Board.

14.2.4 The Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

14.2.5 For any loss, the Director of Finance should consider whether any insurance claim can be made.

14.2.6 The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded.

15. Information Technology

15.1 The Trust, under the terms of its Authorisation agreement, is required to participate in the National Programme for Information Technology, in accordance with any guidance issued by the Regulator. This requirement extends to the Director of Finance in fulfilling their responsibilities for the computerised financial data of the Trust as set out below.

15.2 The Director of Finance, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

a. devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which they are responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 2018;
b. ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;
c. ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;
d. ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as he/she may consider necessary are being carried out.

15.3 Where a new financial system or significant amendment to a current financial system is proposed, the Director of Finance will ensure that an appropriate Business Case is prepared and approved in advance at the appropriate level. The Director of Finance will also ensure that such systems are developed in a controlled manner, with appropriate project planning mechanisms, and are thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

15.4 In the case of new financial systems which are sponsored jointly by a number of healthcare or other organisations, including the Trust, the Director of Finance will seek to ensure that the same approval/ planning requirements as set out in paragraph 3 above are complied with and that the Trust is fully signed up to the development.

15.5 The Director of Finance shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

15.6 Where another health organisation or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

15.7 Where computer systems have an impact on corporate financial systems the Director of Finance shall satisfy him/her self that:

15.7.1 systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

15.7.2 data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

15.7.3 Director of Finance staff have access to such data; and

15.7.4 such computer audit reviews as are considered necessary are being carried out.

16. Patients' Property

16.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

16.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets;
- hospital admission documentation and property records; and
- the oral advice of administrative and nursing staff responsible for admissions;

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt. The sole exception to this requirement is where patients are admitted in the circumstances outlined in paragraph 1 above.

16.3 The Chief Operating Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to safeguard the interests of the patient.

16.4 Where good practice guidance (e.g. Department of Health instructions to non-Foundation Trusts) suggests the need to open separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the Director of Finance.

16.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

16.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

16.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

17. Funds Held on Trust (Charitable Funds)

17.1 Standing Orders (SOs) identify the Trust's responsibilities as a corporate trustee for the management of funds it holds on trust (charitable funds) and define how those responsibilities are to be discharged. They explain that the trustee responsibilities must be discharged separately and full recognition given to the guidance and regulation as determined by the Charity Commission.

17.2 The Board, in its corporate trustee capacity, shall determine where decisions regarding the exercise of dispositive discretion are to be taken and by whom. Directors and officers must take account of that guidance before taking action. SFIs are intended to provide guidance to persons who have been delegated to act on behalf of the corporate trustee.

17.3 The over-riding principle is that the integrity of each trust must be maintained and statutory and trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

18. Acceptance of Gifts by Staff

18.1 The Director of Finance shall ensure that all staff are made aware of the Trust's policy on acceptance of gifts and other benefits in kind by staff. This policy should follow the guidance contained in the Department of Health Standards of Business Conduct for NHS Staff.

19. Retention of Documents

19.1 The Chief Executive shall be responsible for defining retention periods in accordance with the relevant legislation and guidance and for maintaining archives for all documents required to be retained.

19.2 The documents held in archives shall be capable of retrieval by authorised persons.

19.3 Documents so held in accordance with HSC 1999/053 shall only be destroyed at the express instigation of the Chief Executive. Records shall be maintained of documents so destroyed.

20. Risk Management & Insurance

20.1 The Chief Executive shall ensure that the Trust has a risk management strategy, in accordance with current controls assurance guidance, which must be approved and monitored by the Board.

20.2 The programme of risk management shall include:

a. a process for identifying and quantifying risks and potential liabilities;

b. engendering among all levels of staff a positive attitude towards the control of risk;

c. management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

d. contingency plans to offset the impact of adverse events;

e. audit arrangements including; internal audit, clinical audit, health and safety review;

f. decision on which risks shall be insured; and

g. arrangements to review the risk management programme.

20.3 The existence, integration and evaluation of the above elements will provide the basis on which to make a statement on the effectiveness of Internal Financial Control within the Annual Report and Accounts as required in the Accounts Direction.

20.4 The Director of Finance shall ensure that insurance arrangements exist where appropriate. In this context, insurance will include any scheme administered by NHS Resolve (such as the risk pooling schemes) in addition to policies operated by commercial organisations. To this end, the Director of Finance shall:

a. be responsible for arranging all cover as may be determined by the Board;

b. be informed promptly of any event which may involve the Trust in a claim, or intended activity, which may involve a risk which has not already been covered; and

c. for any loss, consider whether a claim can be made against the appropriate insurance policy or scheme.

Appendix 1: Financial Delegation Limits

1. Revenue and Capital Expenditure

1.1 The Standing Financial Instructions require that revenue and capital budgets are prepared for approval by the Board on an annual basis. SFIs 4.2.5 and 4.4.1 specifically require that budgetary delegation limits are set.

1.2 At the start of each financial year the Board will,

(a) approve a financial plan for the year
(b) approve details of budgets ("Budget Book") to be delegated to budget holders
(c) approve levels for provisions and reserves identified in the financial plan. These will cover, inter alia, inflation, planned developments grouped by their nature, planned savings and a general contingency for unplanned developments and costs.

1.3 In accordance with SFIs 4.2.5 and 4.4.1 the Chief Executive may

(a) approve expenditure against provisions and reserves identified in the financial plan.
All such approvals will
- be reported to the Board each month by the Finance Director as he monitors the position on all such provisions and reserves (both revenue and capital)
- be backed by documentary evidence signed by the Chief Executive and also by the Finance Director (who in signing is confirming that the expenditure is both appropriate and consistent with the Trust's financial plans and procedures).

Subject to the availability of funds a reserve for infrastructure, risk reduction, training, quality enhancement, etc. will be managed by the Main Board itself reflecting the subjectivity of prioritisation in this area

Capital business cases, for expenditure or asset disposal, over £1,000,000 require Board approval. (For disposals this is to be taken as the higher of book value and estimated sale proceeds)

(b) approve increases in the real terms cost of revenue or capital developments identified specifically in the financial plans of the Trust, or reported individually in any Board agenda, provided that the cost increase can be funded within one of the approved provisions or reserves. Any increases exceeding 10% must be submitted to the Board for approval (as well as the reporting and authorisation requirements in 1.3(a) above)

(c) seek in year variations from the Board to the limits on provisions and reserves

(d) vire expenditure between approved revenue budgets and between capital budgets and identify savings for re-allocation, provided that variations which involve a significant change in Trust policy or reduction in services to patients are presented to the Board for approval

(e) adjust approved budgets and development schemes for inflation, provided that additional costs can be met from the Inflation Reserve. It is expected that the Chief Executive will delegate this responsibility to the Finance Director, who

will also adjust budgets as appropriate for other events totally outside the control of managers, e.g. taxation changes

(f) exercise virement of the Trust's resources between years, after taking advice from the Finance Director.

1.4 In exercising these responsibilities the Chief Executive will delegate within agreed limits. For virement each Executive Director will be authorised to vire up to £100,000 between budgets within his or her control. Each Divisional Director will be authorised to vire up to £25,000 within budgets in his or her control but provided that the virement is agreed by each of the three (four) Divisional Directors that limit is increased to £100,000. Budget holders at the tier below Divisional Director level will be authorised to vire up to £5,000 between budgets under their control.

1.5 Individual budget holders will be authorised by the Directors to vire up to £5,000 non-recurringly and £1,000 recurringly between revenue budgets within their control.

1.6 In exercising the delegated powers outlined in paragraphs 1.3 to 1.6 above officers must liaise with the Director of Finance or his/her nominated representative to obtain advice and must ensure that full details are reported to him/her.

2. Revenue and Capital Income

2.1 Payment by Results, Patient Choice and competition from Independent Sector Providers mean that the Trust's income streams are less certain and more complex than in the past.

2.2 The Chief Executive will

(a) sign legally binding contracts with NHS commissioners and other funders
(b) ensure that the financial plan for the year reflects realistic income expectations and contains adequate flexibility
(c) organise clinical capacity and service delivery to optimum effect taking account of legally binding contracts, the Trust's commitment to its patients and its staff and the Trust's financial needs and opportunities
(d) report significant events and variations to the Board
(e) report systematically on patient activity against plan to the Board.

2.3 The Director of Finance will

(a) report to the Board on actual income against planned income
(b) identify the implications for provisions and reserves in year and for the Trust in future years.

2.4 Capital income from borrowing will be limited to the net sum necessary to fund schemes authorised in accordance with the Financial Plan and section (1) above. Schemes funded from separate capital allocations will only be approved if revenue costs are authorised in accordance with section (1).

2.5 The Trust will only borrow revenue or capital funds for its own needs unless specific Board approval has been given.

3. Purchase Orders

3.1 All purchase orders will be subject to the limits set below.

Upto £1,000	Budget Holder
£1,000 to £10,000	Level 2 Approvers
£10,000 to £50,000	Level 3 Approvers

£50,000 to £100,000	Chief Executive and Director of Finance
£100,000 to £500,000	Trust Leadership Team
£above £500,000	Board

Purchase order limits and authorisation apply to agreed goods and services that are exempt from P2P.

4. Tendering Limits

4.1 The following limits will apply

Expenditure Range	Action Required
up to £5,000	Single supplier or quotations via Procurement Shared Services
£5,001 to £25,000	Competitive quotations/tenders via Procurement Shared Services
£25,001 to EU threshold	Formal tender procedure via Procurement Shared Service
Above EU threshold	Formal tender procedure via Procurement Shared Services under Public Contract Regulations

5. Authorisation to enter into and sign Contracts for goods and services

5.1 Where the Trust intends to award or extend a contract, approval must be sought according to the delegated authority limits.

5.2 The delegated authority limits for contract approval are:

	Level 3 Budget Holders	Trust Leadership Team	Finance and Digital Committee	Trust Board
Total contract value (over the lifetime of the contract including permitted extensions)	0 - £250k	>£250k - £1m	>£1m - £5m	>£5m

5.3 Contract approvals must be submitted to all relevant groups depending upon value.

5.4 Contracts must be signed by an authoriser in accordance with 3.1 above.

6. Charitable Funds

6.1 The following limits will apply for authorisation of Charitable Funds expenditure

Expenditure Range	Responsibilities
up to £1,000	Fund holders (unless a lower limit is specified by the Chief Operating Officer and Deputy Chief Executive.)

£1,001 to £5,000	Chief Operating Officer and Deputy Chief Executive (who may delegate as he/she judges appropriate to senior managers)
Above £5,000	Charitable Funds Committee

N.B. all of the above limits (Sections 3, 4 and 5) are excluding VAT

GLOUCESTERSHIRE HOSPITALS

NHS FOUNDATION TRUST

SCHEDULE OF DECISIONS RESERVED TO THE BOARD AND THE SCHEME OF DELEGATION

Version Control			
Version	**Author**	**Date**	**Changes**
0.1	Lukasz Bohdan	08-01-2019	First draft
0.2	Lukasz Bohdan	08-02-2019	Amendments made following Audit and Assurance Committee feedback

Approved by the Board of Directors on [insert date]

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1 Introduction

1.1 Reservation of powers

Subject to a provision in the authorisation or the Constitution, the Board may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee, appointed by virtue of Standing Order 5 or by a Director or an officer of the Trust in each case subject to such restrictions and conditions as the Board thinks fit. The NHS Foundation Trust Code of Governance and the Code of Accountability requires the Board of Directors to draw up a schedule of decisions reserved to itself and to ensure that management arrangements are in place to enable the clear delegation of its other responsibilities. This document sets out the powers reserved to the Board of Directors and the Scheme of Delegation including financial limits and approval thresholds. However, the Board of Directors remains accountable for all of its functions, including those which have been delegated, and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

1.2 Role of the Chief Executive

All powers of the Foundation Trust, which have not been retained as reserved by the Board of Directors or delegated to a Board committee or sub-committee, shall be exercised on behalf of the Board of Directors by the Chief Executive. The Scheme of Delegation identifies any functions which the Chief Executive shall perform personally and those able to be delegated to other directors or officers. All powers delegated by the Chief Executive can be re-assumed by them should the need arise.

1.3 Caution of the use of delegated powers

Powers are delegated to directors and officers on the understanding that they would not exercise delegated power in a manner which could be a cause for public concern.

1.4 Absence of directors or officers to whom powers have been delegated

In the absence of a director or officer to whom powers have been delegated, those powers shall be exercised by that director or officer's superior unless alternative arrangements have been approved by the Board of Directors. If the Chief Executive is absent, powers delegated to them may be exercised by the Deputy Chief Executive and in their absence a nominated officer acting in their absence after taking appropriate advice from the Executive Director of Corporate Governance. In the absence of the Executive Director of Corporate Governance, appropriate advice should be sought from the Director of Finance.

1.5 Review and awareness of delegated powers

The Scheme of Delegation is reviewed annually. As part of ensuring a sound system of corporate governance prevails, there is a requirement for staff with budgetary and/or senior managerial responsibility to sign a statement acknowledging awareness of this document and the Standing Financial Instructions and Standing Orders, and agreeing to apply them to their everyday approach to carrying their work for the Trust. This approach promotes compliance and effectiveness.

2 Schedule of Decisions Reserved to the Board

REF[1]	Decisions reserved to the Board of Directors
	General Enabling Provision The Board of Directors may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers.
	Regulations and Control 1 Approve Standing Orders (SOs) and Reservation of Powers to the Board.
	2 Suspend SOs, subject to SOs 3.30-3.34.
	3 Amend SOs, subject to SO 3.3.5.
	4 Approve Standing Financial Instructions (SFIs), including Financial Delegation Limits.
	5 Ratify the exercise of powers, which the Board has retained to itself, by the Chief Executive and the Chair in emergency, subject to SO 4.2.
SO 4.4 SO 5.5	6 Approve a scheme of delegation of executive powers from the Board of Directors to committees or sub-committees, which it has formally constituted, and authorise the delegation of a committee's executive powers to a sub-committee.
	7 Require and receive the declaration of Directors' interests that may conflict with those of the Trust and determining the extent to which that Director may remain involved with the matter under consideration in accordance paragraph 11 of the Constitution.
	8 Receive reports from committees including those that the Trust is required by the Secretary of State or other regulation to establish and to take appropriate action on such reports.
	9 Confirm or otherwise the recommendations of the Trust's committees where the committees do not have executive powers.
	10 Establish terms of reference and reporting arrangements of all committees that are established by the Board of Directors.
SFI 17.1 SO 2.2	11 Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust.
C 19.1 SO 11.2	12 Authorise the use of the seal and agree a policy to define those documents that must be sealed.
	13 Ensure the quality and safety of healthcare services, education, training and research delivered by the NHS Foundation Trust and applying the principles and standards of clinical governance set out by the Department of Health, the CQC, and other relevant NHS bodies.
	Appointments/ Dismissal
C 9.7	1 Appoint one of the independent Non-Executive Directors to be the Senior Independent Director in consultation with the Council of Governors.
SO 5.6	2 Approve the appointments to each of the committees, which it has formally constituted, and approve the terms of such appointments.
	3 Confirm appointment of members of any committee of the Trust as representatives on outside bodies.
SFIs 9.1.3 & 9.1.4	4 Approve proposals of the Remuneration Committee regarding the remuneration and terms of service of Directors.
	Strategy, Plans and Budgets
SFI 1.3.1	1 Define the strategic aims and objectives of the Trust each year.
	2 Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust, having regard to any guidance issued by NHS Improvement (Monitor).

[1] Reference Key: Constitution (C), Standing Financial Instructions (SFIs), SFI Appendix (SFI A) and Standing Orders (SOs).

SFI 20.1	3 Approve and monitor the Trust's risk management strategy.
	4 Approve the Trust's financial plan and annual budget.
SFI 4.1.5	5 Approve the Trust's capital programme.
	6 Approve annually the Trust's Operational Plan.
SFI 12.2.1	7 Approve Private Finance Initiative proposals (subject to any guidance issued by the Regulator).
	8 Approve the opening of bank or investment accounts.
SFI A1.5.2	9 Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to, over £5,000,000.
SFI A1.1.3	10 Approve capital expenditure, business cases and PFI schemes, including approval of variations, amounting to over £1,000,000.
SFI A1.1.3	11 Approve of increases in the real terms cost of revenue or capital developments identified specifically in the financial plans of the Trust, or reported individually in any Board agenda, provided that the cost increase can be funded within one of the approved provisions or reserves where the increase is >10% of the value in the agreed financial plan.
SFI A1.3	12 Approve purchase orders amounting to over £500,000.
SFI 8.5	13 Approve participation in a tendering exercise where retaining a service provided by the Trust amounts to over £50,000,000 and where acquiring a new service amounts to over £25,000,000.
SFI 2.1.1	14 Approve individual compensation payments.
SFI 10.1.1	15 Approve the level of non-pay expenditure on an annual basis.
SFI 11.1	16 Approve long term and short term borrowing facilities.
	Policy Determination 1 Determine insurance policy.
	Audit 1 To provide feedback to Governors to inform the appointment (and, where necessary, dismissal) of the External Auditor. 2 Approve the appointment (and where necessary, dismissal) of the Internal Auditors. 3 Receive reports of the Audit and Assurance Committee meetings, highlighting significant internal and external audit issues, and take appropriate action. 4 Receive the annual management letter received from the external auditor and agreement of proposed action, taking account of the advice of the Audit and Assurance Committee where appropriate.
	Annual Reports and Accounts 1 Approve the Trust's Annual Report, the Quality Account and Annual Accounts.
	Monitoring 1 Receive Board Assurance Framework reports and reports from committees in respect of their exercise of powers delegated such as the Board of Directors sees fit. 2 Continuous appraisal of the affairs of the Trust by means of the provision of information to the Board as the Board may require from Directors, committees and officers of the Trust as set out in management policy statements. All monitoring returns required by NHS Improvement (Monitor) shall be reported, at least in summary, to the Board of Directors. 3 Receive reports on all aspects of the Trust's performance, and particularly those covering performance against budget, financial plans, performance improvement plans, internal or national targets, and measures of activity and quality.

