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 11 APRIL 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 11 April 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

29 March 2019

AGENDA

				Approximate Timings
1.	Welcome and Apologies			12:30
2.	Declarations of Interest			
3.	Patient Story			12:30
4.	Minutes of the meeting held on 14 March 2019	**PAPER**	**For approval**	13:00
5.	Matters Arising	**PAPER**	**For assurance**	
6.	Chief Executive's Report	**PAPER** (Emma Wood)	**For information**	13:05
7.	Chair's Update	**PAPER** (Peter Lachecki)	**For information**	13:10
8.	Trust Risk Register	**PAPER** (Lukasz Bohdan)	**For assurance**	13:15
9.	Quality and Performance:			13:20
	- Assurance Report of the Chair of the Quality and Performance Committee - meeting held on 27 March 2019	**PAPER** (Claire Feehily)	**For assurance**	
	- Quality and Performance Report	**PAPER** (Steve Hams, Rachael DeCaux, Mark Pietroni)	**For assurance**	
	- Learning from Deaths Report	**PAPER** (Mark Pietroni)	**For assurance**	
10.	Finance and Digital:			13:40
	- Assurance Report of the Chair of the Finance Committee - meeting held on 28 March 2019	**PAPER** (Keith Norton)	**For assurance**	
	- Financial Performance Report	**PAPER** (Sarah Stansfield)	**For assurance**	
11.	Audit and Assurance Committee			13:50
	- Assurance Report of the Chair of the Audit and Assurance Committee - meeting held on 19 March 2019	**PAPER** (Rob Graves)	**For assurance**	
	- Annual Trust Seal Report	**PAPER** (Lukasz Bohdan)	**For Assurance**	

12.	Gloucestershire Managed Services (GMS): - Assurance Report of the Chair of the GMS Committee meeting held on 11 March 2019	**PAPER** (Mike Napier)	**For assurance**	14:00
13.	2019/20 Plan	**PAPER** (Simon Lanceley and Sarah Stansfield)	**For assurance**	14:05
	Governor Questions			
14.	Governors' Questions – A period of 10 minutes will be permitted for Governors to ask questions			14:15
	Staff Questions			
15.	A period of 10 minutes will be provided to respond to questions submitted by members of staff			14:25
	Public Questions			
16.	A period of 10 minutes will be provided for members of the public to ask questions submitted in accordance with the Board's procedure.			14:35
17.	New Risks Identified	**VERBAL** (All)		
18.	Items for the Next Meeting	**VERBAL** (All)		
19.	Any Other Business			
	Close			**14:45**

COMPLETED PAPERS FOR THE BOARD ARE TO BE SENT TO THE CORPORATE GOVERNANCE TEAM NO LATER THAN 17:00 ON TUESDAY 2 APRIL 2019

Date of the next meeting: The next meeting of the Main Board will take place on **Thursday 9 May 2019** in the **Lecture Hall, Redwood Education Centre, Gloucestershire Royal 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."

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE TRUST BOARD HELD IN THE LECTURE HALL, SANDFORD EDUCATION CENTRE, CHELTENHAM GENERAL HOSPITAL ON THURSDAY 14 MARCH 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
	Steve Hams	SH	Director of Quality and Chief Nurse
	Mark Hutchinson	MH	Chief Digital and Information Officer
	Simon Lanceley	SL	Director of Strategy and Transformation
	Caroline Landon	CL	Chief Operating Officer
	Mark Pietroni	MP	Medical Director
	Sarah Stansfield	SS	Director of Finance
	Emma Wood	EW	Director of People and Organisational Development and Deputy Chief Executive
	Claire Feehily	CF	Non-Executive Director
	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	Bilal Lala	BL	Associate Non-Executive Director
IN ATTENDANCE	Patrick Collins	PM	Patient and Volunteer *(for item 079/19)*
	Suzie Cro	SC	Deputy Director of Quality *(for item 079/19)*
	Natashia Judge	NJ	Corporate Governance Manager
	Craig Macfarlane	CM	Head of Communications and Marketing
	Katie McClure	KM	Hospital Chaplain *(for item 079/19)*

PUBLIC & PRESS Two governors, one member of staff and one member of the public.

The Chair welcomed all to the meeting.

078/19 DECLARATIONS OF INTEREST **ACTIONS**

LB declared an interest, noting that he was a GMS Director.

079/19 PATIENT STORY

SC introduced KM, Hospital Chaplain, and PC, a patient and now chaplaincy volunteer. KM gave a presentation on the Trust's chaplaincy services, describing how the team supported both religious and non-religious patients and staff. PC then described his experience as a patient of the Trust and how the support from KM during his period of illness ultimately led to him volunteering with the chaplaincy team.

PL thanked PC for sharing his story. The following comments and queries were raised by the Board:

- SH acknowledged the impact the chaplaincy team had within the Trust and said they were the best he had ever worked with.
- MP reflected on how important it was to have someone able to come and listen to patients. PC concurred, adding that patient-led conversations were crucial.
- AM said that KM and PC must see all aspects of clinical care and asked

if there were any areas where the Trust could improve. PC answered that issues with patient transport needed to be addressed. KM highlighted a number of areas where the Trust could do better, including worship space at Cheltenham, access to TrakCare records to identify patients who requested spiritual care, confidence in referring to the team and further promoting the chaplaincy service to staff so that they could in turn refer patients where appropriate. SH said that work was under way to improve the prayer facilities on the Cheltenham site but access to additional space was a constraint. MH agreed to address the TrakCare issue. **MH**

080/19 MINUTES OF THE MEETING HELD ON 14 FEBRUARY 2019

RESOLVED: That the minutes of the Board meeting held on 14 February 2019 be agreed as a correct record and signed by the Chair.

081/19 MATTERS ARISING

FEBRUARY 2019 052/19 REVISED GOVERNANCE DOCUMENTS
PL felt further discussions were needed on the role of the GMS/Estates Committee. He proposed that the Board approve the Scheme of Delegation document with the exception of the GMS/Estates Committee section. Similarly, the Estates Committee Terms of Reference would need to be agreed at a future meeting.
Ongoing: LB said that the discussions on the role and the remit of the Committee continued. The item would remain open and the updated governance documents would return to Board in April.

FEBRUARY 2019 052/19 REVISED GOVERNANCE DOCUMENTS - AM ASKED WHETHER THE TRUST HAD A COMMON APPROACH TO ASSESSING EFFECTIVENESS OF BOARD COMMITTEES.
LB said that the Audit and Assurance Committee completed a formal self-assessment annually; common approach will be developed by the end of the financial year.
Ongoing: Draft self-assessment questionnaire developed. Approach to be discussed by the Chair and Director of Corporate Governance on 13 January.

LB added that a template had been agreed which built on the format previously at Audit and Assurance Committee. LB would be writing to all Committee Chairs and inviting members and attendees to complete the questionnaire. **LB**

082/19 CHIEF EXECUTIVE'S REPORT

DL presented her report to the Board. In response:

- PL said that he felt the appointment of a new interim Integrated Care System (ICS) Chair was a positive development. PL added that an ICS Remuneration Committee was being set up.
- PL asked the Executive Triumvirate whether they felt the change to the Accident and Emergency (A&E) standards would make a difference to the health of the population and what this could mean for Gloucestershire and the Trust. SH felt the new standards would bring about a more nuanced approach with a welcome emphasis on the sickest patients and would potentially drive alternative treatment options for the less sick patients. MP concurred, adding that while the 4 hour standard placed an important focus on patients' waiting time, it was a narrow measure of overall performance. He felt the new metrics focused more on quality; he cautioned, however, that the Trust should not lose

focus on patient flow. CL welcomed the change.

- RG asked whether the new metrics could present as a challenge to the Trust's information systems. DL answered that a national exercise was underway with 14 Trusts testing each standard to understand any challenges in respect of data capture and to test any (unwelcome) unintended consequences of the new standards
- DL welcomed the focus on mental health standards, recognising the importance of how the system responded to these patients. However, DL expressed concern regarding some of the supporting standards, such as the 26 week standard which would require significant amounts of additional capacity in the Gloucestershire system and most likely the independent sector, in light of the number of patients currently waiting over 26 weeks.
- MN asked whether the Board would see the CQC action plan. DL explained that this would be presented to the Quality and Performance Committee on an exception reporting basis; oversight rests with the Quality Delivery Group (QDG). Director of Corporate Governance advised that all the Board members should have access to all the Committee papers. NJ would ensure Directors had access to all Committee papers and circulate the CQC Must Do Action Plan. **NJ**

083/19 TRUST RISK REGISTER

LB presented the Trust Risk Register, noting that there had been four changes since the last Board meeting. In particular he highlighted that following previous discussions the capital risk (**F2522**) had been closed and replaced by two new risks (**C2894COO** and **C2895COO**).

MN acknowledged changes to the wording in response to his previous comments on the wording of the risk C2895COO but felt that further revisions were necessary. MN explained that the focus should be on the operational impact of the equipment/facilities failure. DL felt that the risk did capture the impact on business continuity and added that the mitigations and controls were associated with operational procedures. DL agreed to further reword the risk. **DL**

AM referred to the new risk **S2775CC** relating to electrical or mechanical failure of equipment in surgery and asked whether an incident had occurred which had escalated this risk. DL answered that the risk had always been apparent but to date had been held within a divisional risk register and not escalated. Replacement equipment was on order and was due for delivery in late March which would replace two thirds of the machines; this would reduce the likelihood of the risk but not the impact if it occurred.

RESOLVED: That the Board receive the report as assurance that the Executives are actively controlling and pro-actively mitigating risks so far as is possible.

084/19 QUALITY AND PERFORMANCE:

ASSURANCE REPORT OF THE CHAIR OF THE QUALITY AND PERFORMANCE COMMITTEE - MEETING HELD ON 27 FEBRUARY 2019

CF presented the assurance report from the February Quality and Performance Committee

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

QUALITY AND PERFORMANCE REPORT

CL, SH and MP presented the Quality and Performance report. They described a difficult month with the Trust not achieving the 4 hour A&E standard nor the 62 day cancer standard. However, the Trust was noted to be performing well when compared to national performance. MP reflected that the Trust had performed well over the last five quarters but performance deteriorated in quarter 4, largely due to challenges resulting from the growth in attendances and higher than planned levels of patients whose discharge is delayed. SH described the system work on discharges with partners engaging to address the issues.

CL noted the number of cancelled operations and CFs request for greater oversight of the issue through the Quality and Performance Committee. DL reflected on the data quality issues related to cancellations which had made reporting difficult since the introduction of TrakCare. The Board agreed that this issue should be reviewed by the Committee in May once the Quality and Performance Report dashboard had been revised to include cancelled operations. DL asked that the reporting included not just on the day cancellations but all provider initiated cancellations (by reason), multiple cancellations of the same patient and presentation by cancer, other urgent and routine operations **NJ**

RESOLVED: That the Board receive the report as assurance that Executives understand the performance issues and are taking corrective actions where necessary.

085/19 FINANCIAL PERFORMANCE

ASSURANCE REPORT OF THE CHAIR OF THE FINANCE COMMITTEE - MEETING HELD ON 28 FEBRUARY 2019

KN reported the key messages from the February Finance and Digital Committee Chair's report.

RESOLVED: That the report 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 10. SS highlighted the movement of the forecast outturn from £29.8m to £29.1m, as a result of confirmation that the Trust would access Provider Sustainability Funding in quarter 4, an issue previously flagged in the forecast outturn.

MN asked whether there had been any response from NHS Improvement (NHSI) regarding the Trust's capital loan request. SS answered that NHSI had not yet responded; SS continued to pursue this on a regular basis. The original application was noted to be for £10m with £1m escalated as an urgent request to fund Information Management and Technology (IM&T) work. The Board acknowledged that availability of capital across the sector presented a significant issue for the Trust.

RG observed that the 'other/non-pay' category within income and expenditure was showing an overspend of £1.2m, half of which related to unidentified CIP. He asked whether this was what should be expected for the rest of the financial year. SS answered that the Board would continue to see the variance grow due to the CIP under-delivery. RG also observed that a number of cost categories

were above budget and queried whether the control mechanisms were appropriate or whether budgets were incorrect. SS answered that the budgets were not incorrect, but that other drivers of the deterioration, such as issues with drugs and overspend on pay due to vacancies within nursing were now manifesting. She observed these were consistent with previous forecasts.

RESOLVED: That the report be received as a source of assurance that Executives understand the financial performance issues and are taking corrective actions where necessary.

SMARTCARE PROGRESS REPORT

MH presented the SmartCare Progress Report to provide assurance on the current position of the TrakCare recovery programme and the progress against the plans to return to Referral To Treatment (RTT) reporting in April 2019 (March performance).

PL suggested the Finance and Digital Committee consider how reporting would evolve over the next 12 months. MH said that a working session was planned to discuss this issue; the outcome would be presented to the Committee.

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

086/19 PEOPLE AND ORGANISATIONAL DEVELOPMENT

ASSURANCE REPORT OF THE CHAIR OF THE PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE - MEETING HELD ON 4 MARCH 2019

AM reported the key messages from the March People and Organisational Development Committee Chair's report.

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

PEOPLE AND ORGANISATIONAL DEVELOPMENT REPORT

The Director of People and Organisational Development presented the report, highlighting a recent nurse retention review and work on exit interviews.

PL asked if there were any other ways to gain insight on why staff left the organisation. EW explained that in the past the Trust had held "Itchy Feet Sessions" for staff considering leaving in order to establish the reasons and address the issues identified in those sessions. EW added that emails were sent to staff members who were leaving and line managers were asked to complete exit interview questionnaires. The Board discussed the importance of ownership of the process amongst line managers and requested that the People and OD Committee give further thought as to how we could increase the number of staff providing information in respect of their reasons for leaving. **EW**

RESOLVED: That the Board note the trends illustrated in the workforce dashboard and measures detailed within to improve performance.

087/19 GLOUCESTERSHIRE MANAGED SERVICES (GMS)

ASSURANCE REPORT OF THE CHAIR OF THE GMS COMMITTEE MEETING HELD ON 14 FEBRUARY 2019

MN reported the key messages from the February GMS Chair's report.

MN added that a joint Trust-GMS workshop would be held in the near future to discuss governance issues. This would inform the changes to the role of the Committee, focusing it on its assurance role.

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

088/19 OPERATIONAL PLAN

SL presented an update on the Trust's progress with the 2019/20 Operational Plan ahead of submission on 4 April 2019.

In response:

- PL queried the paper's recommendation and felt it was difficult for the Board to approve the contents for submission given that the document was not finished. DL suggested the approval be delegated to Finance and Digital Committee. Members supported this suggestion.
- LB asked SL to feedback to governors on how their input had been taken on board. **SL**
- DL asked whether the new strategic objectives would be included in the submission. SL said that the submission would include draft objectives. DL asked that the final draft be circulated to the Board and governors so that their views could be incorporated. **SL**
- The final operational plan would return to Board in April. **NJ** (for the work plan)

RESOLVED: That the Board note the report and accompanying Operational Plan narrative and delegate the approval to the Finance and Digital Committee.

089/19 GOVERNORS' QUESTIONS

The following points were raised by AD, the Cotswold District Council area Governor:

- AD was surprised to hear of an incorrect dosage of medicine being administered by a GP recounted in the patient story. AD queried the process of relaying information between the hospital and primary care. MP answered that he was unable to comment on the specific case but that a number of communications took place between the Trust and a GP surgery following patient discharge. MP would investigate the circumstances of the case described in the patient story and feedback key points at the Governors' Quality Group. **MP**
- AD reflected on the importance of personal contact to establish the reasons behind why staff were leaving the organisation. SH explained that conversations with staff were taking place but they were not always recorded in ways that made analysis.
- AD expressed concern about moving away from providing printed papers for the Board and Committee meetings. PL reassured AD that the Corporate Governance Manager would work with governors to ensure appropriate solutions were in place and to provide support during the transition

The following points were raised by AT, the Lead Governor:

- AT described the patient story as powerful. He observed that issues with chaplains' access to TrakCare were also raised at a Volunteer Day in 2016.
- AT asked how governors would receive feedback on their input to strategy development. SL agreed to consider the best way to do this, **SL**

likely including a written communication in the near future followed by papers/presentations at the Strategy and Engagement Group meeting and the Council of Governors meeting.

- AT expressed his support for the 'Paperless Board' initiative.

090/19 STAFF QUESTIONS

There were none.

091/19 PUBLIC QUESTIONS

There were none.

092/19 ANY OTHER BUSINESS

PL noted that this was CL's last Board Meeting. The Board thanked CL for all her work as Chief Operating Officer, noting her achievements in the role.

093/19 DATE OF NEXT MEETING

The next **Public** meeting of the **Trust Board** will take place at 12:30 on **Thursday 11 April 2019** in the **Lecture Hall, Sandford Education Centre, Cheltenham General Hospital**

004/19 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 14:37

Chair
11 April 2019

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

TRUST BOARD – APRIL 2019

MATTERS ARISING

CURRENT TARGETS

Target Date	Month/Minute/Item	Action with	Issue	Action	Update
March 2019	February 2019 052/19 Revised Governance Documents	**LB**	PL felt further discussions were needed as to the role of the GMS/Estates Committee forward.	LB proposed that the Board approve the Scheme of Delegation document with the exception of the GMS/Estates Committee section. Similarly, the Estates Committee Terms of Reference would need to be agreed at a future meeting.	*Ongoing:* *Discussions on the role and the remit of the Committee continue.* *Item to remain open and updated governance documents to return to Board in April.*
April 2019	February 2019 052/19 Revised Governance Documents	**LB**	AM asked whether the Trust had a common approach to assessing effectiveness of Board committees.	LB said that the Audit and Assurance Committee completed a formal self-assessment annually; common approach will be developed by the end of the financial year. LB added that a template had been agreed which built on the format previously at Audit and Assurance Committee. LB would be writing to all Committee Chairs and inviting members and attendees to complete the questionnaire.	*Ongoing:* *Questionnaire shared with Committee Chairs. Survey version of the questionnaire being developed.*

April 2019	March 2019 079/19 Patient Story	**MH**	KM highlighted a number of areas where the Trust could do better, including access to TrakCare records to identify patients who requested spiritual care.	MH agreed to address the TrakCare issue.	*<u>Completed:</u>* *TrakCare access for Chaplains agreed with Caldicott Guardian.* *As no Chaplain role and workflow available in TrakCare, access and workflow is being agreed with Chaplains and access to be provided accordingly.*
April 2019	March 2019 082/19 Chief Executive's Report	**NJ**	MN asked whether the Board would see the CQC action plan.	NJ would ensure Directors had access to all Committee papers and circulate the CQC Must Do Action Plan.	*<u>Completed:</u>* *Access given and action plan circulated.*
April 2019	March 2019 083/19	**DL**	MN acknowledged changes to the wording in response to his previous comments on the wording of the risk C2895COO but felt that further revisions were necessary. MN explained that the focus should be on the operational impact of the equipment/facilities failure. DL felt that the risk did capture the impact on business continuity and added that the mitigations and controls were associated with operational procedures.	Risk C2895COO to be re-worded to focus on the service continuity impact.	*<u>Completed:</u>* *Amended risk on the Trust Risk Register.*

April 2019	March 2019 084/19 Quality and Performance Report	**NJ**	CL noted the number of cancelled operations and CFs request for greater oversight of the issue through the Quality and Performance Committee. DL reflected on the data quality issues related to cancellations which had made reporting difficult since the introduction of TrakCare. The Board agreed that this issue should be reviewed by the Committee in May once the Quality and Performance Report dashboard had been revised to include cancelled operations. DL asked that the reporting included not just on the day cancellations but all provider initiated cancellations (by reason), multiple cancellations of the same patient and presentation by cancer, other urgent and routine operations.	Q&P to do a 'deep dive' into cancelled operations once the dashboard has been produced. NJ for the work plan (May).	*Completed:* *Added to May Quality and Performance work plan.*
April 2019	March 2019 086/19 People and Organisational Development Report	**EW**	PL asked if there were any other ways to gain insight on why staff left the organisation. EW explained that in the past the Trust had held "Itchy Feet Sessions" for staff considering leaving in order to establish the reasons and address the issues identified in those sessions. EW added that emails were sent to staff members who were leaving and line managers were asked to complete exit interview questionnaires. The	People and OD Committee to give further thought as to how we could increase the number of staff providing information in respect of their reasons for leaving.	*Completed:* *People and OD committee due to meet on April 15th. The committee receives regular updates on leaver information and the People and OD team continue to look for ways to improve exit interview processes to ensure that reasons for leaving are recorded centrally.*

			Board discussed the importance of ownership of the process amongst line managers.		
April 2019	March 2019 088/19 Operational Plan	**SL**	LB asked SL to feedback to governors on how their input had been taken on board.	SL to circulate new Strategic Objectives to the Board and Governors at the same time as the TLT paper is circulated.	*Completed:* *On the April Council of Governors agenda.*
April 2019	March 2019 088/19 Operational Plan	**SL**	DL asked whether the new strategic objectives would be included in the submission.	SL said that the submission would include draft objectives.	*Completed:* *Item on the agenda.*
April 2019	March 2019 088/19 Operational Plan	**NJ**	The final operational plan would return to Board in April.	NJ to add to work plan.	*Completed:* *Item on the agenda.*
April 2019	March 2019 089/19 Governors' Questions	**MP**	AD was surprised to hear of an incorrect dosage of medicine being administered by a GP recounted in the patient story. AD queried the process of relaying information between the hospital and primary care.	MP would investigate the circumstances of the case described in the patient story and feedback key points at the Governors' Quality Group.	*Completed (to Board):* *The patient has been approached for permission to share details of their case. Once received, MP will investigate and feedback the key points.*
April 2019	March 2019 089/19 Governors' Questions	**SL**	AT asked how governors would receive feedback on their input to strategy development.	SL agreed to consider the best way to do this, likely including a written communication in the near future followed by papers/presentations at the Strategy and Engagement Group meeting and the Council of Governors meeting.	*Completed:* *The Head of Business Development and Planning will be attending the next Council of Governors to update on strategy development and how Governors input has been incorporated.*

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

TRUST BOARD - APRIL 2019

REPORT OF THE CHIEF EXECUTIVE

1. Our Trust

1.1 Finally, green shoots emerging that suggest we may be emerging from the winter months. Operational pressures are starting to ease and I am delighted that the Trust ended the operational year with 95% performance against the A&E four hour standard in our final weekend, which ensured delivery of another 90%+ month and quarter, and saw the Trust achieve 92.8% for the year. Given just two years ago the Trust was struggling to consistently deliver 80%, this is a huge turnaround in the waiting experience for our patients and testament to our staff and system partners.

1.2 We continue to make good progress in respect of the development of plans to realise our vision for two centres of excellence for planned and urgent care. Teams across the Trust are working up the future models of care for their services in the wider context of our aim to further separate planned and emergency care, where the evidence supports this will deliver better care for patients, and support our efforts to recruit and retain the very best staff. We believe strongly that when people have serious illness or injury, they should receive treatment in centres providing the highest quality specialist care, with the right expertise and facilities to maximise chances of survival and recovery. A pivotal event is planned for the 5th April which will bring together stakeholders from across the system, including governors and other patient representatives to engage in work to *co-design* these new models of care. A verbal update on the event will be provided at the Board. Meanwhile a wider programme of engagement/consultation is planned throughout the year which will help inform our thinking.

1.3 The time of the year means that planning and contracting dominate much of the activities of the Trust's leadership team, alongside business as usual. Not surprisingly, this has been a particularly challenging planning round, in large part driven by a lower than expected allocation to our local Clinical Commissioning Group (CCG) and the requirement for the system to eliminate its deficit in one year, all of which currently resides with GHFT. The consequences of this context are largely twofold; very limited investment in the system's priorities and a greater need than ever for transformation to reduce costs in the system as well as improve quality. All partners are committed to ensuring we continue to make the good progress we have achieved to date despite these challenges and make the very best use of the *Gloucestershire £.*

1.4 The Trust submitted its Operational Plan for 2019/20 on the 4th April which sets out the ambition and priorities for the year ahead. Of note, the Trust's original Control Total of a 'breakeven' plan has been revised by a further £1.5m to a £1.5m deficit plan. The submitted plan describes the intended progress against the current constitutional standards including the continued delivery of A&E waiting performance in excess of 90% and delivery of the full suite of cancer standards, including the elusive 62 day GP Referral to Treatment standard, from September 2019. In respect of the 18 week Referral To Treatment (RTT) standard, limited improvement in performance is assumed due to a lack of system resource to prioritise investment in this area but we will seize opportunities wherever we can to release capacity, to deliver non-recurrent activity which will in turn reduce backlogs and waiting times thus improving RTT performance against the current 92% standard.

1.5 Given this context, it's very good news that the Trust and CCG were successful in securing national transformation funds to support the NHS Long Term Plan's ambitions in respect of outpatient care and following a competitive tender, last week we secured the support of an external partner to help drive this work forward. The initial phase of work will concentrate on driving improvements within the Trust from referral to discharge and pilot a range of initiatives in four specialities with a view to adoption and spread of the most effective practices.

1.6 Phase two of the programme will concentrate on reducing demand for hospital outpatient care through both changes to pathways and the development of digital alternatives to face to face care.

1.7 A recurrent theme through my weekly message has been the importance the Trust Board places on diversity; the evidence is unequivocal, the more positively an organisation or community embraces diversity, the more successful it will be. With this context, I am delighted by the range of activities that the Trust has undertaken in the past month. Steve Hams, Director of Quality and Chief Nurse began preparation for the launch of the *rainbow badge* and in doing so garnered support from the Trust's charity; the badge signifies the inclusion of the LGBTQ+ community in all that we do and is importantly championing the role of 'allies' – those who do not share the 'characteristic' but who are passionate about ensuring an inclusive work place and patient care free form discrimination. Our Diversity Network also goes from strength to strength and has established three sub-groups to broaden the depth and breadth of their work and its April meeting, the Trust Leadership Team (TLT) agreed the four Equality Objectives for the period 2019-24; whilst final words are to be agreed they will focus on:

- Developing conversations with our communities to ensure the 'local voice' is heard within our service development, improvement and evaluation work
- Developing a 'person-centred' charter which clearly states our commitment to providing services that are non-discriminatory
- Strengthen the support to staff with a disability and improve the knowledge, competence and sensitivity, in relation to disability, of colleagues and line managers with the aim of narrowing the gap in the staff experience of this group, when compared to non-disabled staff
- Further develop the support and reporting mechanism for staff who experience or observe violence, bullying, harassment or aggression.

1.8 The Trust continues to enjoy significant support from its charitable partners. Last week we saw the Oncology Department open its doors to supporters, including donors, of the Focus Appeal. Staff from the charity, service and Board gave up their time to show donors what their generosity had achieved and also to talk about our priorities for the future. We are equally fortunate in the support we get from local partner Cobalt, who not only provide us with diagnostic care for our patients but they have now successfully raised funds to provide new state of the art mammography imaging equipment which has been sadly lacking in our local screening service. Finally, last week the LINC charity, working with Cheltenham Borough Council and volunteers, completed their work on an area of land in Sandford Park where they have created the most wonderful Sanctuary Garden – a place for peaceful contemplation or a welcome break from the day to day for patients, families, staff and wider community. The official opening is planned for 4pm 9th May 2019.

1.9 Finally, this month saw Rachael De Caux join the Trust and I'd like to take the opportunity to formally welcome Rachael to the Board; her talents, experience and diverse professional background is already adding value to the executive team and wider organisation.

2. National and Regional

2.1 Nationally, changes at the top of the NHS remain uncertain with the key role of Chief Operating Officer remaining unfilled; in the interim Ian Dalton continues in post. The two Chairs of NHSI and NHSE, Baroness Dido Harding and Lord David Prior, continue to set out their very clear expectations with regard to culture and behaviours throughout the NHS and this focus is very welcome.

2.2 Unsurprisingly, the NHS continues to prepare for a *No Deal Brexit and robust plans are in plan should the country leave without transition arrangements. Nationally the focus* remains on the supply chain and timely procurement, delivery and receipting of goods both clinical and non-clinical. Staff across the NHS, and beyond have been reminded of the heightened risks to cyber-security during this time and we have enhanced our communication to staff about the measures they can take to mitigate this risk.

3. Our System and Community

3.1 Work on the Gloucestershire response to the NHS Long Term Plan is now underway with larger than anticipated numbers of people attending the engagement events throughout the county; attendees have included patient, public and NHS staff. Particular thanks to the CCG who have organised and supported many of these events.

3.2 The Integrated Care System (ICS) Board met again last week and spent some time considering its major priorities for the coming year. Whilst there is more work to be done to confirm the final priorities, emerging clinical priorities are diabetes and respiratory care. These reflect both the scale of impact on health and social care which arises from these conditions as well as the opportunities for improving outcomes and reducing cost, based on our performance relative to others.

3.3 Finally, last month saw partners, patients and supporters from across the county join Steve Syer and his wife alongside members of the Trust's Organ Donation Committee come together to celebrate the 35th anniversary of Steve's heart transplant. Having been the 87th heart transplant patient, Steve is now the longest surviving recipient of a donor heart and was thrilled to receive a personal message from his surgeon Magdi Yacoub. Steve's wife Chris was at his side having played her own special part in Steve's life when she gave him a kidney a few years ago. Together, the couple have raised more than £2m to further the cause of organ donation and transplant.

3.4 Exciting times!

Deborah Lee
Chief Executive Officer

April 2019

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

TRUST BOARD – APRIL 2019

CHAIR'S ACTIVITIES UPDATE

In order to present a snapshot of the wider perspective of Chair activities undertaken, a written summary is presented at Public Trust Board meetings on a quarterly basis. This excludes regular meeting attendances at Board, Council of Governors, Board Committees and 1:1s with Directors and Governors. Period from 4th January to the 1st April 2019.

Trust Activities

DATE	EVENT
16 1 19	Learning and Development Presentation of Certificates
18 1 19	100 Leaders meeting
21 1 19	Visit to Cheltenham General Hospital (CGH) Theatres
22 1 19	Non-Executive Director (NED) strategy session
29 1 19	Medical Director panel interviews
6 2 19	Attending Better Births event – Gloucestershire Royal Hospital (GRH)
7 2 19	Chief Operating Officer panel interviews
11 2 19	Consultant panel interviews – Emergency Department
12 2 19	Associate Non-executive Director interviews
27 2 19	NED appraisal and development review
1 3 19	Gloucestershire Managed Services Chair recruitment panel
5 3 19	Non-Executive Director interviews
7 3 19	NED appraisal and development review
12 3 19	Consultant panel interviews – acute paediatrics
13 3 19	Nutrition and Hydration Week event on wards
26 3 19	Organ Donation celebratory event (GRH)
27 3 19	Focus Charity supporter evening (CGH)
1 4 19	Visit to Stroud Maternity Unit

Gloucestershire Health Economy

DATE	EVENT
14 1 19	GCS/2gether Executive Director recruitment panels
15 1 19	Health and Care Overview and Scrutiny Committee
5 2 19	Chairing Research4Gloucestershire meeting
6 2 19	Interim Integrated Care System (ICS) Chair panel interview
20 2 19	Health and Care Overview and Scrutiny Committee
20 2 19	Meeting with Interim ICS Independent Chair – Nick Relph
26 2 19	Gloucestershire Strategic Forum
5 3 19	Health and Care Overview and Scrutiny Committee
6 3 19	Chairing Research4Gloucestershire meeting
20 3 19	Meeting with Vice Chancellor – University of Gloucestershire
26 3 19	ICS Board (formerly Gloucestershire Strategic Forum) meeting
1 4 19	Meeting with Chair – Age UK Gloucestershire

National Stakeholders + others

DATE	EVENT
28 2 19	South West Regional Chairs' meeting
19 3 19	NHS Providers' quarterly Chairs and CEOs meeting

Peter Lachecki
Trust Chair - 2nd April 2019

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – APRIL 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

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

Key issues to note

- The Trust Risk Register enables the Board to have oversight, and be assured of the active management, of the key risks within the organisation which have the potential to affect patient safety, care quality, workforce, finance, business, reputation or statutory matters.
- Divisions are required on a monthly basis to submit reports indicating any changes to existing high risks and any new 12+ for safety and 15+ other domains to the Trust Leadership Team (TLT) for consideration of inclusion on the Trust Risk Register.
- 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.