GMS Schedule of Matters Reserved and Delegated	**Matters concerning GMS** 1 Responsibilities of the Trust as shareholder of GMS as defined in company law. 2 Admission of additional shareholders for GMS. 3 Approval to issue any shares in GMS or grant any options or other right to subscribe for shares in GMS. 4 Approval to consolidate, sub-divide, convert, cancel, reduce, redesignate, purchase or redeem any share capital of GMS. 5 Approval of any change to the registered or trading name(s) of GMS, or to its brand. 6 Approval to change the location of GMS's registered office or its principal place of business. 7 Engage, carry on or establish any business outside of the United Kingdom or provide for the payment of any monies other than in good faith for the purposes of or in connection with the carrying on of such business outside of England and Wales. 8 Dissolution of GMS. 9 Approval and amendment of GMS's articles of association. 10 Appointment and removal of directors and the company secretary for GMS. 11 Appointment of a director to act as chairman of the GMS Board of Directors. 12 Approval of the terms and conditions of appointment for directors and the company secretary of GMS. 13 Approval of the GMS' schedule of matters reserved and delegated. 14 Approval of the membership and responsibilities of the Trust Estates Committee. 15 Oversight and approval to issue, defend or settle any litigation, claim or other legal proceedings (other than actions to recover debts in the ordinary course of business) for fees and other costs in excess of £10,000. 16 Approval to create issue or allow to come into being any encumbrance over the whole or any part of the undertaking or assets of GMS (save for charges arising by operation of law in the ordinary course of business or under retention of title covenants with suppliers to GMS). 17 Approval to make any capital distributions or dividend distributions. 18 Approval of capital transactions or contracts not within the approved Trust capital plan for the year. 19 Providing parent company guarantees for new GMS contracts. 20 Approval of staffing establishment and structure that could adversely affect services provided to a client or have significant impact on the staffing structure (e.g. redundancies). 21 Approval of changes to terms and conditions, excluding non-contractual policies, for employees who transfer from the Trust to GMS. 22 Approval of pension scheme arrangements for employees who transfer from the Trust to GMS.

3 Decisions/Duties delegated by the Board to Committees

3.1 Audit and Assurance Committee

<table>
<tr>
<td>Audit and Assurance Committee Terms of Reference</td>
<td>The Audit and Assurance Committee will:
Integrated governance, risk management and internal control

Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical), that supports the achievement of the organisation's objectives.
Review the adequacy and effectiveness of:

All risk and control related disclosure statements (in particular the annual governance statement), together with any accompanying head of internal audit opinion, external audit opinion or other appropriate independent assurances, prior to submission to the Board;
The underlying assurance processes that indicate the degree of achievement of the organisation's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications;
The policies and procedures for all work related to counter fraud, bribery and corruption as required by the NHS Counter Fraud Authority (NHSCFA).

Utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources.
Seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.
Maintain effective relationships with other key committees, for example, the Quality and Performance Committee so that it understands processes and linkages. However, these other committees must not usurp the Committee's role.
Monitor compliance with Standing Orders and Standing Financial Instructions.
Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Director of Finance (for losses and special payments).
Approve the terms of reference and membership of its sub-committees (as may be varied from time to time at the discretion of the Committee) and oversee their work, receiving reports for consideration and action as necessary.

Internal and External Audit

Oversee internal and external audit services.
Ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards, 2017 and provides appropriate independent assurance to the Committee, Accountable (or Accounting) Officer and the Board.
Review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process.
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	• Review the work and findings of the external auditors and consider the implications and management's responses to their work. • Provide feedback to the Council of Governors for the appointment of external auditors and assess the external (financial) auditors on an annual basis in terms of the quality of their work. *Clinical Audit* • Ensure that there is an appropriate and effective clinical audits programme. The remit of the Committee will cover the processes for clinical audits, whereas the outcomes of clinical audits will be considered by the Quality and Performance Committee. *Other assurance functions* • Review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation. These will include, but will not be limited to, any reviews by Department of Health and Social Care arm's length bodies or regulators/Inspectors for example, the Care Quality Commission, NHS Resolution, etc. and professional bodies with responsibility for the performance of staff or functions- for example, Royal Colleges, accreditation bodies, etc. • Review the work of other committees within the organisation, whose work can provide relevant assurance to the Committee's own areas of responsibility. In particular, this will include any clinical governance, risk management or quality committees that are established. • Review the work of the clinical governance committee and issues around clinical risk management and gain assurance regarding the clinical audit function *Counter Fraud* • Gain assurance that the organisation has adequate arrangements in place for counter fraud, bribery and corruption that meet NHSCFA's standards and shall review the outcomes of work in these areas. • Refer any suspicions of fraud, bribery and corruption to the NHSCFA. *Management* • Request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control. • Request specific reports from individual functions within the organisation (for example, clinical audit). *Financial reporting* • Monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance. • Ensure that the systems for financial reporting to the Board including those of budgetary controls are subject to review as to the completeness and accuracy of the information provided. • Review the annual report and financial statements before submission to the Board. *Whistleblowing* • Review the adequacy and security of the Trust's arrangements for its employees and contractors to raise concerns, in confidence, about

	possible wrongdoing in financial reporting or other matters and ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow up action. • Review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently. • Ensure that the Trust has appropriate and effective Freedom to Speak Up arrangements. The remit of the committee will cover the processes, whereas the issues and themes will be considered by the People and Organisational Development Committee. *Oversight of the Trust's subsidiaries' audit arrangements* • Gain assurance that any subsidiaries set up and owned by the Trust have appropriate and effective audit arrangements.

3.2 Estates Committee

	The Estates Committee will:
Estates Committee Terms of Reference	**A. Estates** • Ensure that the Trust's Estates Strategy is aligned to and responds to the Trust's Clinical Strategy and strategic/operational plans. • Ensure that the Trust's Estates Strategy takes account of and is aligned to the Integrated Care System (ICS)'s estates strategy. • Provide assurance and oversight in the delivery of the Trust's £39.5 million Capital Development Programme (and further major capital programmes as identified). • Ensure that the estates maintenance and refurbishment programmes are aligned to Trust strategy and the risks and impact on service delivery are understood and actively managed. • Maintain oversight of risks related to the estates/infrastructure and provide assurance to the Board that risks are being assessed and managed effectively.
GMS Schedule of matters reserved and delegated	**B. GMS** • On behalf of the Trust's Board of Directors, authorise any conflicts of interests for any directors of the Trust who are also directors of GMS; • Approve the responsibilities of the GMS Board of Directors; • Approve risk management arrangements for GMS[2]; • Approve arrangements to ensure compliance with regulatory requirements; • Ensure GMS compliance with the health and safety legal and regulatory requirements; • Approve GMS's corporate strategy/strategic direction; • Approve the annual business plan and annual budget for GMS (including objectives and any other strategic measures of performance), and any amendments to them; • Approve the financial plan for GMS; • Approve any of GMS's services to be sub-contracted to another

[2] The GMS Committee and the GMS Board of Directors shall consult with each other to establish appropriate risk management arrangements in respect of GMS.

<table>
<tr><td></td><td>provider;
• Change the nature of GMS's business or commence any new business which is not ancillary or incidental to the business (otherwise than in accordance with approved business plan);
• In consultation with Chair of the Audit and Assurance Committee, appoint or remove the external auditor for GMS;
• In consultation with Chair of the Audit and Assurance Committee, appoint or remove any internal auditor for GMS;
• Approve the acquisition or disposal of GMS assets with a value exceeding £20,000 up to the upper limit within the remit of the Committee;
• Enter into a loan agreement with the Trust or another lender, including any mortgage or other charge, on behalf of the Trust;
• Acquire any interest or share capital in another body corporate;
• Make any loan or grant credit, other than trade credit in the normal course of business on arm's length terms, or grant any guarantee or indemnity of the obligations of any person;
• Approve accounting and financial policies and procedures subject to compliance with the approved budget and financial plan;
• Approve any change to GMS's accounting reference date;
• Approve the opening or closing of any bank account for GMS;
• Enter into or a renew a contract or series of connected revenue or capital contracts for any material matter(s) (excluding business authorised through the approved business plan) for consideration payable being in excess of £250,000 or consideration receivable represents on average in excess of £250,000 per annum;
• Obtain assurance that the findings and recommendations of GMS-related internal audit reports have been addressed by the GMS; and
• Approve revenue transaction of over £50,000 not within the approved business plan for the year.</td></tr>
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3.3 Finance and Digital Committee

<table>
<tr><td>Finance and Digital Committee Terms of Reference</td><td>The Finance and Digital Committee will:
• Finance

Financial strategy and business planning:
• Ensure delivery of the financial aspects of the Operational Plan.
• Ensure delivery of the annual and medium-term financial plans: income and expenditure plans/budgets, revenue investment, capital investment, working capital, statement of financial position and cash flow, and associated targets for savings to ensure sustainability going forward. The Committee shall assess the assumptions therein and the alignment with overall Trust objectives.
• Approve the investment and borrowing strategy and associated policies.
• Review in-year performance against financial plan, particularly gaining an understanding of key assumptions and risks within the Trust projections.
• Review levels of contingency within the Trust financial plans and the phasing of key developments and efficiency schemes, ensuring that the full impact of any developments (including depreciation and cost of capital) have been appropriately included.</td></tr>
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	• Review and develop reporting arrangements.
	• Ensure the availability and quality of financial management information (to ensure a consistent approach to financial management).
	• Ensure sustainable service commissioning from a financial and funding perspective.
	• Review and maintain an overview of financial and service delivery agreements and key contractual arrangements.
	• Oversee the development, management and delivery of the Trust's annual capital programme.
	• Review business cases and either:
	  o approve as appropriate on behalf of the Board, if within the Committee's delegated authority; or
	  o endorse prior to Board approval, if above the Committee's delegated authority.
	• Consider key financial policies e.g. investment policy, issues and developments to ensure that they are shaped, developed and implemented in the Trust appropriately.
	
	Income and contracts management:
	• Review the Trust contracting approach with key commissioners
	• Monitor in-year income against contract and levels of risk, including commissioner challenges, accrued income, fines and penalties, and income disputes.
	• Review arrangements for non-activity related income streams, particularly CQUIN, to understand alignment with Trust clinical priorities and levels of income risk.
	• Consider material opportunities to grow new income streams and market share of existing services.
	
	Transformation and Efficiency:
	• Set financial performance benchmarks and monitor the performance of investments.
	• Seek and consider evidence of organisational compliance with the Capital Investment Policy
	• Review proposed revisions to the Capital Investment Policy for approval by the Board each year.
	• Review the process for developing the CIP and for the oversight and delivery of the programme within the Trust.
	• Review the process for developing the transformation plan and for the oversight and delivery of the programme within the Trust.
	• Consider and recommend any major transformation programmes that the Trust should undertake.
	• Review the annual CIP and transformation plan to provide assurance that delivery risk is minimised and productivity and efficiency maximised, in particular that contingency, phasing and risk mitigation plans are appropriate and that savings programmes are realistic and deliverable.
	• Receive assurances regarding efficient and effective resource planning, particularly with respect to staffing and the deployment of agency staff.
	• Receive benchmarking and other information (for example from Carter metrics) to assess Trust productivity and ensure targeting or efficiency programmes.
	• Receive assurance that any process reviews are conducted using an appropriate methodology.

Procurement

- Review the Trust procurement strategy, systems and arrangements for obtaining best value.
- Monitor progress against the NHS standards of Procurement within the Trust.

Other:

- Oversee funding arrangement for DH transaction deficit support.
- Gain assurance that cash management arrangements are robust.
- Approve the terms of reference and membership of its sub-committees (as may be varied from time to time at the discretion of the Committee) and oversee their work, receiving reports for consideration and action as necessary.
- Review financial systems arrangements including those used for costing, income and service level reporting where appropriate.
- Review and consider any bids for external capital.
- Any other relevant matters as referred by the Board.

The Duties of the Committee are to consider and examine:-

- Key financial performance indicators.
- Monthly/annual consolidated financial performance summaries and related plans/budgets.
- Cost improvement plans.
- The monthly/annual statement of financial position.
- Working capital performance.
- Cash flow status.
- Capital Programme.
- Risks associated with financial plans.
- Financial relationships with Trust Commissioners.
- Financial Risk Ratings applied by NHS Improvement.
- Financial performance forecasts.
- Cash flow forecasts.
- Financial aspects of the Board Assurance Framework.

- **Digital**

Digital Strategy and Delivery Plan

- Approve the Digital Strategy.
- Oversee the delivery of the strategic and operational priorities set out in the Strategy through scrutiny of the Delivery Plan.
- Make recommendations to the Board in respect of the annual IM&T capital budget.
- Provide assurance in respect of budgetary control against the agreed annual budget.
- Consider and examine risks associated with the digital strategy and delivery plan.
- Obtain assurance in respect of the digital aspects of the Board Assurance Framework.

Information Governance

- Approve the Trust's information governance Policy on an annual basis.

	• Obtain assurance that the Trust's policies and procedures with respect to data privacy, covering patients, staff and members, are compliant with all relevant legislation and guidance including the Data Protection Act 1998. • Receive a quarterly report on information governance activities including: ▪ Serious reportable data breaches including assurance on incident investigation and lessons learnt ▪ Training compliance status ▪ Progress against national IG Toolkit Compliance *Partnerships* • Receive regular updates from the Integrated Care System on relevant programmes. • Ensure there is effective collaboration with partner organisations and other stakeholders in relation to the implementation of digital solutions and sharing of systems in a controlled manner. • Ensure the Trust is an effective host and partner in respect of the Countywide IT Service (CITS).

3.4 People and Organisational Development Committee

P&OD Committee Terms of Reference	**The People and Organisational Development Committee will:** • Obtain assurance that there are practices in place which ensure the sustainability and affordability of workforce supply on a short, medium and long term basis including workforce planning, development, redesign, recruitment and retention; • Obtain assurance that the Trust attracts and retains a high performing workforce capable of delivering the Trust operational clinical strategies; • Obtain assurance that the Trust implements effective and equitable reward packages that positively impact on performance and meet national and legislative parameters; • Obtain assurance that strategic education issues and external relationships which impact on supply and engagement are included in Trust planning; • Obtain assurance that the Trust delivers services which are fair and equitable promoting diversity and equality of opportunity; • Obtain assurance that the Trust is driving improved employee engagement, ensuring appropriate mechanisms for the employee voice to ensure that rapid action is taken to improve staff experience. Agree the Trust Workforce Strategy and establish, monitor and report to the Trust Board on an annual programme of work to implement the strategy; • Agree annual objectives for Health and Safety; • Agree (where necessary) People and Organisational Development reports prior to publication and review implications of national reports that have been published; • Identify risks associated with People and Organisational Development issues ensuring ownership with mitigating actions, escalating to Trust Board as required; • Approve the terms of reference and membership of its sub-committees (as may be varied from time to time at the discretion of

	the Committee) and oversee their work, receiving reports for consideration and action as necessary. • Consider and approve action plans, programmes of work and strategic objectives as a result of national audit related to protected characteristics and provide assurance to the Board on progress; and • Work with the Quality and Performance Committee to obtain assurance on safer and optimal staffing and that education, learning and development is aligned with the Trust's quality priorities.

3.5 Quality and Performance Committee

Quality and Performance Committee Terms of Reference	**The Quality and Performance Committee will:**
	General Governance Arrangements:
	• Ensure that all statutory elements of quality governance are adhered to within the trust.
	• Carry out statutory responsibilities on behalf of the Board (e.g. with regard to learning from deaths, safeguarding and infection control).
	• Agree the annual quality priorities and monitor progress and ensure that the Trust has reliable, real time, up-to-date information about what it is like being a patient and experiencing care administered by the Trust, so as to identify areas for improvement and ensure that these improvements are effected.
	• Review and approve the Trust's annual quality governance and Quality Account before submission to the Board.
	• Approve the terms of reference and membership of its sub-committees (as may be varied from time to time at the discretion of the Committee) and oversee their work, receiving reports for consideration and action as necessary.
	• Consider matters referred to the Committee by the Board.
	• Consider matters referred to the Committee by its sub-committees.
	• Obtain assurance that the Trust's policies and procedures with respect to the use of clinical data and patient identifiable information are compliant with all relevant legislation and guidance including the Caldicott Guidelines and the Data Protection Act 1998.
	• Make recommendations to the Audit and Assurance Committee concerning the annual programme of internal audit work, to the extent that it applies to matters within these terms of reference.
	• Receive internal audit reports relevant to the remit of the Committee and obtain assurance that findings recommendations are acted on.
	• Review outcomes of clinical and internal audits and obtain assurance findings recommendations are acted on.
	• Obtain assurance that all quality and performance-related contract performance notices (CPNs) have local recovery plans and that appropriate monitoring arrangements are in place at the Divisional and Trust.
	• Obtain assurance that the Trust has effective policies and procedures in the areas covered by the remit of the Committee, e.g.:
	  o Infection prevention and control annual report and programme
	  o Complaints policy
	  o Claims policy
	  o Incident reporting policy
	  o Consent policy

	o Safeguarding children policy o Safeguarding adults policy *Quality and excellence in patient care:* • Shape and influence the Trust's Quality Strategy and framework and associate strategic objectives, including overseeing the development and production of the annual Quality Account. • Obtain assurance that the registration criteria of the Care Quality Commission continue to be met. • Support the Trust's objectives to strive for continuous quality improvement through the work for the Gloucestershire Safety and Quality Improvement Academy. • Promote the Trust's open and honest reporting culture. • Obtain assurance that robust arrangements are in place for the review of patient safety incidents from within the Trust and wider NHS (including near-misses, complaints, claims reports from HM Coroner, reports from the Healthcare Safety Investigation Branch). • Identify trends and areas for focused or organisation-wide learning from the review of patient safety incidents and to ensure that actions for improvement identified in incident reports, reports from HM Coroner and other similar documents are addressed. • Identify areas for improvement in respect of incident themes and complaint themes from the results of national patient survey/PALS and ensure appropriate action is taken. • Oversee the system within the Trust for obtaining and maintaining any licences relevant to clinical activity in the Trust (e.g. licences granted by the Human Tissue Authority or any successor organisation). • Monitor the Trust's compliance with the fundamental standards of quality of the Care Quality Commission, and monitor licence conditions that are relevant to the Committee's area of responsibility. • Provide assurance to the Board so that the Board may approve the Trust's annual declaration of compliance and corporate governance statement. • Obtain assurance that risks to patients are minimised through: • Considering areas of significant risk, setting priorities and agreeing actions using the assurance framework; • Obtaining assurance that the Trust incorporates the recommendations from external bodies and reports (e.g. the National Confidential Enquiry into Patient Outcomes and Death or Care Quality Commission, Care Quality Commission, commissioners) and those made internally (e.g. serious incident reports) into practice and has mechanisms to monitor their delivery; and • To ensure those areas of risk within the Trust are regularly monitored and that effective disaster recovery plans are in place. • Obtain assurance that there are processes in place that safeguard children and adults within the Trust. • Escalate to the Executive Team, Audit and Assurance Committee and/or Board any identified unresolved risks arising within the scope of these terms of reference that require executive action or that pose significant threats to the operation, resources or reputation of the Trust.