Changes in the reporting period

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

No risks have been **downgraded** in this reporting period.

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

One risk has been **closed:**

- **C2894COO** Risk that patients and staff are exposed to unforeseen service interruptions arising from failure of core equipment and/or buildings, as a consequence of the Trust's inability to access emergency capital. Closed as risk has now been mitigated.

One risk has had the wording changed:

- **C2895COO** *Previous wording*: Risk that the Trust's future capital funding is insufficient to make the required progress on estate maintenance / repair / refurbishment and equipment replacement with the resulting impact on business and service continuity.

Revised wording: Risk that patients and staff are exposed to poor quality care or service interruptions arising from failure to make required progress on estate maintenance, repair and refurbishment of core equipment and/or buildings to prevent cumulative degradation, as a consequence of the Trust's inability to generate and borrow capital.

The Trust Leadership Team met on 3 April 2019 and agreed the above changes.

The full Trust Risk Register with 13 risks is attached (Appendix 1).

Conclusions

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

Implications and Future Action Required

Ongoing compliance with and continuous improvement to the risk management processes.

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

Resource Implications			
Finance	**x**	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 & Assurance Committee	**Finance and digital Committee**	**GMS Committee**	**People and OD Committee**	**Quality & Performance Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
						3 April 2019	
Outcome of discussion when presented to previous Committees/TLT							
TLT recommended to the Board endorsing the above changes to the TRR.							

Appendix 1 **Trust Risk Register** **April 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
C2895COO	Risk that patients and staff are exposed to poor quality care or service interruptions arising from failure to make required progress on estate maintenance, repair and refurbishment of core equipment and/or buildings to prevent cumulative degradation, as a consequence of the Trust's inability to generate and borrow capital..	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 2019/20 2. Ongoing escalation to NHSI and system	Partially complete	Major (4)	Likely - Weekly (4)	16	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Environmental	Chief Operating Officer	GMS 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

Appendix 1 **Trust Risk Register** **April 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
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
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 to 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

Appendix 1 **Trust Risk Register** **April 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
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
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	Partially complete	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
S2775CC	The risk to patient safety of respiratory or/and cardiovascular instability and even death in the event of either an electrical or mechanical failure or as a result of needing to change over to a different mechanical ventilator	1. Alarmed ventilators 2. All staff trained to hand-ventilate and portable ventilators available on both sites and in theatres	1. Replacement ventilators for DCC have been purchased and ordered via procurement. 6 machines of the 8 required. The 6 machines are due to arrive at the Trust on or before the 25th March 2019. 2. 2 further machines have been approved via MEF for the Capital programme of 19/20	Partially complete	Catastrophic (5)	Rare - Less than annually (1)	5	Surgical	Safety	Medical Director	Quality and Performance Committee

REPORT TO TRUST BOARD – APRIL 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 27 March 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
Learning from Deaths Report	Quarterly report to December 2018. Comprehensive report that described progress with internal arrangements for reviews of deaths and engagement with families, together with themes arising from reviews to date. Areas emerging as needing improvement were: • Response to deteriorating patients • Communications between teams • Early senior review • Completion of documentation	The Cttee commended authors for progress with this reporting. • Could future reports make clear where circumstances of deaths have been recorded in Datix? • Suggested changes in details of reported material to strengthen Cttee's assurance • How closely integrated is Trust work on Serious Incidents and Learning from Deaths?	Agreed Agreed Room for improvement here, and plans to strengthen information flows and learning from cases of deteriorating patients, specifically, were described.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	Report highlighted areas of excellent care and very positive feedback. Plans to extend and deepen family engagement were reported. Report also confirmed Trust's progress with reporting of requisite mortality indicators.	• What is the forum for examining lessons that arise from the deaths of complex elderly patients? • Greater clarity requested about a specific case and in future reporting of whether or not deaths were avoidable.	Speciality Director and divisional oversight described, together with opportunities arising from Quality Improvement projects.	Specific case to be followed up and general point made clearer in future reporting.
Serious Incidents (SIs), including Quarterly Report on Learning	Regular report confirming that Trust is meeting contracted standards for investigating incidents. Further reporting confirmed proposed approach to strengthening how SIs are investigated and how the Trust delivers learning and change. There has been one never event since the last report: a case of wrong-site surgery.	In cases of deteriorating patients, where are the various aspects of incidents brought together and learning / improvements shared across divisions? How can the Cttee be assured that Divisions are adopting a consistent approach to their investigations? The importance of widespread competence and confidence with human factors training was emphasised.	Arrangements are currently being re-examined by Quality Delivery Group and the outcome will be reported to a future Q and P Cttee. Delivery plans are currently being examined, and forthcoming internal audit review will provide further evidence and insight. Reporting templates have recently been standardised. Trust has some expertise in this but the ambition is for more extended training.	Update on human factors training to be reported to Cttee in September.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	There have been two SIs declared: one case of delays in care to a deteriorating patient with sepsis; and delayed appointments in opthalmology causing permanent harm.	Re theatres improvement plan, do we have the correct balance between urgency and longer term improvements?	Exec felt that the current balance was the correct one, albeit that more work may be needed to confirm sources of assurance.	
CQC Must Do Action Plan	Report to provide assurance that CQC's 12 Must Do actions have been appropriately assigned and that progress is on target. The report included an improvement plan that had been submitted to CQC on 4 March 2019 in which all actions are planned to be completed within next 6 months. Plan to be monitored by Quality Delivery Group each month with quarterly updates to Q and P Cttee. The 'should do' action plan to be reported to Cttee in April 2019.	The Trust has failed historically to achieve the ED 60 minute target. What gives us confidence that required improvements are possible? What level of confidence is there that timescales are realistic and achievable?	Revised and improved arrangements were described, which are likely to take 1 month – 6 weeks to implement. There has been some revision to timescales and confidence is currently high.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Quality and Performance Report and Exception Reports from Delivery Groups A revised dashboard will be presented from April 2019.	**<u>Quality Delivery Group (QDG)</u>** Highlighted areas included: • Medical Division and Diabetes • Updating out of date policies • Dementia metrics under review • Violence and aggression • International dysphagia standardisation initiative (IDDSI)	Re out-of-date policies: Has the backlog been risk-assessed and prioritised? More generally, how can Cttee be certain that it is receiving the correct and relevant outputs from QDG, given the range and scale of its work? I	Yes The quality of exception reporting is good, however, it was agreed that minutes of each of the delivery groups will be included for future Q and P Cttees as a source of further assurance.	
Cancer Delivery Group (CDG)	Comprehensive report demonstrating performance and recovery / improvement intentions across each of the cancer standards. CDG had focussed particularly upon: • Delivery of 2 week standard (93.7% in February) • Plan in place to enable delivery of 62 day standard by March 2019 (Feb performance: 61.8%) • Urology continuing to impact adversely	Continued high quality reporting, enabling good discussion and insights and Cttee focus on those areas of specific challenge as well as areas of excellent performance. What is the progress with histopathology backlogs? What are the top 3 pieces of patient feedback about cancer care and how are they influencing the work of the Cancer Delivery Group?	Increased focus, new leadership and additional funding have been secured. Current feedback processes described. Scope for further improvement in integration of patient feedback in Delivery Groups acknowledged.	Additional analysis to confirm position in April reporting.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	• 104 day position improving but remains a significant concern (43 patients waiting) • NB good performance in regular delivery of national standards for screening (95-100% against national standard of 84.6%)	How is public being advised / supported re post-menopausal bleeding services and screening in light of current media coverage re national performance etc? What are the drivers of success of the Living With and Beyond performance and can they be shared more widely? (Trust reported 5th best nationally in terms of activity levels and care plans).	• Need for improved information and faster diagnosis • Content of letters to patients has been reviewed following feedback and revisions will be implemented soon. CCG examining primary care communications with public More analysis required but the support from Macmillan has made a significant contribution.	Update to April Cttee.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Planned Care Delivery Group	Comprehensive report indicating strong focus on waiting list oversight and progress towards resumption of RTT reporting within 2018-19. Specific highlights of report: • Continued focus on integrity of patient lists • Slower progress than planned on 52 week waits • Good progress with clinic typing which is now at satisfactory levels • Opthalmology and backlog of follow-up appointments, including CCG interest and intervention.	What are the sources of assurance available to the Cttee as to the level and completeness of clinical oversight of those patients waiting for appointments who are not within the 'do not breach' category? Could future reports include more assurance as to how such judgements are exercised? What are the Execs' top 3 concerns about the current position? Work in ENT commended. Are there similar clinical champions in other specialities?	Relevant clinical validation process described and arrangements for 'do not cancel' patients. Further exec review planned. Outcome to be reported to next Cttee. Recent work within ENT commended for its impact on improving accuracy of waiting list. Numbers due follow-ups from 2017; completeness of picture as to deterioration; problems in ENT and Opthalmology that are also being experienced nationally. Yes, good levels of ownership in each specialty.	Future reporting to include trajectory for complete clinical validation for patients awaiting a delayed follow up and plan to clear backlog. Further consideration at next Cttee.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
		Have we reached a point where we have stopped adding to the backlog problem with each new time period? Concern that Trust has not achieved the nationally set reduction in 52 week waits. What are the intentions and are they realistic and achievable? NB fines will be incurred for non-delivery of target.	Patient list validation processes were described and further scope remains to improve data and reporting. Revised trajectory with target date of end-June has been agreed.	52 week revised delivery plan to be reported to next Cttee.
Unplanned Care Delivery Group	Reporting on February's performance. 86.1 % on national ED 4 hour standard. Average of 418 attendances per day. 6.5% increase since Feb 2018. Failure to achieve 15 minute initial assessment (83.6%) or 60 minute time to treatment (32.4%). Currently 75 (average) Medically Stable for Discharge patients against target of 45. 34 daily average of Delayed Transfer of Care (DTOC) Static results in Friends and Family feedback.	Can we have visibility on performance of balancing measures as well as analysis of those exceeding 4 hour wait, corridor waits and consequential elective cancellations? What were the longest waits for patients? Are the improvement plans for mental health patients gaining traction?	19 hours (for a mental heath patient). Also two further patients with waits in excess of 10 hours. Still concerns with those patients who need a crisis response and acute bed. Pathway redesign taking place to include some	For inclusion in future reports and oversight by QDG Time series of patient wait times (to demonstrate distribution of all waits) to be included in future reporting to Cttee.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	During Feb. Trust in 'black escalation' on 21 days, compared to 4 days in Feb. 2018.	What is progress with acquiring county-wide bed management system?	designated space for such patients. Project progress described. Not yet close to acquisition / implementation.	
Additional performance discussion		Will C Diff limit be changing for 2019? Lack of progress during last year with patient summaries being sent to GPs within 24 hours. Changes required to dementia graphs.	Yes. Under review as part of examination of discharge arrangements. Agreed.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Governor questions		Comments were made as to the circumstances in which a patient would be 'pulled forward' a day for discharge. The terminology and circumstances were clarified. The issue of quoracy at the Infection Control Cttee was raised. It was acknowledged that there have been difficulties with this.		

Claire Feehily
Chair of Quality and Performance Committee
1 April 2019

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – APRIL 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 February 2019 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.

Quality Delivery Report

The Quality Delivery Group (QDG) continues to monitor the performance of the quality metrics with the Divisions providing exception reports. The delivery of any action plans to deliver improvement are also reviewed within this forum, high level metrics are also highlighted below.

Friends and Family Test positive scores <93%
Changes are being made to the FFT set up and will need to be implemented by June 2019. We await the National guidance from NHS England. There is no change in the top themes that are being reported positive and negative. All ward managers have access to their own data and are able to create “You said” “We did” posters to show that they are taking improvement action in response to comments. The hope is that the new changes to the system will make this a more useable feedback mechanism so that improvements can be made in response to comments.

VTE metric
The task and finish group continue to trial changes to see how they can make improvements to the data recording in Trak. Difficulties with data quality on Trak led to the completion of monthly ward audits of VTE risk assessment compliance to provide a true picture of results for UNIFY upload.

Mortality Indicators
All the key mortality indicators were within the expected ranges. One of the Governor indicators to be reviewed by auditors for the Quality Account will be SHMI.

Dementia metrics
Retrospective audits are to commence within the Quality Team to look at current Trust position and notes have been requested since the change in clerking documentation was made. A report should be available to QDG for the next meeting. The problem within Trakcare is that the data has to be reported on 3 different pages and so this is not user friendly and so compliance with reporting digitally is not

robust.

CDiff

There were 5 cases of trust-apportioned C. difficile during February 2019. Investigations of individual cases have focused on antimicrobials and environmental cleanliness as a leading risk factor, this case rate is above the expected limits for the month. All cases are reviewed internally and presented to the CCG. The trust have a comprehensive action plan to bring about improvements. Additionally in February education on expectations of cleaning, cleaning technique and the correct use of wipes was also provided to staff trust wide (ward based activities). Also, further assurance monitoring and review of cleaning standards are being undertaken jointly by the Lead Nurse for IPC and GMS facilities manager every fortnight.

Performance

During February the Trust did not meet the national standards or Trust trajectories for; A&E 4 hour standard and the 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 February 2019, the trust performance against the 4hr A&E standard was 86.1%. 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 March 2019 data in April 2019. 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. An inpatient list has now been issued to operational teams to test to support the correct chronological booking of our elective work. In addition, our theatre utilisation has significantly improved, again supporting the effective use of our existing capacity to treat our patients. The inpatient list has been deployed and will support the Task and Finish work through the review of pre-operative assessment, validation work on the list is ongoing.

Our performance against the cancer standard saw delivery in delivery for the 2 week standard in February at 93.7%, continued compliance is expected, subject to fluctuations in referral rates.

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. Positively the Trust is planning to address the backlog to enable delivery of 62 day by March 2019 and has also in month received a further amount of additional funding to support this recovery.

Cancer 62 day Referral to Treatment (GP referral) performance for January (un-validated) was 77.4%, with 46.5 breaches. This comprised of 23 urological reaches, 6.5 Lower GI breaches; 4.5 gynaecological; 4 Upper GI breaches). it is recognised that this is not a stable position as we treat the urology backlog throughout the spring.

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.

Conclusions

Cancer delivery, with a particular focus on Urology recovery and backlog clearance during January through to March continue, 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, a number of these are outlined in the supporting QPR documentation.

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 presented to previous Committees and/or TLT

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

Outcome of discussion when presented to previous Committees/TLT

TLT recommended to the Board endorsing the above changes to the TRR.

Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report

Reporting period February 2019

to be presented at March 2019 Quality and Performance Committee

Executive Summary

Delivery of agreed action plans remains critical to restore operational performance to the expected levels. During January 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 February and suspended reporting of the 18 week referral to treatment (RTT) standard continues.

The Trust did not meet the 4 hour standard in February 86.08% against the STP trajectory at 90% against a backdrop of significant attendances.

The Trust has met the diagnostics standard for February at 0.21%.

The Trust has met the standard for 2 week wait cancer at 93.7% in February, this is as yet un-validated performance at the time of the report.

The key areas of focus remain for delivery of Cancer quality and performance against speciality level trajectories. The Cancer Delivery plan is reviewed 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. Significant work is underway to reduce our longest waiting patients of over 52 weeks.

The Quality Delivery Group (QDG) continues to monitor the performance of the quality metrics with the Divisions providing exception reports. The delivery of any action plans to deliver improvement are also reviewed within the meeting.

Strengths

4 hour performance continues to perform well in comparison to other Trusts, despite 6% increased attendances (Feb 18 to Feb 19).

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

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.

Progress has been made in clinic typing and in a reduction of follow up patients, though the latter remains an identified operational risk.

Work continues with Trak optimisation and positive progress has been made in preparation for reporting RTT and with the Theatres programme.

Agreement has been reached through Outpatient Improvement Board (ICS) to support transformational work within outpatients, this will bring new rigor and challenge to this area and lead to improvements in services for our patients.

VTE Assessments
Patient receiving appropriate VTE risk assessments improved to 96.6% but has seen a slight decline this month and so the trend will be continued to be monitored.

Never Events
Trend - there have been no further never events reported this month.

Weaknesses

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

Dementia
Changes to the clerking documentation have been made and manual audits have been recommenced in order for the data to be reviewed across the Trust.
The recording of the dementia fair test question remain an issue because of how it is recorded within Trakcare.

Opportunities

Refreshed QPR report
Development still with the first new style report will be planned for April 2019.

Friends and Family Test
Our FFT data remains in a static position. Wards continue to complete "You said" "We did" posters to demonstrate how they have responded to the data. NHS England have also made a decision that the system needs an overhaul and will be making changes to the question which will go live in April 2019.

Significant progress with our Urology Cancer backlog and benefits for our patients to be treated.

Work to assess our preparedness for the new access standards, specifically the 28 day faster diagnosis standard for Cancer has been completed in readiness for April 2020 alongside this year's plan to implement an upgrade to the IT system supporting Cancer delivery.

We are taking length of stay forwards by implementing a work programme of additional services which will reduce admissions to wards, this will be reported into the Emergency Care Delivery Group.

Risks & Threats

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

30 day readmissions
During 2018/19 a number of additional services have been put in place within the Trust which centre on the introduction/piloting of assessment areas – the purpose of these areas is to take patients who are deemed 'fit to sit' and to provide assessment service to reduce direct admissions to the wards, improve the patient experience and improve flow within the organisation.
There have been on-going discussions with commissioner colleagues to reach agreement on how to record this activity and in line with national guidance a local solution has been reached. As patients within the assessment areas do not meet the NHS Data Dictionary of an admission we have taken the decision to categorise these as 'assessments' – to this end we have retrospectively adjusted reporting from April 2018.

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 in order to support the shared system aim to detect more cancer.

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

As last month, 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 inpatient PTL has now been issued.
Work on 4 specific Data Quality indicators between operational and business intelligence teams is critical to continued delivery of both reporting and visibility of patients dated correctly on PTLs. 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 continues to be positive within month, with identified issues being worked through between the teams.
Progress has been made in addressing our longest waiting follow up patients, but risk to patient experience in long delays remain. Specific specialities with extraneous waits have been identified and clear plans to provide additional activity and / or utilise existing capacity are underway. Further details are provided within the exception report.

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												
		Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
ED Total Time in Department – Under 4 Hours	Trajectory	80.00%	83.50%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
	Actual	88.46%	86.94%	91.98%	91.58%	93.33%	91.34%	90.26%	89.01%	90.54%	91.59%	87.55%	84.46%	86.08%
Referral To Treatment Ongoing Pathways Under 18 Weeks (%)	Trajectory	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	0.49%*	0.26%	0.56%	1.26%	0.52%	0.55%	1.27%	0.63%	0.03%	0.35%	0.20%	0.67%	0.21%
Cancer - Urgent Referrals Seen in Under 2 Weeks from GP	Trajectory	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.10%	93.00%	93.10%	93.00%	93.00%	93.00%	93.00%
	Actual	90.60%	90.50%	86.60%	86.30%	88.60%	90.40%	88.90%	82.80%	91.80%*	90.60%*	94.30%*	92.00%*	93.70%*
2 week wait Breast Symptomatic referrals	Trajectory	93.20%	93.30%	93.20%	93.30%	93.40%	93.40%	93.30%	93.20%	93.40%	93.40%	93.10%	93.00%	93.50%
	Actual	97.60%	94.50%	91.30%	91.90%	95.10%	96.00%	97.80%	98.90%	99.20%*	94.50%*	97.60%*	95.50%*	97.00%*
Cancer – 31 Day Diagnosis To Treatment (First Treatments)	Trajectory	96.10%	96.30%	96.10%	96.30%	96.10%	96.20%	96.30%	96.20%	96.20%	96.30%	96.20%	96.40%	96.20%
	Actual	97.60%	97.90%	96.70%	96.90%	97.10%	96.80%	96.90%	93.50%	93.20%*	94.00%*	93.80%*	92.30%*	91.00%*
Cancer – 31 Day Diagnosis To Treatment (Subsequent – Drug)	Trajectory	100.00%	98.40%	98.50%	100.00%	98.80%	98.10%	100.00%	98.40%	98.00%	98.10%	100.00%	100.00%	100.00%
	Actual	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	98.80%	100.00%*	100.00%*	100.00%*	100.00%*	100.00%*
Cancer – 31 Day Diagnosis To Treatment (Subsequent – Radiotherapy)	Trajectory	94.10%	94.20%	95.50%	95.80%	94.60%	95.10%	94.60%	95.00%	94.30%	94.70%	94.50%	94.40%	94.20%
	Actual	100.00%	100.00%	100.00%	100.00%	100.00%	98.70%	100.00%	100.00%	98.60%*	98.60%*	98.60%*	100.00%*	98.90%*
Cancer – 31 Day Diagnosis To Treatment (Subsequent – Surgery)	Trajectory	94.50%	94.10%	95.10%	95.00%	94.20%	95.90%	94.60%	95.30%	94.30%	95.00%	94.80%	94.30%	94.60%
	Actual	95.50%	98.00%	94.90%	96.60%	94.50%	96.00%	95.70%	94.30%	98.30%*	96.60%*	92.50%*	94.80%*	98.00%*
Cancer 62 Day Referral To Treatment (Screenings)	Trajectory	92.90%	90.50%	92.00%	94.70%	90.50%	90.00%	91.20%	92.10%	92.90%	92.90%	90.90%	92.90%	92.90%
	Actual	95.90%	95.90%	100.00%	94.10%	100.00%	100.00%	100.00%	85.50%	93.50%*	93.50%*	100.00%*	93.90%*	96.30%*
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	80.00%	94.10%	76.50%	100.00%	84.60%	53.30%	100.00%	75.00%	77.80%*	58.80%*	70.00%*	69.20%*	75.00%*
Cancer 62 Day Referral To Treatment (Urgent GP Referral)	Trajectory	85.40%	85.20%	82.80%	84.40%	85.30%	79.70%	77.10%	81.70%	82.00%	83.70%	82.80%	80.90%	82.60%
	Actual	79.10%	78.10%	80.30%	79.90%	66.90%	74.70%	76.30%	69.00%	68.00%*	78.40%*	72.50%*	75.90%*	61.80%*

Summary Scorecard

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

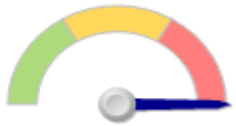
RAG Rating : Overall RAG rating for a domain is an average performance of lead indicators against national standards.
Where data is not available the lead indicator is treated as Red.

QUALITY

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

OPERATIONAL PERFORMANCE

% waiting for Diagnostics 6 Week Wait and over (15 Key Tests)
Cancer 62 Day Referral To Treatment (Screenings)
Cancer 62 Day Referral To Treatment (Upgrades)
Cancer 62 Day Referral To Treatment (Urgent GP Referral)
ED Total Time in Department – Under 4 Hours
Referral To Treatment Ongoing Pathways Under 18 Weeks (%)



FINANCE

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

LEADERSHIP AND DEVELOPMENT

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

Trust Scorecard

* = unvalidated data

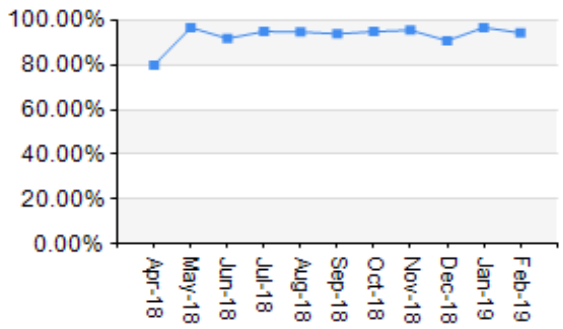
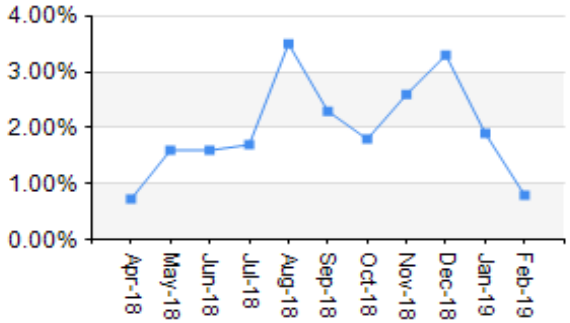
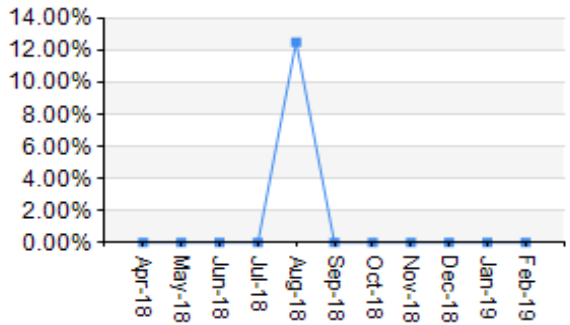
Category	Indicator	Standard 2017/18	Month		Standard 2018/19	Month											Quarter	Annual
			Feb-18	Mar-18		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	18/19 Q3	18/19
Quality	**Key Indicators - Quality**																	
	Friends & Family Test – ED % Positive	>=86%	82.7%	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% *	82.7% *	82.8% *	82.1%	83.1% *
	Friends & Family Test – Inpatients % Positive	>=95%	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% *	91.9% *	89.2% *	91.5%	91.2% *
	Friends & Family Test – Maternity % Positive	>=97%	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% *	100.0% *	93.5% *	99.4%	87.9% *
	Friends & Family Test – Outpatients % Positive	>=93%	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% *	93.4% *	92.5% *	92.8%	92.6% *
	Friends & Family Test – Total % Positive		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% *	91.9% *	90.7%	91.3%	91.1% *
	Infection Control – MRSA Bloodstream Cases – Cumulative Totals	0	0 *	0 *	0	1	1	1	2 *	3	5	5	5	5	5 *	5	5	5 *
	Mortality – Hospital Standardised Mortality Ratio (HSMR)	Dr Foster confidence level	95	96	Dr Foster confidence level	98.3	95.2	96	96.4	98.1	99.8	100.8	99.1					99.1 *
	Mortality – Hospital Standardised Mortality Ratio (HSMR) – Weekend	Dr Foster confidence level	97.7	98.4	Dr Foster confidence level	101.1	97.3	97.1	97.9	96.6	98.4	101.7	101.4					101.4 *
	Mortality – Summary Hospital Mortality Indicator (SHMI) – National Data	Dr Foster confidence level		107.2	Dr Foster confidence level			103.3			102.6							102.6 *
	MSA – Number of Breaches of Mixed Sex Accommodation	0	7	6	R>=20 A11-19 G<=10	8	8	20	5	6	0	7	2	6	2	1	15	65 *
	Readmissions – Emergency re-admissions within 30 days following an elective or emergency spell	Q1<6% Q2<5.8% Q3<5.6% Q4<5.4%	7.9% *	7.2% *	R>8.75% A8.25-8.75% G<8.25%	7.1% *	6.9% *	7.2% *	7.2% *	7.2% *	6.7% *	7.1% *	6.1% *	7.1% *	6.7% *		6.8% *	6.9% *
	VTE Prevention – % of Adult Inpatients who have Received a VTE Risk Assessment	>95%	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% *	96.6% *	94.2% *	93.7% *	93.0% *
	Detailed Indicators - Quality																	
	Dementia Screening – % of patients who have been screened for Dementia (within 72 hours)	>=90%	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%	3.3%	1.9%	0.8% *	2.6%	2.0% *
	Dementia Screening – % of patients who have received a dementia diagnostic assessment with positive or inconclusive results that were then referred for further diagnostic advice/FU (within 72 hours)	>=90%	0.0%	0.0%	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%	0.0% *	0.0%	2.9% *
	Dementia Screening – % of patients who have scored positively on dementia screening tool that then received a dementia diagnostic assessment (within 72 hours)	>=90%	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%	40.0%	0.0% *	26.1%	27.7% *
	ED Checklist – ED Safety checklist compliance CGH	R<50% A50-79% G>=80%	83% *	82% *	R<50% A50-79% G>=80%	82% *	89% *	84% *	88% *	90% *	89% *	90% *	93% *	93% *	92%	91% *		
	ED Checklist – ED Safety checklist compliance GRH	R<50% A50-79% G>=80%	81% *	81% *	R<50% A50-79% G>=80%	85% *	73% *	73% *	75% *	85% *	90% *	90% *	91%	93% *	90%	83% *	87%	
	Emergency Department – ED: % of time to initial assessment – Under 15 minutes	>=99%	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%	85.2% *	83.6%	87.9%	88.2% *
	Emergency Department – ED: % of time to start of treatment – Under 60 minutes	>=90%	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%	34.9% *	32.4%	34.4%	33.6% *
	Infection Control – C.Diff Cases – Cumulative Totals	18/19 = 36	49	56	R>3 G<=3	5	14	16	23	29	32	36	40	41	47 *	52	41	52 *
	Infection Control – Ecoli – Cumulative Totals		240 *	258 *	TBC	17	32	56	79 *	107	139	164	168	171	39 *	41	171	41 *
	Infection Control – Klebsiella – Cumulative Totals				TBC	6	12	13	22 *	29	39	46	49	51	25 *	28	51	28 *
	Infection Control – MSSA Cases – Cumulative Totals	No target	93 *	100 *	TBC	9	18	28	41	49	63	72	76	2 *	25 *	30	8 *	30 *
	Infection Control – Pseudomonas – Cumulative Totals				TBC	2	3	6	14 *	17	20	23	24	24	11 *	12	24	12 *
	Maternity – Percentage of Spontaneous Vaginal Deliveries		63.4% *	61.8% *	TBC	57.5% *	61.4% *	60.0% *	64.3% *		63.1% *	59.2% *	59.4% *	59.3% *	57.9% *	55.7% *	59.2% *	60.2% *
	Maternity – Percentage of Women Seen by Midwife by 12 Weeks	>90%	88.8% *	90.9% *	>90%	92.0% *	87.4% *	90.1% *	89.4% *	87.0% *	90.4% *	90.1% *	91.8% *	90.2% *	90.5% *	90.4% *	90.9% *	89.8% *