	Operational performance and the NHS Constitution standards: • Obtain assurance that the Trust delivers services which are consistently meeting nationally defined minimum standards and performance and notably the four key standards required by the Trust's regulator. Where performance is below the standard required, the Committee will ensure that robust recovery plans are developed and implemented (A&E four hour wait, Cancer waiting times, referral to treatment and 6 week diagnostic standards). *Efficient and effective use of resources through evidence-based clinical practice:* • In liaison with the Finance and Digital Committee, obtain assurance the Quality Impact Assessments are completed for proposals for cost improvement programmes and other significant service changes and that the assessment of their impact on the Trust's quality of care determines whether to proceed to implementation. • Ensure that care is based on evidence of best practice/national guidance. • Ensure that there is an appropriate process in place to monitor and promote compliance across the Trust with clinical standards and guidelines, including but not limited to NICE guidance and guidelines and radiation use and protection regulations (IR(ME)R). • Review the implications of confidential enquiry reports for the Trust and to endorse, approve and monitor the internal action plans arising from them. • Monitor trends in complaints received by the Trust and commission actions in response to adverse trends where appropriate. • Monitor the development of quality indicators throughout the Trust. • Identify and monitor any gaps in the delivery of effective clinical care ensuring progress is made to improve these areas, in all specialties. • Obtain assurance that he research programme and governance framework is implemented and monitored. • Obtain assurance that that where practice is of high quality, that practice is recognised and propagated across the Trust. • Obtain assurance that the Trust is outward-looking and incorporates the recommendations from external bodies into practice with mechanisms to monitor their delivery. The duties of the Committee will include: • Ensuring that staff effectively involve patients and their carers in the planning and evaluation of services so as to ensure that services meet the needs and preferences of patients, so far as is possible. • Working with the People and Organisational Development Committee to obtain assurance on safer and optimal staffing and that education, learning and development is aligned with the Trust's quality priorities. • Working with the Finance and Digital Committee to ensure that the availability of resources does not adversely impact upon the quality of services to the extent that patient safety is compromised or care is delivered that doesn't meet the required mandatory quality standards as defined by the CQC and NHSI. • Maintaining effective links to Divisions via exception reports (e.g.

	from the Quality Delivery Group; Planned Care Delivery Group; Cancer Delivery Group; and Emergency Care Delivery Group). • Triangulating data in support of its purpose.

3.6 Remuneration Committee

SFI 9.1	**The Remuneration Committee will:** **A. Appointments Role** • Periodically review the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board, making use of the output of the board evaluation process as appropriate, and make recommendations to the Board, and Governance and Nominations Committee of the Council of Governors, as applicable, with regard to any changes. • Give full consideration to and make plans for succession planning for the chief executive taking into account the challenges and opportunities facing the trust and the skills and expertise needed on the Board in the future. • Appoint candidates to fill all the executive director positions on the Board. • Consider any matter relating to the continuation in office of any board executive director including the suspension or termination of service of an individual as an employee of the trust, subject to the provisions of the law and their service contract. ***B. Remuneration Role*** • Monitor and evaluate the performance of the Chief Executive through the Chair's appraisal process. • Determine the remuneration and terms of service of Executive Directors. • Discuss and, if appropriate, confirm the assessments made of performance related pay by the Chair for the Chief Executive the Chief Executive for the other Executive Directors. • Determine pay rises and review the need for any other adjustments. If a performance related pay scheme is in operation then a meeting of the Committee will review the performance of individual directors prior to the award of any bonus payments. (If a group PRP scheme is in place covering the most senior managers as well as Executive Directors then the Committee will determine membership of the scheme and payments for the scheme as a whole). • Advise on and oversee appropriate contractual arrangements for Executive Directors, including any termination payments.

4 Scheme of Delegation of Powers from the Constitution

Constitution Ref	Delegated to	Authorities/Duties Delegated
7.4.3 & 7.4.4 & 7.4.5	Director of Corporate Governance	Make decisions regarding Members' and applicants' eligibility or disqualification.
7.7.9	Chair	Preside at the Annual Members' Meeting.
8.6.1	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.
8.7.2	Director of Corporate Governance	Ensure NHS Improvement (Monitor) is provided with details of the serving Lead Governor.
8.11.2	Director of Corporate Governance	Request, where the vacancy arises amongst the appointed Governors, the appointing organisation appoints a replacement to hold office for the remainder of the term of office.
9.5	Chair	May exercise a second or casting vote where the number of votes for and against a motion is equal at a meeting of the Board of Directors.
17.5	Chair	Judge whether a transaction is “deemed to be high risk by its nature” or “of specific relevance to governor priorities”.
Annex 2 3.4	Chair	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; 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.
Annex 2 3.7	Chair	Call a meeting of the Council of Governors at any time.
Annex 2 3.9	Chair	Serve notice of a Council of Governors meeting on governors.
Annex 2 3.17	Chair	Exercise a casting vote where the number of votes for and against a motion is equal at a meeting of the Council of Governors.
Annex 2 3.27	Chair	Decide questions of order, relevance, regularity and any other matters at a meeting of the Council of Governors.
Annex 2 3.33	Director of Corporate Governance	Keep records of all written resolutions of any matter determined by the Council of Governors.
Annex 2 5.1.1 & 5.1.2	Governors	Declare any actual or potential conflict of interest.
Annex 2 5.1.3	Chair	Determine what action to take if a Governor has a conflict of interest.
Annex 2 5.3.1	Director of Corporate Governance	Ensure a register of interests is established to record formally declarations of interests of Governors.

5 Scheme of Delegation of Powers from the Board Standing Orders (SOs)

SO Ref	Delegated to	Authorities/Duties Delegated
1.1	Chair	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).
3.4	Chair	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 Board's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted.
3.7	Chair	Call a meeting of the Trust Board at any time.
3.9	Chair	Serve notice of the meeting of the Trust to every Director.
3.16 & 3.26	Chair	Exercise a casting vote where the number of votes for and against a motion is equal.
3.25	Chair	Decide questions of order, relevance, regularity and any other matters at the meeting of the Trust.
4.2	Chief Executive and Chair	Exercise the powers which the Board has retained to itself within the Standing Orders in emergency.
4.5	Chief Executive	Determine which functions they will perform personally and nominate officers to undertake the remaining functions for which they will still be accountable to the Board.
4.6	Director of Corporate Governance	Prepare a Scheme of Delegation identifying their proposals which shall be considered and approved by the Board, subject to any amendments agreed during the discussion; and periodically propose amendment to the Scheme of Delegation.
6.3.5	Chair	Determine what action to take if during the course of a meeting of the Board a Director has a conflict of interest.
6.13	Director of Corporate Governance	Ensure a register of interests is established to record formally declarations of interests of Directors.
7.6	Directors, Governors and officers of the Trust	Disclose to the Chief Executive any relationship with a candidate for any staff appointment of whose candidature that Director or officer is aware.
7.6	Chief Executive	Report to the Trust any disclosure made by any Director, Governor and officer of the Trust concerning any relationship with a candidate of whose candidature that Director or officer is aware.
8.4	Director of Finance or nominated officer	Maintain a list of applicable exemptions from waivering competition.
8.5	Director of Finance	Waive competitive tendering/quotation procedures in specific circumstances as defined in SO 8.5.1-8.5.4.
8.6	Chief Executive and Director of Finance	Waive formal tendering procedures over £25,000 excluding VAT and under the thresholds of the EU Procurement Directives given specific circumstances as defined in SO 8.6.1-8.6.5.
8.16	Chief	Evaluate quotations and select the one which gives the best

	Executive or officer nominated by them	value for money.
8.18	Chief Executive	Ensure best value for money can be demonstrated for all services provided under contract or in-house.
8.19.1	Chief Executive	Demonstrate the use of private finance represents value for money and genuinely transfers risk to the private sector.
8.22 & 10.4	Chief Executive	Nominate an officer who shall oversee and manage each contract on behalf of the Trust.
8.22	Chief Executive	Nominate officers with delegated authority to enter into contracts for the employment of other officers, to authorise regrading of staff, and enter into contracts for the employment of agency staff or temporary staff.
8.23	Chief Executive	Nominate officers to assess the tax status on individuals/personal services companies to ensure compliance with HMRC Self-Employment/IR35 status, prior to entering into any contracts of this nature.
8.23	Director of Finance or Director of People or Head of Shared Services or Head of Procurement	Assess the tax status on individuals/personal services companies to ensure compliance with HMRC Self-Employment/IR35 status, prior to entering into any contracts of this nature.
8.25	Chief Executive	Nominate officers with power to negotiate for the provision of healthcare services with commissioners of healthcare.
11.1 & 11.5	Director of Corporate Governance	Keep the Common Seal of the Trust in a secure place and maintain a register of sealing.
11.3	Director of Finance	Approve and sign the sealing of any building, engineering, property or capital document.
11.3	Chief Executive	Authorise and countersign the sealing of any building, engineering, property or capital document.
11.4	Director of Corporate Governance	Witness and attest to the affixing of the seal.
12.1	Chief Executive	Sign any documents where the signature will be a necessary step in legal proceedings involving the Trust.
12.2	Chief Executive	Sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board or committee or sub-committee to which the Board has delegated appropriate authority.
13.1	Chief Executive	Ensure that existing Directors and officers and all new appointees are notified of and understand their responsibilities within Standing Orders and Standing Financial Instructions.
Annex A	Chief Executive	Perform tendering procedure as designated in Annex A of the SOs.

6 Scheme of Delegation of Powers from the Standing Financial Instructions (SFIs)

SFI Ref	Delegated to	Authorities/Duties Delegated
1 Introduction		
1.3.6 & 1.3.9	Chief Executive	Ensuring that all members of the Board, employees of the Trust and contractor are notified of and understand their responsibilities within SFIs.
1.3.7	Finance Director	1 Implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies; 2 Maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions; 3 Ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time; 4 Ensuring that good financial practice is followed in accordance with accepted professional standards and advice received from internal and external auditors; 5 Providing of financial advice to the Trust and its Directors and employees; 6 Designing, implementing and supervising of systems of internal financial control; and 7 Preparing and maintaining of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.
1.3.8 & 1.3.9	All directors, staff and contractors	Security of Trust property; avoiding loss; exercising economy and efficiency in the use of resources; conforming to the Constitution, Standing Orders, SFIs and the Scheme of Delegation; and reporting suspected theft or fraud to the Director of Finance.
2 Audit		
2.1.1	Audit and Assurance Committee	1 Overseeing Internal and External Audit services; 2 Reviewing systems of internal control and ensuring they are fit for purpose; 3 Monitoring compliance with Standing Orders and Standing Financial Instructions; and 4 Reviewing schedules of losses and compensations and making recommendations to the Board.
2.1.3	Director of Finance	Ensuring adequate internal audit service is provided
2.1.4	Audit and Assurance Committee	Making a recommendation to the Council of Governors to the appointment of external auditors; assessing the external (financial) auditors on an annual basis in terms of the quality of their work
2.2.1	Chief Executive / Director of Finance	Monitoring and ensuring compliance with the directions issued by the Secretary of State for Health and/or NHS Counter Fraud Authority on fraud, bribery and corruption.
2.2.4	Local Counter Fraud	Providing a written report at least annually on counter fraud work within the Trust.

	Specialist	
2.2.5	All staff	Informing the Finance Director or Local Counter Fraud Specialist if they discover or suspect a loss of any kind
2.3.1	Director of Finance	1 Ensuring that there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function; 2 Ensuring that the internal audit is adequate and meets the NHS mandatory audit standards; 3 In conjunction with the Counter Fraud and Security Management Service, deciding at what stage to involve the police in cases of misappropriation, and other irregularities; 4 Ensuring that an annual Internal Audit Report is prepared for the consideration of the Audit and Assurance Committee and the Board; 5 Ensuring that a three year strategic Internal Audit Plan is prepared for the consideration of the Audit and Assurance Committee and the Board; and 6 Ensuring that an annual Internal Audit Plan is produced for consideration by the Audit and Assurance Committee and the Board, which sets out the proposed activities for the function for the forthcoming financial year.
2.3.3	All staff	Notifying the Director of Finance or Local Counter Fraud Service whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature.
2.4.1	Director of Finance	Ensuring an Internal Audit function is in place and operates efficiently and effectively.
2.4.2	Internal Auditor	1 Providing assurances about the effectiveness of controls in place across all of the Trust's activities; 2 Reviewing the overall arrangements the Board itself has in place for securing adequate assurances and providing an opinion on those arrangements to support the Statement on Internal Control; and 3 Reviewing the way in which the Board has identified objectives, risks, controls and sources of assurance on these controls, and assessed the value of assurances obtained.
2.5.2	Council of Governors	Appointing (or removing) the external (financial) auditor on behalf of the Trust in accordance with the selection criteria in the Audit Code for NHS Foundation Trusts.
2.6.1	Chief Executive	Ensuring compliance with the Audit Code for NHS Foundation Trusts.
3 Financial Targets		
3.3	Chief Executive	Ensuring the Trust aims to maintain its financial viability and meets any specific financial targets set by the regulator; setting appropriate internal targets in order to ensure financial viability; signalling to the Finance and Digital Committee and the Board where the Trust's financial viability or key targets are at risk.
3.4	Director of Finance	1 Advising the Board and Chief Executive on progress in meeting these targets, recommending corrective action as appropriate; 2 Ensuring that adequate systems exist internally to monitor

		financial performance; 3 Managing the cash flow and external borrowings of the Trust; and 4 Providing the Regulator with such financial information as is necessary to monitor the financial viability of the Trust.
4 Business Planning, Budgets and Budgetary Control		
4.1.1	Council of Governors	Providing the Board with its views on the Trust's forward plans for each financial year.
4.1.1	The Board	Consulting the Council of Governors on the Trust's forward plans for each financial year.
4.1.2	Chief Executive	Compiling and submitting to the Board and the Council of Governors an annual business plan which takes into account financial targets and forecast limits of available resources.
4.1.3	Chief Executive	Submitting the approved Business Plan to the Regulator as required.
4.1.4	Chief Executive	Ensuring on behalf of the Board that the Council of Governors is consulted on any significant changes to the Business Plan in year.
4.1.5	Director of Finance	Preparing and submitting revenue and capital budgets for approval by the Board.
4.1.6	Director of Finance	Monitoring financial performance against budget and the Business Plan and report to the Board.
4.1.7	Budget holders	Providing information as required by the Director of Finance to enable budgets to be compiled and to explain variances.
4.1.8	Director of Finance	Ensuring adequate, on-going training is delivered to budget holders to help them manage their budgets successfully.
4.2.1	Director of Finance	Delegate the management of a budget to permit the performance of a defined range of activities.
4.2.1 & 4.3.2	Budget holders	The management of a budget to permit the performance of a defined range of activities.
4.3.1	Director of Finance	Devise and maintain systems of budgetary control including monthly financial reports to the Board containing sufficient information to ascertain financial performance.
4.3.3	Chief Executive	Ensuring the identification and implementation of cost improvements and income generation initiatives in accordance with the requirements of the annual Business Plan and agreed Control Total.
4.3.4	Director of Finance	Advising the Chief Executive and the Board on the financial consequences of any changes in policy, pay awards and other events impacting on budgets and also on the financial implications of future plans and developments proposed by the Trust.
4.5.1	Chief Executive	Providing the Regulator with the appropriate monitoring information.
4.5.2	Chief Executive	Ensuring the Trust contributes to standard national NHS data flows required for NHS policy development/ funding decisions as well as performance assessment by the Healthcare Commission.
5 Annual Accounts and Reports		
5.1	Director of Finance	1 Preparing annual accounts in accordance with the Regulator's Manual of Accounts and any other guidance from the same, the Trust's accounting policies and generally accepted accounting practice; 2 Preparing and submitting annual accounts to the Board and

		an audited summary of the Main Financial Statements to an Annual Members' Meeting convened by the Council of Governors, certified in accordance with current guidelines; and 3 Laying a copy of the annual accounts, and any report of the external (financial) auditor thereon, before Parliament and subsequently send them to the Regulator.
5.4.1	Director of Corporate Governance	Preparing and submitting annual reports to the Board and an audited summary to an Annual Members' Meeting convened by the Council of Governors.
6 Bank Accounts		
6.1.1 & 6.4.1	Director of Finance	Managing and regularly reviewing the Trust's banking arrangements and advising the Trust on the provision of banking services and operation of accounts.
6.2.1	Director of Finance	Responsible for bank accounts; establishing separate bank accounts for the Trust's charitable funds; ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made; and reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.
6.3.1	Director of Finance	Preparing detailed instructions on the operation of bank accounts.
6.3.2	Director of Finance	Advising the Trust's bankers in writing of the conditions under which each account will be operated.
7 Income, Fees and Charges and Security of Cash, Cheques and Other Negotiable Instruments		
7.1.1	Director of Finance	Designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.
7.1.3	Director of Finance	Banking of all monies received.
7.2.2	Director of Finance	Approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute.
7.3.1	Director of Finance	Take appropriate recovery action on all outstanding debts and provide the Finance and Digital Committee with a monthly analysis of debtors profiled by age and actions to recover.
7.4.1	Director of Finance	1 Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable; 2 Ordering and securely controlling any such stationery; 3 Providing adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and 4 Prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.
8 NHS Contracts for the Provision of Services		
8.1	Chief Executive	Ensuring that the Trust enters into suitable legally binding contracts with NHS commissioners both for the mandatory healthcare services specified in the Trust's Authorisation agreement with the Regulator and also other healthcare services.
8.2	Chief	Ensuring the Trust works will all partner agencies involved in

	Executive	both the delivery and the commissioning of the service required.
8.3	Director of Finance	Ensuring regular reports are provided to the Finance and Digital Committee and the Board detailing forecast/ budgeted and actual income from contracts with NHS commissioners, particularly highlighting the impact of differences between planned and actual numbers of patients treated and outline any action required to address such variances and periodically providing information on the impact of differences between the actual cost to the Trust of treating patients in individual service lines and the relevant national tariff.
9 Terms of Service and Payment of Directors and Employees		
9.1.2	Remuneration Committee	1 Periodically review the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board, making use of the output of the board evaluation process as appropriate, and make recommendations to the Board, and Governance and Nominations Committee of the Council of Governors, as applicable, with regard to any changes; 2 Give full consideration to and make plans for succession planning for the chief executive taking into account the challenges and opportunities facing the trust and the skills and expertise needed on the Board in the future; 3 Appoint candidates to fill all the executive director positions on the Board; 4 Consider any matter relating to the continuation in office of any board executive director including the suspension or termination of service of an individual as an employee of the trust, subject to the provisions of the law and their service contract; 5 Monitor and evaluate the performance of the Chief Executive through the Chair's appraisal process; 6 Determine the remuneration and terms of service of Executive Directors; 7 Discuss and, if appropriate, confirm the assessments made of performance related pay by the Chair for the Chief Executive the Chief Executive for the other Executive Directors; 8 Determine pay rises and review the need for any other adjustments. If a performance related pay scheme is in operation then a meeting of the Committee will review the performance of individual directors prior to the award of any bonus payments. (If a group PRP scheme is in place covering the most senior managers as well as Executive Directors then the Committee will determine membership of the scheme and payments for the scheme as a whole); and 9 Advise on and oversee appropriate contractual arrangements for Executive Directors, including any termination payments.
9.1.3	Remuneration Committee	Send recommendations in report to the Board.
9.2.2	Vacancy Control Panel	Authorise changes to the funded establishment.
9.3.1	Vacancy Control Panel	Authorise changes in any aspect of remuneration, unless the changes are within the limit of the employee's approved budget

		and funded establishment.
9.3.1	Budget holders	Recruit to vacancies provided that this is within their approved budget and funded establishment.
9.4.1	Director of Finance	1 Specifying timetables for submission of properly authorised time records and other notifications; 2 Authorising the final determination of pay; 3 Making payment on agreed dates; and 4 Agreeing method of payment.
9.4.2	Director of Finance	Issuing instructions regarding processing of payroll.
9.4.3	Nominated managers	1 Submitting time records, and other notifications in accordance with agreed timetables; 2 Completing time records and other notifications in accordance with the Director of Finance's instructions and in the form prescribed by the Director of Finance; and 3 Submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination or retirement. Where an employee fails to report for duty in circumstances that suggest they have left without notice, the Director of Finance must be informed immediately.
9.4.4	Director of Finance	Ensuring the chosen method for providing the payroll service is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.
9.5.1	Director of People and OD	1 Ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and 2 Dealing with variations to, or termination of, contracts of employment.
10 Non-pay Expenditure		
10.1.1	Chief Executive	Determine level of delegation to budget managers.
10.1.2	Director of Finance	Set out the list of managers who are authorised to place requisitions for the supply of goods and services; and the maximum level of each requisition and the system for authorisation above that level.
10.1.3	Director of Finance	Ensuring the Trust has clearly established arrangements for the purchase of goods and services.
10.1.4	Director of Finance	Ensuring the Trust makes optimum use of corporate, national or regional contracts for the acquisition of goods and services, in order to ensure best value for money.
10.2.1	Requisitioners	Obtain the best value of money for the Trust when choosing an item to be supplied, seeking the advice of the Procurement Shared Service.
10.2.2	Director of Finance	Paying accounts and claims promptly and paying contract invoices in accordance with contract terms or otherwise national guidance.
10.2.3	Director of Finance	1 Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed;

		2 Prepare procedural instructions on the obtaining of goods, works and services incorporating the thresholds; 3 Be responsible for the prompt payment of all properly authorised accounts and claims and for advising the Board on a monthly basis of performance against targets set under the Government's Better Payments Practice Code; 4 Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. 5 Be responsible for ensuring that payment for goods and services is only made once the goods and services are received, except in exceptional circumstances where prepayments are permitted.
10.2.4	Budget holders	Ensuring all items due under a prepayment contract are received and informing the appropriate manager if problems are encountered.
10.2.4	Director of Finance	Be satisfied with the proposed arrangements for prepayments before contractual arrangements proceed.
10.2.6	Managers	Ensure full compliance with the guidance and limits specified by the Director of Finance concerning contracts and other commitments which may result in a liability.
10.2.7	Director of Finance	Ensuring arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the appropriate guidance.
11 Treasury Management		
11.1.2	Director of Finance	Advise the Board concerning the Trust's ability to pay a dividend on, and repay Public Dividend Capital (PDC) and any proposed new borrowing, within the limits set by the Department of Health and report periodically to the Board concerning the PDC debt and all loans financing facilities and overdrafts,
11.1.3	Director of Finance	Make, or delegate an employee to make, any application for a loan, financing facility or overdraft.
11.1.4	Director of Finance	Prepare detailed procedural instructions concerning applications for loans, financing facilities and overdrafts.
11.1.5	Director of Finance	Authorise short term borrowing requirements.
11.2.2	Director of Finance	Advise the Board on investments and report periodically to the Board concerning the performance of investments held, other than short term temporary cash surpluses.
11.2.3	Director of Finance	Prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.
11.3.1	Director of Finance	Manage and monitor the overall cash flow of the Trust and provide reports thereon to the Finance and Digital Committee and the Board.
12 Capital Investment, Private Financing, Fixed Asset Registers and Security of Assets		
12.1.1	Chief Executive	Ensure adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans; be responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and ensure that the capital investment is not undertaken without consideration of the availability of resources to finance all revenue consequences, including capital charges.

12.1.2	Chief Executive	Ensure that for every capital expenditure proposal a business case is produced and the Director of Finance has certified to the costs and revenue consequences detailed in the business case which is approved by the Board subject to agreed delegated limits.
12.1.3	Director of Finance	Issue procedures for the management of capital schemes where the contracts stipulate stage payments; and issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.
12.1.4	Chief Executive	Issue necessary authority to the manager responsible for any capital programme and a scheme of delegation for capital investment management in accordance with "Estatecode" guidance and the Trust's Standing Orders.
12.1.5	Director of Finance	Issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.
12.2.1	Director of Finance	Demonstrate the use of private finance represents value for money and appropriately transfers significant risk to the private sector.
12.3.1	Responsible Officer	Maintain registers of assets and arrange a physical check of assets against the asset register to be conducted once every two years.
12.3.5	Director of Finance	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
12.4.1	Chief Executive	Control of fixed assets.
12.4.2	Director of Finance	Approve asset control procedures.
12.4.4	Directors and senior employees	Apply appropriate routine security practices in relation to NHS property.
13 Stores and Receipt of Goods		
13.2	Chief Executive	Delegate day-to-day responsibility for the control of stores of goods, subject to the responsibility of the Director of Finance for the systems of control.
13.3 & 13.7	Designated Manager / Pharmaceutical Officer	Define in writing the responsibility for security arrangements and the custody of keys for all stores and locations; be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles; and report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice.
13.4	Director of Finance	Set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.
13.5	Director of Finance	Agree stocktaking arrangements.
13.8	Director of Finance	Identify those authorised to requisition and accept goods supplied via the NHS Supply Chain central warehouses.
14 Disposals and Condemnations, Losses and Special Payments		
14.1.2	Director of Finance	Prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.
14.1.4	Director of	Authorise employees to condemn or otherwise all unserviceable

& 14.1.5	Finance	articles; approve the form in which this is recorded; and take appropriate action if there is evidence of negligence.
14.1.4 & 14.1.5	All staff	If authorised by the Director of Finance, condemn or otherwise all unserviceable articles; record in a form approved by the Director of Finance; and report any evidence of negligence in use to the Director of Finance.
14.2.1	Director of Finance	Prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.
14.2.2	All staff	Inform their head of department if they discover or suspect a loss of any kind, who must immediately inform the appropriate officer.
14.2.3	Director of Finance	Report losses apparently caused by theft, fraud, arson, neglect of duty or gross carelessness, except if trivial, to the Audit and Assurance Committee.
14.2.4	Director of Finance	Take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.
14.2.5	Director of Finance	Consider whether any insurance claim can be made for any loss.
14.2.6	Director of Finance	Maintain a Losses and Special payments Register.
15 Information Technology		
15.2	Director of Finance	Ensuring the accuracy and security of the computerised financial detail.
15.3	Director of Finance	Ensuring an appropriate Business Case is prepared and approved for a new financial system or significant amendment to a current financial system.
15.5	Director of Finance	Ensuring contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage.
16 Patients' Property		
16.2	Chief Executive	Ensuring patients or their guardians, as appropriate, are informed before or at admission that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.
16.3	Chief Operating Officer	Provide arrangements for the administration of patient property.
18 Acceptance of Gifts by Staff		
18.1	Director of Finance	Ensure staff are aware of the Trust's policy on acceptance of gifts and other benefits in kind by staff.
19 Retention of Documents		
19.1 & 19.3	Chief Executive	Maintaining archives for all documents required to be retained in accordance with Department of Health guidelines; instigating the destruction of these documents and maintaining a record of destroyed documents.
20 Risk Management & Insurance		
20.1	Chief Executive	Ensuring the Trust has a programme of risk management which is approved and monitored by the Board.
20.4	Director of Finance	Ensuring insurance arrangements exist where appropriate.

Appendix 1: Financial Delegation Limits

1.1 Revenue and Capital Expenditure (SFI Appendix 1.1.3)

Responsibility	**Board**	**Chief Executive, delegated to the Trust Leadership Team**
Approval of capital expenditure, business cases & PFI schemes, including approval of variations	>£1,000,000	<£1,000,000
Approval of increases in the real terms cost of revenue or capital developments identified specifically in the financial plans of the Trust, or reported individually in any Board agenda, provided that the cost increase can be funded within one of the approved provisions or reserves	If the increase is >10% of the value in the agreed financial plan	If the increase is equal to or >10% of the value in the agreed financial plan

1.1.1 Authorisation of Virement (SFI Appendix 1.1.4-1.1.5)

Executive Director	**Divisional Director**	**Budget holders**
<£100,000 between budgets with their control	<£25,000 within budgets in their control (but <£100,00 provided each of the three (four) DD's agree)	<£5,000 between budgets under their control (<£5,000 non-recurringly and <£1,000 recurringly between revenue budgets within their control)

1.2 Purchase Orders (SFI Appendix 1.3)

Expenditure range	**Authorised personnel**
Up to £1,000	Budget Holder
£1,000 to £10,000	Level 2 Approvers
£10,000 to £50,000	Level 3 Approvers
£50,000 to £100,000	Chief Executive & Director of Finance
£100,000 to £500,000	Trust Leadership Team
above £500,000	Board

1.3 Tendering Limits (SFI Appendix 1.4)

Expenditure range	**Action required**
Up to £5,000	Single supplier or quotations via Procurement Shared Services
£5,001 to £25,000	Competitive quotations/tenders via Procurement Shared Services
£25,001 to EU threshold	Formal tender procedure via Procurement Shared Service
Above EU threshold	Formal tender procedure via Procurement Shared Services under Public Contract Regulations

1.4 Authorisation to enter into and sign Contracts for goods and services (SFI Appendix 1.5)

	Level 3/4 Budget Holders	Trust Leadership Team	Finance and Digital Committee	Trust Board
Total contract value (over the lifetime of the contract including permitted extensions)	0 - £250k	>£250k - £1m	>£1m - £5m	>£5m

1.5 Delegated authority limits associated with tendering (SFI 8.5)

	Director of Finance (in consultation with Chief Executive)	**Trust Leadership Team**	**Trust Board**
Decision not to bid	No limit	Not applicable	Not applicable
Total or annual value range where services are provided by the Trust and tender is to retain the current provision	0 - £10m	>£10m - £50m	>£50m
Total or annual value range where services are not currently provided by the Trust and tender is to acquire provision	0 - £5m	>£5m - £25m	>£25m

1.6 Charitable Funds (SFI Appendix 1.6)

Expenditure range	**Authorised personnel**
Up to £1,000	Fund holders (unless a lower limit is specified by the Chief Operating Officer and Deputy Chief Executive.)
£1,001 to £5,000	Chief Operating Officer and Deputy Chief Executive (who may delegate as he/she judges appropriate to senior managers)
Above £5,000	Charitable Funds Committee

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

AUDIT AND ASSURANCE COMMITTEE

TERMS OF REFERENCE – FEBRUARY 2019

1. Purpose and status

The Audit and Assurance Committee (the Committee) has been established by the Board of Directors (the Board) of Gloucestershire Hospitals NHS Foundation Trust (the Trust).

The purpose of the Committee is to:

- Monitor the integrity of the financial statements
- Assist the Board in its oversight of risk management and the effectiveness of internal control, oversight of compliance with corporate governance standards and matters relating to the external and internal audit functions
- Provide the Board with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Trust's activities both generally and in support of the annual governance statement

The scope of the Audit and Assurance Committee's remit covers the Gloucestershire Hospitals NHS Foundation Trust and any subsidiary companies thereof (the Group).

2. Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request by the Committee.

The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

3. Responsibilities

The Committee will:

Integrated governance, risk management and internal control

- Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical), that supports the achievement of the organisation's objectives.
- Review the adequacy and effectiveness of:
    - All risk and control related disclosure statements (in particular the annual governance statement), together with any accompanying head of internal audit opinion, external audit opinion or other appropriate independent assurances, prior to submission to the Board;
    - The underlying assurance processes that indicate the degree of achievement of the organisation's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
    - The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications;

    - The policies and procedures for all work related to counter fraud, bribery and corruption as required by the NHS Counter Fraud Authority (NHSCFA).
- Utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources.
- Seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.
- Maintain effective relationships with other key committees, for example, the Quality and Performance Committee so that it understands processes and linkages. However, these other committees must not usurp the Committee's role.
- Monitor compliance with Standing Orders and Standing Financial Instructions.
- Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Director of Finance (for losses and special payments).
- Approve the terms of reference and membership of its sub-committees (as may be varied from time to time at the discretion of the Committee) and oversee their work, receiving reports for consideration and action as necessary.
- Review the Single Tender Action Report

Internal and External Audit

- Oversee internal and external audit services.
- Ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards, 2017 and provides appropriate independent assurance to the Committee, Accountable (or Accounting) Officer and the Board.
- Review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process.
- Review the work and findings of the external auditors and consider the implications and management's responses to their work.
- Provide feedback to the Council of Governors for the appointment of external auditors and assess the external (financial) auditors on an annual basis in terms of the quality of their work.

Clinical Audit

- Ensure that there is an appropriate and effective clinical audits programme. The remit of the Committee will cover the processes for clinical audits, whereas the outcomes of clinical audits will be considered by the Quality and Performance Committee.

Other assurance functions

- Review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation. These will include, but will not be limited to, any reviews by Department of Health and Social Care arm's length bodies or regulators/Inspectors for example, the Care Quality Commission, NHS Resolution, etc. and professional bodies with responsibility for the performance of staff or functions- for example, Royal Colleges, accreditation bodies, etc.
- Review the work of other committees within the organisation, whose work can provide relevant assurance to the Committee's own areas of responsibility. In particular, this will include any clinical governance, risk management or quality committees that are established.

- Review the work of the clinical governance committee and issues around clinical risk management and gain assurance regarding the clinical audit function

Counter Fraud

- Gain assurance that the organisation has adequate arrangements in place for counter fraud, bribery and corruption that meet NHSCFA's standards and shall review the outcomes of work in these areas.
- Refer any suspicions of fraud, bribery and corruption to the NHSCFA.

Management

- Request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.
- Request specific reports from individual functions within the organisation (for example, clinical audit).

Financial reporting

- Monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance.
- Ensure that the systems for financial reporting to the Board including those of budgetary controls are subject to review as to the completeness and accuracy of the information provided.
- Review the annual report and financial statements before submission to the Board.

Whistleblowing

- Review the adequacy and security of the Trust’s arrangements for its employees and contractors to raise concerns, in confidence, about possible wrongdoing in financial reporting or other matters and ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow up action.
- Review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently.
- Ensure that the Trust has appropriate and effective Freedom to Speak Up arrangements. The remit of the committee will cover the processes, whereas the issues and themes will be considered by the People and Organisational Development Committee.

Oversight of the Trust’s subsidiaries’ audit arrangements

- Gain assurance that any subsidiaries set up and owned by the Trust have appropriate and effective audit arrangements.

4. Membership

Members

The Committee shall comprise:

One Non-Executive Director (who shall be the Committee Chair)

Two further Non-Executive Directors (one of whom should also be a member of the Finance Committee).

At least one Committee Member should have financial qualification (i.e. qualified accountant: ACCA/CIMA/ACA/IPFA)

The Chair of the Trust shall not be a member of the Committee.

Any member (with the exception of the Chair) who is unable to attend a meeting of the Committee may appoint a substitute. Any substitute appointed for the Non-Executive Director member of the Committee must also be a Non-Executive Director of the Trust.