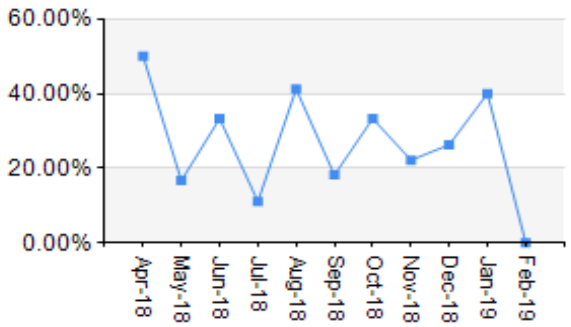
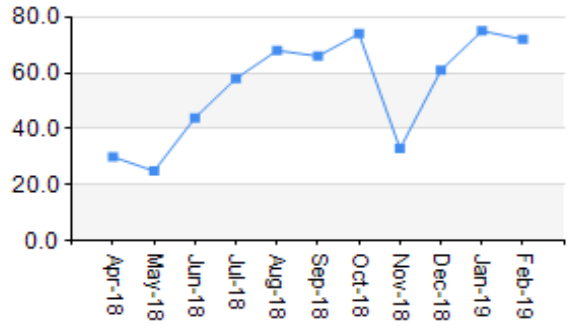
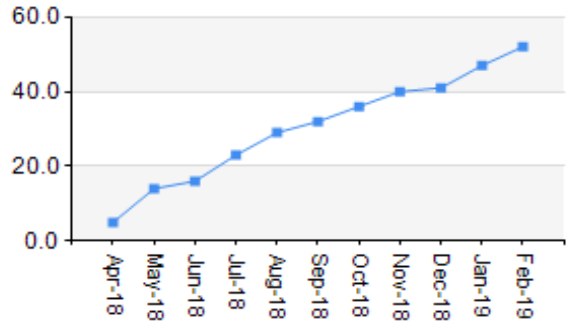
Category		Indicator	Standard 2017/18	Month		Standard 2018/19	Month										Quarter	Annual
				Feb-18	Mar-18		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	18/19 Q3	18/19
	Medicines	Rate of Medication Incidents per 1,000 Beddays	Current mean	3.5 *	3.6 *	Current mean	3.6 *	4.6 *	4.4 *	4.3 *	4 *	3.8 *	4.3 *	4.6 *	3.8 *	3.2 *	3.6 *		
	Patient Safety Incidents	Number of falls per 1,000 bed days	Current mean	7.3 *	7.7 *	TBC	8.3 *	7.6 *	8.3 *	6.9 *	6.3 *	7.5 *	7.3 *	6.8 *	7.2 *	6.8 *	7.1 *		
		Number of falls resulting in harm (moderate/severe)		10 *	8 *	TBC	10 *	8 *	7 *	11 *	6 *	9 *	8 *	6 *	8 *	8 *	2 *		8 *
		Number of Patient Safety Incidents - severe harm (major/death)		1 *	1 *	TBC	2 *	1 *	1 *	1 *	1 *	2 *	1 *	0 *	1 *	0 *	3 *		1 *
		Number of Patient Safety Incidents Reported		1,139 *	1,229 *	TBC	1,192 *	1,210 *	1,199 *	1,206 *	1,142 *	1,202 *	1,228 *	1,249 *	1,153 *	1,408 *	1,277 *		
		Pressure Ulcers – Category 2	R=1% G<1%	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% *	0.52% *	0.91% *		
		Pressure Ulcers – Category 3	R=0.3 G<0.3%	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% *	0.00% *	0.26% *		
		Pressure Ulcers – Category 4	R=0.2% G<0.2%	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% *	0.13% *	0.00% *		
	Research	Research Accruals	17/18 = >1100	61 *	64 *	TBC	64 *	136 *	406 *	149 *	147 *	121 *	199 *	96 *	84 *	71 *	81 *	379 *	19 *
	RIDDOR	Number of RIDDOR	Current mean	1 *	1 *	Current mean	4 *	0 *	1 *	2 *	2 *	5 *	4 *	1 *	4 *	1 *	3 *		
	Safe nurse staffing	Care Hours per Patient Day total		7	7	TBC	7	7	8	7	7	7	7	7	7 *	7 *	7 *	7 *	7 *
	Safety Thermometer	Safety Thermometer – Harm Free	R<88% A89%-91% G>92%	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% *	94.1% *	94.1% *		
		Safety Thermometer – New Harm Free	R<93% A94%-95% G>96%	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% *	97.3% *	97.7% *		
	Sepsis Identification and Treatment	% of patients screened in ED for Sepsis	>90%	98.0% *	100.0% *	R<50% A50-89% G>=90%	98.0% *	98.0% *	100.0% *	98.0% *	98.0% *	98.0% *	100.0% *	98.0% *	100.0% *				
		% of patients who were administered IVABs with 1 hour of arriving to ED	>50%	84.0% *	78.0% *	R<50% A50-89% G>=90%	82.0% *	88.0% *	88.0% *	72.0% *	79.0% *	79.0% *	82.0% *	86.0% *	83.0% *				
	Serious Incidents	Number of Never Events reported	0	0 *	1 *	0	1 *	0 *	0 *	0 *	0 *	0 *	0 *	0 *	0 *	0 *	0 *		1 *
		Number of Serious Incidents Reported		10 *	2 *	0	3 *	10 *	5 *	0 *	4 *	4 *	2 *	1 *	1 *	3 *	0 *		
		Percentage of Serious Incident Investigations Completed Within Contract Timescale		100% *	100% *	>80%	100% *	100% *	100% *	100% *	100% *	100% *	100% *	100% *	100% *	100% *	100% *		
		Serious Incidents - 72 Hour Report completed within contract timescale		100.0% *	100.0% *	G>90%	100.0% *	100.0% *	100.0% *	100.0% *	100.0% *	100.0% *	100.0% *	100.0% *	100.0% *	100.0% *	100.0% *		
	Staff Safety Incidents	Rate of Incidents Arising from Clinical Sharps per 1,000 Staff	Current mean	2.4 *	2.8 *	Current mean	1.4 *	2.8 *	1.7 *	2.5 *	2.3 *	2.2 *	3.9 *	3 *	1.3 *	1.3 *	1.6 *		
		Rate of Physically Violent and Aggressive Incidents Occurring per 1,000 Staff	Current mean	2.6 *	2.8 *	Current mean	4 *	2.8 *	2.5 *	3.3 *	2.1 *	2.9 *	2.8 *	1.6 *	2.3 *	2.7 *	3 *		
	Stroke Care	High Risk TIA Patients Starting Treatment Within 24 Hours	>=60%	60.0%	76.0%	>=60%	69.4%	73.5%	69.6%	58.6%	70.8%	51.5%	42.6%	48.3%	61.1%	68.8%	72.0%	47.9%	61.2% *
		Stroke Care: Percentage of patients Receiving Brain Imaging Within 1 Hour	>=50%	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%	37.1%	32.7%	31.0%	38.0% *
		Stroke Care: Percentage of patients Spending 90%+ Time on Stroke Unit	>=80%	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%	91.9%	88.7%		87.3%	91.7% *
	Trauma & Orthopaedics	% of fracture neck of Femur patients treated within 36 Hours		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% *	83.9% *	85.6% *	70.9% *	76.0% *
		Fracture Neck of Femur – Time To Treatment 90th Percentile (Hours)		42.3 *	64.4 *	TBC	48.1 *	42.3 *	49.8 *	51.8 *	38.4 *	38.6 *	52.2 *	60.3 *	43.9 *	42.5 *	41.1 *	50.3 *	31 *
		Fracture Neck of Femur Patients Seeing Orthogeriatrician Within 72 Hours		100.0% *	98.4% *	TBC	94.4% *	91.2% *	93.7% *	100.0% *	98.4% *	90.9% *	100.0% *	98.5% *	100.0% *	100.0% *	100.0% *	99.5% *	99.0% *
Operational Performance	**Key Indicators - Operational Performance**																		
	Cancer	Cancer 62 Day Referral To Treatment (Screenings)	>=90%	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% *	93.9% *	96.3% *	95.9% *	95.6% *
		Cancer 62 Day Referral To Treatment (Upgrades)	>=90%	80.0%	94.1%	>=90%	76.5%	100.0%	84.6%	53.3%	100.0%	75.0%	77.8% *	58.8% *	70.0% *	69.2% *	75.0% *	67.4% *	69.3% *
		Cancer 62 Day Referral To Treatment (Urgent GP Referral)	>=85%	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% *	72.5% *	75.9% *	61.8% *	72.6% *	74.2% *
	Diagnostics	% waiting for Diagnostics 6 Week Wait and over (15 Key Tests)	<1%	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%	0.35%	0.20%	0.67%	0.21%	0.20% *	0.60% *
	Emergency Department	ED Total Time in Department – Under 4 Hours	>=95%	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%	84.46%	86.08%	90.02%	89.84% *
	RTT	Referral To Treatment Ongoing Pathways Under 18 Weeks (%)	>=92%			>=92%													

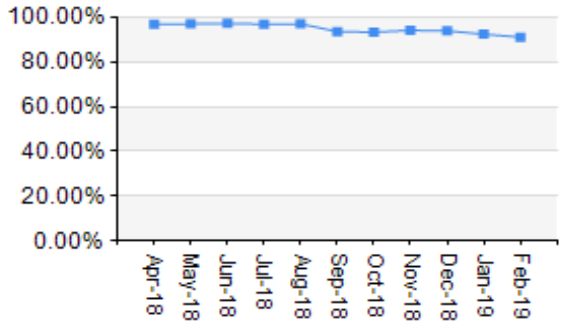
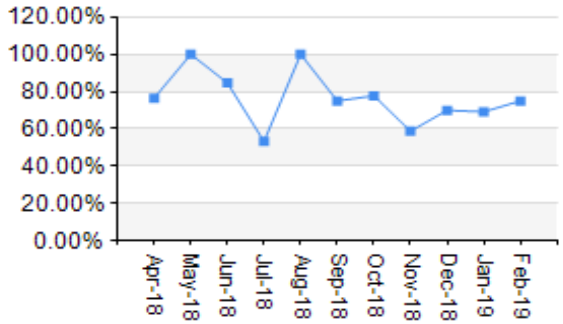
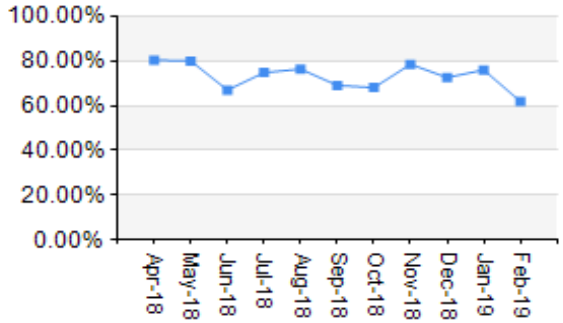
Category		Indicator	Standard 2017/18	Month		Standard 2018/19	Month											Quarter	Annual
				Feb-18	Mar-18		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	18/19 Q3	18/19
	Detailed Indicators - Operational Performance																		
	Cancer	2 week wait Breast Symptomatic referrals	>=93%	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% *	95.5% *	97.0% *	97.2% *	96.0% *
		Cancer – 31 Day Diagnosis To Treatment (First Treatments)	>=96%	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% *	93.8% *	92.3% *	91.0% *	93.8% *	95.4% *
		Cancer – 31 Day Diagnosis To Treatment (Subsequent – Drug)	>=98%	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% *	100.0% *	100.0% *	99.9% *
		Cancer – 31 Day Diagnosis To Treatment (Subsequent – Radiotherapy)	>=94%	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% *	100.0% *	98.9% *	98.6% *	99.5% *
		Cancer – 31 Day Diagnosis To Treatment (Subsequent – Surgery)	>=94%	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% *	92.5% *	94.8% *	98.0% *	96.2% *	95.6% *
		Cancer - Urgent Referrals Seen in Under 2 Weeks from GP	>=93%	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% *	94.3% *	92.0% *	93.7% *	92.1% *	89.9% *
		Number of patients waiting over 104 days with a TCI date	0	4	6	0	9	12	6	8	22	26	7	13	8	8	8	8	127 *
		Number of Patients waiting over 104 days without a TCI date	0	14	17	TBC	18	18	22	28	24	30	39	37	27	42	37	27	322 *
	Diagnostics	The number of planned / Surveillance Endoscopy Patients Waiting at Month End		106	123	TBC	188	223	260	311	407	576	630 *	680 *	686 *	639 *	600 *	686 *	600 *
	Discharge	Number of patients delayed at the end of each month	<14	23	34	TBC	37	27	36	47	44	41	44 *	40 *	34 *	29 *	24 *	34 *	24 *
		Patient discharge summaries sent to GP within 24 hours			46.5% *	R<75% A75-87% G>=88%	50.1% *	50.2% *	51.7% *	52.6% *	49.7% *	51.9% *	51.7% *	49.2% *	47.4% *	52.3% *		49.4% *	50.7% *
	Emergency Department	Ambulance Handovers – Over 30 Minutes	< previous year	44	49	< previous year	30	25	44	58	68	66	74	33	61 *	75 *	72	168 *	606 *
		Ambulance Handovers – Over 60 Minutes	< previous year	3	3	< previous year	1	3	1	0	2	2	2	1	1 *	0 *	0	4 *	13 *
		ED: % total time in department - Under 4 Hours CGH	>=95%	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%	93.70%	95.50%	96.51%	96.40% *
		ED: % total Time in Department – Under 4 Hours GRH	>=95%	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%	80.10%	81.60%	86.89%	86.60% *
		ED: Number of patients experiencing a 12 Hour Trolley wait (>12hours from decision to admit to admission)	0	1	0	0	0	0	0	0	0	0	0	0	0 *	0	0	0	0 *
	Length of Stay	Average Length of Stay (Spell)		5.04 *	4.99 *	TBC	5.18 *	4.73 *	4.71 *	4.64 *	4.95 *	4.79 *	4.88 *	4.98 *	4.66 *	4.96 *	5.18 *	4.84 *	4.87 *
	Operational Efficiency	Length of Stay for General and Acute Elective Spells (Occupied Bed Days)	<=3.4	2.99 *	3.03 *	R>4.5 A3.5-4.5 G<=3.4	2.82 *	2.78 *	2.52 *	2.61 *	3 *	2.75 *	2.47 *	2.84 *	2.89 *	2.6 *	2.7 *	2.73 *	2.72 *
		Length of Stay for General and Acute Non-Elective (Occupied Bed Days) Spells	Q1/Q2<5.4 Q3/Q4<5.8	5.53 *	5.46 *	TBC	5.72 *	5.27 *	5.34 *	5.17 *	5.4 *	5.3 *	5.48 *	5.54 *	5.06 *	5.45 *	5.81 *	5.36 *	5.41 *
		Number of LMCs Not Re–admitted Within 28 Days	0	25 *	21 *	0	12 *	23 *											
		Number of Patients Stable for Discharge	<40	65	67	TBC	67	66	71	71	75	80	75	76	69 *	74 *	72 *	69 *	72 *
		Number of stranded patients with a length of stay of greater than 7 days		464	482	TBC	384	395	369	373	382	376 *	374 *	382 *	374 *	399 *	412 *	374 *	412 *
	RTT	Referral To Treatment Ongoing Pathways Over 52 Weeks (Number)	0	63	95 *	0	95	92	98	113	125	105	103	105	97	89	97	97	97 *
	SUS	Percentage of Records Submitted Nationally with Valid GP Code	>=99%	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% *	100.0%	100.0% *
		Percentage of Records Submitted Nationally with Valid NHS Number	>=99%	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% *	99.8%	99.8% *
Finance	**Key Indicators - Finance**																		
	Finance	YTD Performance against Financial Recovery Plan		-10.8 *	-18.4 *	TBC	.05	.07	.09	.18 *	.2	.2	.2	.4	.04	-3	-6.6		
	Detailed Indicators - Finance																		
	Finance	Agency – Performance Against NHSI Set Agency Ceiling		3 *	3 *	TBC	2	2	2	2	2	3	3	3	3	3	3		
		Capital Service		4 *	4 *	TBC	4	4	4	4	4	4	4	4	4	4	4		
		Cost Improvement Year to Date Variance		-7,085	10,475	TBC	-51	121	1,116	2,365	2,342	2,975	2,994	2,013 *	1,593	0	-1,784		
		Liquidity		4 *	4 *	TBC	4	4	4	4	4	4	4	4	4	4	4		
		NHSI Financial Risk Rating	3	4 *	4 *	3	4	4	4	4	4	4	4	4	4	3	4		
		Total PayBill Spend		28.5 *	28.5 *	TBC	28.4	28.5	28.05	28.5	30.5	27.5	29.5	29.03	29.7	29.4	29.9		

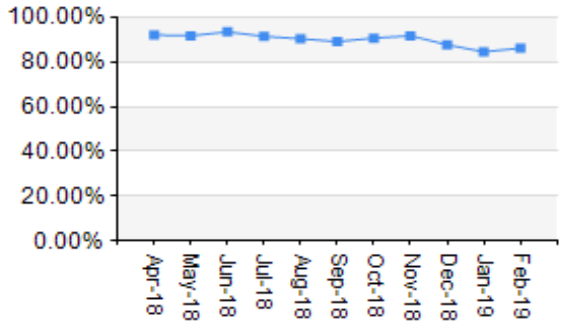
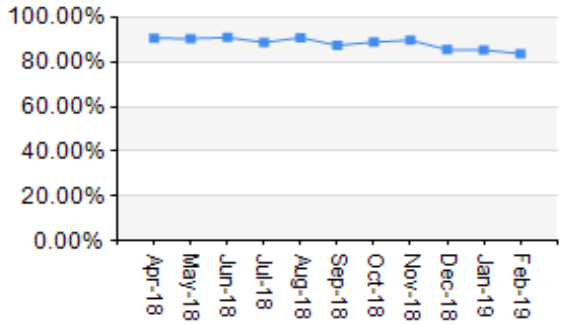
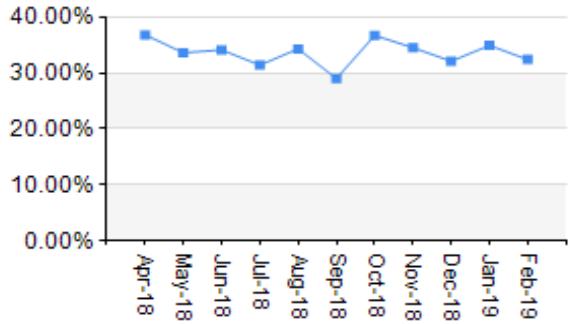
Category		Indicator	Standard 2017/18	Month		Standard 2018/19	Month										Quarter	Annual
				Feb-18	Mar-18		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	18/19 Q3	18/19
Leadership and Development	**Key Indicators - Leadership and Development**																	
	Workforce Expenditure and Efficiency	% Sickness Rate	G<3.6% R>4%	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% *	3.9%	3.9% *
		% Turnover	G<11% R>15%	11.4%	12.1%	TBC	12.0%	11.8%	12.3%	12.3%	12.0%	12.1%	11.9%	11.6%	11.7%	11.7%	11.8% *	11.6%	12.3% *
	Detailed Indicators - Leadership and Development																	
	Appraisal and Mandatory Training	Trust total % mandatory training compliance	>=90%	79%		R<70% A70-89% G>=90%			87%	87%	88%	90%	91% *	91% *	91% *	89%	89%	90%	89% *
		Trust total % overall appraisal completion	G>=90% R<70%	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%	79.0%	79.5%	79.0% *

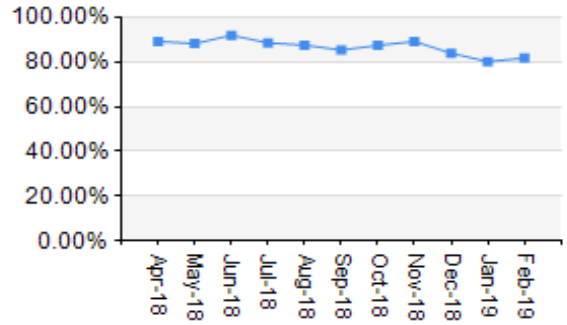
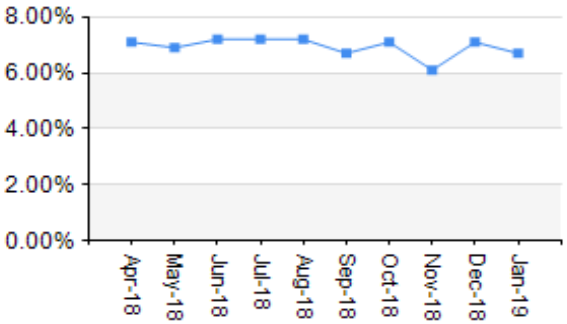
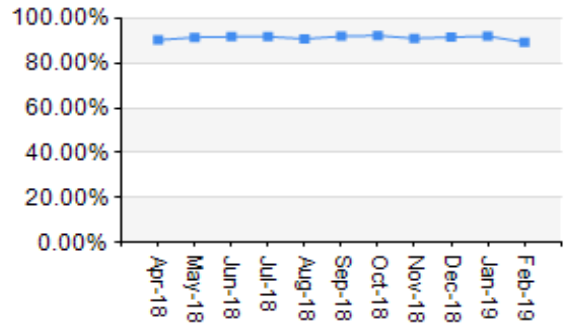
Exception Report

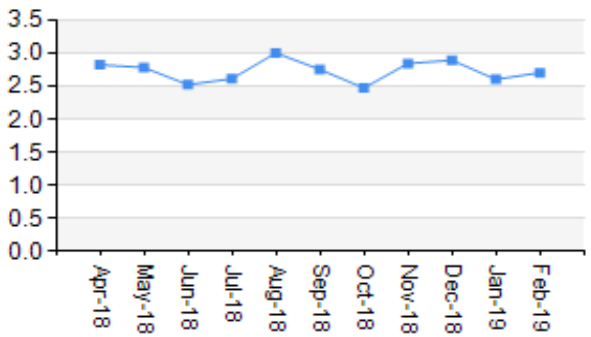
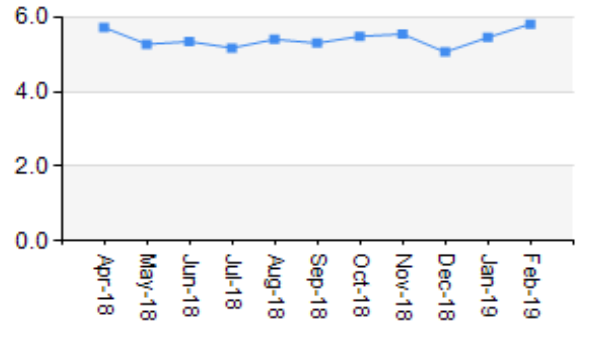
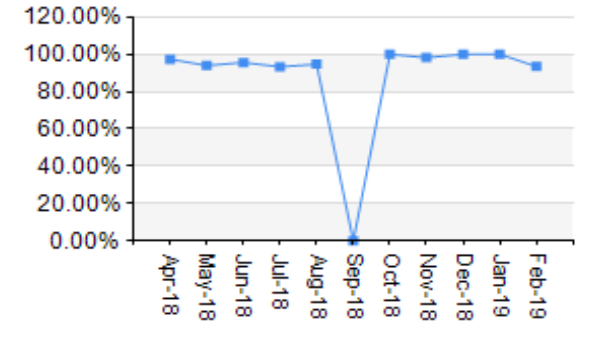
Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of Adult Inpatients who have Received a VTE Risk Assessment **Standard: R<=95% A96% G>97%**		Clinical audit continues to check performance for VTE. A newVTE committee is being launched too maintain improvement.	Director of Safety
% of patients who have been screened for Dementia (within 72 hours) **Standard: R<70% A70-89% G>=90%**		Audit work being progressed. Issue remains and plan as in previous reports.	Deputy Chief Nurse
% 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%**		Recovery plan still in development audit work in place.	Deputy Chief Nurse

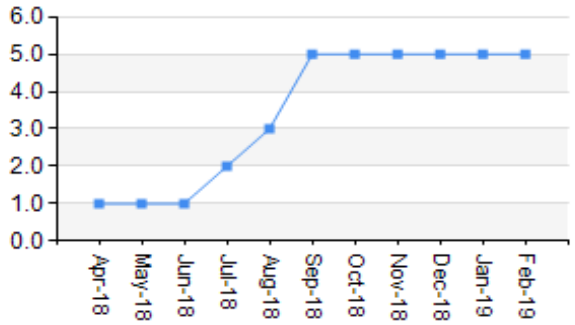
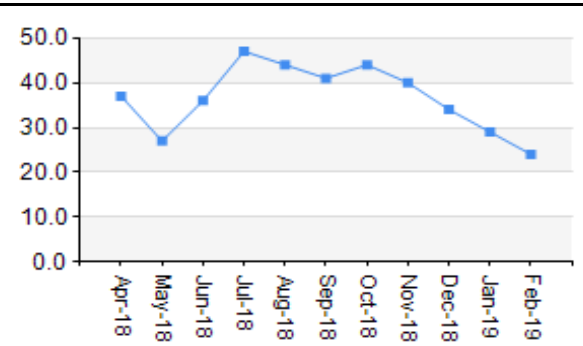
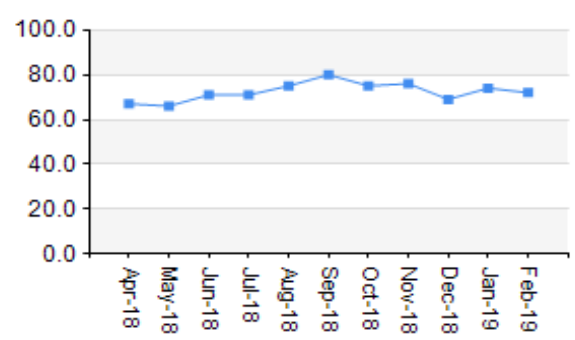
Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of patients who have scored positively on dementia screening tool that then received a dementia diagnostic assessment (within 72 hours) **Standard: R<70% A70-89% G>=90%**		Recovery plan still in development audit work in place	Deputy Chief Nurse
Ambulance Handovers – Over 30 Minutes **Standard: < previous year**		The increase in ambulance handover delays are directly correlated to the changes in the triage process.	Director of Unscheduled Care and Deputy Chief Operating Officer
C.Diff Cases – Cumulative Totals **Standard: R>3 G<=3**		There were 5 cases of trust-apportioned C. difficile during February 2019. Investigations of individual cases have focused on antimicrobials and environmental cleanliness as a leading risk factor, this case rate is above the expected limits for the month. All cases are reviewed internally and presented to the CCG. The trust have a comprehensive action plan to bring about improvements. Additionally in February education on expectations of cleaning, cleaning technique and the correct use of wipes was also provided to staff trust wide (ward based activities). Also, further assurance monitoring and review of cleaning standards are being undertaken jointly by the Lead Nurse for IPC and GMS facilities manager every fortnight.	Associate Chief Nurse and Deputy Director of Infection Prevention and Control

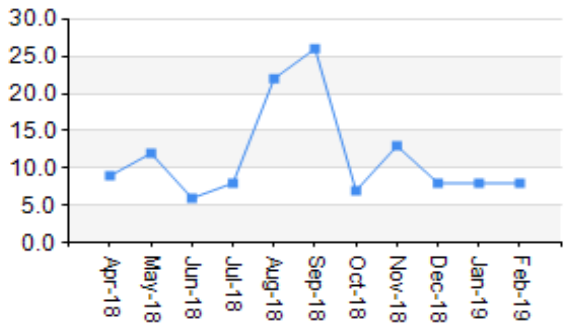
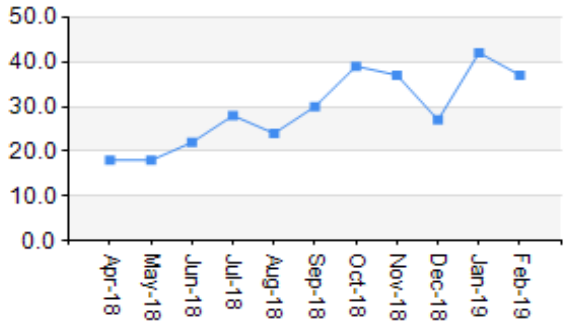
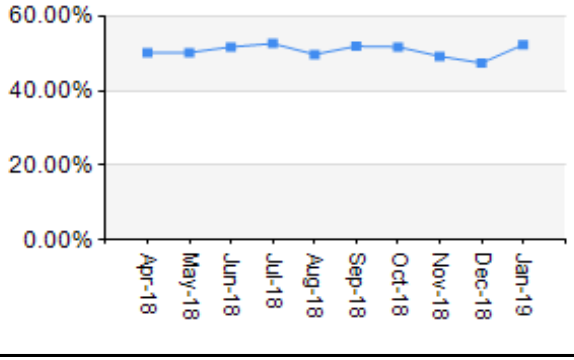
Metric Name & Standard	Trend Chart	Exception Notes	Owner
Cancer – 31 Day Diagnosis To Treatment (First Treatments) **Standard: R<94% A94-95% G>=96%**		Performance - 90.3% Target - 96% National performance - 97.1% Urology performance declined with 17 breaches - 75.7% Gynae - 8 breaches (74.2%) Skin - 1 breach	Director of Planned Care and Deputy Chief Operating Officer
Cancer 62 Day Referral To Treatment (Upgrades) **Standard: >=90%**		Performance - 60% Internal target - 90% National performance - 85.9% 5 treatments 2 breaches 2 x gynae 1 - change in treatment decision - surgery to chemorad 1 - elective surgical capacity	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%**		Feb performance - 61.8% (unvalidated) Exc uro performance - 78.8% Target - 85% National performance - 81% Performance will improve with projected 35 skin treatments yet to be added Urology - 23 breaches (45.2%) Gynae - 9 breaches (40%) Lower GI - 5.5 breaches (71.8%) Upper GI - 3.5 breaches (76.7%)	Director of Planned Care and Deputy Chief Operating Officer

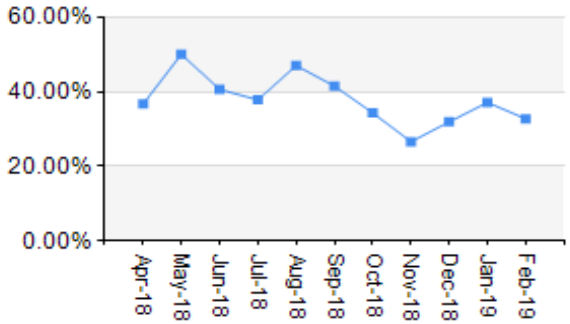
Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED Total Time in Department – Under 4 Hours **Standard: R<90% A90-94% G>=95%**		ED performance in February 2019 was 86.08% (95.5% CGH / 81.60% GRH) with a 6.2% increase in attendances. Compared to Feb 18 performance dipped by 2.4%. AMIA is still being maximised to reduce admissions and keep ED under 50 patients in addition to the SAU. Surges in attendances remain an issue with record surges per hour experienced in February.	Director of Unscheduled Care and Deputy Chief Operating Officer
ED: % of time to initial assessment – Under 15 minutes **Standard: R<92% A92-94% G>=95%**		Triage performance was 83.6% in Feb 19. Changes have been made to improve the quality of triage which has seen a predicted decrease in this metric.	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%**		This metric continues to remain between 30 and 35%. There has been renewed focus on chasing plans at 2 hours but this has not impacted the 60 minute metric. Emergency dept rotas are continually monitored and adjusted to ensure optimum cover across both sites.	Director of Unscheduled Care and Deputy Chief Operating Officer

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % total Time in Department – Under 4 Hours GRH **Standard: R<90% A90-94% G>=95%**		ED performance in February 2019 was 81.60% in GRH. Compared to Feb 18 performance dipped by 3.7%. AMIA is still being maximised to reduce admissions and keep ED under 50 patients in addition to the SAU. Surges in attendances remain an issue with record surges per hour experienced in February.	Director of Unscheduled Care and Deputy Chief Operating Officer
Emergency re-admissions within 30 days following an elective or emergency spell **Standard: R>8.75% A8.25-8.75% G<8.25%**		During 2018/19 a number of additional services have been put in place within the Trust which centre on the introduction/piloting of assessment areas – the purpose of these areas is to take patients who are deemed 'fit to sit' and to provide assessment service to reduce direct admissions to the wards, improve the patient experience and improve flow within the organisation. There have been ongoing discussions with commissioner colleagues to reach agreement on how to record this activity and in line with national guidance a local solution has been reached. As patients within the assessment areas do not meet the NHS Data Dictionary of an admission we have taken the decision to categorise these as 'assessments' – to this end we have retrospectively adjusted reporting from April 2018.	Deputy Medical Director
Inpatients % Positive **Standard: R<93% A93-95% G>=96%**		We continue to support staff monitoring their FFT comments. Improvements are being made in response to feedback.	Deputy Director of Quality