Attendees

The Committee may decide that any other person must attend one or all of its meetings to contribute to discussions but no such person shall form part of the quorum nor have decision-making authority. The following post-holders have a standing invitation to attend the Committee meetings:

Chief Executive
All Executive Directors
All Non-Executive Directors
Director of Safety
Director of Operational Finance
Representatives of the External Auditors
Representatives of the Internal Auditors
A representative of the Local Counter Fraud Service

One Governor of the Trust may attend any meeting of the Committee as an observer.

Access

Representatives of internal audit and external audit have right of direct access to the Chair of the Committee.

5. Accountability and Reporting

Accountability

After each of its meetings the Committee shall report to the Board, via the Chair's report, such issues as it considers should be brought to the Board's attention or require a decision from the Board.

The Committee shall provide such information and other support as the Board requires in order for the non-executive directors of the Trust to give account to the Council of Governors in respect of the Committee's remit.

The Committee will reviews its effectiveness and report to the Board at least annually on its work in support of the Annual Governance Statement.

The annual report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they are addressed.

Reporting in
The following groups will report into the Committee:

Not applicable.

6. Conduct of business and administrative matters

The Committee shall conduct its meetings in accordance with these Terms of Reference and any other Trust governance requirements that apply to it (subject to below).

Any member who has a conflict of interests in respect of any matter shall not count in the quorum for the Committee's discussions and any decisions in respect of that matter.

The quorum for the Committee's meetings shall be any two members or their duly appointed substitutes.

The Committee shall determine the frequency of its meetings to allow it to discharge all of its responsibilities. It is expected the Committee shall meet at least bi-monthly, including at least one meeting a year with both the internal and external auditors but without executive Board members.

The external auditors or internal auditors may request a meeting if they consider that one is necessary.

The Chair may request an extraordinary meeting at any time if they consider one to be necessary.

The agenda and any papers for the Committee's meetings shall be issued not less than five working days before each meeting.

Minutes shall be taken of each of the Committee's meetings and shall be circulated to the members within timescales agreed by the Committee.

The Committee may agree that its members 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.

Administrative support, including retention of meeting papers and other relevant documents, shall be provided by the Executive Assistant to the Director of Finance.

7. Approval and Review

These ToR were approved by the Board on […].

These ToR were adopted by the Committee at its meeting on […].

These ToR shall be reviewed at least annually.

Version Control			
Version	**Author**	**Date**	**Changes**
0.1	Lukasz Bohdan	08-01-2019	First draft
0.2	Lukasz Bohdan	08-02-2019	Amendments made following Audit and Assurance Committee feedback

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

ESTATES COMMITTEE

TERMS OF REFERENCE – FEBRUARY 2019

1. Purpose and status

The Estates Committee (the Committee) has been established by the Board of Directors (the Board) of Gloucestershire Hospitals NHS Foundation Trust (the Trust).

The purpose of the Committee is to:

- Provide the Board with assurance concerning the development and delivery of the Estates Strategy and Capital Programmes in support of getting the best clinical outcomes and experience for patients, within the resources set out in the annual plan.
- Provide oversight of, and to exercise the authority in respect of, Gloucestershire Managed Services (GMS). GMS is a company limited by shares which is wholly-owned by, and provides estate management services to, the Trust. GMS is managed by its board of directors (the GMS Board).

2. Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request by the Committee.

With regard to GMS, the Committee has the authority defined in the Schedule of Matters Reserved and Delegated (the Schedule) approved by the Board.

The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

These Terms of Reference (TOR) are subject to the Schedule and to the Standing Orders and other relevant governance documents that apply to the Committee.

3. Responsibilities

The Committee will:

A. Estates

- Ensure that the Trust's Estates Strategy is aligned to and responds to the Trust's Clinical Strategy and strategic/operational plans.
- Ensure that the Trust's Estates Strategy takes account of and is aligned to the Integrated Care System (ICS)'s estates strategy.
- Provide assurance and oversight in the delivery of the Trust's £39.5 million Capital Development Programme (and further major capital programmes as identified).
- Ensure that the estates maintenance and refurbishment programmes are aligned to Trust strategy and the risks and impact on service delivery are understood and actively managed.
- Maintain oversight of risks related to the estates/infrastructure and provide assurance to the Board that risks are being assessed and managed effectively.

B. GMS

- Maintain strategic oversight of GMS as defined in Appendix A. The Committee has no remit over the operational monitoring of the services which GMS provides to the Trust, or otherwise over the management of the Trust's contract(s) with GMS, except to the extent defined in the sub-section 'Strategy and planning' in Appendix A. The responsibilities of the Committee can be found in Appendix A.

4. Membership

Members

The Committee shall comprise:

One Trust Non-Executive Director (who shall be the Committee Chair)

Two further Trust Non-Executive Directors

Trust Chief Executive

Trust Director of Finance

Trust Chief Operating Officer

And, additionally:

For Part A. Estates

Trust Director of Strategy and Transformation

For Part B. GMS

Trust Director of Corporate Governance

Any member who is unable to attend a meeting of the Committee may appoint a substitute. Any substitute appointed for the Non-Executive Director member of the Committee must also be a Non-Executive Director of the Trust.

Attendees

The Committee may decide that any other person must attend one or all of its meetings to contribute to discussions but no such person shall form part of the quorum nor have decision-making authority. The following post-holders have a standing invitation to attend Committee meetings:

At least one representative of GMS, agreed between the Committee and the GMS Board.

And, additionally:

For Part A. Estates

Associate Director of Strategy and Transformation

For Part B. GMS

Trust Contract Manager

One Governor of the Trust may attend any meeting of the Committee as an observer.

5. Accountability and Reporting

Accountability
After each of its meetings the Committee shall report to the Board, via the Chair's report, such issues as it considers should be brought to the Board's attention or require a decision from the Board, including on the matters in respect of which authority is reserved to the Board (as defined in the GMS Schedule of matters reserved and delegated).

The Committee shall provide such information and other support as the Board requires in order for the non-executive directors of the Trust to give account to the Council of Governors in respect of the Committee's remit.

The Committee will review its effectiveness at least annually.

Reporting in
The following groups will report into the Committee:

Not applicable.

6. Conduct of business and administrative matters

The Committee shall conduct its meetings in accordance with these Terms of Reference and any other Trust governance requirements that apply to it (subject to below).

For GMS part, any conflicts of interests for the Committee's members shall be addressed through the Articles of Association. Any member who has a conflict of interests in respect of any matter shall not count in the quorum for the Committee's discussions and any decisions in respect of that matter.

The quorum for the Committee's meetings shall be three members, two of whom must be Non-Executive Directors.

The Committee shall determine the frequency of its meetings. It is expected the Committee shall meet at least bi-monthly.

The Chair may request an extraordinary meeting at any time if they consider one to be necessary.

The agenda and any papers for the Committee's meetings shall be issued not less than five working days before each meeting.

Minutes shall be taken of each of the Committee's meetings and shall be circulated to the members within timescales agreed by the Committee.

The Committee may agree that its members 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.

Administrative support, including retention of meeting papers and other relevant documents, shall be provided by the Corporate Governance Officer.

7. Approval and Review

These ToR were approved by the Board on […].

These ToR were adopted by the Committee at its meeting on […].

These ToR shall be reviewed at least annually.

Version Control			
Version	**Author**	**Date**	**Changes**
0.1	Lukasz Bohdan	08-01-2019	First draft
0.2	Lukasz Bohdan	08-02-2019	Amendments made following Audit and Assurance Committee feedback

Appendix A

Governance and company law matters

- Advise and make recommendations to the Board as necessary on the exercise of its responsibilities and authority as shareholder of GMS, including as defined in the Schedule.
- Advise the Board as necessary on the exercise of its responsibilities in respect of appointment or removal of, and setting the terms and conditions for, the directors (including the chairman) and the company secretary of GMS.
- In accordance with the Trust's Constitution and having regard to the Articles of Association of GMS, on behalf of the Board authorise any conflicts of interests for any directors of the Trust who are also directors of GMS.
- Monitor the corporate governance arrangements in respect of GMS, both within the Trust and within GMS, to ensure that they comply with regulatory requirements, adopt relevant good practice, and are effective.
- Assure the effectiveness of the Trust's arrangements for managing its contract(s) with GMS, including the monitoring of GMS' performance against key indicators or other measures of service delivery.

Legal and regulatory compliance

- Ensure that the Trust's governance and other arrangements in respect of GMS are compliant with all relevant regulatory requirements.
- Ensure that the Trust and GMS understand clearly the legal and regulatory obligations that apply to each of them, and the arrangements necessary to ensure compliance, including any requirements which apply to both the Trust and GMS so that action is required jointly.
- Monitor GMS' compliance with all relevant regulatory requirements and require that action is taken to address any non-compliance.
- Where necessary ensure compliance with regulatory requirements, including the health and safety legal and regulatory requirements, and agree with the GMS Board any action which must be taken jointly by the Trust and GMS.

Strategy and planning

- Receive from the GMS Board proposals for a corporate strategy for GMS, ensuring that it addresses the Trust's requirements for GMS and is consistent with relevant Trust strategies. Approve the strategy on behalf of the Board.
- Receive from the GMS Board proposals for a business plan for each financial year, ensuring that it includes at least the Trust's objectives for GMS and any other content that the Committee requires as a minimum. Approve the business plan on behalf of the Board.
- Monitor the implementation of the business plan to ensure that all objectives (defined in the business plan) are delivered by the GMS Board.
- Consider and where appropriate give approval for any of GMS' services to be sub-contracted to another provider.
- Consider and where appropriate approve any proposals for GMS to enter into new business not specified in the annual business plan approved by the Committee.
- Ensure that the Trust’s Estates Strategy is aligned to and responds to the Trust’s Clinical Strategy and strategic/operational plans.
- Provide assurance and oversight in the delivery of the Trust’s £39.5 million Capital Development Programme (and further major capital programmes as identified).
- To ensure that the Estates maintenance and refurbishment programmes are aligned to Trust strategy and the risks and impact on service delivery are understood and actively managed.

Risk management

- Ensure that the Trust has in place appropriate risk management arrangements in respect of GMS, including a risk register.
- Review regularly the Trust's management of its risks in respect of GMS and where necessary require that action is taken by relevant managers.
- Monitor GMS' risk management arrangements to ensure that they are appropriate and effective (as determined by the Committee).
- Where necessary to manage any risks, agree with the GMS Board any action which must be taken jointly by the Trust and GMS.

Financial matters and internal control

- Following consultation with the Chair of the Trust's Audit and Assurance Committee, approve the appointment of GMS' external auditor and any internal auditor.
- Liaise with the GMS Board as necessary in respect of its:
  - Oversight of GMS' internal control and risk management framework, including reports from any internal auditor;
  - Approval of GMS' statutory annual report and accounts.
- Where the Trust decides that this is appropriate, work with the GMS Board to develop a financial plan, ensuring that it addresses the Trust's financial objectives for GMS. Approve the financial plan on behalf of the Board.
- Work with the GMS Board to develop a budget for each financial year, ensuring that it is consistent with the strategy, annual business plan and any financial plan for GMS. Approve the budget on behalf of the Board.
- Advise the Board on the exercise of its authority in respect of financial matters as defined in the Schedule.
- Monitor GMS' performance against any financial plan and the annual budget to ensure that they are delivered by the GMS Board.
- Monitor insurance arrangements and other financial arrangements put into place by the GMS Board to ensure that they are appropriate.
- Approve proposals for GMS to enter into a contract or series of connected contracts for any material matter(s) (excluding business authorised through the approved business plan) as defined in the Schedule.

Resourcing

- Approve the appointment of professional advisors or consultants required by GMS with fees or other costs in excess of the threshold defined in the Schedule.
- Approve proposals for any single item of expenditure not within the approved business plan for the year as defined in the Schedule.
- Monitor the staffing establishment and structure for GMS and advise the Board on the exercise of its authority to approve any amendments that could adversely affect services provided to a client or have a significant impact upon the staffing establishment.
- Advise the Board on the exercise of its authority to approve changes to the terms and conditions, including pension arrangements, of staff who transfer from the Trust.
- Provide to the GMS Board any advice, information or support that it requires such that it may approve the terms and conditions, including pension arrangements, for staff appointed by GMS (who do not transfer from the Trust), provided that the GMS Board consult the Trust and have regard to its views in accordance with the Schedule.

GMS Board accountability arrangements

- Agree with the GMS Board the arrangements through which it will give account to the Committee, including the information which the Committee requires in order to exercise its responsibilities as defined in these TOR.

FINANCE AND DIGITAL COMMITTEE

TERMS OF REFERENCE – FEBRUARY 2019

1. Purpose and status

The Finance and Digital Committee (the Committee) has been established by the Board of Directors (the Board) of Gloucestershire Hospitals NHS Foundation Trust (the Trust).

The purpose of the Committee is to:

A. Finance

- Support the Board's strategic direction and stewardship of the Trust's finances, investments and financial sustainability.
- Review arrangements for procurement, productivity and efficiency within the Trust, including plans to deliver savings and transformation.
- Provide assurance to the Board about the integrity and deliverability of the Trust financial and efficiency plans.
- Provide assurance to the Board concerning all aspects of finance and operational performance relating to the provision of care and services in support of getting the best clinical outcomes and experience for patients, within the resources set out in the annual plan.

B. Digital

- Advise the Board in discharging its functions and meeting its responsibilities with regard to information management and technology (IM&T) and information governance (IG). Such advice relates to:
  - GHFT's information management and digital strategies, including Trak recovery and the wider SmartCare programme
  - Data protection, confidentiality and privacy
  - Information security including information sharing protocols
  - Data quality and integrity
  - Records management
  - Appropriate access and use of information (including patient and personal information) to support its provision of high quality care
- Provide assurance to the Board that arrangements are in place to assess and deliver benefits of innovative technology and information for use in decision making, and
- Provide assurance to the Board that IM&T services are safe and sustainable, and that risks are being assessed and managed effectively.

'Digital' in the context of our Trust means delivering high quality and reliable care efficiently through the use of digital technology and information. It means harnessing the potential data and technology offers to understand our patients, staff and other stakeholders' needs, expectations and experience and using the insights gained to improve/transform in opening up new ways of delivering services. It further means using business intelligence to understand our organisation and use the insight and foresight to improve evidence-based decision making.

2. Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request by the Committee.

The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

3. Responsibilities

The Committee will:

A. Finance

Financial strategy and business planning:

- Ensure delivery of the financial aspects of the Operational Plan.
- Ensure delivery of the annual and medium-term financial plans: income and expenditure plans/budgets, revenue investment, capital investment, working capital, statement of financial position and cash flow, and associated targets for savings to ensure sustainability going forward. The Committee shall assess the assumptions therein and the alignment with overall Trust objectives.
- Approve the investment and borrowing strategy and associated policies.
- Review in-year performance against financial plan, particularly gaining an understanding of key assumptions and risks within the Trust projections.
- Review levels of contingency within the Trust financial plans and the phasing of key developments and efficiency schemes, ensuring that the full impact of any developments (including depreciation and cost of capital) have been appropriately included.
- Review and develop reporting arrangements.
- Ensure the availability and quality of financial management information (to ensure a consistent approach to financial management).
- Ensure sustainable service commissioning from a financial and funding perspective.
- Review and maintain an overview of financial and service delivery agreements and key contractual arrangements.
- Oversee the development, management and delivery of the Trust's annual capital programme.
- Review business cases and either:
    - approve as appropriate on behalf of the Board, if within the Committee's delegated authority; or
    - endorse prior to Board approval, if above the Committee's delegated authority.
- Consider key financial policies e.g. investment policy, issues and developments to ensure that they are shaped, developed and implemented in the Trust appropriately.

Income and contracts management:

- Review the Trust contracting approach with key commissioners

- Monitor in-year income against contract and levels of risk, including commissioner challenges, accrued income, fines and penalties, and income disputes.
- Review arrangements for non-activity related income streams, particularly CQUIN, to understand alignment with Trust clinical priorities and levels of income risk.
- Consider material opportunities to grow new income streams and market share of existing services.

Transformation and Efficiency:

- Set financial performance benchmarks and monitor the performance of investments.
- Seek and consider evidence of organisational compliance with the Capital Investment Policy
- Review proposed revisions to the Capital Investment Policy for approval by the Board each year.
- Review the process for developing the CIP and for the oversight and delivery of the programme within the Trust.
- Review the process for developing the transformation plan and for the oversight and delivery of the programme within the Trust.
- Consider and recommend any major transformation programmes that the Trust should undertake.
- Review the annual CIP and transformation plan to provide assurance that delivery risk is minimised and productivity and efficiency maximised, in particular that contingency, phasing and risk mitigation plans are appropriate and that savings programmes are realistic and deliverable.
- Receive assurances regarding efficient and effective resource planning, particularly with respect to staffing and the deployment of agency staff.
- Receive benchmarking and other information (for example from Carter metrics) to assess Trust productivity and ensure targeting or efficiency programmes.
- Receive assurance that any process reviews are conducted using an appropriate methodology.

Procurement

- Review the Trust procurement strategy, systems and arrangements for obtaining best value.
- Monitor progress against the NHS standards of Procurement within the Trust.

Other:

- Oversee funding arrangement for DH transaction deficit support.
- Gain assurance that cash management arrangements are robust.
- Approve the terms of reference and membership of its sub-committees (as may be varied from time to time at the discretion of the Committee) and oversee their work, receiving reports for consideration and action as necessary.
- Review financial systems arrangements including those used for costing, income and service level reporting where appropriate.
- Review and consider any bids for external capital.
- Any other relevant matters as referred by the Board.

The Duties of the Committee are to consider and examine:-

- Key financial performance indicators.
- Monthly/annual consolidated financial performance summaries and related plans/budgets.
- Cost improvement plans.
- The monthly/annual statement of financial position.
- Working capital performance.
- Cash flow status.
- Capital Programme.
- Risks associated with financial plans.
- Financial relationships with Trust Commissioners.
- Financial Risk Ratings applied by NHS Improvement.
- Financial performance forecasts.
- Cash flow forecasts.
- Financial aspects of the Board Assurance Framework.

B. Digital

Digital Strategy and Delivery Plan

- Approve the Digital Strategy.
- Oversee the delivery of the strategic and operational priorities set out in the Strategy through scrutiny of the Delivery Plan.
- Make recommendations to the Board in respect of the annual IM&T capital budget.
- Provide assurance in respect of budgetary control against the agreed annual budget.
- Consider and examine risks associated with the digital strategy and delivery plan.
- Obtain assurance in respect of the digital aspects of the Board Assurance Framework.

Information Governance

- Approve the Trust’s information governance Policy on an annual basis.
- Obtain assurance that the Trust’s policies and procedures with respect to data privacy, covering patients, staff and members, are compliant with all relevant legislation and guidance including the Data Protection Act 1998.
- Receive a quarterly report on information governance activities including:
    - Serious reportable data breaches including assurance on incident investigation and lessons learnt
    - Training compliance status
    - Progress against national IG Toolkit Compliance

Partnerships

- Receive regular updates from the Integrated Care System on relevant programmes.

- Ensure there is effective collaboration with partner organisations and other stakeholders in relation to the implementation of digital solutions and sharing of systems in a controlled manner.
- Ensure the Trust is an effective host and partner in respect of the Countywide IT Service (CITS).

4. Membership

Members

The Committee shall comprise:

One Non-Executive Director (who shall be the Committee Chair)

Two further Non-Executive Directors (one of whom should also be a member of the Audit and Assurance and Quality and Performance Committees).

Two of the Non-Executive Directors should have recent relevant financial expertise.

Chief Executive

Director of Finance

Chief Information and Digital Officer

Chief Operating Officer

Medical Director

And, additionally, for Part B: Digital

Director of Quality and Chief Nurse

Any member who is unable to attend a meeting of the Committee may appoint a substitute. Any substitute appointed for the Non-Executive Director member of the Committee must also be a Non-Executive Director of the Trust.

Attendees

The Committee may decide that any other person must attend one or all of its meetings to contribute to discussions but no such person shall form part of the quorum nor have decision-making authority. The following post-holders have a standing invitation to attend the Committee meetings:

Part A: Finance

Director of Operational Finance
Director of Quality and Chief Nurse
Director of PMO

One Governor of the Trust may attend any meeting of the Committee as an observer.

5. Accountability and Reporting

Accountability

After each of its meetings the Committee shall report to the Board, via the Chair's report, such issues as it considers should be brought to the Board's attention or require a decision from the Board.

The Committee shall provide such information and other support as the Board requires in order for the non-executive directors of the Trust to give account to the Council of Governors in respect of the Committee's remit.

The Committee will review its effectiveness at least annually.

Reporting in
The following groups will report into the Committee:

SmartCare Programme Board
IM&T Programme Board

6. Conduct of business and administrative matters

The Committee shall conduct its meetings in accordance with these Terms of Reference and any other Trust governance requirements that apply to it (subject to below).

Any member who has a conflict of interests in respect of any matter shall not count in the quorum for the Committee's discussions and any decisions in respect of that matter.

The quorum for this Committee is three members, two of whom must be Non-Executive Directors.

The Committee shall determine the frequency of its meetings to allow it to discharge all of its responsibilities. It is expected the Committee shall meet at least monthly.

The Chair may request an extraordinary meeting at any time if they consider one to be necessary.

The agenda and any papers for the Committee's meetings shall be issued not less than five working days before each meeting.

Minutes shall be taken of each of the Committee's meetings and shall be circulated to the members within timescales agreed by the Committee.

The Committee may agree that its members 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.

Administrative support, including retention of meeting papers and other relevant documents, shall be provided by the Corporate Governance Officer.

7. Approval and Review

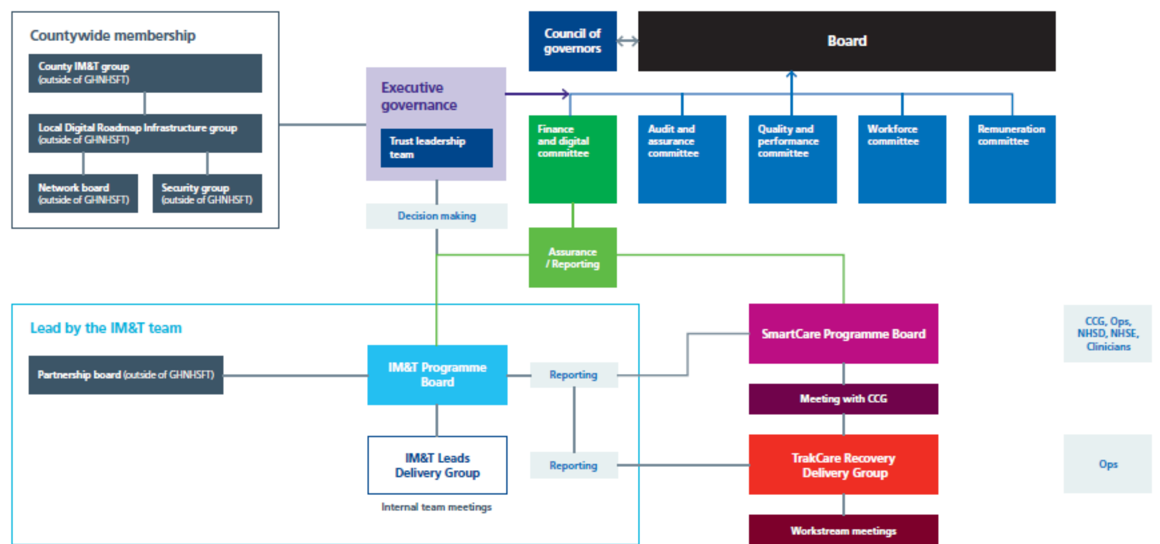
These ToR were approved by the Board on […].

These ToR were adopted by the Committee at its meeting on […].

These ToR shall be reviewed at least annually.

Version Control			
Version	**Author**	**Date**	**Changes**
0.1	Lukasz Bohdan	08-01-2019	First draft
0.2	Lukasz Bohdan	08-02-2019	Amendments made following Audit and Assurance Committee feedback

APPENDIX 1



GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE

TERMS OF REFERENCE – FEBRUARY 2019

1. Purpose and status

The People & Organisational Development (OD) Committee (the Committee) has been established by the Board of Directors (the Board) of Gloucestershire Hospitals NHS Foundation Trust (the Trust).

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

2. Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request by the Committee.

The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

3. Responsibilities

The Committee will:

- Obtain assurance that there are practices in place which ensure the sustainability and affordability of workforce supply on a short, medium and long term basis including workforce planning, development, redesign, recruitment and retention
- Obtain assurance that the Trust attracts and retains a high performing workforce capable of delivering the Trust operational clinical strategies
- Obtain assurance that the Trust implements effective and equitable reward packages that positively impact on performance and meet national and legislative parameters
- Obtain assurance that strategic education issues and external relationships which impact on supply and engagement are included in Trust planning
- Obtain assurance that the Trust delivers services which are fair and equitable promoting diversity and equality of opportunity
- Obtain assurance that the Trust is driving improved employee engagement, ensuring appropriate mechanisms for the employee voice to ensure that rapid action is taken to improve staff experience. Agree the Trust Workforce Strategy and establish, monitor and report to the Trust Board on an annual programme of work to implement the strategy
- Agree annual objectives for Health and Safety
- Agree (where necessary) People and Organisational Development reports prior to publication and review implications of national reports that have been published
- Identify risks associated with People and Organisational Development issues ensuring ownership with mitigating actions, escalating to Trust Board as required
- Approve the terms of reference and membership of its sub-committees (as may be varied from time to time at the discretion of the Committee) and oversee their work, receiving reports for consideration and action as necessary.

- Consider and approve action plans, programmes of work and strategic objectives as a result of national audit related to protected characteristics and provide assurance to the Board on progress
- Work with the Quality and Performance Committee to obtain assurance on safer and optimal staffing and that education, learning and development is aligned with the Trust's quality priorities

4. Membership

Members

The Committee shall comprise:

One Non-Executive Director (who shall be the Committee Chair)

Two further Non-Executive Directors

Director of People and OD/ Deputy CEO

Director of Quality and Chief Nurse

Medical Director

Any member who is unable to attend a meeting of the Committee may appoint a substitute. Any substitute appointed for the Non-executive Director member of the Committee must also be a Non-Executive Director of the Trust.

Attendees

The Committee may decide that any other person must attend one or all of its meetings to contribute to discussions but no such person shall form part of the quorum nor have decision-making authority. The following post-holders have a standing invitation to attend the Committee meetings:

Deputy Director of People and OD

Deputy Director of Finance

Head of Leadership and OD

Associate Director of Education and Development

One Public or Patient Governor of the Trust and one Staff Governor of the Trust may attend any meeting of the Committee as an observer.

5. Accountability and Reporting

Accountability

After each of its meetings the Committee shall report to the Board, via the Chair's report, such issues as it considers should be brought to the Board's attention or require a decision from the Board.

The Committee shall provide such information and other support as the Board requires in order for the non-executive directors of the Trust to give account to the Council of Governors in respect of the Committee's remit.

The Committee will review its effectiveness at least annually.

Reporting in
The following groups will report into the Committee:

- Health and Safety Committee
- Strategic Education and Sustainable Workforce Group
- Equality Steering Group

6. Conduct of business and administrative matters

The Committee shall conduct its meetings in accordance with these Terms of Reference and any other Trust governance requirements that apply to it (subject to below).

Any member who has a conflict of interests in respect of any matter shall not count in the quorum for the Committee's discussions and any decisions in respect of that matter.

The quorum for this Committee is three members, two of whom must be Non-Executive Directors.

The Committee shall determine the frequency of its meetings to allow it to discharge all of its responsibilities. It is expected the Committee shall meet at least bi-monthly.

The Chair may request an extraordinary meeting at any time if they consider one to be necessary.

The agenda and any papers for the Committee's meetings shall be issued not less than five working days before each meeting.

Minutes shall be taken of each of the Committee's meetings and shall be circulated to the members within timescales agreed by the Committee.

The Committee may agree that its members 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.

Administrative support, including retention of meeting papers and other relevant documents, shall be provided by the Executive Assistant to the Director of People and Organisational Development and Deputy Chief Executive.

7. Approval and Review

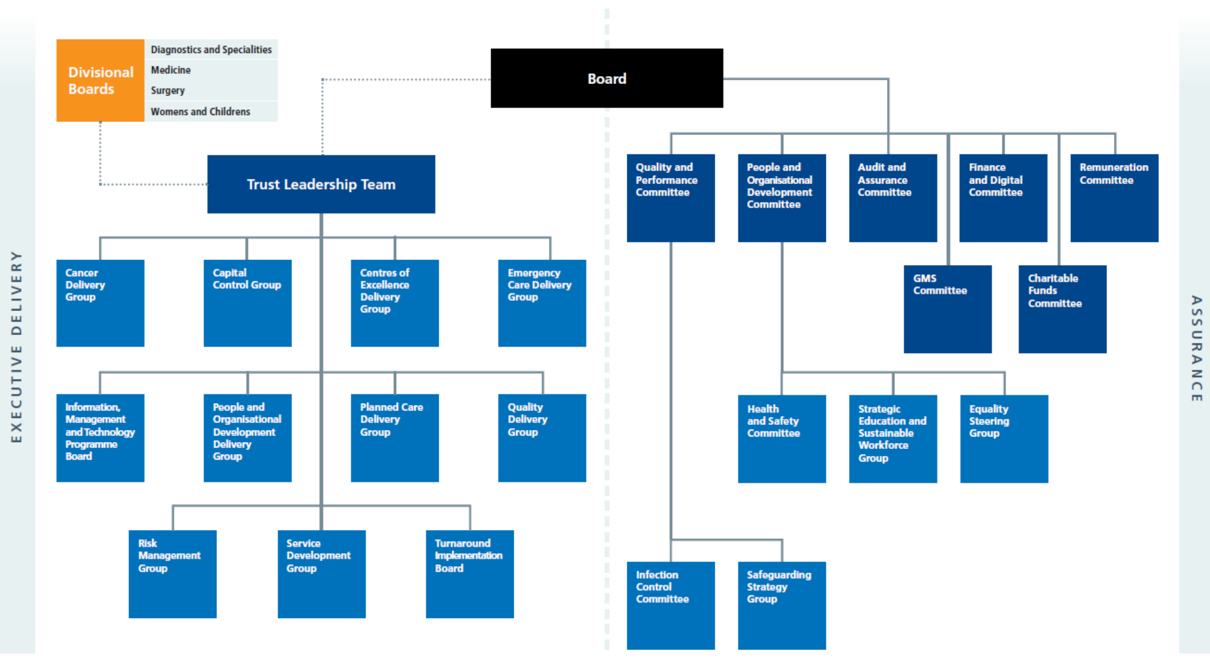
These ToR were approved by the Board on […].

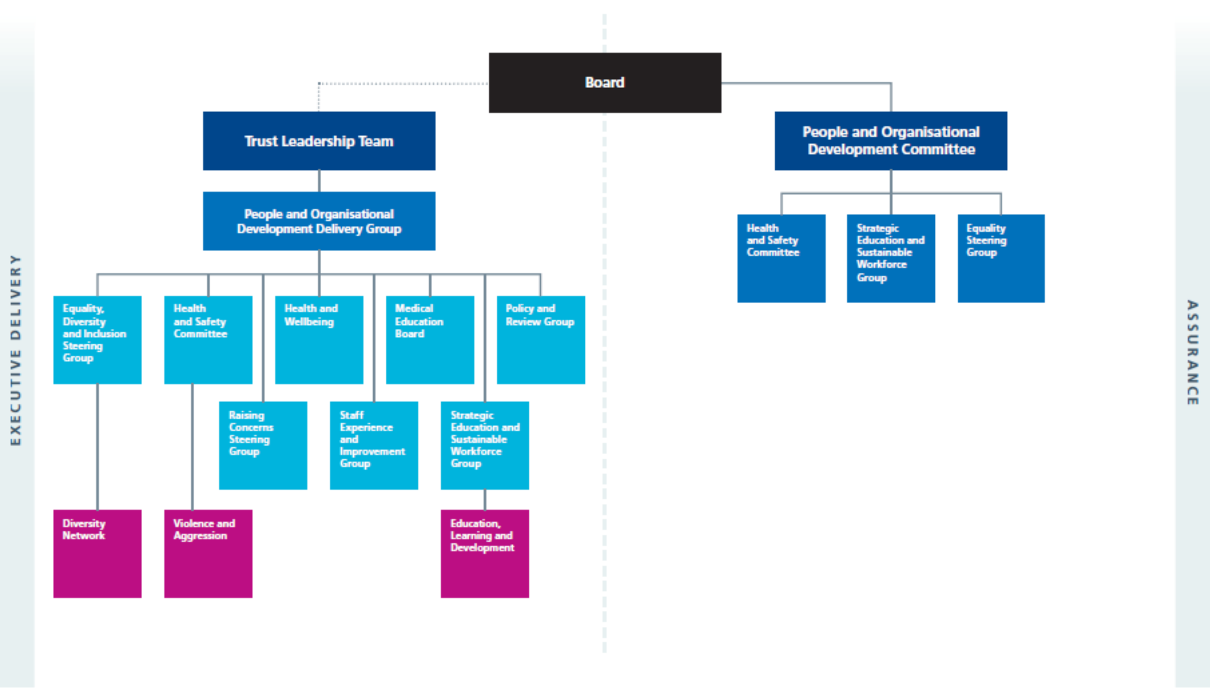
These ToR were adopted by the Committee at its meeting on […].

These ToR shall be reviewed at least annually.

Version Control			
Version	**Author**	**Date**	**Changes**
0.1	Lukasz Bohdan	08-01-2019	First draft
0.2	Lukasz Bohdan	08-02-2019	Amendments made following Audit and Assurance Committee

APPENDIX 1





GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

QUALITY AND PERFORMANCE COMMITTEE

TERMS OF REFERENCE – FEBRUARY 2019

1. Purpose and status

The Quality and Performance Committee (the Committee) has been established by the Board of Directors (the Board) of Gloucestershire Hospitals NHS Foundation Trust (the Trust).

The purpose of the Committee is to enable the Board to obtain assurance that high standards of care are provided by the Trust and, in particular, that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to:

- Deliver excellence in patient care (experience, safety and effectiveness).
- Deliver operational performance and the NHS Constitution standards.
- Obtain assurance that risks arising from clinical care are adequately controlled and or mitigated and provide assurance to the Board that risk management arrangements for safety, quality and patient experience risks are in place and operate effectively.
- Ensure compliance with legal, regulatory and other obligations.

2. Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request by the Committee.

The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

3. Responsibilities

The Committee will:

General Governance Arrangements:

- Ensure that all statutory elements of quality governance are adhered to within the trust.
- Carry out statutory responsibilities on behalf of the Board (e.g. with regard to learning from deaths, safeguarding and infection control).
- Agree the annual quality priorities and monitor progress and ensure that the Trust has reliable, real time, up-to-date information about what it is like being a patient and experiencing care administered by the Trust, so as to identify areas for improvement and ensure that these improvements are effected.
- Review and approve the Trust's annual quality governance and Quality Account before submission to the Board.
- Approve the terms of reference and membership of its sub-committees (as may be varied from time to time at the discretion of the Committee) and oversee their work, receiving reports for consideration and action as necessary.
- Consider matters referred to the Committee by the Board.