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Length of Stay for General and Acute Elective Spells (Occupied Bed Days) **Standard: R>4.5 A3.5-4.5 G<=3.4**		During 2018/19 a number of additional services have been put in place within the Trust which centre on the introduction/piloting of assessment areas – the purpose of these areas is to take patients who are deemed 'fit to sit' and to provide assessment service to reduce direct admissions to the wards, improve the patient experience and improve flow within the organisation. There have been ongoing discussions with commissioner colleagues to reach agreement on how to record this activity and in line with national guidance a local solution has been reached. As patients within the assessment areas do not meet the NHS Data Dictionary of an admission we have taken the decision to categorise these as 'assessments' – to this end we have retrospectively adjusted reporting from April 2018.	Deputy Chief Operating Officer
Length of Stay for General and Acute Non-Elective (Occupied Bed Days) Spells **Standard: TBC**		During 2018/19 a number of additional services have been put in place within the Trust which centre on the introduction/piloting of assessment areas – the purpose of these areas is to take patients who are deemed 'fit to sit' and to provide assessment service to reduce direct admissions to the wards, improve the patient experience and improve flow within the organisation. There have been ongoing discussions with commissioner colleagues to reach agreement on how to record this activity and in line with national guidance a local solution has been reached. As patients within the assessment areas do not meet the NHS Data Dictionary of an admission we have taken the decision to categorise these as 'assessments' – to this end we have retrospectively adjusted reporting from April 2018.	Deputy Chief Operating Officer
Maternity % Positive **Standard: R<94% A94-96% G>=97%**		The maternity team continue to view feedback. They currently have 16 QU projects and this feedback will be reviewed by the teams.	Deputy Director of Quality

Metric Name & Standard	Trend Chart	Exception Notes	Owner
MRSA Bloodstream Cases – Cumulative Totals **Standard: 0**		During September 2018 the trust had two cases of trust-apportioned MRSA bacteraemia in a patient with a known history of MRSA, thought to be a possible blood culture contaminant and another in a patient with a surgical site infection (associated with another trust). These cases were reviewed by the IPC team and the clinical team. There have been no further cases to end of February.	Associate Chief Nurse and Deputy Director of Infection Prevention and Control
Number of patients delayed at the end of each month **Standard: TBC**		This number has risen slightly to previous month due to higher acuity of patients needing specific requirements. Choice policy being used outside of its criteria. Simple discharges not as fluid over the month and complex delays have all led to month end delays	Director of Unscheduled Care and Deputy Chief Operating Officer
Number of Patients Stable for Discharge **Standard: TBC**		Number of patients stable for discharged has stayed the same as the previous month. Despite conscious efforts with system partners on a day to day review basis delays have occurred with patients not remaining medically fit, delays with community placements. Choice policy being used and reduced placements re DTA beds and POC.	Director of Unscheduled Care and Deputy Chief Operating Officer

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of patients waiting over 104 days with a TCI date **Standard: 0**		Cancer Category Total Head & neck 2 Lower GI 2 Urological 17 Grand Total 21	Director of Planned Care and Deputy Chief Operating Officer
Number of Patients waiting over 104 days without a TCI date **Standard: TBC**		Cancer Category Total Haematological 1 Lower GI 8 Other 1 Upper GI 1 Urological 13 Grand Total 24	Director of Planned Care and Deputy Chief Operating Officer
Patient discharge summaries sent to GP within 24 hours **Standard: R<75% A75-87% G>=88%**		Changes made to inclusion criteria. We now reporting % discharged with 24 hours as opposed to % discharged within one working day. QI project underway in a specific area to try to address the underlying issues.	Medical Director

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Stroke Care: Percentage of patients Receiving Brain Imaging Within 1 Hour **Standard: R<45% A45-49% G>=50%**		34.5% of patients scanned within one hour within February, compared with a revised 39% position for January 2019. The majority of breaches, when analysed, show that there was either no Stroke Specialist Nurse (SSP) in the dept (due to leave or after shift end) or the SSP was not alerted to the stroke patient in ED in a timely manner to prevent the breach. The service have, via Emergency are Delivery Group, presented data on breach analysis for this metric within ED by time of day admitted and compared with surges in ED attendances. Additionally, a data analysis has been completed to review whether patients are being delayed after scan has been requested to actual time into scanner in Radiology. Results of the data analysis demonstrate that breaches occur later in the evening just as surge begins at 6pm. There is no delay once the request has been made for the scan, therefore focussed recovery attention will be on time between initial triage and scan request being made. To that end, the service have had funding granted (0.6 WTE) to create an additional 1 WTE Stroke Specialist Nurse role (currently out to advert March 2019) with the opportunity to appoint to a second Stroke Specialist Nurse on the day if more than one candidate is appointable. This will take the team from 3 WTE to 5 WTE and will support a seven day rota until 10pm with the aim to get to a 24/7 rota by the end of the year, if a sixth SSP can be recruited. They will be based predominantly in the Emergency Dept., to directly take pre-alerts from SWAST and to then support earlier pick up and patient management.	Director of Unscheduled Care and Deputy Chief Operating Officer

Gloucestershire Hospitals
NHS Foundation Trust

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

Report Title
Learning from Deaths Quarterly Report
Sponsor and Author(s)
Author: Prof Mark Pietroni, Interim Medical Director Sponsor: Prof Mark Pietroni, Interim Medical Director

Executive Summary

Purpose

To comply with National Guidance on Learning from Deaths – a quarterly update should be presented to the open session of the Board. Following review by the Quality & Performance Committee, the attached report will go to the April Trust Main Board.

Key issues to note

- All deaths in the Trust are reviewed by the Bereavement Team and Trust Medical Examiners.
- Detailed mortality reviews are triggered by the Bereavement Team using the Datix system.
- Unless defined by another process, all mortality reviews now are undertaken using the Structured Judgment Review process (SJR).
- The SJR process has been rolled out and embedded across all Divisions.
- Learning themes from problems in care is being driven through the Hospital Mortality Group.
- Thematic learning from problems in care and excellence is beginning to emerge.
- Aligning learning to improvement programmes is becoming more systematic although a consistent approach to achieving this for excellent care is not yet established.
- Family involvement at the Hospital Mortality Group is being progressed at pace.
- The rate of identifying problems in care contributing to death remains low (1.6% of reviews)

Conclusions

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

Implications and Future Action Required

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

Recommendations

Main Board is asked to note the fifth Learning from Deaths Quarterly Report.

Impact Upon Strategic Objectives
This work links directly to our Trust objectives for our patients to be safe in our care and to be treated with care and compassion
Impact Upon Corporate Risks
None
Regulatory and/or Legal Implications
National requirement to report to Trust Board.
Equality & Patient Impact
None

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

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

Outcome of discussion when presented to previous Committees/TLT
Confirmation of letters sent to families where a Structured Judgement Review was conducted following a death, to be included in future Learning from Deaths reports.

TRUST BOARD – APRIL 2019

LEARNING FROM DEATHS QUARTERLY REPORT

1. Aim

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

1.2 The period covered is that to the end of Q3 2018/19.

2. Executive Summary

2.1 100% of deaths in the Trust have a high level review by the Trust Bereavement Team and the Trust Medical Examiners.

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

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

2.4 The feedback is overwhelmingly positive and is routinely shared with the relevant ward area. Areas for improvement reflect the general pressure on staff.

2.5 Themes are now emerging of areas for improvement (Appendix IV) on our response to the deteriorating patient, communication between teams, the importance of early senior review and the importance of ensuring the completion of robust documentation.

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

2.7 Further work is ongoing to draw out learning themes from death reviews across all Divisions, with the Divisional Representatives on the Hospital Mortality Group now bringing to the group the top three themes to emerge from deaths reviews to each monthly meeting.

2.8 It is intended to separate the Hospital Morality group into two sections in preparation for the attendance of two family representatives at the meeting. It is also under discussion to set up a separate family represented reference group.

2.9 Family attendance at a surgical multidisciplinary group is being planned with the intention of rolling this approach out to other Divisions.

3. Mortality Review Process

3.1 The input of the Bereavement Team continues to add huge value to our process which has now managed to ensure all deaths are recorded in real time. All family feedback is relayed to the wards (positive and negative), the many positive comments of which the ward teams find motivating.

3.3 Specialities review deaths through their M&M process and a standardised approach to this has been rolled out through all Divisions. Areas of note or concern, as a result of the M&M review of deaths, are brought to the Hospital Mortality Group on a monthly basis via the Divisional representative.

3.4 The SJR approach is now embedded within all divisions as evidenced by the significant increase in the last quarter of the number of SJRs completed vs total number of deaths (up from 17.7% to 26% from the previous quarter). All SJRs are reported on Datix which captures an overall assessment of care together with any associated learning points.

3.5 The establishment of a structured approach to using this feedback, both for any poor or excellent care identified, is under discussion at the Hospital Mortality Group.

3.6 Three news doctors from across Specialities have been appointed into the role of medical examiners.

3.7 Further detail of the LeDeR mortality review process together with some case histories can be seen in Appendix VI.

4. Family Involvement

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

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

4.3 As stated in 3.1, family feedback is fed back to the wards. In addition, Surgical Division MDT is meeting with a family to narrate the experience of the care of their relative and explore approaches to improving this.

4.4 It is also planned to invite a family / lay representative to join the Hospital Mortality Group to provide further valuable input into the improvement of current approaches. Significant progress has been made towards this with the inclusion

4.5 Apart from direct feedback to clinical areas, however, we have not yet identified a consistent approach to using the family feedback to drive change.

5. Learning from Deaths

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

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

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

5.4 Themes and learning points now routinely emerge via any SJRs reported on Datix, and areas of poor care identified are reviewed together with areas of excellent care.

5.5 The establishment of a structured approach to using this feedback, both for any poor or excellent care identified, is being progressed through the Hospital Mortality Group.

5.6 In addition to the learning themes from deaths reviews being brought to the Hospital Mortality group on a monthly basis, the Hospital Mortality Group will also assure oversight of these themes as they are passed on to the relevant committee for progression.

5.7 Over the third quarter, the main themes of learning are our response to the deteriorating patient, communication between teams, the importance of early senior review and the importance of ensuring the completion of robust documentation.

5.8 Conversely, the main themes emerging around reported excellent care are early recognition that the patient is in the terminal phase of life, prompt assessment and management together with good communication with the family at all stages.

6. Learning with Partners

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

6.2 We are active members of the Countywide Mortality Group. In addition, we review our mortality data with colleagues in the CCG at the Quality Contract Review Group.

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

7. Mortality Dashboard (Appendices)

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

a) The total number of deaths in the quarter

b) The most recent mortality indicators

c) The number of deaths having a high level review

d) The number of deaths where problems in care contribute significantly (a score of < 3 in SJR)

e) The number of deaths investigated under the Serious Incident approach

f) Themes and issues identified

g) Any changes that have resulted.

8. Conclusions

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

8.2 New Medical Examiners have added breadth and stability to the ME team

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

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

9. Recommendations

9.1 The Quality & Performance Committee is asked to note the fifth Learning from Deaths Quarterly Report and approve in advance of it going to the Trust Main Board in April.

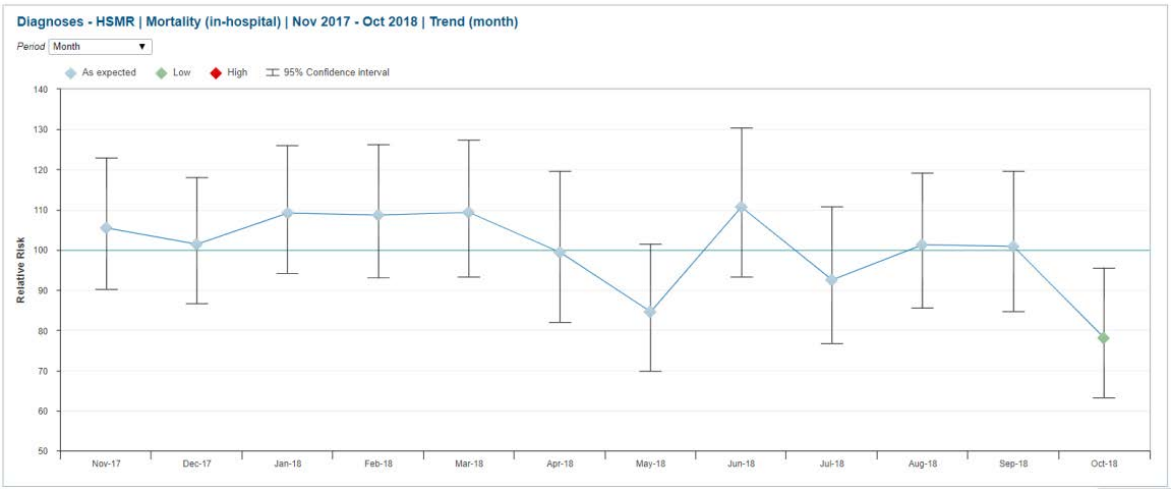
Prof Mark Pietroni
Interim Medical Director

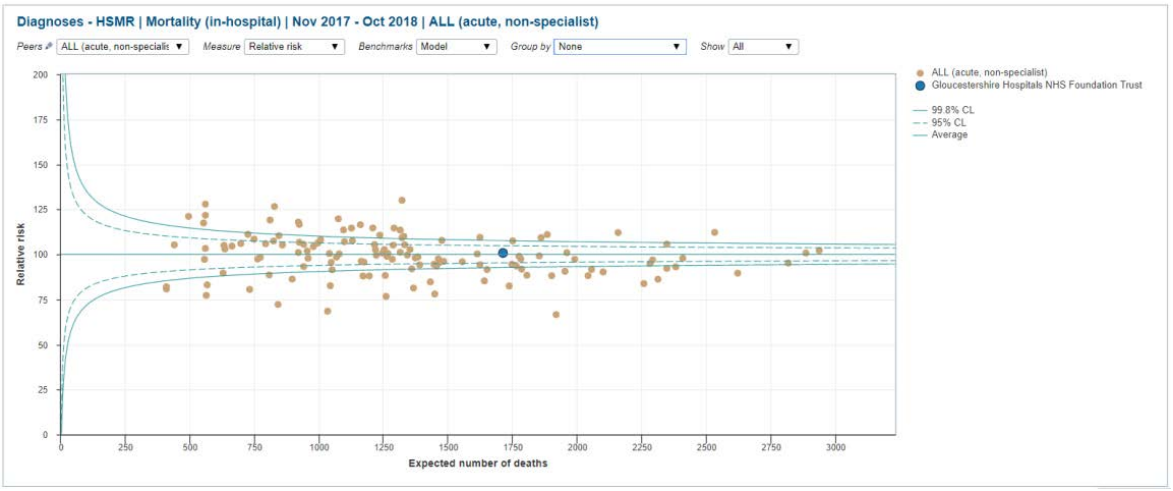
APPENDIX I – HSMR DETAILS

HSMR Dashboard 2017/18/19			
	Deaths	Bereavement	ME Review
Q4 17/18	651	651	651
Q1 18/19	460	460	460
Q2 18/19	463	463	463
Q3 18/19	475	475	475

HSMR Graph

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



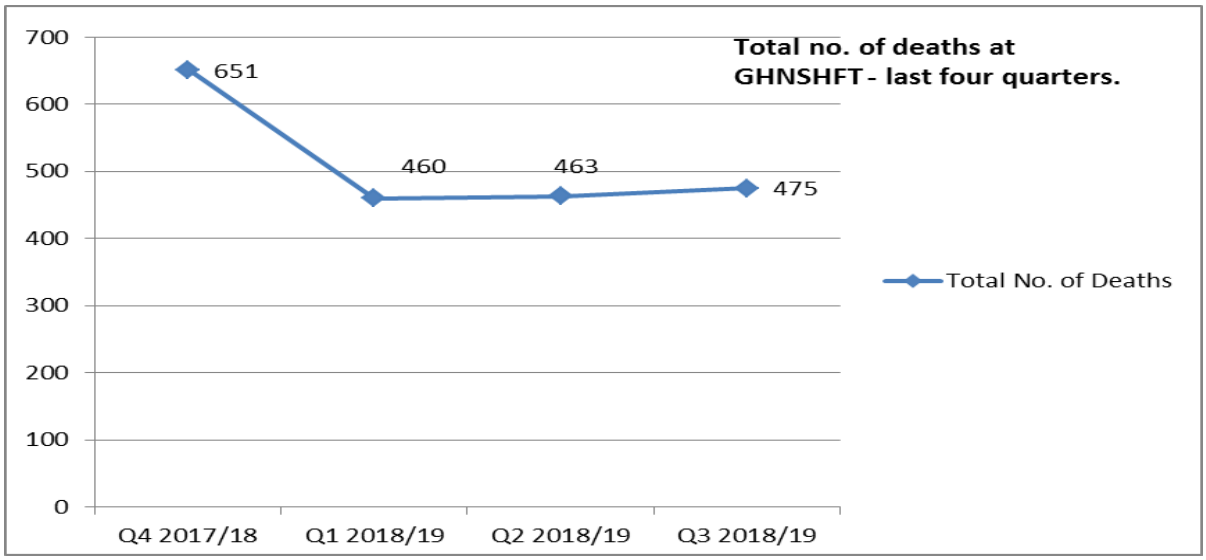


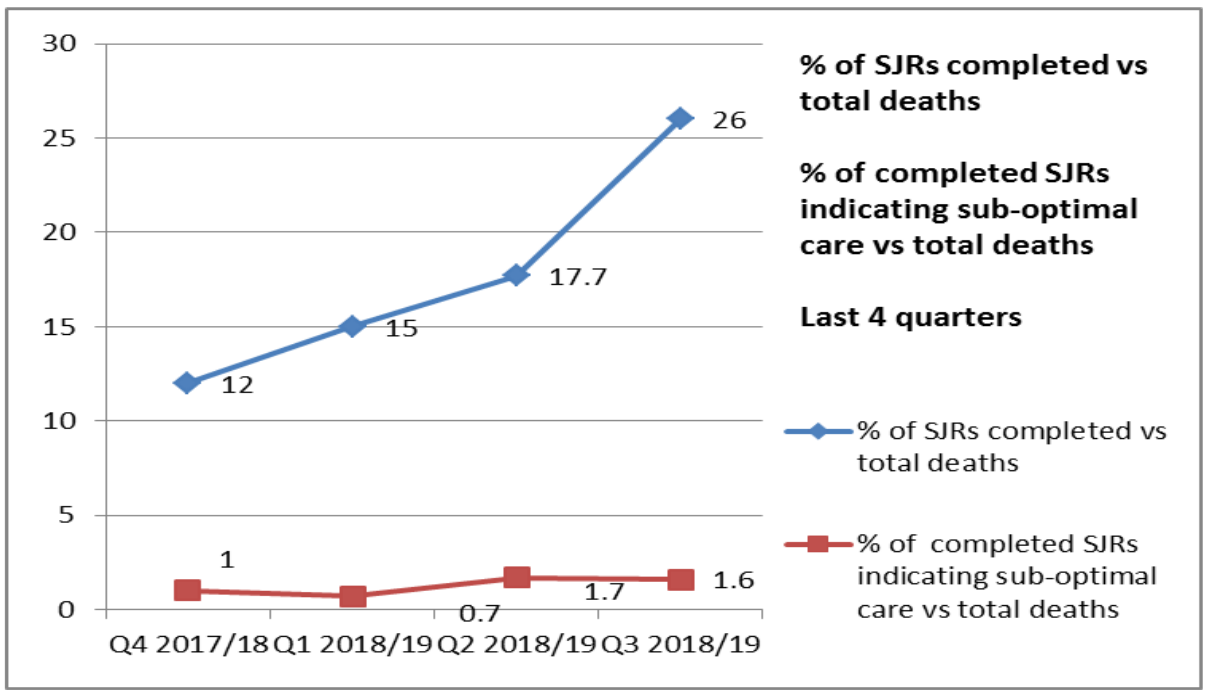
APPENDIX II - OVERVIEW

Overview

- **Total number of deaths = 475 across all divisions**
- **Total number of SJRs completed * = 124**
- **Of which**
  - **8 indicated sub-optimal care**
  - **13 indicated excellent care across all areas**

**Due to the length of time taken to conduct an SJR (approx. 3 months), the SJRs may have been initiated in the previous quarter and may not correlate entirely with the number of deaths in the quarter being reported on.*





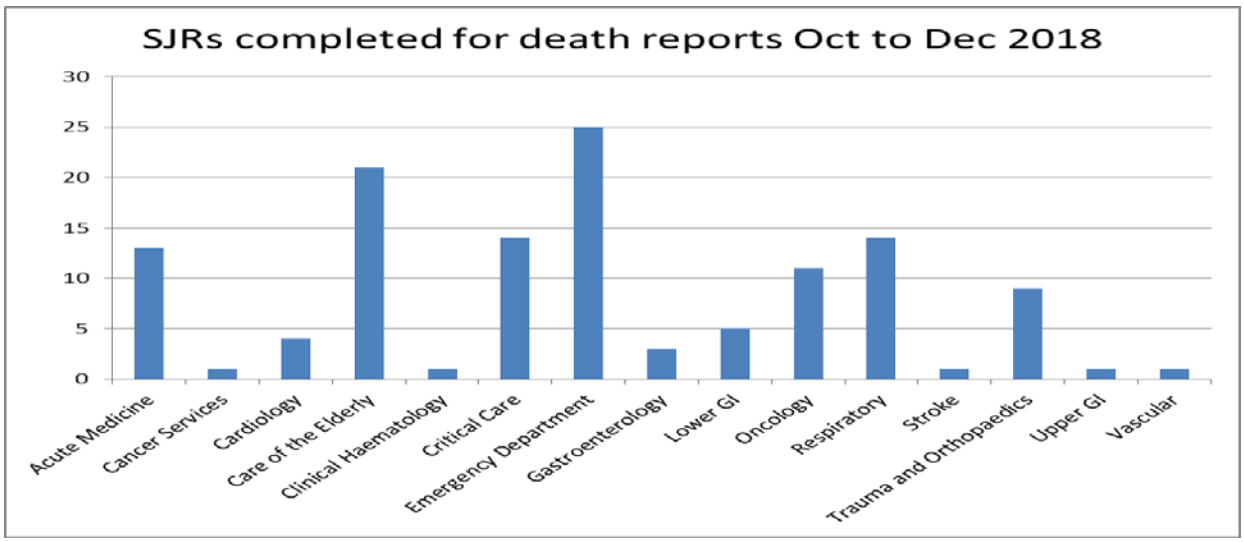
Learning from Deaths

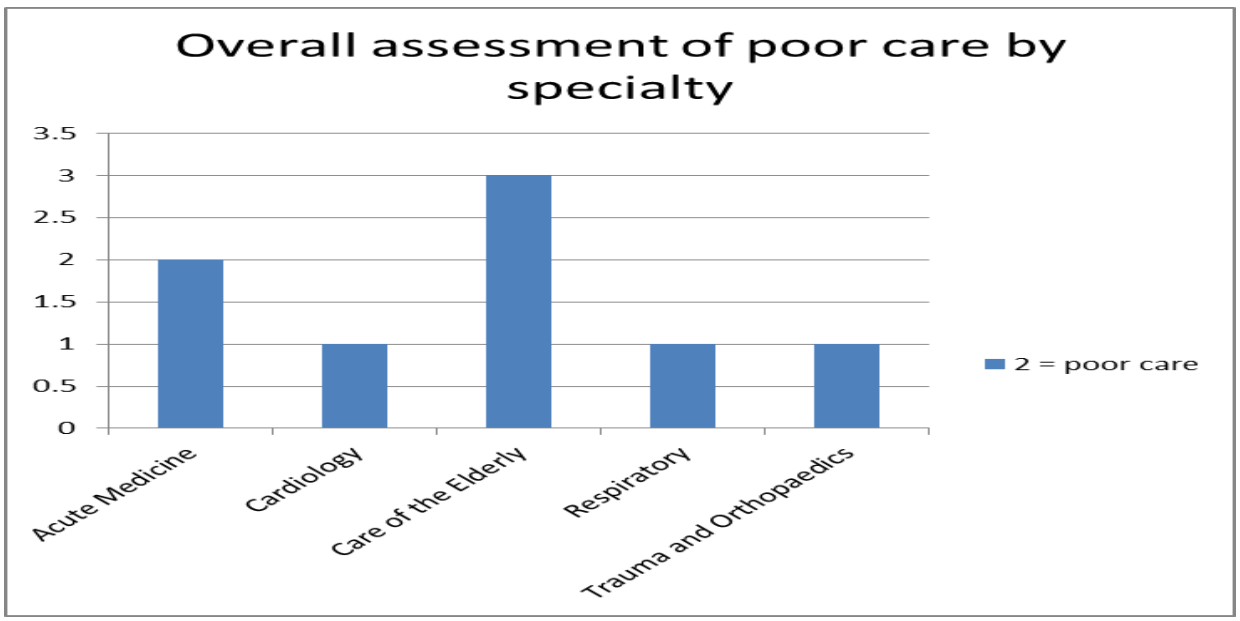
Quarter 3 (October to December 2018)

Overview continued

Division	Deaths	ME +/- bereavement review	SJRs completed (or national)	Rating of poor or very poor care	DoC or SI reviews of deaths	Rating of excellent care
Surgery	76	76	30	1	0	7
Medicine	367	367	81	7	0	5
D&S	31	31	13	0	0	0
W&C	1	1	0	0	0	0
Total (%)	**475**	**475 (100%)**	**124 (26%)**	**8 (1.6%)**	**0***	**13 (2.7%)**

**Number of Duty of Candour or SI reviews resulting from in-hospital deaths.*

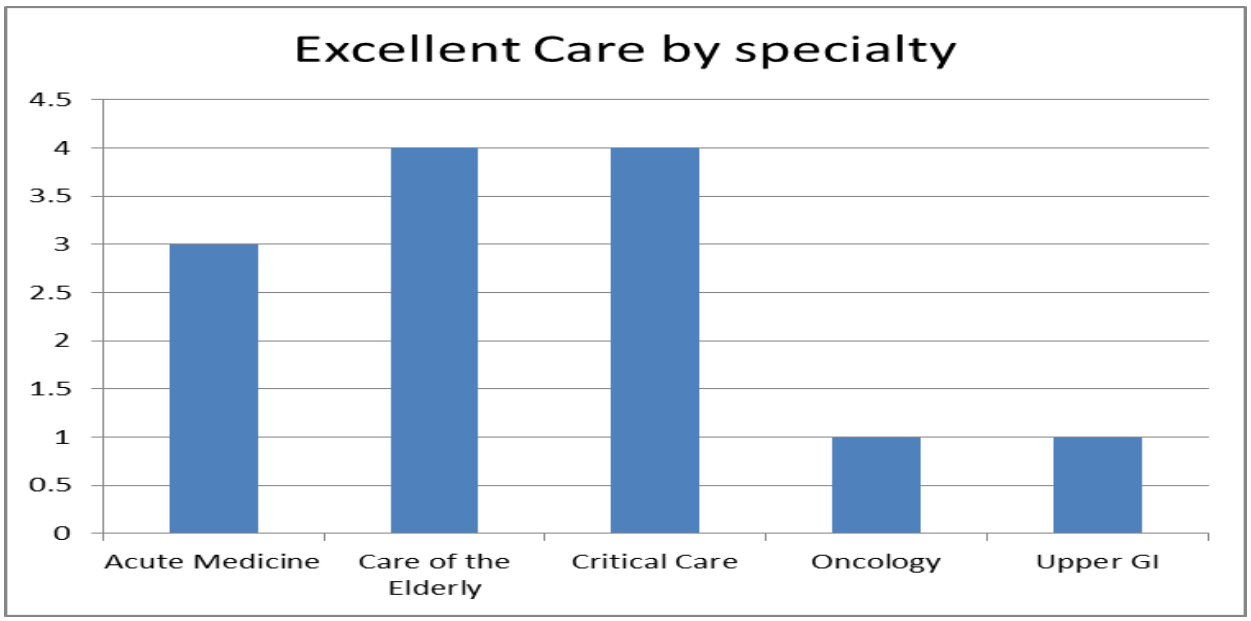




Learning from Deaths

Quarter 3 (October to December 2018)

Overview continued



Deaths by Special Type – Q2	
Type	***Number***
LeDeR	5 **
Paediatrics	1
Coroner Inquests	1 *
SI	1

***Number of Coroner Inquests resulting from an SI.**
****Additional LeDeR analysis provided in Appendix VI - Learning Disabilities Mortality Review (LeDeR) Programme.**

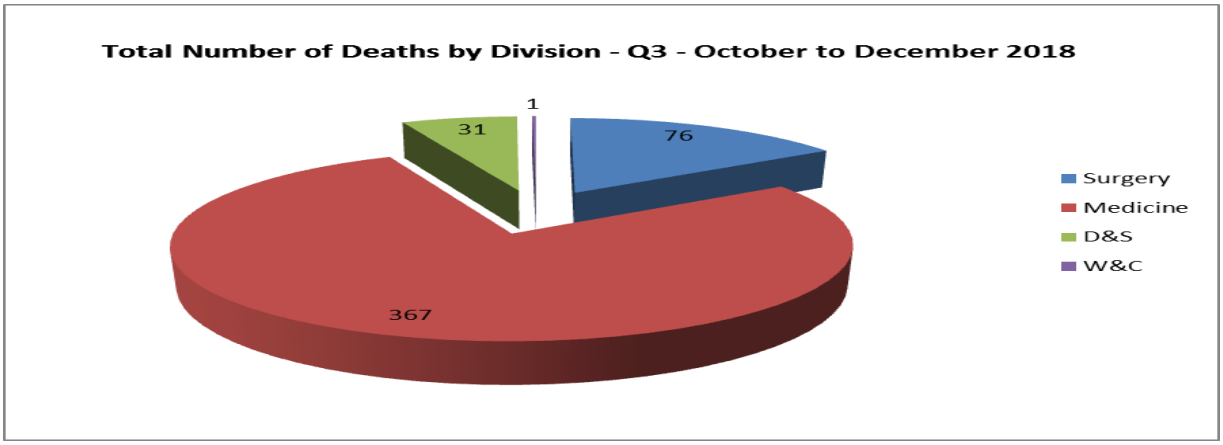
Learning from Deaths

Quarter 3 (October to December 2018)

Overview continued

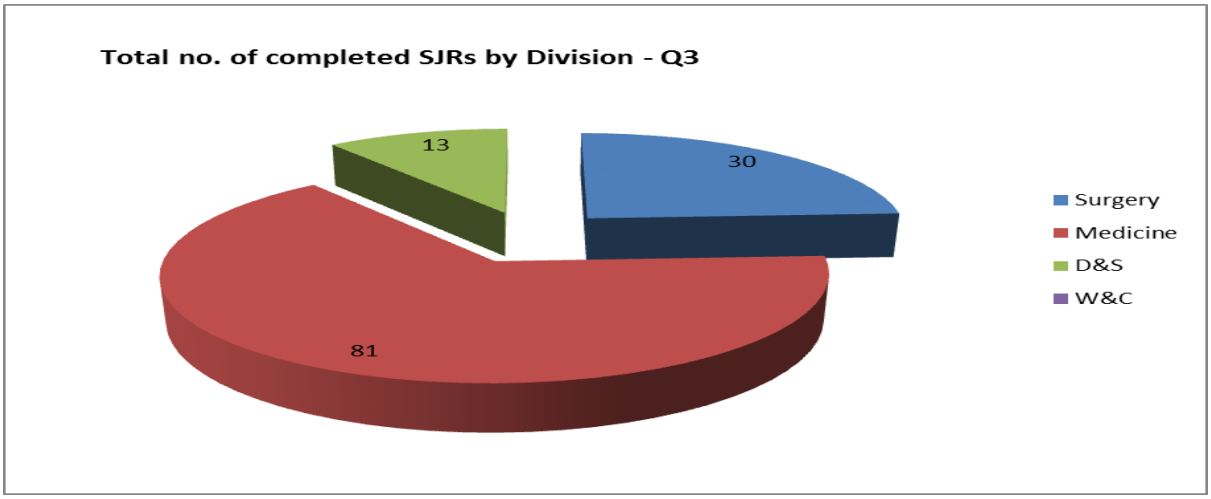
Total number of deaths at GHNHSFT = 475

DEATHS BY DIVISION (Q3: Oct - Dec 2018)			
Surgery	**Medicine**	**D&S**	**W&C**
76	**367**	**31**	**1**



Total number of SJRs completed = 124

COMPLETED SJRs BY DIVISION (Q3: Oct - Dec 2018)			
Surgery	**Medicine**	**D&S**	**W&C**
30	**81**	**13**	**0**



APPENDIX III – DIVISIONAL DETAIL

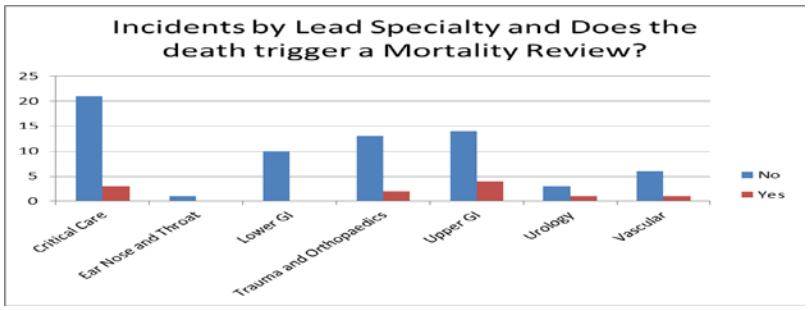
Learning from Deaths

Quarter 3 (October to December 2018)

Surgical Division

Total number of deaths = 76
Number of completed SJRs = 30
Number of SJRs indicating sub-optimal care = 1
Number of SJRs indicating excellent care = 7

		2018/19			
Division at Death	**Specialty at Death**	**Oct**	**Nov**	**Dec**	**Q3 total**
Surgical	Colorectal surgery	0	0	0	**0**
	Critical care medicine	10	6	9	**25**
	ENT	1	0	0	**1**
	General surgery	8	6	10	**24**
	Maxillo Facial Surgery	0	0	0	**0**
	Oral surgery	0	0	0	**0**
	Pain Management	0	0	0	**0**
	Trauma and Orthopaedics	5	5	3	**13**
	Upper gastrointestinal surgery	0	1	2	**3**
	Urology	0	1	2	**3**
	Vascular surgery	3	2	2	**7**
	Division total	**27**	**21**	**28**	**76**



Number of SJRs by Speciality

Speciality	*No. of SJRs conducted*	*No. of SJRs indicating sub-optimal care*	*No. of SJRs indicating excellent care*
Critical Care	**14**	**0**	**4**
Lower GI	**5**	**0**	**0**
T&O	**9**	**1**	**0**
Upper GI	**1**	**0**	**1**
Vascular	**1**	**0**	**0**

TOTAL = 30

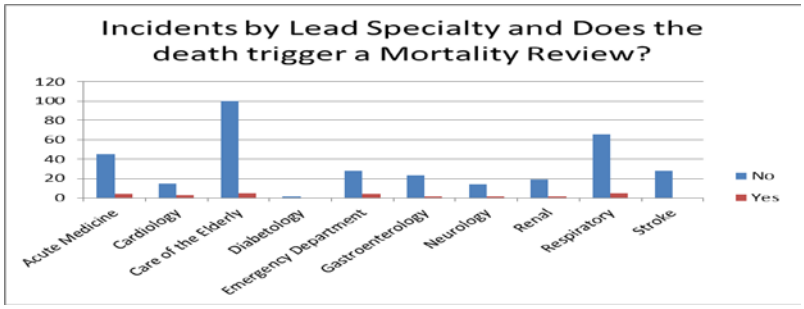
Learning from Deaths

Quarter 3 (October to December 2018)

Medical Division

Total number of deaths = 367
Number of completed SJRs = 81
Number of SJRs indicating sub-optimal care = 7
Number of SJRs indicating excellent care = 5

		2018/19			
Division at Death	**Specialty at Death**	**Oct**	**Nov**	**Dec**	**Q3 total**
Medical	**Accident and Emergency**	0	2	0	**2**
	Cardiology	6	9	5	**20**
	Diabetic medicine	0	0	0	**0**
	Emergency Medicine	10	8	12	**30**
	Endocrinology	1	3	2	**6**
	Gastroenterology	12	9	3	**24**
	General medicine	23	35	31	**89**
	Geriatric medicine	38	45	34	**117**
	Nephrology	3	2	2	**7**
	Neurology	2	1	2	**5**
	Respiratory medicine	24	20	23	**67**
	Respiratory physiology	0	0	0	**0**
	Division total	**119**	**134**	**114**	**367**



Number of SJRs by Speciality

Speciality	*No. of SJRs conducted*	*No. of SJRs indicating sub-optimal care*	*No. of SJRs indicating excellent care*
Acute Medicine	**13**	**2**	**3**
Cardiology	**4**	**1**	**0**
Care of the Elderly	**21**	**3**	**4**
Emergency	**25**	**0**	**0**
Gastroenterology	**3**	**0**	**0**
Respiratory	**14**	**1**	**0**
Stroke	**1**	**0**	**0**

TOTAL = 81

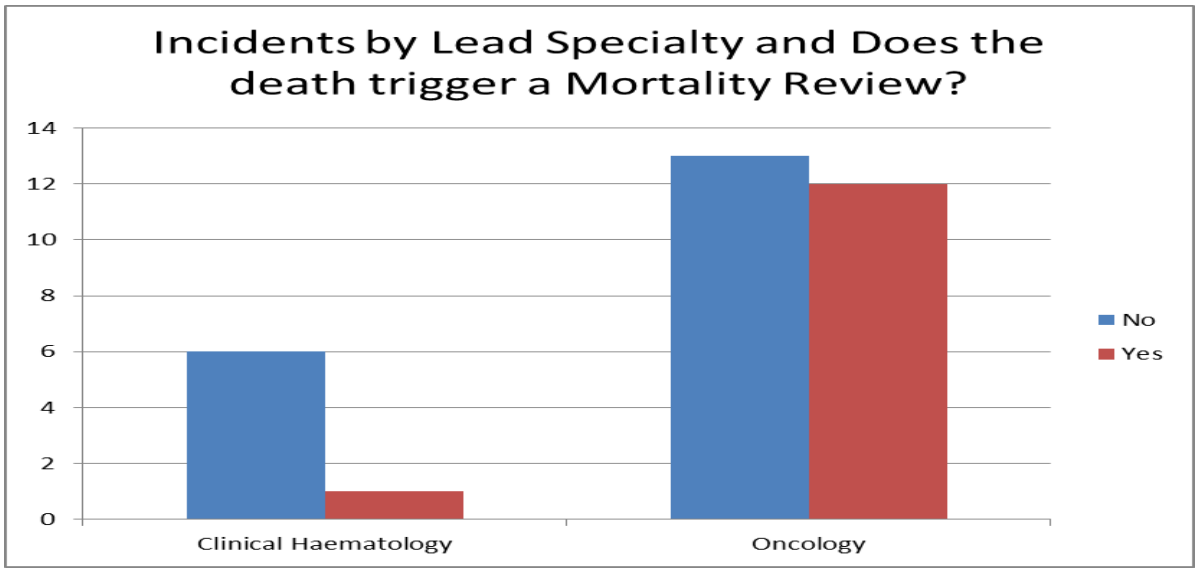
Learning from Deaths

Quarter 3 (October to December 2018)

D&S Division

Total number of deaths = 31
Total number of completed SJRs = 13
Number of SJRs indicating sub-optimal care = 0
Number of SJRs indicating excellent care = 0

Division at Death	Specialty at Death	Oct	Nov	Dec	Q3 total
Diagnostic & Specialist	Clinical haematology	1	3	4	8
	Medical oncology	8	7	8	23
	Division total	9	10	12	31



Number of SJRs by Speciality

Total number of completed SJRs = 0, broken down by Speciality			
Speciality	*No. of SJRs conducted*	*No. of SJRs indicating sub-optimal care*	*No. of SJRs indicating excellent care*
Oncology	**12**	**0**	**1**
Clinical Haematology	**1**	**0**	**0**

TOTAL = 13

Learning from Deaths

Quarter 3 (October to December 2018)

W&C Division

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

Women & Children	**Gynaecological oncology**	0	0	0	**0**
	Gynaecology	0	0	0	**0**
	Neonatology	0	0	1	**1**
	Obstetrics	0	0	0	**0**
	Paediatrics	0	0	0	**0**
	Well babies	0	0	0	**0**
	Division total	**0**	**0**	**1**	**1**

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

APPENDIX IV – LEARNING THEMES AND ACTIONS

Learning from Deaths

Quarter 3 (October to December 2018)

Data taken from Datix

IDENTIFIED POOR CARE		ACTIONS/OBSERVATIONS
1.	**Acute Medicine -** In hospital death. Admitted with w BP, Diarrhoea. Recent upper GI bleed, bowel perforation.	This is based on the missed perforation in ED and also the 5hr delay between plain films and definitive imaging. Perforation was not an overtly apparent diagnosis, but I think there is enough available information to have it as an important differential diagnosis. The only available notes are on EPR and despite pulling the hospital records I cannot find inpatient notes. I do not know whether this patient was considered to be a surgical candidate, but a 9 hour delay in diagnosis is significant. High index of suspicion in elderly abdominal pain.
2.	**Acute Medicine -** In hospital death. Admitted with SOB, angina and anaemia.	Delay in cardio review Inappropriate level of monitoring Delayed review of cardiac patient - working group set up No UP form filled or discussed - ongoing education in dept No VTE prescribed - consultants reminded... No cardiac monitoring - we are getting a proforma for this
3.	**Cardiology -** Complex congenital heart disease patient admitted 24/03/18 with abdo pain & distension, peripheral oedema & SOB. Managed on AMU for a week prior to being referred to cardiology. Seen for the first time by cardiology on 30/03/18. Requested by cardiology consultant to inform her parent consultant of admission and for him to review her, in spite of this, he was not aware of her admission until she was in extremis on the day of her death.	Patients with complex cardiological problems should be promptly referred to cardiology team for their expert care and management.
4.	**Care of the Elderly -** In hospital death Admitted with confusion and agitation. Previous admission for chest infection, deteriorated	A review of the discharge summary from previous admission would have revealed that the patient did not have stridor of discharge despite having known vocal cord paralysis and this may have prompted more aggressive treatment and involvement of ENT.

IDENTIFIED POOR CARE		ACTIONS/OBSERVATIONS
5.	**Care of the Elderly -** In hospital death. Admitted with pyrexia, increased confusion - getting worse in last 24 hrs. Rash on right thigh - cellulitis - resolved during admission.	Poor care. As mentioned before, primarily F1 level medical input without escalation to seniors. No consistent consultant input. Notes difficult to follow and lack clarity. Variable discussion with family with reliance on on-call team to update. Holistic approach not evident until late in admission. Importance of holistic approach to complex elderly patients. Family communication is vital.
6.	**Care of the Elderly -** In hospital death Fall backwards onto steps admitted with lower back pain and low sats. Known COPD	Medical team need to be aware of Pt's admitted with T2RF - 12 hours is too long for a second review
7.	**Respiratory** - In hospital death. Recent discharge from GRH, treated for community acquired pneumonia. Breathless recurred and treated in hospital for hospital acquired pneumonia. Background of COPD, Rheumatoid arthritis. Fluid overloaded with hyponatraemia. Bowel dilatation developed and patient developed hypercapnic respiratory failure. Brief period of non-invasive ventilation but deteriorated and died.	- NIV initiation to be discussed with respiratory consultants - NIV to only be delivered by adequately trained staff in respiratory high-acuity bay (if at GRH)
8.	**T&O -** In hospital death. Admitted following a fall 2 week ago, cracked right hip	Delay in getting adequate pain control Complete lack of clinical reviews over weekend initially in a patient with pneumonia on IV antibiotics, then pre-operative, then end of life. Poor documentation of management of femoral catheter - risk of infection/adverse reaction Missing notes but also lack of documentation regarding deterioration. Patients should receive appropriate weekend reviews Adequate pain control is a priority Nursing staff should be advised on how to manage (and document care of) interventions such as femoral catheters

SUMMARY OF THEMES / LEARNING POINTS	
1.	Recognising the possible negative effect on possible outcome of: ➢ Loss of notes

	➢ Inadequate documentation ➢ Delayed referral to other Specialties ➢ Delayed reviews or inadequate reviews at weekends.
2.	Failure to review DS from previous admission which might have led to more aggressive treatment.
3.	Importance of holistic approach to complex elderly patients.
4.	NIV to only be delivered by adequately trained staff in respiratory high-acuity bay (if at GRH).
5.	Nursing staff should be advised on how to manage (and document care of) interventions such as femoral catheters.

APPENDIX IV – LEARNING THEMES AND ACTIONS

Learning from Deaths

Quarter 3 (October to December 2018)

IDENTIFIED EXCELLENT CARE		ACTIONS/OBSERVATIONS
1.	**Acute Medicine** - In hospital death. Admitted with d&v - gp referral	UP form filled out on admission after discussion with both patient and NoK. Early prescription of symptomatic medications and given in line with pall care wishes.
2.	**Acute Medicine** - In hospital death. Admitted with seizures found unresponsive at nursing home	Good outcome following early implementation of shared care plan in frail terminal patient
3.	**Acute Medicine** - In hospital death. Admitted with abdo distension, vomiting and diarrhoea.	UP form filled out appropriately.
4.	**Care of the Elderly** - In hospital death Episode of haematemesis, ? duodenal obstruction. Deterioration and EOL.	Medical team appropriately decided to withdraw active treatment within 36 hours of admission in view of patient's dementia, frailty and fitness for surgery. Thorough discussion with family prior to withdrawal of treatment.
5.	**Care of the Elderly** - In hospital death. Unwell. Known terminal CA lung with brain met's, now admitted with confusion and falls, for palliation	Excellent palliative care provided. Patient family were full of praise for the care he received.
6	**Care of the Elderly** - In hospital death. Admitted with confusion and requiring palliative care after family not coping at home, known oesophageal CA. Deterioration and EOL	Team recognised soon after admission that the patient was in the terminal phase of life and provided outstanding palliative care.
7.	**Care of the Elderly** - In Hospital Death. Admitted into hospital unwell with possible chest infection/sepsis. Expected death.	Overall good end of life care. No anticipatory medication used by always documented in notes that patient was comfortable. Admitted unwell with GCS of 4 and poor pre morbid state.
8.	**Critical Care**- In hospital death. Admitted with cardiac arrest and signs of sepsis.	Patient's relatives expressed their gratitude for the efforts made by all departments to preserve patient's life. Good communication with them at all stages seems to have been an important part of the overall excellent care.
9.	**Critical Care** - 52 F. Admitted 17/08 with epigastric pain. Known to gastroenterology- Dx gastroduodenitis OGD 18/08-haemorrhagic gastritis and erosive duodenitis On ward NEWS 0-1 from 15:35 on 18/08 until 22:55 on 19/08.Total of 130mg oramorph in 24	In situations where large doses of strong analgesics are being used consider further patient review, examination and investigation

IDENTIFIED EXCELLENT CARE		ACTIONS/OBSERVATIONS
	hours from 19/08 (90mg in previous 24 hours) NEWS 4 at 03:45 20/08/18. ABG-@ 05:45- pH 7.08 and lactate 10.1. Surgical review@ 06:40 Theatre (no CT due to clinical signs)-08:40 Bowel ischaemia whole small bowel, necrotic R colon, proximal stomach necrotic-RIP 13:00 20/08/18	
10.	**Critical Care** - In hospital death Admitted with OOH cardiac arrest. Recent admission for cellulitis/exemia. PMH Alcohol excess (no fixed abode at time of admission)	Nil significant learning
11.	**Critical Care** - In hospital death. Admitted with abdo pain and reduced urine output. Hartman's procedure 5/5/2018.	Prompt assessment and management from the initial presentation until patient's unfortunate death on the Intensive care Unit. Despite prompt and appropriate interventions, some patients will nonetheless not survive an acute severe insult.
12.	**Oncology** - In hospital death GP ref. Chest pain and fatigue, recent new diagnosis of CA with mets ?primary.	Regular discussions with family throughout - especially if complex medical problems as in this case.
13.	**Upper GI** - In hospital death. Admitted with abdo pain, ? sepsis.	Exceptional management of this ladies end of life care.

SUMMARY OF THEMES	
1.	Early prescription of symptomatic medications and given in line with palliative care wishes.
2.	Early implementation of shared care plan in frail terminal patient
3.	UP form filled out appropriately.
4.	Early recognition that the patient was in the terminal phase of life.
5.	No anticipatory medication used but always documented in notes that patient was comfortable.
6.	Good communication with family at all stages.
7.	Learning point - In situations where large doses of strong analgesics are being used consider further patient review, examination and investigation
8.	Prompt assessment and management.

APPENDIX V – ADDITIONAL DETAIL

Learning from Deaths

Quarter 3 (October to December 2018)

Categories of Care which Trigged a Structured Judgement Review

TRIGGER	No.	%
Deaths within 24hrs of admission	5	8
Concern raised by family	11	17
Concern raised by healthcare staff	12	19
Deaths following readmission (within 72hrs)	7	11
Deaths following elective admission	3	5
Deaths taking place during or shortly after a procedure	2	3
Patients with a Learning Disability	6	9
Safeguarding concerns	1	2
Systemic Anti-Cancer Treatment (SACT) in last 30 day - (Specialty Trigger)	10	16
DCC Specialty Trigger	4	6
Other Trigger	3	5

Learning from Deaths

Quarter 3 (October to December 2018)

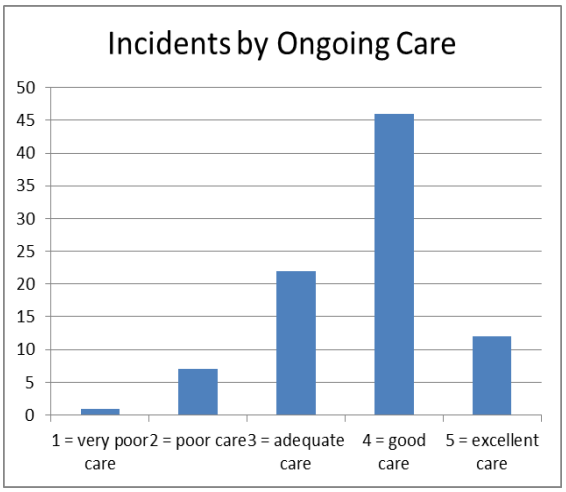
Location at Time of Death

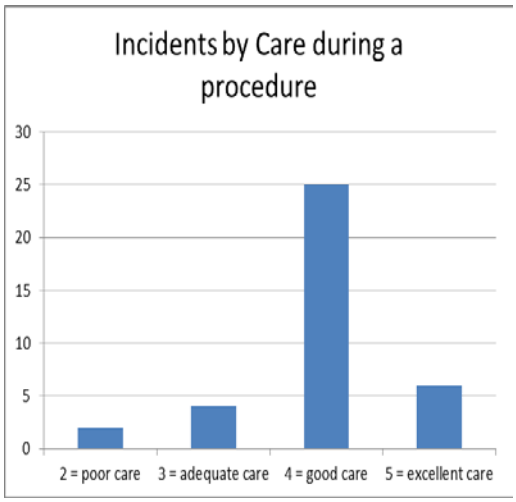
LOCATION	No.
8b Respiratory	37
Emergency Department	35
4b COTE	29
Avening Respiratory	28
6b stroke	22
9b COTE (pre change Nov 18)	20
Ryeworth Ward	20
Woodmancote COTE	20
ACUA / AMU	19
Critical Care CGH	16
Rendcomb Oncology	16
7a Gastro (pre change Nov 18)	15
8a Neuro	15
Lilleybrook Oncology	14
Cardiology Ward, GRH	13
Guiting Vascular	12
3b Trauma	10
5a / SAU	10
Snowshill Ward (Gastro)	10
3a Trauma	9
4a COTE	9
5b Upper & Lower GI	9
7b Renal	9
Critical Care GRH	9
4a Acute Medicine / Endocrine (pre change Nov 18)	7
6a Stroke	7
9b Acute Medicine	7
ACUC	7
Knightsbridge Respiratory	7
7a Renal	6
Bibury Ward (Lower GI & Gen Surgery)	6
Cardiac Cardiology, CGH	5
2b Head and Neck	4
Prescott Ward (Urology & Breast)	4
Gallery Ward (MSFD), GRH	3
Gynae / General Theatres	2
2a Trauma	1
Discharge Waiting Area	1
Hartpury suite, specialist investigations	1

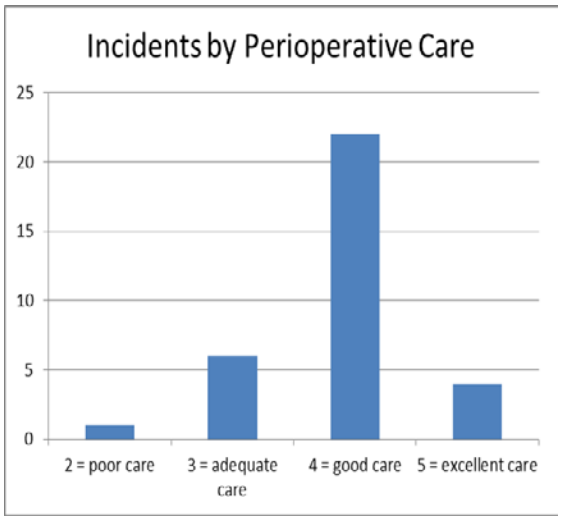
Learning from Deaths

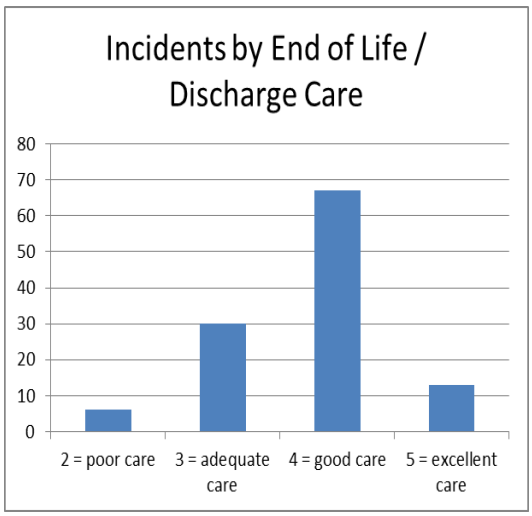
Quarter 3 (October to December 2018)

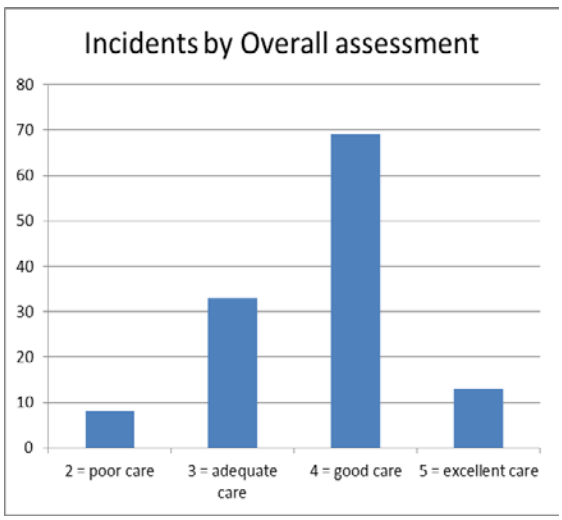
Ratings by Stage of Care











APPENDIX VI – LeDeR

- LeDeR has reported 5 in-hospital deaths for Q3 2018/19.
- The latest report states that Gloucestershire have had 101 LD deaths referred to LeDeR since 2017.
- 45 reviews have been completed with 56 open.
- 41% of people died at home and GRH being the second highest place of death with 30%.
- 65% of the deaths were males compared with a national average of 58% males.

Learning themes

- Communications and support to access primary care LD annual health checks.
- Reasonable adjustments made to access to mainstream healthy lifestyles preventative services
- Suitable reasonable adjustments being put in place in mainstream health services is inconsistent
- Utilisation and documentation of the MCA by mainstream health services is inconsistent
- Treatment escalation protocols.

LeDeR paper recently submitted to the Quality Delivery Group:

Learning Disabilities Mortality Review (LeDeR) Programme.

Background
The Learning Disabilities Mortality Review (LeDeR) Programme was established in response to the recommendations of the Confidential Inquiry into the premature deaths of people with learning disabilities (CIPOLD). It is commissioned by NHS England, managed by the Healthcare Quality Improvement Partnership (HQIP) and is delivered by the University of Bristol. It commenced in June 2015, as yet it is not clear if it will continue after May 2019 or not.

CIPOLD reported that people with learning disabilities are three times more likely (than the general population) to die from a cause of death that was amenable to good quality care.

The LeDeR Programme was set up to contribute to improvements in the quality of health and social care for people with learning disabilities in England. It does so by supporting local areas to carry out local reviews of deaths of people with learning disabilities. Through an agreed local review process, it aims to firmly embed the responsibility for conducting the reviews and implementing any recommendations and plans of action, into the hands of regional and local services.

The main purpose of the LeDeR review is to;

- Identify any potentially avoidable factors that may have contributed to the person's death.
- Develop plans of action that individually or in combination, will guide necessary changes in health and social care services in order to reduce premature deaths of people with learning disabilities.

Process
All deaths of people with Learning Disability have to be reported to LeDeR. Anyone is able to do this. If a patient with a known or suspected LD dies in GHT, the bereavement office will inform the LD Liaison Nurses who report the death to LeDeR. Reporting the death can be done as a telephone call or via the

LeDeR website through an online secure referral form. If the death meets the LeDeR criteria a reviewer is allocated to the case. The review should involve a family member or someone who knew the patient well to discuss the circumstances leading up to the patient's death. The reviewer has to extract key information from a minimum of one set of notes, this is usually determined by which professionals had the closest involvement with the patient prior to their death. From the discussion and notes the reviewer develops a timeline of the circumstances leading up to their death and a pen portrait of the person. This information is used to complete the LeDeR programme online documentation and an action plan, which is reviewed by the local area contact (Cheryl Hampson) and Local LeDeR Steering Group and as part of the National LeDeR Programme.
Depending on the reviewers' findings, it is decided if a multi-agency review is indicated to discuss the person's death and any learning points that could improve future practice.

A multi-agency review has to be done if
Care fell short of current best practice in one or more significant areas; although this is not considered to have had the potential for adverse impact on the person, some learning could result from a fuller review of the death.
Or
Care fell short of current best practice in one or more significant areas resulting in the potential for, or actual, adverse impact on the person.

The purpose of the multi-agency review is to include the views of a broader range of people and agencies who were involved in supporting the person who has died, where it is felt that further learning could be obtained from a more in-depth analysis of the circumstances leading up to the person's death.

Challenges
Not enough reviewers leading to a backlog in reviews of deaths.
Most reviewers are seconded from their employment; it can be difficult to fit reviews in with other work obligations.
In the GHT there are two reviewers.
Providing access to acute medical notes to LeDeR reviewers, this was initially done by the safeguarding team, who would order notes and then provide a room and a member of staff to be with the reviewer to help them understand the notes and answer questions, however due to their workload safeguarding will now order the notes and then the HLNLDs will support the reviewers in looking through them adding to their busy workload.

Feedback to GHT
Feedback has been via a newsletter that provides key findings from LeDeR reviews, however where GHT requires more information about the care and practices within the Trust that may have contributed to poor care or fell short of best practice, or highlights good practice; it has been agreed that Cheryl Hampson the Local Area Contact for LeDeR will meet with GHT LD Lead to discuss any acute care specific learning from cases.

Quantitative Findings
As of January 2019 Gloucestershire had received **101** LeDeR referrals of which **45** have been completed.
2017 46 referrals
2018 49 referrals
2019 6 referrals

Cause of death themes in Gloucestershire
Circulatory system (and sepsis) – 26 (sepsis is to become a category in it's own right)
Other - 26

Cause of death themes continued….
Respiratory diseases - 24
Cancers - 16
Unknown - 6
Gastrointestinal - 3

Average age of death
The average age of death is lowest in those with a severe learning disability – 49.67 in females and 55.08 in males.
Men with a mild learning disability live longer on average (69.68) than women with a mild learning disability (61.23) but this is well below the national average for men and women.

Learning into action – Some feedback from completed reviews for GHT
March 2017
70 year old male Care graded as 3- satisfactory. Areas for improvement – Wording on DNACPR could be seen as inappropriate. EOL pathway had been started later than potentially anticipated. Good practice identified – Best interest decision making, SLT input, Intensive health outreach team (IHOT) team continuing input throughout admission.

Feb 2017
64 year old female Care graded as 4 – fell short of current best practice in one or more areas. Areas for improvement – Did not have an annual health check, various appointments for mainstream services not attended or followed up, Mainstream processes in relation to following up DNA's for people with LD

Oct 2017
73 year old male Care graded as 2 – Good care. Areas for improvement – No evidence that clinicians considered the patient was nearing the end of life. Patient could have been on an EOL pathway. Best interest and IMCA decision to insert PEG. This didn't happen.

Apr 2018
63 year old male Care graded as 2 – good care. Good practice identified – GP home visits, Reasonable adjustments in hospital, PBS plans in place, hospital passport, familiar carers 1:1 support in hospital.

Mar 2018
53 year old female Care graded 3 – satisfactory. Areas for improvement – Acute nursing staff would often leave carers to undertake roles which were the responsibility of ward staff. Good practice identified – best interest decision making.

A general theme identified for GHT is the poor completion of documentation in relation to eating and drinking guidelines, food and fluid charts.
Poor uptake in hospital staff reading the hospital passports.

CF/BF.Feb 2019

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

REPORT TO TRUST BOARD – APRIL 2019

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

This report describes the business conducted at the Finance Committee held 28 March 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	Year to date position is £6.6m adverse to budget, but £0.4m favourable to the forecast position (this is a timing issue and not indicative of an improved forecast). Income settlements with commissioners have minimised the risk to income for 2018/19. Cashflow has improved due to increased borrowing and BPPC performance has improved in February.	Has anything occurred that presents material risk to the year end forecast? Does the income position address previously loss-making services – as highlighted in the drivers of the deficit analysis?	Continued pressure in non-elective and some higher than expected agency use had put some pressure on the forecast but it was expected that this would be managed within the expected envelope. A number of services remain in a deficit operating position – this will be further addressed through efficiency measures and the 2019/20 contract settlement – it will not be possible to address all of these recurrently in year	

Capital Programme Update	Confirmation that the £10m requested borrowing has been approved for action to spend in the 2019/20 financial year. Year-end forecast for capital maintained at previous levels.	Does imaging equipment constitute a particular risk? How will the options appraisal for future funding be taken forward?	The proposed managed equipment service will look to address this risk but will unlikely take effect in the coming financial year. Agreed to house the forward work in the Estates Committee.	
Cost Improvement Programme (CIP) Update	At Month 11 the trust has delivered £24.6m of CIP YTD against the YTD NHS Improvement target of £26.4m. The Month 11 position is consistent with the projection as at Month 8, therefore the FOT has been held. A gap remains in identification of 2019/20 schemes in excess of £10m.	What is being done to bridge the 2019/20 gap?	Weekly deep dives with divisions will continue, supported by additional deliver resources. The Trust continues to use Model Hospital and external benchmarking to identify further opportunities.	Further work to be done on 2019/20 – to be reported to next Committee

Financial Planning and Budget Setting	The plan presents an overall income and expenditure breakeven position, after national funding of PSF (£8.5m), FRF (£7.3m) and MRET (£4m), which is contingent on acceptance of a breakeven control total issued by NHSI. In year receipt of PSF and FRF is contingent on financial delivery on a quarterly basis. There is currently risk of non-delivery of the plan reflecting the status of CIP (£12.2m currently unidentified), and the position on income settlements with commissioners, with a gap on assumptions of between £6m and £7m.	Is there an associated cashflow?	Yes, a detailed forward cashflow accompanies the I&E plan – this will be included in the NHSI planning submission and reported to Committee next month.	
EPR Business Case and Procurement	Final Business case discussed and approved.			