- Consider matters referred to the Committee by its sub-committees.
- Obtain assurance that the Trust's policies and procedures with respect to the use of clinical data and patient identifiable information are compliant with all relevant legislation and guidance including the Caldicott Guidelines and the Data Protection Act 1998.
- Make recommendations to the Audit and Assurance Committee concerning the annual programme of internal audit work, to the extent that it applies to matters within these terms of reference.
- Receive internal audit reports relevant to the remit of the Committee and obtain assurance that findings recommendations are acted on.
- Review outcomes of clinical and internal audits and obtain assurance findings recommendations are acted on.
- Obtain assurance that all quality and performance-related contract performance notices (CPNs) have local recovery plans and that appropriate monitoring arrangements are in place at the Divisional and Trust.
- Obtain assurance that the Trust has effective policies and procedures in the areas covered by the remit of the Committee, e.g.:
    - Infection prevention and control annual report and programme
    - Complaints policy
    - Claims policy
    - Incident reporting policy
    - Consent policy
    - Safeguarding children policy
    - Safeguarding adults policy

Quality and excellence in patient care:

- Shape and influence the Trust's Quality Strategy and framework and associate strategic objectives, including overseeing the development and production of the annual Quality Account.
- Obtain assurance that the registration criteria of the Care Quality Commission continue to be met.
- Support the Trust's objectives to strive for continuous quality improvement through the work for the Gloucestershire Safety and Quality Improvement Academy.
- Promote the Trust's open and honest reporting culture.
- Obtain assurance that robust arrangements are in place for the review of patient safety incidents from within the Trust and wider NHS (including near-misses, complaints, claims reports from HM Coroner, reports from the Healthcare Safety Investigation Branch).
- Identify trends and areas for focused or organisation-wide learning from the review of patient safety incidents and to ensure that actions for improvement identified in incident reports, reports from HM Coroner and other similar documents are addressed.
- Identify areas for improvement in respect of incident themes and complaint themes from the results of national patient survey/PALS and ensure appropriate action is taken.
- Oversee the system within the Trust for obtaining and maintaining any licences relevant to clinical activity in the Trust (e.g. licences granted by the Human Tissue Authority or any successor organisation).
- Monitor the Trust's compliance with the fundamental standards of quality of the Care Quality Commission, and monitor licence conditions that are relevant to the Committee's area of responsibility.
- Provide assurance to the Board so that the Board may approve the Trust's annual declaration of compliance and corporate governance statement.
- Obtain assurance that risks to patients are minimised through:

- Considering areas of significant risk, setting priorities and agreeing actions using the assurance framework;
  - Obtaining assurance that the Trust incorporates the recommendations from external bodies and reports (e.g. the National Confidential Enquiry into Patient Outcomes and Death or Care Quality Commission, Care Quality Commission, commissioners) and those made internally (e.g. serious incident reports) into practice and has mechanisms to monitor their delivery; and
  - To ensure those areas of risk within the Trust are regularly monitored and that effective disaster recovery plans are in place.
- Obtain assurance that there are processes in place that safeguard children and adults within the Trust.
- Escalate to the Executive Team, Audit and Assurance Committee and/or Board any identified unresolved risks arising within the scope of these terms of reference that require executive action or that pose significant threats to the operation, resources or reputation of the Trust.

Operational performance and the NHS Constitution standards:

- Obtain assurance that the Trust delivers services which are consistently meeting nationally defined minimum standards and performance and notably the four key standards required by the Trust's regulator. Where performance is below the standard required, the Committee will ensure that robust recovery plans are developed and implemented (A&E four hour wait, Cancer waiting times, referral to treatment and 6 week diagnostic standards).

Efficient and effective use of resources through evidence-based clinical practice:

- In liaison with the Finance and Digital Committee, obtain assurance the Quality Impact Assessments are completed for proposals for cost improvement programmes and other significant service changes and that the assessment of their impact on the Trust's quality of care determines whether to proceed to implementation.
- Ensure that care is based on evidence of best practice/national guidance.
- Ensure that there is an appropriate process in place to monitor and promote compliance across the Trust with clinical standards and guidelines, including but not limited to NICE guidance and guidelines and radiation use and protection regulations (IR(ME)R).
- Review the implications of confidential enquiry reports for the Trust and to endorse, approve and monitor the internal action plans arising from them.
- Monitor trends in complaints received by the Trust and commission actions in response to adverse trends where appropriate.
- Monitor the development of quality indicators throughout the Trust.
- Identify and monitor any gaps in the delivery of effective clinical care ensuring progress is made to improve these areas, in all specialties.
- Obtain assurance that he research programme and governance framework is implemented and monitored.
- Obtain assurance that that where practice is of high quality, that practice is recognised and propagated across the Trust.
- Obtain assurance that the Trust is outward-looking and incorporates the recommendations from external bodies into practice with mechanisms to monitor their delivery.

The duties of the Committee will include:

- Ensuring that staff effectively involve patients and their carers in the planning and evaluation of services so as to ensure that services meet the needs and preferences of patients, so far as is possible.
- Working with the People and Organisational Development Committee to obtain assurance on safer and optimal staffing and that education, learning and development is aligned with the Trust's quality priorities.
- Working with the Finance and Digital Committee to ensure that the availability of resources does not adversely impact upon the quality of services to the extent that patient safety is compromised or care is delivered that doesn't meet the required mandatory quality standards as defined by the CQC and NHSI.
- Maintaining effective links to Divisions via exception reports (e.g. from the Quality Delivery Group; Planned Care Delivery Group; Cancer Delivery Group; and Emergency Care Delivery Group).
- Triangulating data in support of its purpose.

4. Membership

Members

The Committee shall comprise:

One Non-Executive Director (who shall be the Committee Chair)

Two further Non-Executive Directors

Chief Executive

Director of Quality and Chief Nurse

Medical Director

Chief Operating Officer

Any member who is unable to attend a meeting of the Committee may appoint a substitute. Any substitute appointed for the Non-Executive Director member of the Committee must also be a Non-Executive Director of the Trust.

Attendees

The Committee may decide that any other person must attend one or all of its meetings to contribute to discussions, but they shall form part of the quorum nor have decision-making authority. The following post-holders have a standing invitation to attend the Committee meetings:

CCG Representative

Planned Care Delivery Group Chair (Chief of Service for Medicine)

Cancer Delivery Group Chair (Chief of Service for Surgery)

Director of Planned Care/Deputy Chief Operating Officer

Director of Safety

Director of Unscheduled Care/Deputy Chief Operating Officer

Deputy Director of Quality

Deputy Chief Nurse

One Governor of the Trust may attend any meeting of the Committee as an observer.

5. Accountability and Reporting

Accountability
After each of its meetings the Committee shall report to the Board, via the Chair's report, such issues as it considers should be brought to the Board's attention or require a decision from the Board.

The Committee shall provide such information and other support as the Board requires in order for the non-executive directors of the Trust to give account to the Council of Governors in respect of the Committee's remit.

The Committee will review its effectiveness at least annually.

Reporting in
The following sub-committees shall report to the Committee:

- Infection Control Committee
- Safeguarding Strategy Group

The Committee will receive an exception report at each meeting from the:

- Cancer Delivery Group
- Emergency Care Delivery Group
- Planned Care Delivery Group
- Quality Delivery Group

6. Conduct of business and administrative matters

The Committee shall conduct its meetings in accordance with these Terms of Reference and any other Trust governance requirements that apply to it (subject to below).

Any member who has a conflict of interests in respect of any matter shall not count in the quorum for the Committee's discussions and any decisions in respect of that matter.

The quorum for this Committee is three members, two of whom must be Non-Executive Directors.

The Committee shall determine the frequency of its meetings to allow it to discharge all of its responsibilities. It is expected the Committee shall meet monthly.

The Chair may request an extraordinary meeting at any time if they consider one to be necessary.

The agenda and any papers for the Committee's meetings shall be issued not less than five working days before each meeting.

Minutes shall be taken of each of the Committee's meetings and shall be circulated to the members within timescales agreed by the Committee.

The Committee may agree that its members 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.

Administrative support, including retention of meeting papers and other relevant documents, shall be provided by the Corporate Governance Officer.

7. Approval and Review

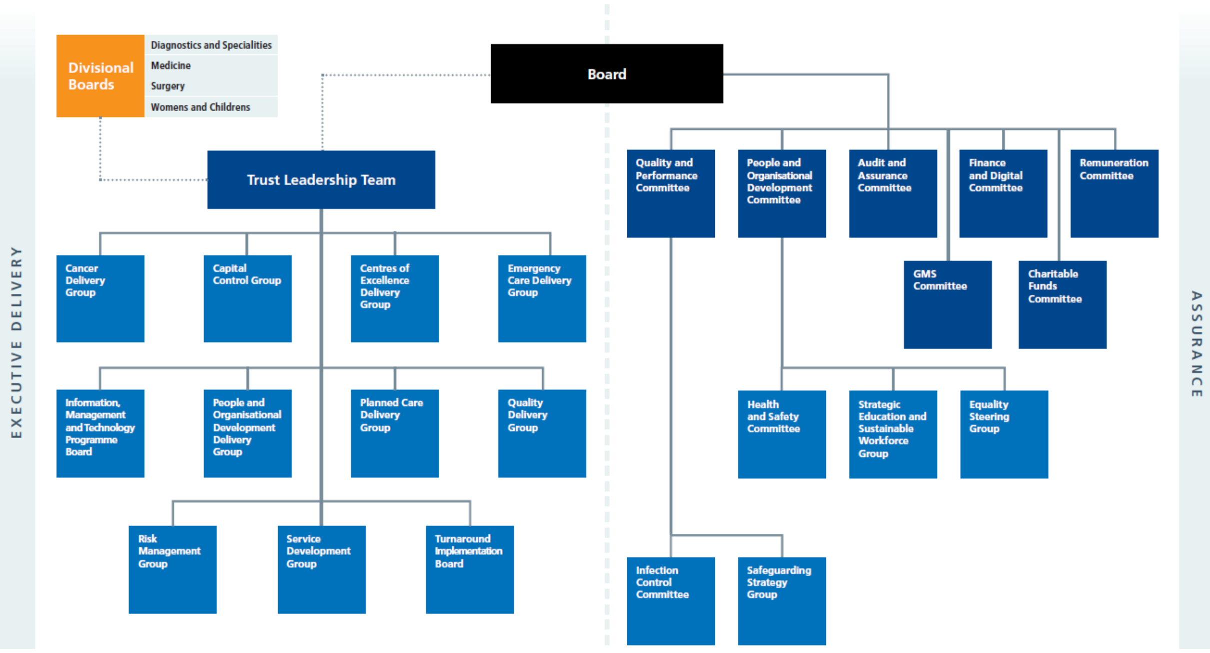
These ToR were approved by the Board on […].

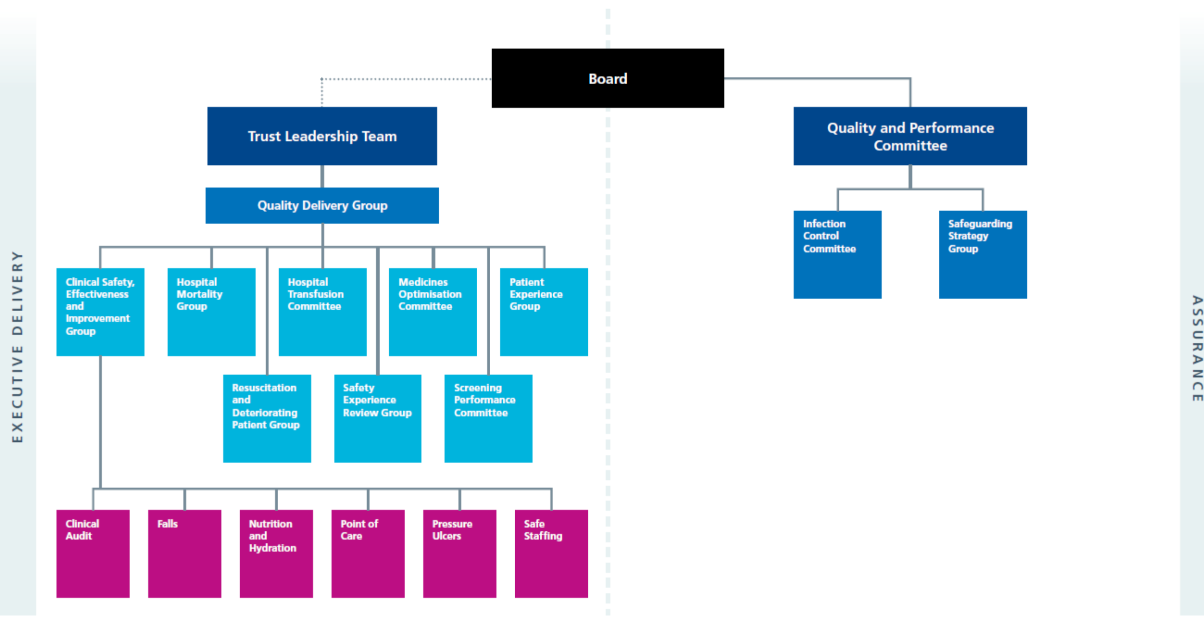
These ToR were adopted by the Committee at its meeting on […].

These ToR shall be reviewed at least annually.

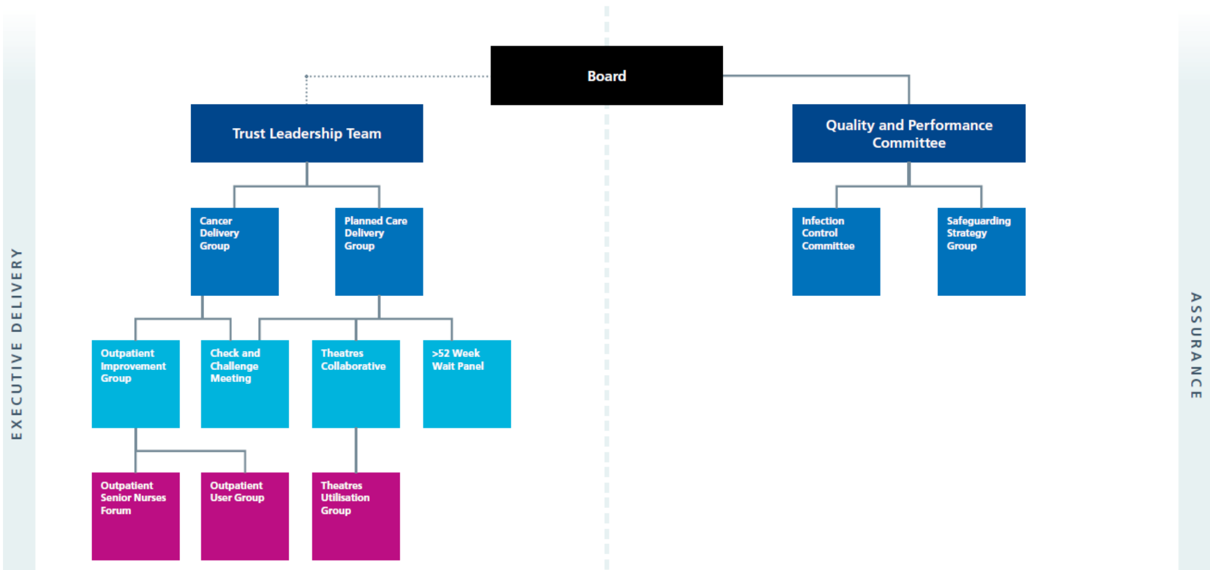
Version Control			
Version	**Author**	**Date**	**Changes**
0.1	Lukasz Bohdan	08-01-2019	First draft
0.2	Lukasz Bohdan	08-02-2019	Edits made following Audit and Assurance Committee

APPENDIX 1

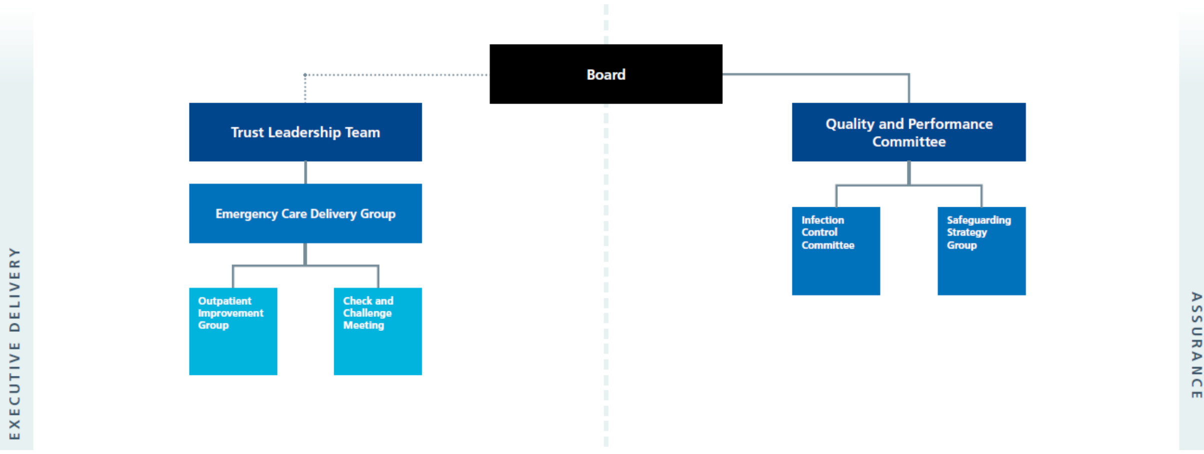




Planned Care Governance Structure



Emergency Care Governance Structure



REMUNERATION COMMITTEE

TERMS OF REFERENCE – FEBRUARY 2019

1. Purpose and status

The Remuneration Committee (the Committee) has been established by the Board of Directors (the Board) of Gloucestershire Hospitals NHS Foundation Trust (the Trust).

The purpose of the Committee is to deal with all matters concerning remuneration and terms of service of Executive Directors.

2. Authority

The Committee has delegated authority to act on behalf of the Board on matters concerning the remuneration and terms of service of Executive Directors. Executive Directors include both voting and non-voting Main Board Executive Directors.

The Committee is authorised by the Board to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions. The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

3. Responsibilities

The Committee will:

A. Appointments Role

- Periodically review the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board, making use of the output of the Board evaluation process as appropriate, and make recommendations to the Board, and Governance and Nominations Committee of the Council of Governors, as applicable, with regard to any changes.
- Give full consideration to and make plans for succession planning for the Chief Executive taking into account the challenges and opportunities facing the Trust and the skills and expertise needed on the Board in the future.
- Appoint candidates to fill all the Executive Director positions on the Board.
- Consider any matter relating to the continuation in office of any Executive Director including the suspension or termination of service of an individual as an employee of the Trust, subject to the provisions of the law and their service contract.
- Dismiss Executive Directors, where appropriate.