Keith Norton
Chair of Finance and Digital Committee
28 March 2019

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

Report Title
Financial Performance Report – Month 11 2018/19
Sponsor and Author(s)
Author: Jonathan Shuter, Director of Operational Finance Sponsor: Sarah Stansfield, Director of Finance
Executive Summary

Purpose

To provide assurance to the Board with regard to the Group financial performance, incorporating the Trust and Gloucestershire Managed Services, for the period ended 28th February 2019.

Key issues to note

- The Group is reporting an actual income and expenditure deficit of £25.4m for the year to date at February 2019. This is an adverse variance of £6.6m to plan and £0.4m favourable to forecast.

- Key highlights of the M11 position:
  - Commissioner income is showing a favourable variance to budget of £2.9m.
  - Other NHS patient related income (including AfC funding) is £0.6m adverse to plan.
  - Private and paying patients' income is £0.5m adverse to plan.
  - Other operating income (including Hosted Services) is favourable by £0.4m.
  - Pay expenditure is showing an adverse variance of £3.3m.
  - Non-pay expenditure is showing an adverse variance of £8.3m.
  - Non-operating costs are showing a favourable variance of £2.8m.

Conclusion, Implications and Future Action Required

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

Recommendations
The Board is asked to note the contents of the report.
Impact Upon Strategic Objectives
Not applicable.
Impact Upon Corporate Risks
Not applicable.
Regulatory and/or Legal Implications
Not applicable.

Equality & Patient Impact
Not applicable.

Resource Implications				
Finance	X	Information Management & Technology		
Human Resources		Buildings		

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

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

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

Gloucestershire Hospitals NHS
NHS Foundation Trust

Report to the Trust Board

Financial Performance Report
Month Ended 28th February 2019

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Introduction and Overview

Gloucestershire Hospitals NHS
NHS Foundation Trust

In April the Board approved budget for the 2018/19 financial year was a deficit of £29.7m on a control total basis (after removing the impact of donated asset income and depreciation). The Board approved a revised control total of £18.8m (including PSF) on 12th June 2018. This has been reflected in Month 11 reporting.

The financial position as at the end of February 2019 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 February the Group's consolidated position shows a year to date deficit of £25.4m. This is £6.6m adverse against plan, and £0.4m favourable to forecast. The Group's forecast remains a deficit of £29.1m.

Statement of Comprehensive Income (Trust and GMS)

	TRUST POSITION			GMS POSITION			GROUP POSITION *		
Month 11 Cumulative Financial Position	**Budget £000s**	**Actuals £000s**	**Variance £000s**	**Budget £000s**	**Actuals £000s**	**Variance £000s**	**Budget £000s**	**Actuals £000s**	**Variance £000s**
SLA & Commissioning Income	406,585	409,527	2,942	0	0	0	406,585	409,527	2,942
PP, Overseas and RTA Income	5,232	4,745	(487)	0	0	0	5,232	4,745	(487)
Other Income from Patient Activities	4,966	4,408	(558)	0	0	0	4,966	4,408	(558)
Operating Income	62,800	62,979	179	40,756	40,827	72	66,522	66,959	437
Total Income	**479,583**	**481,659**	**2,076**	**40,756**	**40,827**	**72**	**483,305**	**485,639**	**2,334**
Pay	302,844	305,514	(2,669)	15,431	16,038	(607)	317,953	321,229	(3,276)
Non-Pay	177,140	184,719	(7,579)	23,398	23,955	(557)	163,827	172,149	(8,322)
Total Expenditure	**479,985**	**490,233**	**(10,249)**	**38,830**	**39,993**	**(1,163)**	**481,781**	**493,378**	**(11,598)**
EBITDA	**(401)**	**(8,574)**	**(8,172)**	**1,926**	**834**	**(1,092)**	**1,525**	**(7,739)**	**(9,264)**
EBITDA %age	**(0.1%)**	**(1.8%)**	**(1.7%)**	**4.7%**	**2.0%**	**(2.7%)**	**0.3%**	**(1.6%)**	**(1.9%)**
Non-Operating Costs	18,929	17,194	1,735	1,926	834	1,092	20,855	18,028	2,826
Surplus/(Deficit)	**(19,330)**	**(25,768)**	**(6,437)**	**0**	**0**	**0**	**(19,330)**	**(25,768)**	**(6,437)**
Excluding Donated Assets	549	339	(210)	0	0	0	549	339	(210)
Control Total Surplus/(Deficit)	**(18,781)**	**(25,428)**	**(6,647)**	**0**	**0**	**0**	**(18,781)**	**(25,428)**	**(6,647)**

* Group Position excludes £37.2m of intergroup transactions including dividends

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Group Statement of Comprehensive Income

Gloucestershire Hospitals NHS
NHS Foundation Trust

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

In February, the Group's consolidated position shows an in month deficit of £4.7m which is £3.7m adverse to plan.

The year to date deficit of £25.4m is an adverse variance of £6.6m against plan.

Month 11 Financial Position	Annual Budget £000s	M11 Budget £000s	M11 Actuals £000s	M11 Variance £000s	M11 Cumulative Budget £000s	M11 Cumulative Actuals £000s	M11 Cumulative Variance £000s
SLA & Commissioning Income	444,587	36,388	36,666	277	406,585	409,527	2,942
PP, Overseas and RTA Income	5,710	480	441	(39)	5,232	4,745	(487)
Other Income from Patient Activities	5,418	453	(127)	(581)	4,966	4,408	(558)
Operating Income	74,297	6,278	5,445	(833)	66,522	66,959	437
Total Income	**530,012**	**43,600**	**42,424**	**(1,176)**	**483,305**	**485,639**	**2,334**
Pay	346,478	28,770	30,418	(1,648)	317,953	321,229	(3,276)
Non-Pay	178,702	14,023	15,251	(1,228)	163,827	172,149	(8,322)
Total Expenditure	**525,180**	**42,794**	**45,669**	**(2,875)**	**481,781**	**493,378**	**(11,598)**
EBITDA	**4,832**	**806**	**(3,244)**	**(4,051)**	**1,525**	**(7,739)**	**(9,264)**
EBITDA %age	**0.9%**	**1.8%**	**(7.6%)**	**(9.5%)**	**0.3%**	**(1.6%)**	**(1.9%)**
Non-Operating Costs	22,751	1,896	1,498	398	20,855	18,028	2,826
Surplus/(Deficit)	**(17,919)**	**(1,090)**	**(4,743)**	**(3,653)**	**(19,330)**	**(25,768)**	**(6,437)**
Excluding Donated Assets	(902)	49	31	(18)	549	339	(210)
Control Total Surplus/(Deficit)	**(18,821)**	**(1,041)**	**(4,712)**	**(3,671)**	**(18,781)**	**(25,428)**	**(6,647)**

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Detailed Income & Expenditure

Gloucestershire Hospitals NHS
NHS Foundation Trust

Month 11 Financial Position	M11 Budget £000s	M11 Actuals £000s	M11 Variance £000s	M11 Cumulative Budget £000s	M11 Cumulative Actuals £000s	M11 Cumulative Variance £000s
SLA & Commissioning Income	36,388	36,666	277	406,585	409,527	2,942
PP, Overseas and RTA Income	480	441	(39)	5,232	4,745	(487)
Other Income from Patient Activities	453	(127)	(581)	4,966	4,408	(558)
Operating Income	6,278	5,445	(833)	66,522	66,959	437
Total Income	**43,600**	**42,424**	**(1,176)**	**483,305**	**485,639**	**2,334**
Pay						
Substantive	26,786	27,743	(957)	295,079	295,875	(796)
Bank	940	1,035	(95)	10,340	10,986	(646)
Agency	1,044	1,640	(596)	12,535	14,369	(1,834)
Total Pay	**28,770**	**30,418**	**(1,648)**	**317,953**	**321,229**	**(3,276)**
Non Pay						
Drugs	5,438	4,647	791	61,272	62,764	(1,492)
Clinical Supplies	3,112	3,774	(662)	35,049	36,759	(1,710)
Other Non-Pay	5,474	6,830	(1,356)	67,506	72,626	(5,120)
Total Non Pay	**14,023**	**15,251**	**(1,228)**	**163,827**	**172,149**	**(8,322)**
Total Expenditure	**42,794**	**45,669**	**(2,875)**	**481,781**	**493,378**	**(11,598)**
EBITDA	**806**	**(3,244)**	**(4,051)**	**1,525**	**(7,739)**	**(9,264)**
EBITDA %age	**1.8%**	**(7.6%)**	**(9.5%)**	**0.3%**	**(1.6%)**	**(1.9%)**
Non-Operating Costs	1,896	1,498	398	20,855	18,028	2,826
Surplus/(Deficit)	**(1,090)**	**(4,743)**	**(3,653)**	**(19,330)**	**(25,768)**	**(6,437)**
Excluding Donated Assets	49	31	(18)	549	339	(210)
Surplus/(Deficit)	**(1,041)**	**(4,712)**	**(3,671)**	**(18,781)**	**(25,428)**	**(6,647)**

Non-Pay – expenditure is showing a £8.3m overspend year to date. Of the £1.2m overspend in month, £1.4m is on Other Non-Pay which relates to unidentified CIPs (£0.6m), Outsourced Clinical Services (£0.1m) most of which is Gastro & Gynae matched by income and a stock adjustment within Surgery (£0.4m).

SLA & Commissioning Income – is £2.9m favourable against plan. This reflects over performance on commissioning contracts.

PP / Overseas / RTA Income – performance has deteriorated slightly with a £0.5m year to date adverse variance. Oncology private patients (£0.2m) and RTA cost recovery (£0.3m) make up the adverse variance.

Other Patient Income – is £0.6m adverse in month. This is reflected in the cumulative position by £0.8m in respect of the clawback of Agenda for Change funding in respect of GMS.

Other Operating Income – The £0.8m in month under performance reflects lower than planned income relating to PSF (£0.9m) offset by higher Hosted Service income which is matched by spend (£0.1m).

Pay – expenditure is showing a £3.3m overspend year to date reflecting an overspend on all staff contract categories. The in month variance of £1.6m adverse is mainly driven by a provision relating to a contingent liability (£0.5m) currently noted in the Trust's accounts, undelivered Pay CIPs (£0.9m), largely Surgery (£0.3m), Medicine (£0.2m) and Diagnostic & Specialist (£0.1m). Other significant in month overspends include qualified nursing agency in Medicine (£0.2m).

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Cost Improvement Programme

Gloucestershire Hospitals NHS
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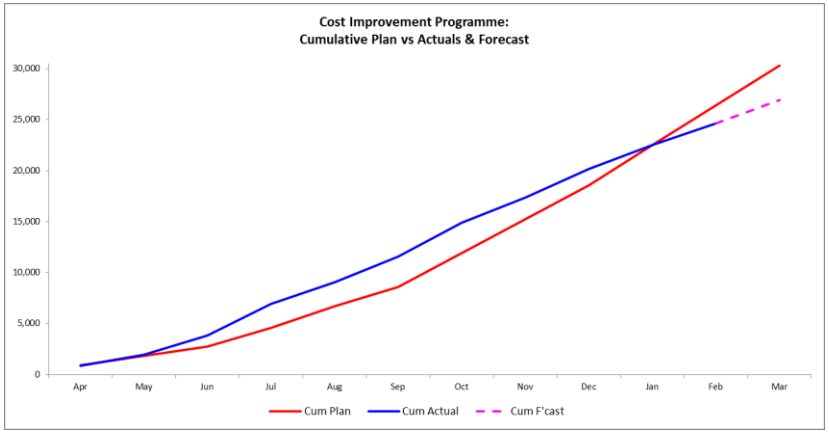
1. At Month 11 the trust has delivered £24.6m of CIP YTD against the YTD NHS Improvement target of £26.4m.
The YTD delivery splits into £19m recurrent and £5.6m of non-recurrent schemes. This translates into a split of 77% of recurrent delivery versus 23% of non-recurrent delivery.
Within the month, the Trust has delivered £2.1m of CIP against an in-month NHSI target of £3.9m.

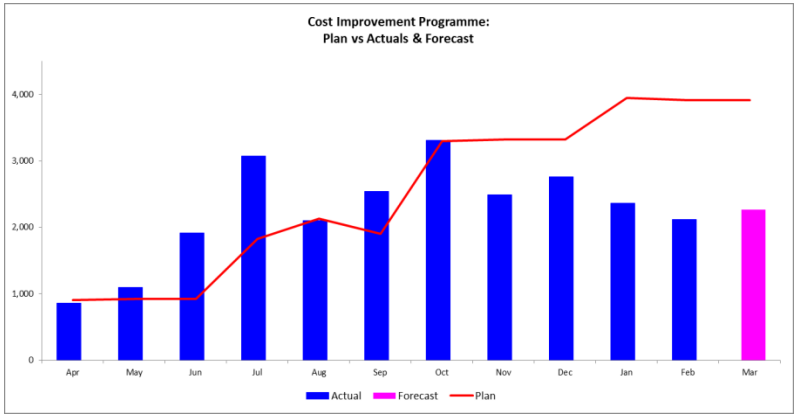
2. At Month 11, the Divisional year end forecast figures indicate delivery of £26.9m against the Trust's target of £30.3m. This is a decrease against M10 FOT of £67k. This is due to a decrease in Trauma and Orthopaedic activity due to cancelled elective work.

3. The cumulative FOT indicates that GHFT has started reporting a negative variance (see graph to the right). This is consistent with previous projections.

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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Balance Sheet (1)

Gloucestershire Hospitals NHS
NHS Foundation Trust

Trust Financial Position	Opening Balance 31st March 2018 £000	GROUP Balance as at M11 £000	B/S movements from 31st March 2018 £000
Non-Current Assests			
Intangible Assets	9,130	10,347	1,217
Property, Plant and Equipment	251,010	251,501	491
Trade and Other Receivables	4,463	4,347	(116)
Investment in GMS		0	
Total Non-Current Assets	**264,603**	**266,195**	**1,592**
Current Assets			
Inventories	7,131	7,204	73
Trade and Other Receivables	19,276	32,865	13,589
Cash and Cash Equivalents	5,447	3,002	(2,445)
Total Current Assets	**31,854**	**43,071**	**11,217**
Current Liabilities			
Trade and Other Payables	(47,510)	(58,387)	(10,877)
Other Liabilities	(3,284)	(4,302)	(1,018)
Borrowings	(4,703)	(11,899)	(7,196)
Provisions	(160)	(160)	0
Total Current Liabilities	**(55,657)**	**(74,748)**	**(19,091)**
Net Current Assets	**(23,803)**	**(31,677)**	**(7,874)**
Non-Current Liabilities			
Other Liabilities	(7,235)	(6,891)	344
Borrowings	(111,219)	(129,748)	(18,529)
Provisions	(1,472)	(1,472)	0
Total Non-Current Liabilities	**(119,926)**	**(138,111)**	**(18,185)**
Total Assets Employed	**120,874**	**96,407**	**(24,467)**
Financed by Taxpayers Equity			
Public Dividend Capital	168,768	170,068	1,300
Equity			
Reserves	43,530	43,530	0
Retained Earnings	(91,424)	(117,191)	(25,767)
Total Taxpayers' Equity	**120,874**	**96,407**	**(24,467)**

The table shows the M11 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)

Gloucestershire Hospitals NHS
NHS Foundation Trust

Commentary below reflects the Month 11 balance sheet position against the 2017/18 outturn

Current Assets

- Inventories have decreased slightly in month giving a year to date movement of £0.1m
- Trade receivables are £13.6m above the closing March 2018 level.
- Cash has reduced by £2.4m since the year-end, reflecting the deficit income and expenditure position, offset by borrowing and the movement in working balances.

Current Liabilities

- Current liabilities have increased by £19.1m, reflecting an increase in creditors/accruals, and borrowings repayable within a year.

Non-Current Liabilities

- Borrowings have increased by £18.5m, reflecting the income and expenditure deficit.

Retained Earnings

- The retained earnings reduction of £25.8m reflects the impact of the in year deficit.

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Better Payment Practice Code (BPPC)

Gloucestershire Hospitals NHS
NHS Foundation Trust

	Cumulative for Financial Year		Current Month February	
	Number	£'000	Number	£'000
Total Bills Paid Within period	103,330	212,698	8,480	17,783
Total Bill paid within Target	77,957	167,484	7,092	15,769
Percentage of Bills paid within target	75%	79%	84%	89%

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. The higher than average BPPC performance in February reflects the draw down of borrowings.

Liabilities – Borrowings

Analysis of Borrowing	As at 28th February 2019 £000
<12 months	
Loans from ITFF	3,317
Distress Funding	6,697
Obligations under finance leases	1,782
Obligations under PFI contracts	103
Balance Outstanding	**11,899**
>12 months	
Loans from ITFF	22,593
Capital Loan	4,500
Distress Funding	82,974
Obligations under finance leases	1,243
Obligations under PFI contracts	18,438
Balance Outstanding	**129,748**
Total Balance Outstanding	**141,647**

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 £27.2m of additional in-year borrowing from the DoH.

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Cashflow : February

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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)**	**(396)**	**(3,959)**	**(1,300)**	**(18,505)**
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)**	**474**	**(3,089)**	**(1,930)**	**(9,559)**
Working capital movements:													
(Inc.)/dec. in inventories	0	71	0	0	0	(330)	33	155	(333)	146	185	0	(73)
(Inc.)/dec. in trade and other receivables	(4,596)	(2,610)	(546)	2,310	(963)	3,647	(3,619)	(615)	(2,064)	1,425	(2,211)	(346)	(10,188)
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	(9,216)	7,261	1,920	12,797
Inc./(dec.) in other financial liabilities	(437)	904	0	0	0	(1,552)	(245)	(35)	2,431	(52)	4	0	1,018
Net cash in/(out) from working capital	**2,123**	**(478)**	**888**	**1,297**	**259**	**1,759**	**(5,485)**	**(1,545)**	**5,620**	**(7,697)**	**5,239**	**1,495**	**3,475**
Capital investment:													
Capital expenditure	(158)	(207)	(459)	(459)	(1,883)	(159)	(1,155)	(2,295)	(253)	(596)	(7,573)	(2,472)	(17,669)
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)**	**(596)**	**(7,573)**	**(2,472)**	**(17,669)**
Funding and debt:													
PDC Received	0	0	0	0	0	0	0	0	1,300	0	0	1,700	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	5,299	32,539
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**	**1,681**	**2,559**	**20,960**
Net cash in/(out)	**1,104**	**(2,906)**	**(364)**	**32**	**519**	**2,258**	**(3,959)**	**1,763**	**6,629**	**(3,779)**	**(3,742)**	**(348)**	**(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**	**6,744**	**3,002**	**5,447**
Closing	**6,551**	**3,645**	**3,281**	**3,313**	**3,832**	**6,090**	**2,131**	**3,894**	**10,523**	**6,744**	**3,002**	**2,654**	**2,654**

The cash flow for February 2019 is shown in the table:

Cashflow Key movements:

Current Assets – The increase in trade and other receivables since month 10 has reduced cash.

Current Liabilities – The increase in trade and other payables since month 10 has increased cash.

The Cash Position – reflects the Group position. The Trust has drawn down loan support of £27.2m.

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.

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Introduction and Overview

This report provides an overview of the progress of the capital programme to date and year end forecast for 2018/19. Adverse and favourable movements are highlighted along with the risks and opportunities in delivering the programme.

Capital Programme Expenditure Summary position at 28th February 2019

Capital Summary	Internal YTD Plan	YTD Spend	YTD Var	18/19 Full Year Plan	FOT 18/19 Spend	Forecast Variance
	£000's	£000's	£000's	£000's	£000's	£000's
Health & Safety Projects	3,729.2	2,679.7	-1,049.5	4,475.0	3,239.2	-1,235.8
Environmental Works	175.0	139.7	-35.3	200.0	176.5	-23.5
Estates Unallocated Allowances	108.0	-18.5	-126.5	125.0	-11.4	-136.4
Non Health & Safety Projects	1,057.5	1,063.0	5.5	1,154.0	1,186.5	32.5
Committed Schemes	2,251.7	2,310.6	58.9	2,679.0	2,549.4	-129.6
Service Reconfiguration	1,017.5	204.2	-813.3	1,221.0	207.9	-1,013.1
Major Equipment Replacement	1,164.7	9.6	-1,155.1	4,588.0	3,203.5	-1,384.5
IM&T	5,293.4	2,783.3	-2,510.1	6,100.0	4,276.8	-1,823.2
MEF	1,711.4	439.7	-1,271.7	2,000.0	550.0	-1,450.0
Other Schemes	0.0	631.6	631.6	1,300.0	1,213.9	-86.1
Contingency	0.0	0.0	0.0	200.0	0.0	-200.0
Strategic Development	1,460.0	446.2	-1,013.8	1,975.0	525.0	-1,450.0
Overspend/(Underspend)	**17,968.4**	**10,689.0**	**-7,279.4**	**26,017.0**	**17,117.3**	**-8,899.7**

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

The forecast underspend of £8.9m against plan reflects the outcome of the capital financing application. The Trust has received confirmation that the £10m application will be received in 2019/20, with expenditure included in the 2019/20 capital plan.

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.
- 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 (£0.5m) and the Infoflex business case (£0.1m).

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Recommendations

The Board is asked to note:

- The Trust is reporting an actual income and expenditure deficit on a control total basis of £25.4m for the year to date at February 2019. This is an adverse variance of £6.6m to plan and a favourable variance to forecast of £0.4m.
- The Trust continues to forecast an income and expenditure deficit of £29.1m.

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

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

Date: **April 2019**

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REPORT TO TRUST BOARD – APRIL 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 19 March 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	Report covered: - Activity update - Revised process for self-assessment sign off - Management change - Ongoing investigation update - Draft Plan for 2019/20	How effective are counter fraud induction sessions? What is the process for linking counter fraud investigation work to HR and professional body registration processes?	Feedback and referral activity indicates the sessions are valuable and have a positive impact .	To be reviewed by CEO, Director of People & OD and Chief Nurse.
Internal Audit	Progress report. Final reports for - Key Financial Systems - Infection Control reporting - Recommendation follow-up - Cyber Security - 2019/20 Plan GMS performance reporting audit complete but follow-up will be at next meeting.	Focus on Cyber Security which received a "Limited Assurance" assessment: - Are resources in place to deliver the actions in the agreed timescales as per the commitments in the management response? - What are the implications of the supplier move made by GCS/2gether?	The report which was undertaken at the direction of the Trust did not contain any surprises and provided assurance that the Trust's position is similar to other comparable Trusts.	Cyber security Assurance report to be provided to the Committee in November.

		- What issues are there with primary care support? - Could unsupported operational systems receive support earlier than planned with additional resource? Re the 19/20 plan: - Will the new risk covering property and medical device maintenance management require an audit? - Will ICS arrangements require inclusion in the audit programme?	Consideration will be given to the need and work scheduled if required.	
External Audit	Update on progress with the 18/19 plan – no issues raised to date. Q4 Health Audit briefing.	Have the delays in providing information been problematic? What are the ramifications of the new accounting standards relating to leases?	Overall responsiveness much improved over last year and no significant timing issues currently	Impact update will be provided at the Accounts "walk through" meeting in April

Emergency Planning Report	Comprehensive update on progress against the action plan for Emergency Planning and Business Continuity	What areas of concern remain?	BCM Plans all up to date. Overall BCN and EPR in a good place, keeping up to date is the ongoing challenge.	Security notably at GRH site is a particular challenge. Committee to review NHS England's external assurance report
Governance Documents	Revised Committee Terms of Reference adopted Annual Report Project Plan Trust Seal Report Risk Register Board Assurance Framework	How does Charitable Funds fit in this plan? Are the reports currently being received the most effective way of addressing the Committee's responsibility?		Plan to be extended to capture Charitable Funds requirements Report content and Terms of Reference to be reviewed to sharpen focus
Reports from the Finance Director	Losses & Compensations Single Tender Actions.	Are all TrakCare waivers independent of one another? Is there a process for measuring the effectiveness of "Health Sector Jobs"? What is the time period of the Datix contract and would we benefit with a longer licence and support agreement?	Yes.	Referred to People & OD Committee for review & assurance To be reviewed.
Gloucestershire Managed Services Update	Update on audit arrangements, accounting timetable, budgeting	Will the year end accounts walk through include GMS results?	Yes, but not via a separate review as these are integrated in the Group results Rev	

		Following the closure of the significant fraud case have all necessary processes been reviewed?	iew substantially complete	Follow up at next meeting

Rob Graves
Chair of Audit and Assurance Committee
April 2019

Gloucestershire Hospitals
NHS Foundation Trust

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

Report Title
Application of the Trust Seal Annual Report
Sponsor and Author(s)
Author: Cecilia Price, Corporate Governance Graduate Trainee Sponsor: Lukasz Bohdan, Director of Corporate Governance
Executive Summary
Background The application of the Trust's seal to documents is reported to Audit and Assurance on a quarterly basis with a full report received annually at Board. The application of the Trust's seal to documents was last reported to the Board in September 2018. The recurrence of the Annual Trust Seal Report has been changed from September to follow the end of the financial year. Seals Applied Since the last report presented to the Board in September 2018, the Trust seal has been applied to the following documents: - March 2019 – Lease for Victoria Warehouse (5 years) - March 2019 – Lease for Pullman Court (6 years)
Recommendations
That the above be noted.
Impact Upon Strategic Objectives
N/A
Impact Upon Corporate Risks
N/A
Regulatory and/or Legal Implications
Ensures compliance with statutory requirements.
Equality & Patient Impact
N/A

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

Date the paper was presented to previous Committees and/or TLT							
Audit & Assurance Committee	**Finance and digital Committee**	**GMS Committee**	**People and OD Committee**	**Quality & Performance Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
✓ Report reviewed on a quarterly basis							
Outcome of discussion when presented to previous Committees/TLT							

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

REPORT TO TRUST BOARD – APRIL 2019

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

This report describes the business conducted at the GMS Committee held 11 March 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	Review of estates and facilities risks remains an open action.	Circa 30 risks have been identified as having no owner following the establishment of GMS.		The Committee wishes to review the full list of estates and facilities risks with owners assigned and actions plans identified to control/mitigate the risks.
	Review of GMS terms and conditions of employment and the associated strategies for recruiting for key roles.	The ability to recruit estates and facilities talent was a key element of the GMS business case.		Report to be submitted to Committee in June.
	Benefits realisation review of GMS.	This was raised by the Trust's Audit and Assurance Committee.		To be addressed in the Annual Report to be written by GMS.
GMS Report	Maintenance of equipment and facilities.	Is the GMS maintenance regime effective?		Committee wishes to have a view on the numbers, types and severities of breakdowns and failures of equipment and facilities, and the speed of repair. These new data to be added to the GMS Report.

Hard Services Report	GMS are moving from a "run to fail" to a planned preventative approach.	How will this be achieved in the current environment of scarce capital?		An effective plan for reducing the maintenance backlog to be included in the GMS Business Plan for 2019/20.
Estates Committee Terms of Reference	The proposed ToR were presented to Committee, the aim being to change the role to more of an assurance committee in line with the others, while also widening the scope to cover strategic estates matters.	The relationship between this Committee and GMS remains unclear. There is the need to respect GMS independence from the Trust while also a need to ensure that GMS performance is managed by the Trust and assured by this Committee.		It was agreed that a separate workshop be held to discuss and agree the relationship between this Committee and GMS in order to update and agreed clear terms of reference.
Briefing on the Approach to meeting National Cleaning Standards		The Committee wishes to understand (a) the consequences of not meeting the national standards and (b) what changes are necessary for the Trust to meet the standards.		GMS to report back to Committee on the proposals to close the gap: to be presented in June.
Security Review	Various options to address perceived gaps in the current security arrangements were presented, with a preferred option	Concerns were raised as to the feasibility of the proposed option, and asked about other trusts adopting a similar approach and whether they had been successful.		Further work will be undertaken and an updated report to come to Committee in June.

Mike Napier
Chair of Gloucestershire Managed Services Committee
31 March 2019

Gloucestershire Hospitals
NHS Foundation Trust

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

Report Title
Operational Plan 2019-20
Sponsor and Author(s)
Author: Dan Corfield, Head of Business Development and Planning Sponsor: Simon Lanceley, Director of Strategy and Transformation; Sarah Stansfield, Director of Finance
Executive Summary

Purpose

To present to the Board the 2019/20 Operational Plan, formally submitted to NHS improvement on 4th April 2019 as required by the national timeline.

Key issues to note

- Operational Planning activities worked to a formal project plan constructed through the process which will be used as a template for future years.
- Engagement from operational leads significantly improved from last year despite recognised operational pressures.
- Completion was challenged, notably in the few days leading to submission, by the difficulties experienced in finalising the contract with our lead commissioner, impacting the position of final activity and growth figures, and contractual and financial positions.
- The submitted plan meets the financial control total offered to the Trust by NHS Improvement - £1.5m deficit for the 2019/20 financial year, planned including a 4% CIP of £22.4m.
- Divisional alignment with new 2019/20 strategic objectives will occur in May/June.

Conclusion, Implications and Future Action Required

- The Operational Plan document provides a compelling narrative regarding the improvements in 2018/19 that form the basis for the 2019/20, year one of our new strategic plan.
- Post-submission lessons learned will be conducted in May/June as proposed to, and agreed by, Audit and Assurance Committee, based on the 2018 audit of operational planning.
- The Trust lessons learned exercise will feed into an ICS-wide lessons learned exercise; this will need input from not just planning leads, but senior operational, finance and business intelligence stakeholders too.
- These lessons will be used to further improve next year's process, which will see a more marked shift towards system operational planning.
- A public version of the plan will be produced for publication in June/July

Recommendations

- The Board is asked to APPROVE the Operational Plan, and NOTE the considerable effort from a diverse group of stakeholders in both operational and corporate areas.
- The Board is also asked to APPROVE a mandate for a rigorous lessons learned exercise both internally and with ICS partners, with full engagement and input from all required stakeholders.

Impact Upon Strategic Objectives
The Trust's new strategic plan for 2019-24, and strategic objectives, are being formulated through April and will be presented to the Board in May. An early draft set of objectives were included in the submitted Operational Plan to provide indicative context, with a clear 'work in progress' marker. The public version of the plan will refer to finalised objectives.
Impact Upon Corporate Risks
Risks to delivery of the plan are included on page 7. Manifestation of many of these risks could impact upon existing registered risks relating to finances, cost improvement and activity, especially if income is compromised leading to shortages in cash, capital and/or growth funding (e.g. F2724, C2894COO, C2895COO, F2722, C2628COO, C1798COO, S2568Anaes)
Regulatory and/or Legal Implications
Submission satisfies regulatory compliance.
Equality & Patient Impact
Not directly applicable.

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

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

Date the paper was 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)**
						03/04/19	
Outcome of discussion when presented to previous Committees/TLT							

Gloucestershire Hospitals
NHS Foundation Trust

Operational Plan Document for 2019-20

4th April 2019

(Version 1.0)

Operational Plan for year ending 31 March 2020

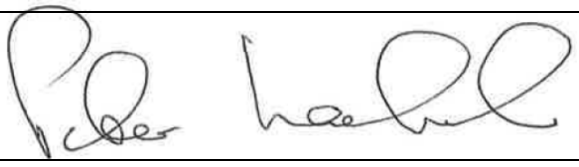
This document completed by (and NHS Improvement queries to be directed to):

Name	Daniel Corfield
Job Title	Head of Business Development and Planning
Email	dan.corfield@nhs.net
Telephone	0300 422 3263
Date	4th April 2019

In submitting this plan, the Trust is confirming that:

- The Operational Plan is an accurate reflection of the current shared vision of the Trust Board having had regard to the views of the Council of Governors and is underpinned by the emergent strategic plan;
- The Operational Plan has been subject to at least the same level of Trust Board scrutiny as any of the Trust's other internal business and strategy plans;
- The Operational Plan is consistent with the Trust's internal operational plans and provides a comprehensive overview of all key factors relevant to the delivery of these plans; and
- All plans discussed and any numbers quoted in the Operational Plan directly relate to the Trust's financial template submission.

Approved on behalf of the Board of Directors by:

Chair: **Peter Lachecki**	Signature 
Chief Executive: **Deborah Lee**	Signature 
Director of Finance: **Sarah Stansfield**	Signature 

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1. Executive Summary

1.1. Introduction

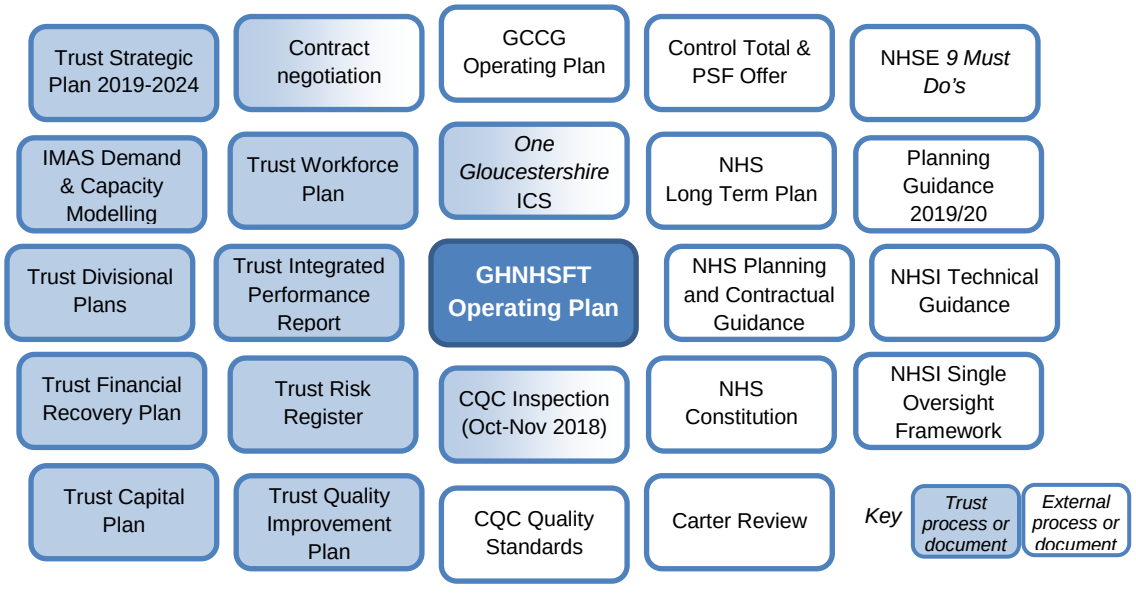
This document confirms the Trust's planning assumptions and priorities for 2019-20. It is the first operating plan to be issued as part of our new Strategic Plan (2019-24), and has been written during the development of the strategy. This plan also forms part of the first *One Gloucestershire* Integrated Care System (ICS) Operating Plan.

Gloucestershire Hospitals NHS Foundation Trust is one of the largest hospital trusts in the country and provides high quality acute, elective and specialist health care for a population of more than 635,000 people. Our population is expected to rise to 662,100 by 2035, of which 23.8% will be over 65 and of this group 59.1% will be living with one or more limiting long term conditions[1]. Our hospitals are district general hospitals with a great tradition of providing high quality services; some specialist departments are concentrated at either Cheltenham General Hospital or Gloucestershire Royal Hospital, so that we can make the best use of our expertise and specialist equipment. In February 2019 we were rated as 'Good' by the CQC, meeting our two-year strategic objective and improving from our last CQC report.

Trust Overview	
Local population:	612,000
Employees (av.):	7,800
District General Hospitals:	2
Inpatient wards	44
Adult Inpatient beds:	902
Day Case beds:	126
Children's beds:	39
Escalation capacity:	58
Operational (2017/18)	
ED attendances:	141,326
Inpatient admissions:	155,844
Outpatient appointments:	696,128
Babies born:	9,317
Financial	
2017/18 revenue:	£498.1m
2017/18 reported deficit:	£33.0m
2018/19 planned deficit:	£18.8m
2018/19 forecast deficit:	£29.1m

This Operating Plan articulates our national and local challenges and states how we will respond to them by continuing our improvement journey and working with our partners across the Gloucestershire health and social care system. It is based on clear and reasonable assumptions, and is informed and shaped by a range of national guidance, local strategies and best practice:

Figure 1 - Inputs to the Operating Plan



[1] http://www.pansi.org.uk and http://www.poppi.org.uk

We recognise the challenges we face, both those within our control and those outside it. In the last year we have made significant progress against our financial recovery plan, and take confidence from improvements recommended by both our own internal standards and drive for excellence, and recommendations from our CQC domain ratings. We have identified a number of key risks that could impact our delivery of this plan, and the actions we will take to manage and mitigate these risks.

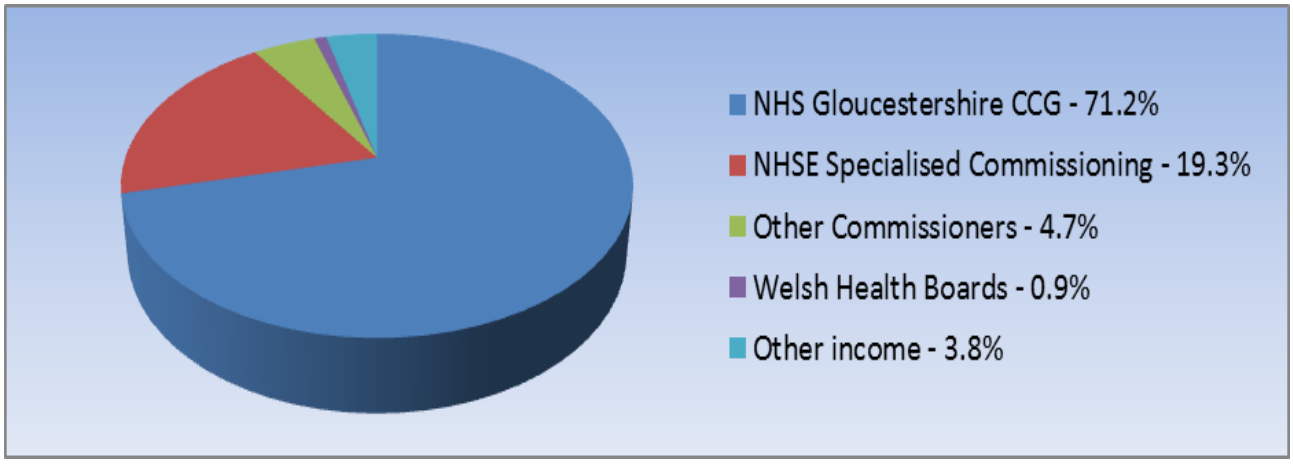
1.2. Operating Context

National – The settlement announced in June 2018 promised NHS England's revenue funding would grow by an average of 3.4% per year average over five years, delivering a real terms increase of £20.5 billion by 2023/24, moving closer to the NHS long-term average funding trend of 3.7% per year since 1948. The extra spending will need to deal with current pressures and unavoidable demographic change and other costs, as well as new priorities. The NHS Long Term plan, published in January 2019, sets out five key 'tests' against this funding increase:

- The NHS (including providers) will return to financial balance;
- The NHS will achieve cash-releasing productivity growth of at least 1.1% a year, with all savings reinvested in frontline care;
- The NHS will reduce the growth in demand for care through better integration and prevention;
- The NHS will reduce variation across the health system, improving providers' financial and operational performance;
- The NHS will make better use of capital investment and its existing assets to drive transformation

Local - The Trust operates within the Gloucestershire health and social care system alongside partner organisations including Gloucestershire Clinical Commissioning Group (GCCG), Gloucestershire Care Services NHS Trust (community services), 2Gether NHS Foundation Trust (mental health services) – these latter two organisations are due to merge in 2019 – South West Ambulance Trust (SWAST), approximately 80 GP surgeries, and Gloucestershire County Council. Collectively these partner organisations form the *One Gloucestershire* ICS. This operating plan is consistent with the *One Gloucestershire* ICS and the anticipated impact and benefits of the ICS plan have been incorporated into our planning assumptions and contracts with commissioners. Our lead commissioner is GCCG and we also provide services to a wide range of other customers:

Figure 2 - Our customers



In 2016 the Trust was placed into Financial Special Measures by our regulator, NHS Improvement (NHSI) due to depletion in our cash reserves and issues regarding historic financial reporting; in response to this we developed a plan to recover our financial position and sustainability. In

November 2018 we came out of special measures due to the improved governance of our financial management. Despite this, and delivery of significant cost improvements over the last three years, we are still operating with a legacy financial deficit. High quality care and financial stewardship go hand in hand, and our operational, transformational and cost improvement work continues to drive our financial recovery.

1.3. Our Vision, Purpose, Values and Objectives

Figure 3 - Our Vision, Purpose, Values and Objectives

Our Vision

Best Care for Everyone

Our Purpose

To improve the health, wellbeing and experience of the people we serve by delivering outstanding care every day

Our Values

Our Values underpin everything we do. They describe, in single words, the way we expect our staff to behave towards our patients and their families and carers, and also towards each other. After listening to patients and staff the Trust identified the following core values:

Caring Listening Excelling

Our Objectives

To achieve the best for our patients, their families and carers, our staff and our communities, we need cohesive priorities for the coming years. Focus on patients and our strategic objectives will ensure that this happens. If we achieve our objectives, we will move closer towards our Vision. Our 2019-24 strategic plan is in development; a summary of the timeline and approach can be found at Appendix 1, with an early draft set of objectives and supporting plan to be finalised in May 2019.

1.4. Summary of progress against 2018/19 objectives

As part of our annual planning process our objectives are prioritised from strategic (overarching organisational objectives) and operational (service-based factors) perspectives.

Detailed operational plans underpin each objective to ensure we deliver what is required by our patients, commissioners and regulator, within realistic and achievable timescales.

Our Strategic Objectives for 2019-24 can be found at Appendix 1. Following is a brief summary of the progress we made towards our objectives through our operational work in 2018/19, which will inform our priorities in 2019/20.

Table 1 - Progress towards 2018/19 strategic objectives

Our Strategic Objectives	Progress 2018/19
Our Patients will… ➢ Be safe in our care ➢ Be treated with care and compassion ➢ Be treated promptly with no delays ➢ Want to recommend us to others **By April 2019 we will…** ➢ Be rated good overall by the CQC ➢ Be rated outstanding in the domain of Caring by the CQC ➢ Meet all national access standards ➢ Have a hospital standardised mortality ratio of below 100 ➢ Have more than 35% of our patients sending us a family friendly test response, and of these 93% would recommend us to their family and friends ➢ Have improved the experience in our outpatients departments, reducing complaints to less than 30 per month	➢ CQC overall rating 'Good' announced February 2019 ➢ CQC 'Caring' domain all rated as 'Good' with 'Outstanding' Critical Care ➢ A&E 4-hour wait standard – sustained position in Segment 2. Performance at >90% sustained throughout the year placing us in the upper quartile of Trusts nationally ➢ RTT reporting recovery plan delivered January 2019 ➢ Hospital standardised mortality ratio below 100 achieved in 2018 and maintained ➢ Diagnostics 6 week standard met – to be sustained to continue meeting national standards ➢ Focused work continues to identify themes and trends in outpatient complaints, for action in the Outpatients programme plan and operational management
Our Staff will… ➢ Put patients first ➢ Feel valued and involved ➢ Want to improve ➢ Recommend us as a place to work ➢ Feel confident and secure in raising concerns **By April 2019 we will…** ➢ Have an Engagement Score in the Staff Survey of at least 3.9 ➢ Have a staff turnover rate of less than 11% ➢ Have a minimum of 65% of our staff recommending us as a place to work through the staff survey ➢ Have trained a further 900 bronze, 70 silver and 45 gold quality improvement coaches ➢ 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	➢ New talent management system launched ➢ Nurse Associate, advanced clinical practice and apprentice roles implemented/further rolled out ➢ Finance and HR establishment records being reconciled ➢ GSQIA programme – further regular cohorts of Bronze training and Silver programmes, exceeding stated objective. Two further Gold Coaching cohorts launched ➢ 'One stop shop' for staff health and wellbeing scoped and in development for launch May 2019

Our Strategic Objectives	Progress 2018/19
Our Services will… ➢ Make best use of our two sites ➢ Be organised to deliver centres of excellence for our population ➢ Promote health alongside treating illness ➢ Use technology to improve **By April 2019 we will…** ➢ 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 ➢ Have systems in place to allow clinicians to request and review tests and prescribe electronically ➢ Rolled our *Getting It Right First Time (GIRFT)* standards across target specialties and be fully compliant in at least two clinical services ➢ Have staff in all clinical areas trained to support patients make healthy choices	➢ New Clinical Model Strategic Outline Case developed ➢ New cancer centre of excellence health planning completed ➢ Allocated £39.5m strategic site development funding; planning in progress ➢ TrakCare governance further strengthened; CDIO appointed to Board, TrakCare Recovery progressing as planned; RTT reporting reinstated ➢ Reconfiguration of Gastroenterology services as part of winter planning ➢ Several hundred staff trained to support patients making healthy choices; training programme to continue, and initiative to link to wider system opportunities
Our Organisation will… ➢ Use our resources efficiently ➢ Use our resources effectively ➢ Be one of the best performing trusts ➢ Be considered to be a good partner in the health and wider community **By April 2019 we will…** ➢ Show an improved financial position ➢ Be among the top 25% of trusts for efficiency ➢ Have worked with partners in the Sustainability and Transformation Partnership to create integrated teams for respiratory, musculoskeletal conditions and leg ulcers ➢ Be no longer subject to regulatory action ➢ Be in segment 2 (targeted support) of the NHSI Single Oversight Framework	➢ Exited Financial Special Measures regulatory action in November 2018 ➢ Cost Improvement Programme (CIP) schemes being delivered; monitored through regular Division 'deep dives' with executives and PMO to increase and sustain pace ➢ Delivery of financial recovery against trajectory not favourable despite significant CIP ➢ Range of investment projects approved through new process to drive further quality and financial improvements ➢ Integration of respiratory teams commenced September 2018 and will continue through 2019/20. New MSK model progressing

1.5. Key planning assumptions

Activity assumptions

- There will be growth in demand due to population changes and requirements from commissioners.
- The use of ad hoc capacity to sustain services and deliver improvement across all specialties is included in our capacity planning assumptions.
- Variable activity plans are based on new national tariffs as per January 2019 planning guidance; some contracts may remain on block to reflect system priorities and incentives.

- Activity plans are aligned to workforce plans; any additional non-recurring costs to deliver services (for example where demand is higher than anticipated) are assumed to be covered by the resulting increases in income, subject to any block contracts.

Quality assumptions

- Our *Quality Impact Assessment* (QIA) process and governance will continue to provide assurance regarding any impact on patient care of financial recovery and service changes.
- Our Quality Improvement Plan will drive our continued long-term strategic objectives towards Outstanding CQC ratings
- We will continue to develop the skills and culture of continuous quality improvement
- Our approach to quality and its governance, and the Board Assurance Framework, will provide triangulation of finance, workforce and quality indicators to improve the quality of care.

Workforce assumptions

- Our Recruitment Services, in partnership with operational managers, will continue to efficiently and effectively provide a pipeline of new staff.
- Our overall staff turnover will be maintained at no more than 11%, retaining a focus on safe staffing both in terms of numbers and skill mix.
- Appraisal rates will increase to and be maintained at 90% or more, building on the first part-year implementation of our new talent recognition and development programme. Our approach to pay progression has been amended to help drive meaningful appraisal completion and compliance.
- Vacancy rates will reduce as appropriate, as indicated by improving annual staff survey results and reduced agency costs. Recruitment campaigns will target the reduction of vacancies in shortage occupation areas, and we will focus on the further recruitment of Trainee Nurse Associates, Clinical Nurse Fellows and Registered General Nurses.
- Reductions in funded posts will be achieved through turnover and deploying staff to vacancies, also helping to minimise our reliance and expenditure on agency staff.
- We will continue to lead and actively participate in the development of new types of roles, collaborating closely with our ICS partners, in anticipation of changing models of healthcare, and to address known national workforce gaps as recognised in the NHS Long Term Plan.
- We will continue to optimise our opportunities for apprenticeships.

Finance assumptions

- The 2019/20 control total set by NHSI for the Trust is a £1.5m deficit position, including Provider Sustainability Funding (PSF) and Financial Recovery Funding (FRF).
- Inflation for pay and non-pay expenditure budgets has been applied in line with planning assumptions, including a provisional pay award for medical staff subject to confirmation. Non-pay inflation includes provision for increases in drug and other non-pay costs.
- Operational cost pressures include: funding to address intolerable risks, investment in non-pay pressures, full year effect of 2018/19 appointments, impact of revised impact of CEAs, and removal of non-recurrent income/expenditure from the previous year.
- There are increases to national tariffs as notified in 2019/20 planning guidance; this will offset the reduced value of Commissioning for Quality and Innovation (CQUIN) schemes and include adjustments for the 2018 NHS pay settlement.
- Where contract settlements have been reached with Commissioners they are reflected in this plan.

1.6. Key risks to the delivery of this plan

Risk		Domain	Mitigating/managing actions	Responsible Executives
Internal	The risk of delayed follow-up care due to outpatient capacity constraints in a number of specialties	Operational	Administrative validation of patient lists; utilise any remaining capacity to reduce long-waits; use alternative follow-up where appropriate.	COO
	The risk of not achieving our planned Cost Improvement Programme resulting in a variance from our planned income and expenditure position	Finance	Executive reviews and regular 'deep dives'. Dedicated PMO monitoring and reporting performance against target. Income recovery.	COO DoF
	The risk of not meeting our performance trajectories and the associated impact on patient experience.	Operational	Ongoing monitoring of performance, and planned preventative measures; process improvement and efficiency, and resource services as required maintaining service levels.	COO
	The risk of excessively high agency spend in non-clinical professions due to high vacancy levels, and impact on care quality and staff experience.	Finance & Quality	Expand Bank staffing; improve staff rostering; ongoing recruitment (incl. overseas), Recruitment and Retention Premiums for hard-to-recruit areas.	DQ&CN DP&OD
	The risk of reduced capacity or safety and quality of care due to failure or breakdown of estate, facilities and/or equipment.	Finance & Operational	Review criteria-driven prioritisation of capital funds; pursue lease/managed service options where appropriate and available.	DoF COO
External / Internal	The risk of misalignment between Trust income expectations and commissioner affordability, and/or agreement regarding activity, impacting baseline deficit position.	Finance	Constructive negotiations with commissioners; full clarity of available data to support position.	DoF
External	The risk of demand exceeding agreed growth assumptions if we remain on block contract with commissioners, restricting additional income despite increased cost.	Operational	Constructive negotiations with commissioners; ongoing Demand and Capacity monitoring and iterative modelling.	COO
	The risk that ICS solutions have a greater impact than anticipated in year and result in a loss of income above the planned level	Finance	Recognising the benefits of reduced activity alongside ongoing robust contract management; reallocate resources to more contributory services.	COO DoF
	The risk of not delivering service quality due to workforce shortages in certain staff groups and types.	Workforce	Appropriate use of agency/locum cover; innovative role design, with ICS; continuous process improvement to optimise staff skill mix and deployment.	DP&OD
	The risk of Brexit – and uncertainty related to its timescales – creating unplanned supply chain and workforce shortages, and having a wider negative economic impact affecting public sector finances, for un unknown period of time	Finance Operational	Workforce impact projected to be negligible; maintain excellent communication regarding national stockpiles, and maintain Trust continuity plans accordingly.	All Executives

2. Activity Plan

2.1. Demand and Capacity Plans, and expected growth

We have applied a robust capacity & demand planning process, based on:

- Use of the *IMAS Advanced Flow Capacity and Demand* tool at service line level.
- 7 months of 2018/19 data, profiled out to a full year estimate in agreement with our commissioners. This is adjusted for seasonal variations and lessons from previous years' winter and system resilience planning, and accounts for projections for known business or service developments.
- Taking into account gaps in our data coding and quality; in 2019/20 we will conclude improvement in this area to make our data significantly more reliable as we complete our TrakCare recovery programme.
- The level of growth at least aligning itself to the growth in the local population and also reflecting those areas where demand is increasing above this level.

Table 2 - Demographic growth 2019/20

Demographic	Growth
Birth (aged 0)	0.2%
Paeds (aged 0-19)	0.8%
Working Age (aged 19 - 65)	-0.2%
Retirement (aged 66-79)	1.5%
Older People (aged 80+)	2.0%
ALL AGES	0.7%

Planning Assumptions

Unscheduled/Non-Elective Care

- There will be underlying growth in the number of A&E attendances
- There will be growth in the number of non-elective admissions
- There will be growth in the number of Emergency assessments
- Delayed Transfers of Care will reduce through system wide plans.

Planned Care

- There will be growth in demand from population changes and commissioner requirements.
- Divisions have reviewed both workforce and previous years' activity and, adjusting for known variations, have provided plans that we are confident reflect our capacity to care for patients and meet demand for our services.
- The use of ad hoc capacity to sustain services and deliver improvement is included in our capacity planning assumptions, as are productivity improvements.
- Activity plans are aligned to workforce plans; any additional non-recurring costs to deliver services (for example where demand is higher than anticipated) are assumed to be covered by the resulting increases in income, dependent on block contracts. This does not extend to the non-recurrent amount that relates to any backlog.
- Our TrakCare Recovery plan continues to be implemented; our updated demand and capacity plans depend on this, and we continue to advise NHS Improvement accordingly.
- Some clinical services are funded, where appropriate, using 2017/18 re-based tariffs relative to the cost of running those services, as agreed with our lead commissioner.
- All other variable activity plans are based on the latest published mandatory PbR tariffs.
- We will ensure our DNA rates benchmark positively against our comparative trusts, relevant to the respective specialty.
- The activity plans submitted based on these assumptions will deliver the recovery trajectories against the key national standards

Expected Growth

Growth for 2019/20 is assessed to be achievable within existing capacity.

Ongoing modelling and analysis of capacity will be undertaken through the year to ensure we have sufficient capacity for variation in activity rather than just planning on averages. Based on activity trends, projections and discussions with commissioners, our anticipated growth rates used as assumptions for planning purposes are in the table to the right.

Table 3 – Anticipated growth rate figures

Area		Anticipated Growth
Unscheduled Care	A&E attendances	5.3%
	Non-elective admissions	0.78%
	Emergency assessments	2.0%
Planned Care	Elective admissions	1.4%
	Elective day cases	1.3%
	Outpatient attendances	2.7%*
	GP referrals	0.2%
Cancer	2 week wait referrals	11.9%
	62 day treatments	11.9%

**includes non-recurrent activity*

2.2. Delivery and Recovery of Key Operational Milestones

Unscheduled Care - Our trajectory for the four hour A&E waiting time standard during 2019/20 has been agreed with Gloucestershire CCG and NHS Improvement to be **90%** for each quarter, continuing our improved and sustained performance during 2018/19. The trajectory for improvements in ambulance handover delays are presented in Appendix 2.

Planned Care *(Trajectory data for the following narrative can be found in Appendix 2)* - The Trust will submit a response for the number of patients waiting at Q1 as required. We confirm that the number of patients on an incomplete pathway will be no higher in the corresponding period through to March 2020, subject to continued TrakCare Recovery and appropriate Commissioner investment in elective provision. We will conduct a programme of improvement in our operating theatres; pre-operative assessment and theatres efficiency programmes will be key work streams, using the current baseline (acute hospital sites only):

- 88% of sessions used that were available
- 86.5% utilisation of the sessions that we used
- i.e. overall 76% efficiency

Further, our Theatres team will investigate better use of the theatre estate, including the feasibility of further longer session days and weekend working to identify opportunities to use our theatres on days and at times that they are currently unused. This will require an in-depth analysis of any impact on job planning and equipment. Revised shift patterns could provide staff with an improved work-life balance (e.g. childcare). We have no plans to use the independent sector; we will review this position contingent on meeting key performance targets, in discussion with our commissioners.

Diagnostics - In 2019/20 we are planning for **7.6%** growth in our Diagnostic testing. The NHS is proposing to bring together clinical expertise into hub and spoke 'pathology networks'[2] to deliver high quality diagnostics in a more efficient way. Gloucestershire will join the 'South 3' network with Bristol and Weston trusts; core services will still take place in our own hospital laboratories, with some samples being analysed quickly and expertly in advanced centres.

Whilst the Trust made a strategic decision in December 2018 to not bid to become one of the up to nine national laboratories providing primary HPV screening, we will continue to offer a mitigation service for as long as possible and will support successful bidders to safely transition services.

Cancer - There will be growth in the number of cancer referrals; in 2018/19 demand increased by **11.9% and we anticipate this will not reduce** due to NICE guidance changes and the national

[2] https://improvement.nhs.uk/resources/pathology-networks/

strategy of finding more cancers. We aim to meet and exceed cancer performance standards as soon as possible in a sustainable way based on our planned improvements and action plans. though recognise this will be challenging. This recognition is reflected in our performance trajectories in Appendix, however good progress is already being made on improving our cancer pathways. There were a number of improvements that were highlighted in last year's plan that have now been delivered:

- 'One-stop diagnostic clinics' for dermatological cancers (where clinically appropriate)
- Gynecological cancer exclusion clinics
- New cancer reporting suite with automated Patient Tracking Lists for 2 week wait (2ww) and 62 day referral to treatment waits, showing daily performance and breach reports, new Faster Diagnosis Standard reports, making us compliant in advance of national deadlines.
- Optimum Timed pathways (*Straight to Colonoscopy* and *Straight to Lung CT*) in collaboration with our regional Cancer Alliance and commissioning colleagues
- New Cancer Access Policy which will be renewed when Cancer Wait Times Data Monitoring Guidance v10 is published
- Devised and delivered all aspects of the tertiary referral improvement plan ensuring more patients are referred early (<day 38) to tertiary treatment centres
- Recruited Cancer Pathway Trackers and Data Validator to improve MDT teams' ability to cope with influx of 2ww referrals and onward diagnostics

With support from NHS England we have expanded our surgical capacity to remove a recognised backlog in urology. We plan to extend these surgical lists dependent on funding streams. This will be complemented by additional surgical capacity with expertise in robotic surgery, helping to bring 2 week wait performance within 0-7 days in line with optimal timed pathways.

We have established that some key demand and capacity issues in the diagnostic stage (Radiology, Pathology Reporting and Biopsy) of the 62-day cancer pathway are impacting our performance. In 2019/20 we will do the following to improve and address these issues:

Table 4 - Summary of 62-day cancer standard improvement initiatives

New Capacity	Risk Mitigations
➢ Further implementation of timed pathways with lung, colorectal and prostate. ➢ Upper GI timed pathway project ➢ Faster Diagnosis Standard project aiming to analyse the capacity required to meet the 28 day standard across the system ➢ Gynaecology pathway review with the aim of: o Gynaecology pathway changes to reduce demand and variation at start of the pathway o Hysteroscopy and surgical capacity ➢ Head and Neck pathway review - same day OPA/US in front end of the pathway ➢ MDT Coordinator team centralisation ➢ Infoflex system upgrade with web view (additional tracking functionality) ➢ Expansion of Cancer Services team re: operational management and pathway trackers	➢ New CT and MRI scanners ➢ Workforce strategy for hard to recruit and retain role e.g. radio-graphers/sonographers/radiologists ➢ Outsourcing scans/reporting where appropriate ➢ Further demand/capacity modelling to be completed to deliver 5-7 day case turn around with new capacity ➢ Diagnostic pathways re-design to ensure initial diagnostics completed prior to being seen by clinician ➢ Pilot and embed transperineal biopsies in order to reduce TRUS biopsies being performed

Increased demand will be met by improved efficiencies and balancing with routine referrals. We will work in partnership with primary care to reduce increases in demand that have not led to a greater

detection in cancer. The Trust's *Cancer Delivery Plan* includes a trajectory for recovering and sustainably delivering the national cancer waiting time standards. The plan consists of a set of actions attributed to specialties to reduce breaches. Headline actions for 2019/20 are:

- Upgrading clinical systems to ensure we can track patients efficiently with multiple data uploads each work day, PTLs able to deal with live data entry, focused tracking through worklists, and system solutions to deliver *Living With and Beyond Cancer*.
- Centralised Cancer MDT team to improve continuity, staff retention and efficiency
- Pathology Rapid Improvement Event to improve pathway reporting elements
- Renew and improve video conferencing equipment to ensure MDTs have functionality to connect across sites and external health partners
- Implementation of single MDT for lung cancer service and specific lung cancer clinics
- Continue to improve colorectal and prostate pathways in line with the national Timed Pathways workstream
- Deliver elements of the draft Timed Upper GI pathway for patients who have suspected cancer following gastroscopy
- Continue working with commissioning colleagues to improve 2ww referral quality and reduce patient choice-related breaches

Effective Capacity and Demand Planning

This plan assumes reductions in both admissions and length of stay in support of the Trust's aim to reduce bed occupancy; the Trust's bed base in 2019/20 will remain 902 with the ability to flex into a further 58 beds at times of peak operational pressure (numbers exclude children's day case beds).

Recognising the significant operational benefits from optimizing our resources, considerable work has been done to ensure that the supply of beds, theatres and other capacity is commensurate with the operational requirements of the Trust and will therefore enable us to respond to demand (including seasonal variations) and deliver access standards and other operational priorities. Access to theatres is assumed to be increased as a continued result of the successful work driven by the Getting It Right First Time (GIRFT) programme and the aforementioned theatres efficiency programme; a theatres maintenance programme will run in conjunction to ensure that our estate is line with our requirements.

Outpatient capacity remains commensurate with planned activity but the outpatient transformation programme is expected to release further capacity which will contribute to waiting time reductions and/or cost reduction.

Managing unplanned change in demand, and our winter plan

Our plans assume that there will be no additional funding for winter pressures in 2019/20. Any seasonal fluctuations in activity are built into our workforce plans for the year. In 2019/20, as an Integrated Care System, we will be consulting with partners and the public on our preferred clinical model for unplanned care (urgent and emergency) and planned care across Gloucestershire. This will include our preferred future configuration of acute care services across Gloucestershire Royal and Cheltenham General Hospitals. The consultation will introduce the *Urgent Treatment Centres* and *Centres of Excellence* concepts, and how they could work together to improve patient access and experience and provide a more consistent and sustainable clinical service model.