B. Remuneration Role

- Monitor and evaluate the performance of the Chief Executive through the appraisal process of the Chief Executive conducted by the Chair.
- Discuss and, if appropriate, confirm the assessments made of performance related pay by the Chair for the Chief Executive and by the Chief Executive for the other Executive Directors.
- Determine pay rises and review the need for any other adjustments.
- Determine clawback for underperformance as mentioned in executive contracts of employment.

- Decide and keep under review the terms and conditions of office of the Trust's Executive Directors and determine the application of the all-staff terms and conditions of service to Executive Directors.
- Advise on and oversee appropriate contractual arrangements for Executive Directors, including any termination payments.

4. Membership

Members

The Committee shall comprise:

Chair of the Trust (who shall be the Committee Chair)

Vice Chair of the Trust (who shall be the Vice Chair)

The Non-Executive Directors

When appointing or removing the Chief Executive, the Committee shall be the Committee described in Schedule 7, 17(3) of the National Health Service Act 2006 as amended by the Health and Social care Act 2012 (the Act) (that is all the Non-Executive Directors).

When appointing or removing the other Executive Directors the Committee shall be the Committee described in Schedule 7, 17(4) of the Act (that is the Chair of the Trust, the Chief Executive and the Non-Executive Directors).

Attendees

The Committee may decide that any other person must attend one or all of its meetings to contribute to discussions but no such person shall form part of the quorum nor have decision-making authority. The following post-holders have a standing invitation to attend the Committee meetings:

Chief Executive

Any non-member will be asked to leave the meeting should their own conditions of employment be the subject of discussion.

5. Accountability and Reporting

Accountability

The Committee shall report to the Board on how it discharges its responsibilities.

Once approved by the Committee, the minutes should be circulated to the Board unless it would be inappropriate to do so.

The Committee will review its effectiveness at least annually.

Reporting in
The following groups will report into the Committee:

Not applicable.

6. Conduct of business and administrative matters

The Committee shall conduct its meetings in accordance with these Terms of Reference and any other Trust governance requirements that apply to it (subject to below).

Any member who has a conflict of interests in respect of any matter shall not count in the quorum for the Committee's discussions and any decisions in respect of that matter.

The quorum for the Committee's meetings shall be the Chair or Vice Chair plus two other members.

The Committee shall determine the frequency of its meetings as required to allow it to discharge all of its responsibilities. It is expected the Committee shall meet at least once in each financial year.

The Chair may request an extraordinary meeting at any time if they consider one to be necessary.

The agenda and any papers for the Committee's meetings shall be issued not less than five working days before each meeting.

Minutes shall be taken of each of the Committee's meetings and shall be circulated to the members within timescales agreed by the Committee.

The Committee may agree that its members 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.

Administrative support, including retention of meeting papers and other relevant documents, shall be provided by the Corporate Governance Manager.

7. Approval and Review

These ToR were approved by the Board on […].

These ToR were adopted by the Committee at its meeting on […].

These ToR shall be reviewed at least annually.

Version Control			
Version	**Author**	**Date**	**Changes**
0.1	Lukasz Bohdan	10-01-2019	First draft
0.2	Lukasz Bohdan	08-02-2019	Amendments made following Remuneration Committee feedback

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

TRUST LEADERSHIP TEAM

TERMS OF REFERENCE – FEBRUARY 2019

1. Purpose, status and authority

The Trust Leadership Team (TLT) is a formal management group established by the Chief Executive.

The purpose of the TLT is to serve as the most senior decision making group beneath the Board and to assist the Chief Executive in achieving the strategies, aims and objectives of the Trust.

2. Responsibilities

The Trust Leadership Team's key responsibilities include:

- Leadership and management of the Trust, within the direction and culture set by the Board;
- Planning and implementation of strategy, operational plans and policies;
- Ensuring achievement of agreed operating and financial performance targets;
- Oversight and mitigation of risk;
- Prioritisation and allocation of resources, within the budget agreed by the Board;
- Monitoring and performance management of major capital schemes;
- Provision of advice to the Trust Board on strategic and operational matters as required;
- Ensuring an effective and consistent approach to corporate and operational messaging to enable strong stakeholder engagement.

3. Membership

Members

The TLT shall comprise:

Chief Executive (who shall be the Chair)

Deputy Chief Executive (who shall be the Vice-Chair)

Executive Directors

Divisional Tris/Quads

Two Specialty Directors

Director of Operational Finance

Director of Planned Care

Director of Unscheduled Care

Any member who is unable to attend a meeting of the TLT may appoint a substitute.

Attendees

The TLT may decide that any other person must attend one or all of its meetings to contribute to discussions but no such person shall form part of the quorum nor have decision-making authority.

4. Accountability and Reporting

Accountability
The TLT shall report to the Board on how it discharges its responsibilities.

The minutes of the TLT's meetings shall be formally recorded by the secretary and submitted to the Board. The Chief Executive shall draw to the attention of the Board any issues that require disclosure to the Board.

Reporting in
The following groups will report into the Committee:

- Cancer Delivery Group
- Capital Control Group
- Centres of Excellence Delivery Group
- Emergency Care Delivery Group
- Information Management and Technology (IM&T) Programme Board
- People and Organisational Development Delivery Group
- Planned Care Delivery Group
- Quality Delivery Group
- Research and Innovation Forum
- Risk Management Group
- Service Development Group
- SmartCare Programme Board
- Strategic Site Development Programme
- Turnaround Implementation Board

5. Conduct of business and administrative matters

The TLT shall conduct its meetings in accordance with these Terms of Reference and any other Trust governance requirements that apply to it (subject to below).

Any member who has a conflict of interests in respect of any matter shall not count in the quorum for the TLT's discussions and any decisions in respect of that matter.

The quorum for the TLT is three corporate members and three divisional members.

The TLT shall determine the frequency of its meetings to allow it to discharge all of its responsibilities. It is expected the TLT shall meet at least monthly.

The Chair may request an extraordinary meeting at any time if they consider one to be necessary.

The agenda and any papers for the TLT's meetings shall be issued not less than five working days before each meeting.

Minutes shall be taken of each of the TLT's meetings and shall be circulated to the members within timescales agreed by the TLT.

The TLT may agree that its members 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.

Administrative support, including retention of meeting papers and other relevant documents, shall be provided by the Executive Assistant to the Chief Executive.

6. Approval and Review

These ToR were approved by the Board on […].

These ToR were adopted by the TLT at its meeting on […].

These ToR shall be reviewed at least annually.

Version Control			
Version	**Author**	**Date**	**Changes**
0.1	Lukasz Bohdan	08-01-2019	First draft
0.2	Lukasz Bohdan	08-02-2019	Amendments made following Audit and Assurance Committee feedback

TRUST BOARD – FEBRUARY 2019
Lecture Hall, Sandford Education Centre commencing at 12:30

Report Title
No-Deal Brexit Risks And Trust Readiness
Sponsor and Author(s)
Author: Cecilia Price, Corporate Governance Graduate Trainee & Lukasz Bohdan, Director of Corporate Governance Sponsor: Lukasz Bohdan, Director of Corporate Governance
Executive Summary

Purpose

To provide assurance to the Board that the Trust has considered and complied with the no-deal Brexit preparations guidelines, that the risks are understood and controls are in place to mitigate the impact on the Trust operations in case of the no-deal Brexit.

Key issues to note

- While the Brexit negotiations continue and the outcome is uncertain, in the absence of an extension or revocation of Article 50, the UK is legally obliged to leave the EU at 11pm on 29 March.
- On 21 December 2018 the Department of Health and Social Care published 'EU Exit Operational Readiness Guidance' listing the actions that providers should take if the UK leaves the EU without a ratified deal and identifying seven areas of activity to review:
    - Supply of medicines and vaccines
    - Supply of devices and clinical consumables
    - Supply of non-clinical consumables, goods and services;
    - Workforce;
    - Reciprocal healthcare;
    - Research and clinical trials; and
    - Data sharing, processing and access.
- The Trust has nominated the Director of Finance as an Executive Lead for Brexit planning. The Executive Directors have been asked to assess the impact of a no-deal Brexit on the areas which fall into their respective portfolios.
- The work to date has not identify any significant risks to the Trust; this is because the Trust is not heavily reliant on the EU workforce, suppliers or other cross-border arrangements.
- The main area of potential concern is the supply of drugs and devices. However, the Government has developed a UK-wide contingency plan to ensure the flow of these products into the UK in a 'no deal' scenario. One of these measures is to increase stock levels of these products at a national level in England; consequently, the Trusts have been advised not to stockpile medicines.
- The Trust has robust business continuity plans and it adheres to all the business continuity guidance issued to the Trusts. The Trust has reviewed business continuity plans from a Brexit perspective and the health economy has completed a joint exercise to test the resilience of our business continuity plans in the case of no-deal Brexit; further exercises are planned. Work in the Local Resilience Forum, Local Health Resilience Partnerships (LHRP) and the Emergency Planning and Resilience Group ensures a coordinated system response is in place in response to the planning guidance issued by NHS England.

Implications and Future Action Required

Continue to horizon scan and review and act on any further guidance and take steps to mitigate risks further analysis identifies.

Recommendations

The Board is asked to receive assurance that the Trust has considered and complied with the no-deal Brexit preparations guidelines that the risks are understood, to the extent described above, and controls are in place to mitigate the impact on the Trust operations in case of the no-deal Brexit.

Impact Upon Strategic Objectives

Not directly applicable.

Impact Upon Corporate Risks

Not directly applicable.

Regulatory and/or Legal Implications

None

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 and/or TLT

Audit and Assurance Committee	Finance and Digital Committee	GMS Committee	People and OD Committee	Quality and Performance Committee	Remuneration Committee	Trust Leadership Team	Other (specify)
							Executive Team

Outcome of discussion when presented to previous Committees/TLT

TRUST BOARD – FEBRUARY 2019

NO-DEAL BREXIT BRIEFING NOTE

1. Aim

To provide assurance to the Board that the Trust has considered and complied with the no-deal Brexit preparations guidelines that the risks are understood and controls are in place to mitigate the impact on the Trust operations in case of the no-deal Brexit.

2. Background

- While the Brexit negotiations continue and the outcome is uncertain, in the absence of an extension or revocation of Article 50, the UK is legally obliged to leave the EU at 11pm on 29 March.
- On 21 December 2018 the Department of Health and Social Care published 'EU Exit Operational Readiness Guidance' listing the actions that providers should take if the UK leaves the EU without a ratified deal and identifying seven areas of activity to review:

1. Supply of medicines and vaccines
2. Supply of devices and clinical consumables
3. Supply of non-clinical consumables, goods and services;
4. Workforce;
5. Reciprocal healthcare;
6. Research and clinical trials; and
7. Data sharing, processing and access.

3. Summary of the Trust's response to the Guidance

The Trust has nominated the Director of Finance as an Executive Lead for Brexit planning. The Executive Directors have been asked to assess the impact of a no-deal Brexit on the areas which fall into their respective portfolios.

3.1 Supply Chain

Medicines supplies

- Chief Pharmacists received advice from Department for Health and Social Care and NHS England not to stock pile medicines locally as it was in the hands of industry to create that buffer stock. Providers have also been advised not to stockpile medical devices or clinical consumables.

- The Government recognises the vital importance of medicines and vaccines, and has developed a UK-wide contingency plan to ensure the flow of these products into the UK in a 'no deal' scenario.

- On 23 October 2018, the Secretary of State for Health and Social Care wrote to all suppliers of medical devices and clinical consumables updating them on the contingency measures the Department is taking to ensure the continuity of product supply. One of these measures is to increase stock levels of these products at a national level in England.

Contracts

- Providers were asked to assess the impact of no-deal Brexit on their contracts. Procurement completed the contract review of third party spend for GHT, GMS, 2G and GCS in November 2018. The review highlighted five contracts into which deep dives were conducted; all have since been rated low given the risk assessment methodology provided by the Department of Health and Social Care. The Trust is currently not taking any other active measures to manage the supply chain in the event of a no deal Brexit, as guided by the current government advice.

3.2 Workforce

The risks to workforce in the event of a no-deal exit were considered by Director of People and OD and assessed as low, as the Trust is not heavily reliant on EU workforce.

Consequently, the Trust does not expect a significant impact due to EU staff leaving around the date when the UK leaves the EU.

At a workforce planning event sponsored this week by NHS England and NHS Improvement the regulators advised that they had conducted a 'South' [region] review of EU nationals, using the data from ESR data bases across the region. This showed that in the South West the % of EU staff was small and no risk were identified.

The EU Settlement Scheme has been publicised to staff who are EU citizens.

3.3 Reciprocal healthcare

Detailed analysis of the no-deal Brexit on reciprocal health care is yet to be completed; however the initial work shows that the total projected value for Overseas Visitors for this financial year is £309,000 and therefore the (financial) impacts are on a small scale.

Further, certain aspects of healthcare would not change under any form of Brexit including A&E being free to anyone going through.

A no-deal Brexit assumes, however, that the European Health Insurance Card (EHIC) becomes invalid in which case the recovery of income would potentially create a risk - especially in the early days where individuals are unable and/or unwilling to pay. That would apply to emergency activity (although hopefully people will take out insurance). Elective activity is pre-agreed and as such the funding should be low risk.

Further analysis would confirm whether the reciprocal arrangement payments are in fact on a 12 month lag. That would mean the Trust income in 2019/20 would include EU pre-Brexit funding sums and the real risk would most impact in 2020/21.

3.4 Research

The Research and Development Department were asked by the Department of Health and Social Care for information regarding the clinical trials and clinical investigations sponsored by the Trust in order to understand the impact of any possible disruption to clinical trial supplies in the event of a no-deal exit.

In response, the Trust confirmed that it is not sponsoring any Clinical Trial of an Investigational Medicinal Product (CTIMP) studies or interventional studies that require supplies from the EU.

3.5 Data Protection

Data Protection officer has reviewed the guidance; further, the guidance was reviewed at the January Information Governance and Health Records and work is underway to complete the analysis of potential impact and risks in this area, including a single data flow.

GDPR will continue to apply regardless of the outcome of Brexit as the EU law provisions have been subsumed into the Data Protection Act 2018.

The trusts have been instructed to '[a]wait further guidance, which will be issued to health and care providers in due course. Assistance will also be available through webinars in early 2019."

3.6 Local EU Exit Readiness Preparations

3.6.1 Business Continuity Planning

The Trust has robust business continuity plans and it adheres to all the business continuity guidance issued to the Trusts. We have been reviewing business continuity plans from a Brexit perspective as part of the regular review. The health economy has completed a joint exercise to test the resilience of our business continuity plans in the case of no-deal Brexit; further exercises are planned.

Work in the Local Resilience Forum, LHRP and the Emergency Planning and Resilience Group ensures a coordinated system response is in place in response to the planning guidance issued by NHS England.

3.6.2 Communication and information

The latest bulletin from the NHSE South West EU Exit team (4 February 2019) confirmed that a regional NHS England EU Exit workshop will be facilitated in the South West during February. Details and an invitation for Senior Responsible Officers are yet to be published. Executive Director(s) will be attending the briefing.

4. Further considerations

While not explicitly covered by the guidance, it is worth pointing out that the UK membership of the EU means mutual recognition of qualifications, pensionable service, recognition of the time spent practicing in a host EU member state by the home state regulators etc.

While the future of these arrangements – and individuals' decisions made in response to them cannot be predicted – there is some indication of change in this area: e.g. recent HSJ article https://www.hsj.co.uk/policy-and-regulation/nhs-threatened-with-spanish-nurse-exodus/7024318.article reported the recent news from the Spanish government, that in a no deal scenario Spanish nurses working in the UK will not have their time spent here recognised by Spanish nursing regulators.

5. Recommendation

The Board is asked to receive assurance that the Trust has considered and complied with the no-deal Brexit preparations guidelines that the risks are understood, to the extent described above, and controls are in place to mitigate the impact on the Trust operations in case of the no-deal Brexit.

ITEM 15

GOVERNOR QUESTIONS

Peter Lachecki
Chair

ITEM 16

STAFF QUESTIONS

Peter Lachecki
Chair

ITEM 17

PUBLIC QUESTIONS

Peter Lachecki
Chair

PROCEDURE FOR PUBLIC QUESTIONS AT BOARD MEETINGS

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

- As a patient or visitor to the hospital by completing a comment card which is available on wards and departments
- By contacting the Patient and Liaison Service (PALS) who offer confidential, impartial help, advice or support to any aspect of a patient's care. The team aim to help resolve issues and concerns speedily by liaising with appropriate staff on your behalf. PALS can be contacted by phone on 0800 019 3282; by text on 07827 281 266; by e-mail ghn-tr.pals@gloshospitals@nhs.net or by writing to the PALS Office, Gloucestershire Royal Hospital, Great Western Road, Gloucester GL1 3NN. Complaints can be made to the Complaints Team by phoning 0300 422 5777, by e-mail ghn.tr.complaints.team@nhs.net or by writing to the Complaints Team at Gloucestershire Royal Hospital/at the above address
- By asking a question at our Board meeting by following the procedure below. Board meetings are open to the public and are normally held on the second Thursday of the month and alternate between the Sandford Education Centre in Cheltenham and the Redwood Education Centre at Gloucestershire Royal Hospital. Meetings normally start at 12:30.

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

Written questions for the Board Meeting

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

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

Notice of questions

A question may only be asked if it has been submitted in writing to the Corporate Governance Team by 12.00 noon 3 clear working days before the date of the Board meeting. Each question must give the name and address of the questioner. If a question is being asked on behalf of an organization then the name of the organization must be stated. Written questions are to be submitted to the Corporate Governance Team, Alexandra House, Cheltenham General Hospital, Sandford Road, Cheltenham, GL53 7AN or by e-mail to ghn-tr.corporategovernance@nhs.net

No more than 3 written questions may be submitted by each questioner.

Procedure

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

Additional Questions

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

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

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

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

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

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

For further information, please contact the Corporate Governance Team on 0300 422 2932 or e-mail ghn-tr.corporategovernance@nhs.net

ITEM 18

ANY OTHER BUSINESS

DISCUSSION