The Centres of Excellence concept forms part of the Trust's long term clinical strategy and will be informed by the ambition and priorities of the NHS Long Term Plan and our own experience of designing and implementing successful service reconfigurations, some of which are currently in pilot stage in Trauma & Orthopaedics and Gastroenterology.

Last year we invested in a range of fixed-term initiatives to help us accommodate the additional pressures that winter brings the NHS, primarily to ensure we could temporarily increase our capacity. We also identified further emergency beds should we encounter an internal major incident. In 2019/20 we will review the impact of these and other initiatives to determine which should be planned earlier for this winter in collaboration with system partners in the *One Gloucestershire* ICS.

3. Quality Plan

3.1. Leadership and quality improvement approach and governance systems

Quality standards for patient services are clearly set out in the NHS Constitution and in the CQC quality and safety standards. They continue to define our expectations for the services we provide. We provide services and treat patients under a single shared view of quality – this means that we share the National Quality Board's 'Shared Commitment to Quality' as agreed by the Department of Health, Public Health England, NHS England, NHS Improvement, the Care Quality Commission, and the National Institute of Care Excellence. We confirm that our quality priorities are consistent with the One Gloucestershire Integrated Care System (ICS) and the NHS Long Term plan.

The Trust's *'Requires Improvement'* CQC rating in July 2017 showed that we needed to embed our quality improvement approach to build our safe, effective, caring, responsive and well-led practice into our processes, standards and systems. Our latest CQC rating of *'Good'* in February 2019 showed this has happened, and sets us on the path to *'Outstanding'*. Quality continues to drive our strategy and day-to-day work and is reflected in our vision, *Best Care for Everyone*. In 2019/20 we will publish our refreshed strategic priorities including our *Enabling Quality Improvement Strategy,* detailing our planned 'Journey To Outstanding' (search Twitter for #*J2O*). The strategy puts the needs of patients and service users, their families and carers first, as well as supporting the Trust priorities and the requirements of national and local plans.

Our Executive Director of Quality and Chief Nurse is the lead responsible for quality improvement in the Trust and works collaboratively with our Medical Director. This board-level clinical leadership for quality ensures robust assurance and challenge about the quality of our services continues to be strategically embedded.

Our Quality Governance System

In 2018/19 we further developed our governance systems to provide greater clarity of the day-to-day delivery of quality in all our operational work. Our quality governance structure can be found in Appendix 3. Quality outcomes are monitored through the Trust Board Assurance Framework, with a 'Ward to Board' approach of measurement, summarised through Divisions and Corporate Committees and with key measures and those key measures being reported by exception to the Board. In addition each month our Board receives a range of updates including an Integrated Quality and Performance Report; this presents a comprehensive set of measures which align with the five CQC domains, including quality, workforce and finance.

Our Quality and Performance Committee of the Board is chaired by one of our Non-Executive Directors and is responsible for quality assurance, also providing assurance reports. The Committee reviews an extensive range of quality reports, audits and reviews (covering topics such as the Risk Register, Serious Incidents, Safer Staffing, safe care metrics, Quality Account updates, and *Getting It Right First Time* reviews).

Our Quality Delivery Group is chaired by the Director of Quality and Chief Nurse. The Group is operationally focused on the delivery of quality across all services and reports by exception directly to the Trust Leadership Team chaired by the Chief Executive and the Quality and Performance Committee. The Quality Delivery Group's value is that Corporate and Divisional Teams can come together and share intelligence, agree action and monitor overall assurance on quality. The Group has a role in reviewing quality plans, metrics and indicators, and working with other committees to assess and manage risks and quality issues. If a concern regarding quality is raised through any other part of our governance structure, part of the Quality Delivery Group's remit is to consider the financial and other resource implications of all options, including 'do nothing'.

Our Quality Improvement Approach

Key to our approach to quality improvement is the Gloucestershire Safety and Quality Improvement Academy (GSQIA). The Academy provides structured training on quality improvement methods, techniques and models at Bronze, Silver and Gold Level. Most importantly all attendees are required at Silver Level to use their new skills in an improvement project in their day to day work as part of their learning and at Gold Level to coach at least 3-4 Silver projects.

The measures we are using to demonstrate and evidence the impact of the investment in quality improvement are the numbers of staff we have trained at each level. To date nearly 2,000 (26%) of our staff have gone through one of the training programmes; our approach embeds continuous quality improvement within our culture. The GSQIA training programme structure is available to view online[3]. Since the introduction of the QI training in the Academy we have now taken further steps to develop our Quality Model (supported by Gold QI Coaches) within the corporate teams and within the Divisions at speciality level. The Quality Model approach enables speciality departments to define improvements and standards based on what they see as 'what is important to you' as local experts. Departments create improvement plans based on their data, supported by Gold QI coaches, and potentially other supporting corporate roles. Divisional and Trust committees' roles monitor the effectiveness of the specialty plans through appropriate check and challenge, but fundamentally trust the speciality department to direct their quality management. Services ask key questions and are expected to meet national quality standards, notably:

- What is important to our service today and tomorrow?
- What do we need to monitor?
- How are we learning and what do we need to improve?

The specialty will continuously monitor key quality indicators that they have identified, manage quality risks and concerns and have a relevant improvement programme. The importance of embedding improvement, rather than just providing assurance against standards, is essential to make sure that changes to meet targets are truly better for our patients rather than simply finding a way to meet targets. Our Quality Framework Model can be found in Appendix 4.

Examples of quality improvement initiatives to be included in our Quality Account 2019/20 Seven day services - Delivering 7-day services remains a quality priority for the Trust. We have carried out a robust self-assessment and we have developed an action plan for service gaps which is being monitored for delivery through the Planned Care Delivery Board and for assurance through our Quality and a Performance Committee. We will continue the improvement work in the next financial year and will report this publicly through our Quality Account.

Preventing healthcare associated Gram-negative bacterial bloodstream infection (BSIs) - Gram negative bloodstream infections are a healthcare safety issue and we aim to halve the incidence of infections by 2021. The ICS-wide action plan has been reviewed and will be further developed with our partners with a particular focus on reducing urinary catheter use and improving hydration in older adults. We have taken part in the successful urinary tract infections collaborative hosted by NHS Improvement and will continue to implement this work. We expect to implement our catheter reduction plan during summer 2019. The action plan delivery is being monitored by the Infection Control and Prevention Committee and for assurance through our Quality and Performance Committee. We will continue the improvement work in the next financial year and will report this through our Quality Account.

Implementation of National Early Warning Scoring version 2 (NEWS2) – We went live with the updated NEWS2 system in April 2018 with an implementation plan that focused on engaging staff;

[3] https://www.gloshospitals.nhs.uk/documents/1751/QI_Professional_Development_Pathway.pdf

as part of the Patient Safety Programme, 'NEWS 2' has now been audited. The priority areas for audit included complete observation recording, accurate NEWS2 score calculation, documentation of response to a concerning NEWS2 score and correct saturation scale use. The results of the audits have informed our 2019/20 improvement plan, to be reported through our Quality Account.

Learning from deaths - In March 2017, the National Quality Board published the first National Learning from Deaths Guidance 'A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care'. In response to this guidance, our Hospital Mortality Review Group has developed a 'Learning from Deaths' improvement programme and policy (which is published on our Trust website). In 2018-19 we presented quarterly progress reports to the Trust Board. We will continue our improvement work in this area and will report this in our Quality Account.

3.2. Quality Improvement Plan

Through reviewing our top risks on our risk register, local finance, patient activity, workforce, quality data and the current national priorities we are currently consulting our staff and our patients on our quality objectives for 2019/20. Detail regarding our Quality Priorities for 2019/20 can be found at Appendix 5. Our CQC reports continue to help us formulate and drive our quality improvement plan:

- Assurance Plan - ensure *Outstanding*, *Good* or *Requires Improvement* are at least maintained
- Proactive Plan – to take us to Outstanding, and will link integrally to the Gloucestershire Safety and Quality Improvement Academy.
- Responsive Plan – Must Do and Should Do actions from our last CQC inspection that rated the Trust as Good overall (see table below – this is our baseline to start 2019/20:

Table 5 - Quality Improvement Plan - Must Do

Core Service	Findings	Actions	Executive Lead(s)
Urgent & Emergency Care	1	6	Medical Director
Medical Care	6	25	Director of Quality & Chief Nurse; Director of Corporate Governance; Chief Operating Officer; Director of Strategy & Transformation
Medical Care/Surgery	1	4	Director of Quality & Chief Nurse
Surgery	4	21	Director of Quality & Chief Nurse; Medical Director

Table 6 - Quality Improvement Plan – Should Do

Core Service	Findings[4]	Responsible Lead(s)
Urgent & Emergency Care	12	Chief Operating Officer
Medical Care	9	Chief of Service for Medicine; Divisional Chief Nurse for Medicine; Deputy Chief Nurse; Director of Operations & Deputy Chief Operating Officer
Surgery	14	Associate Chief Nurse & Deputy Director of Infection Prevention & Control; Divisional Chief Nurse for Surgery; Director of Safety; Director of Operations & Deputy Chief Operating Officer
Outpatients	5	Matrons; Director of Operations & Deputy Chief Operating Officer

3.3. Quality Impact Assessment Process and Oversight

Quality Impact Assessments (QIAs) are a critical part of how we manage change. Developing into a formal process from the findings of the *Report of the Mid Staffordshire NHS Foundation Trust*

[4] Due to the proximity of publication, *Should Do* actions are being formulated at the time of writing

Enquiry[5] (the 'Francis Report'), QIAs are essential in ensuring cost reduction and efficiency happen with full regard for service quality and patient safety. An essential part of how we work, and fully endorsed by our Board, QIAs focus on input from clinicians and other colleagues who conduct the work that might be affected by a proposed change to understand the impact thoroughly. The QIA process, information requirements and metrics can be found at Appendix 6. QIAs are conducted in various functions around the Trust, most notably:

Cost Improvement Programme (CIP)

As proposed by the National Quality Board[6] our CIP governance is led by an executive director and ensures that:

- Patient care comes first.
- Quality is everyone's business and we speak up about concerns without hesitation.
- We listen carefully to what patients and our staff tell us about the quality of care, and we ensure we see these concerns first hand.
- We share what we are told and what we learn with others, and seek advice if we're not sure what decision to make.
- We behave in accordance with our own values[7] and the NHS Constitution.

Significant Service Changes and Good Ideas

The Trust needs to continually improve for a wide range of reasons including: responding to the increasing patient numbers and changes in demographics, advances in medical science, new patient pathways and treatment, ideas from staff about process improvements, or simply deterioration in our physical buildings and equipment over time. Whenever an improvement is proposed there can be a range of direct and indirect impacts on other services or processes, both for our own organisation and our partners.

Similarly, to make the most of opportunities to improve care and reduce costs, we have a process that encourages all staff to come forward with proposals that can be assessed for their ability to deliver improvement, and checked for any unintended adverse impacts on the quality of care we provide. Conducting robust QIAs in both large and small-scale change eliminates or minimises the negative impacts or risks, creating real benefits for patients and staff. We do this by listening and talking to all interested stakeholders who support or are dependent upon our changing services, and work with them to model how our proposed changes affect their processes.

[5] https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry
[6] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212819/How-to-Quality-Impact-Assess-Provider-Cost-Improvement-Plans-.pdf
[7] http://www.gloshospitals.nhs.uk/en/About-Us/About-the-Trust/Our-Values/

4. Workforce Plan

4.1. Our Workforce Strategy

The Trust has a Workforce strategy which seeks to ensure that through the People and Organisational Development (OD) agenda patients receive the best possible care. It sets out our ambition to deliver the right sized and skilled workforce through effective recruitment, retention and education. Our approach to workforce saw a significant shift in 2018/19, with development of more robust transactional recruitment services and our transformational People and OD services. This included the introduction of a specialist HR Business Partner Role, focussing on sustainable workforce initiatives and the growth of new roles, whilst linking our workforce planning methodology to strategic programmes of transformation.

4.2. Our Workforce Challenges

Table 7 - Workforce Challenges

Workforce Challenge	Impact on workforce	Initiatives in place
Retention, where it falls outside of benchmarked norms (i.e. Additional Clinical Services >15%)	Additional pressure in areas with hard to fill vacancies.	➢ Onboarding co-ordinator joining February 2019 to support new employee experience. ➢ Periodic staff experience surveys during first 12 months in post. ➢ Quarterly HCA Conference –scheduled for Spring 2019 ➢ Drop in Career Clinics and Promotion of alternative career pathways including: Trainee Nurse Associate role. ➢ Core skills support for HCA's (English and Maths) ➢ Review of HCA Terms and Conditions (ongoing – review as potential cost pressure for 2019) ➢ Trust wide review and implementation of the Health and Wellbeing Hub. ➢ Further exploratory review of Nursing Career pathways e.g. Specialist Nurses; focus on tackling bullying & harassment, and gaining true added value from appraisals ➢ Staff and Patient Experience Improvement Group
Recruitment to hard to fill posts	Pressure on existing workforce, impacting on staff experience and retention	➢ Recruitment Steering Group working on a wide range of initiatives including: ➢ Social Media campaigns ➢ Targeted BAME recruitment ➢ Refreshed marketing material ➢ Overseas campaigns ➢ Streamlining onboarding processes and reducing 'time to hire'. ➢ Production of trajectories and vacancy forecasts ➢ 'Grow our own' initiatives and apprenticeship pathways. ➢ Increased recruitment to Trust Bank to ensure safe, flexible and competent workforce
Staff Engagement *Cont'd...*	The risk of continued poor levels of staff engagement and poor staff experience impacting negatively on retention, recruitment and patient experience	➢ Triangulation of Staff and Patient Experience information to identify 'hotspots', through the Staff and Patient Experience Improvement Group. ➢ Implementation of a range of staff engagement, health and wellbeing actions relating to staff experience. ➢ Staff Engagement Activity such as: blogs, Involve, staff meetings, social media, and 'pulse surveys' to identify and measure items of interest.

Workforce Challenge	Impact on workforce	Initiatives in place
		➢ Freedom to Speak Up agenda (Freedom to Speak up Friday) ➢ Leadership and professional development opportunities ➢ Leadership Engagement Forums (100 Leaders, Extended Network, GM Forum) ➢ Development of informal change toolkit for managers and leaders. ➢ Working with clinical leaders to develop enhanced care pathways. ➢ Staff recognition: 'Going the Extra Mile' (GEM) awards, annual staff awards and divisional/local awards ➢ Talent Management (Accelerated Development Pool) ➢ Health and wellbeing hub launch; review of health & safety systems and practices. ➢ Health and Wellbeing Campaigns including: Junior Dr mental health programme and the Health and Wellbeing Charter. ➢ Equality of Opportunity Plan

4.3. Our Workforce Risks, Issues and Mitigations

Table 8 - Workforce Risks, Issues and Mitigations

Description of workforce risk	Impact of risk	Risk response strategy	Timescales and progress to date
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.	High	Recruitment and Retention Group; leading on initiatives such as : overseas recruitment, new innovative branding/ recruitment imagery and social media presence	
		Maturation of talent development system (July 2018)	Ongoing programme of work
		Overseas Nurse Recruitment Workstream/ Pipeline (Non EU)	Australia recruitment event booked Mar-2019. Recruitment pipeline and timescales will be determined post-visit
		Alternative Role Development Implementation of new roles and the extension of relationships with education partners to create and support these; e.g.: Nurse Associates, Higher apprentices.	
		Development of ACP business case	In progress – ACP Business Case due Mar-2019 for Trust approvals process and implementation 2019/20
		Implementation of Chief Nurse Fellow role	CNF's implemented Dec-2018; further cohort(s) 2019/20
		Scoping potential trial of Associate Specialist role on the Acute floor	Timescales yet to be agreed
		Design of initiatives to develop own talent in radiography	November 2019
		Revised Workforce Planning Process aligned with Business Planning cycle and linked to central workforce planning for the ICS	In place and continuing to develop through 2019/20

Description of workforce risk	Impact of risk	Risk response strategy	Timescales and progress to date
The risk of continued poor levels of staff engagement and poor staff experience impacting negatively on retention, recruitment and patient experience.	High	Triangulation of Staff and Patient Experience information Development of Staff and Patient Experience Improvement Group to implement a range of staff engagement, health and wellbeing actions and begin triangulation of data relating to staff experience. Development of a dedicated role to analyse and review trends across staff and patient data to aid problem solving. Work in progress to triangulate staff and patient data to identify 'hotspots' where engagement could improve and intervention is required. The Staff and Patient Experience Improvement Group are overseeing key work such as: The Violence and Aggression focus group and the HCA retention plan (Launched August 2018, work continuing throughout 2019/20)	Ongoing through 2019/20
		Engagement Activities Monthly Diversity Network coffee socials and bimonthly meetings Promotion of Freedom to Speak Up Friday and FTSU week, develop the role of FTSU ambassador Ongoing engagement events – weekly CEO blog, monthly 'Involve' Executive briefings, staff meetings, social media *Journey to Outstanding* (J2O) programme to motivate staff to agree divisional and departmental ambitions	Ongoing through 2019/20
		Leadership Development and Engagement Following establishment of GM/AGM Forum and Operational Matrons Group, develop these groups New Extended Leadership Network aimed at mid-level managers (Network met in August and November 2018, and February 2019) Development of informal change toolkit for managers and leaders. Working with clinical leaders to develop enhanced care pathways.	Ongoing through 2019/20 Ongoing through 2019/20 Draft toolkit completed Jan-2019 , roll out to managers Feb-Mar 2019 for implementation through 2019/20 Ongoing through 2019/20
		Professional Development and Staff Recognition Career pathway developments – such as the nurse 10 year career plan and AHP development. Education programmes for CPD, leadership, professional practice 'Keep me' and itchy feet conversations, Nurse Rotation Scheme GEM awards, staff awards and divisional/local awards New talent management and succession planning with new appraisal process focused on staff development. First Accelerated Development Pool launched November 2018	Ongoing through 2019/20 Ongoing through 2019/20 Ongoing through 2019/20 Ongoing through 2019/20 Ongoing through 2019/20

Cont'd…

Description of workforce risk	Impact of risk	Risk response strategy	Timescales and progress to date
The risk of continued poor levels of staff engagement and poor staff experience impacting negatively on retention, recruitment and patient experience.	High	Focus on Staff Health and Wellbeing Health and wellbeing hub launch Health and Wellbeing Campaigns including: Junior Dr mental health programme and the Health and Wellbeing Charter.	Apr-2019 Launched 2018/19, peer support network development throughout 2019/20
		Equality, Diversity and Inclusion EDS2 output-based equality of opportunity action plan: 1. Better health outcomes relative to community needs 2. Improved patient access and experience 3. A represented a supported workforce 4. Inclusive leadership Analysis of gender pay to design solutions to reduce gaps Preparation to improve the recoding of protected characteristics ahead of WDES	Published 2018/19, work ongoing throughout 2019/20 Analysis April 2019, action plan to follow Through 2019/20
		Quality Led Initiatives Quality summits following reports on patient care issues and Schwartz rounds Gloucestershire Safety and Quality Improvement Academy (GSQIA) Nurse accreditation scheme	In place; ongoing through 2019/20 In place; ongoing through 2019/20 In place; ongoing through 2019/20
Risk of staff in critical posts (i.e. Consultants) reducing additional PA's or Waiting List Initiatives as a result of the reduced Annual Allowance threshold	Low	Encourage employees to seek independent financial advice. Assess likely risk areas/hotspots with support of clinical leads	Providing NHS Pension workshops to support understanding of the issue, individual Total Reward Statements and earnings (however not providing any financial advice). Development of a Pension Recycle Policy (launch Apr-2019) to provide an alternative remuneration solution

4.4. Our Long-Term Vacancies

Table 9 - Long Term Vacancies

Description of vacancy & longevity	WTE Impact (Feb 19)	Impact on Service Delivery	Initiatives in place, with timescales
Registered Nursing Posts (Band 5, >12 months) *Cont'd...*	136.25 (10.8%)	Increased Bank and Agency usage. Increased pressure on existing workforce, impacting on staff experience & retention	Increased recruitment to Trust Bank to ensure safe, flexible and competent workforce. New pay incentives reviewed October 2018; to review Quarterly. Daily, dynamic review of safer staffing numbers with Executive leadership and site/ activity management input. Development of alternative workforce roles (i.e. Nurse Associate)

Description of vacancy & longevity	WTE Impact (Feb 19)	Impact on Service Delivery	Initiatives in place, with timescales
		Potential negative impact on the delivery of safe, quality care to patients.	Recruitment initiatives: Australia recruitment trip for RGNs March 2019. Refer a Friend scheme (live) UK recruitment fairs Ongoing Philippines pipeline (offered and awaiting IELTS)
Doctor in Training Gaps (various gaps – some short term and maternity cover)	42.0 (incl. 16 Deanery)	Impact mitigated through additional working and temporary cover	Physicians Associates in place: further recruitment planned spring/ summer 2019. Advanced Clinical Practitioners: Business case Q1 Associate Specialist role: Scoping the option of introducing a trust contract which may support consultant gaps in the future. This work will be considered by our Local Negotiating Committee as it develops (timescales to be identified). Review of scope of SAS roles (timescale tbc)
<u>Consultant Posts</u> Care of the Elderly Gastro Acute Diabetes Oncology Microbiologist	 2.0 1.0 4.0 1.0 1.0 1.0	Impact mitigated through additional working and temporary cover	Active recruitment campaigns Locum and Agency cover Internal support (i.e. additional PA's). Social Media campaigns
Radiographers (>12 months)	13.0	Reduced support to community services. Impact on staff morale and sickness absence.	Reduced staffing in community hospitals (approved by HOSC) . Pay incentive for overtime agreed January 2019. Currently exploring 'Grow your own' initiatives to include: Assistant Practitioners (Band 4), 2 year training programme to convert to Band 6. (Timescales yet to be identified). Overseas Recruitment (Australia).
Cytology (B4/B5 Cytoscreener/BMS) (>12 months)	3.0	National changes to programme means we do not intend to fill these vacancies. Ad-hoc overtime when demand is high	Service change means action plan to fill vacancies is not necessary/ appropriate.
Band 7 Cardiac Physiologists (>12 months)	5.0	Partial agency cover in place. Existing team providing cover.	Review of skill mix and alternative professional roles is underway.
Vascular Surgeon/ Clinical Fellow	2.0	Existing team & some agency provide cover	Review of skill mix and alternative professional roles will commence post April 2019.
Vascular Scientists	2.0	Partial agency cover in place.	Review of skill mix and alternative professional roles will commence post April 2019.
Band 5 Audiologist (>12 months)	2.0	Impact reduced since apprenticeship pathway launched (graduates targeted and skills mix changed). Agency cover provided.	New apprenticeship pathway in place (implemented 2018), recruitment to remaining 2 roles was unsuccessful, however further efforts will be made to advertise these during 2019)

Description of vacancy & longevity	WTE Impact (Feb 19)	Impact on Service Delivery	Initiatives in place, with timescales
Paediatric Nursing (not same vacancy, turnover is 16.5%)	9.5	Agency cover where appropriate.	Recruitment of overseas Nurses (in pipeline for 2019) Development of specialist Paediatric roles, supporting improved retention. Developing Paediatric Nurse specialist to provide enhanced support to Emergency Department. Nurse
Gloucestershire Managed Services (Wholly Owned Subsidiary) Electrical/ Mechanical Technician Roles	4.0	Cover via technical contractors and internal resource.	Wholly owned subsidiary company established April 2018. Development of alternative pay framework and benefits providing flexible reward package to compete with local market place. Recruitment and Retention incentive payments in place for existing (transferred staff).
Gloucestershire Managed Services (Wholly Owned Subsidiary) Chef	1.0	Internal cover and ad hoc agency support	Wholly owned subsidiary company established April 2018. Development of alternative pay framework and benefits providing flexible reward package to compete with local market place.

4.5. Workforce planning, engagement and collaborative working

Workforce planning is an essential element of our business planning cycle, incorporating the Trust vision of Best Care For Everyone and forming an integral part of our Journey to Outstanding. In 2018/19 we revised our workforce planning template, to enable divisions to plot clear baseline workforce numbers from which to project workforce trends aligned to known patterns of demand and capacity. The revised workforce planning template forms part of the operational plan and supports Divisions to:

- Understand and assess the appropriate deployment of sufficient suitably qualified, competent, skilled and experienced staff to meet care and treatment needs safely and effectively.
- Maintain a systematic approach to determining the number of staff and range of skills required to meet the needs of people using the service and keep them safe at all times
- Ensure that workforce design reflects current legislation and guidance where it is available.

There are a number of factors for consideration as part of the process of aligning workforce to demand and capacity, including:

- Type, acuity, dependency, etc. of service using evidence based tools
- Activity levels, including seasonal and other known variation demands
- Patients outcome measures
- Service changes and transformation, including ICS initiatives and reconfiguration of patient pathways
- Contract/commissioning factors/constraints
- Workforce supply issues and known impact, and subsequent newly developed roles (such as ACP's and Physicians' Associates)
- Bank/agency usage and controls
- Safe staffing levels and staff outcome measures; 5 year workforce demographic profiled

When considering the ratio of staff to patients and/or acuity, any alteration/deviation from recognised and agreed ratios can only be approved by the Medical Director/Trust Chief Nurse as

appropriate. This is managed dynamically, on a daily basis, to ensure that any impact to service delivery and quality is fully assessed.

Our Divisional workforce plans include a focus on staff Engagement, Development and Health and Wellbeing and align to the overarching Trust work streams, linkage in development initiatives such as talent management through our new Accelerated Development Programme (ADP) and the introduction of a new Health and Wellbeing Hub for our workforce.

Effective Deployment of Workforce and Temporary Staffing

We have recently implemented the HealthRoster system which will enable more effective deployment of all nursing and midwifery staff. Medical staff are managed through a robust process of annual job planning to ensure that the greatest level of efficiency is achieved. Progress is audited through sub-committees of the Trust Board: The Finance and Digital Committee and the Quality and Performance Committee.

The Trust ensures that staffing levels and people metrics are well scrutinised to ensure that the Trust delivers the services required. The Board and Committees also scrutinise the effectiveness of its workforce to provide quality care and monitor measures such as turnover and sickness. Action plans are put in place where staffing levels cause concern and are monitored through the People and OD Committee.

Vacancy Control Process

The Trust follows a strict vacancy control processes. Vacancies are considered at divisional level first for approval with new posts being presented to a Vacancy Control Panel (VCP) for executive approval. In order to expedite requests to recruit and minimise potential impact to services, vacancies filled on a 'like for like' basis, with financial approval or posts related to approved business cases are approved directly by the Executive Director of People. All VCP's are considered alongside a quality impact assessment and a number of posts are excluded from the process such as: Band 5 Nurses, HCA's Midwives, Radiographers and Doctors in training.

Sustainable Workforce Solutions

The Trust has embedded a Recruitment Strategy Group (RSG), reporting to the People and OD Group which in turn reports into the People & OD Committee. RSG focuses on hard to fill posts and continues to develop medical staffing and AHP opportunities with clinical leads to attract and retain the best talent. Current education opportunities offer a variety of development pathways outside of statutory and mandatory training, which assist in the retention of all staff. Our workforce sustainability agenda focusses on new roles such as Advanced Clinical Practitioners, Nurse Associates, Associate Specialist roles, and other alternatives to hard to fill vacancies. The Trust has commenced a review on filling medical workforce gaps by reviewing the level of autonomy of SAS Doctors and introducing new roles to fill rota gaps – this is well advanced in some areas such as paediatrics and neonatal care.

In response to particular challenges in the recruitment of technical estates and facilities staff, the Trust has established a Wholly Owned Subsidiary and is exploiting the flexibilities this model affords us to attract staff into these hard to recruit posts.

The Trust values staff and looks to support them with absence due to sickness, linking engaged staff to good patient outcomes. The HR Advisory centre assists managers in sickness management and the Trust offers a variety of health and wellbeing services aimed at keeping staff fit and healthy. To ensure staff engagement the Trust invests in staff listening events and forums. These include the Chief Executive's blog, Involve (monthly staff meetings), Outline (staff

magazine), Executive Safety & Patient Experience walkabouts and the *100 Leaders* and *Extended Leadership* networks to name a few.

Retention Activity

Analysis of Nurse leavers within the last year shows increased turnover for those staff with less than 5 years' service, in the 21-35 age demographic. We also observe more leavers across medicine and surgery in contrast to the other Divisions.

Whilst our turnover is below the UK average it is still important to retain our talent and to maximise our retention of qualified staff, as a result, we have looked at a number of strategies and schemes to support our retention. Our newly formed (2018) Staff and Patient Experience Group is focussing on building capacity to triangulate this data with other key performance indicators and are responsible for the review of specific action plans – such as the 'Healthcare Assistant retention action plan'. The group is also considering generation specific requirements in terms of how we can best support staff and what is attractive to each staff group. This includes the review of Terms and Conditions, implementing pre-exit ('Itchy Feet') interventions, transfer and rotational opportunities and 'Keep Me' conversations. We are currently exploring a review of the exit process; potentially to include resignation to Chief Nurse/lead professional and increased exit interviews to support intervention where possible. Feedback we have received indicates professional development and career opportunities are important to our staff so we have developed clear, accessible pathways with peer support and supervision with our Professional Development and Education Team.

Health and Wellbeing

From April 2019 the Trust will launch a new Health and wellbeing service for staff. This will provide 'one stop shop' and signposting service for our staff and students, to ensure our workforce (and potential workforce) are able to access immediate support to support attendance at work and personal health and wellbeing to include: counselling support, musculoskeletal pathways, occupational health referrals, debt advice, etc. Anticipated benefits include reduced absence and turnover, increased staff engagement and improved staff experience. There will be cash-releasing benefits from reduced absence and associated backfill costs.

Armed Forced Covenant

The Armed Forces Covenant is a promise from the nation that those who serve or have served, and their families, are treated fairly and we have been recognised by the Armed Forces Covenant Employer Recognition Scheme with a Gold Award for our support of those who serve. We have many staff working in our hospitals who have previously been a member of the Armed Forces or has a partner who has been or is still in the Armed Forces and some of our staff also serve as Reservists. These individuals are best placed to understand the difficulties that this cohort of patients and their families encounter and have experience of the challenges that can be faced in accessing and receiving health care services.

4.6. Equality, 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'. Equally applicable to our staff and volunteers as they are our service users, these are key enablers for an engaged, productive and safe workforce. The Trust is committed to demonstrating compliance with, and ultimately becoming

an exemplar of, the requirements laid out in The Public Sector Equality Duty[8] and The Equality Delivery System[9] (EDS2) – not just due to legal obligations, but more importantly because of the long-term benefits for patients and staff, and because it is simply the right thing to do. Our Executive and Non-Executive Board members have taken individual leads for protected characteristics. In order to champion awareness and provide mentorship, supporting inclusion and equality of opportunity, during 2018/19 the Trust published an Equality of Opportunity Plan[10], summarised below:

Table 10 - Summary of Equality Delivery System 2 Outputs

Group	Current grading for baseline	Goal	
Patients	Developing: people from only some protected groups fare as well as people overall	1. Better health outcomes	5 outcomes
		2. Improved patient access and experience	4 outcomes
Staff	Developing: staff members from only some protected groups fare well compared with their numbers in the local population and/or the overall workforce	3. A representative and supported workforce	6 outcomes
		4. Inclusive leadership	3 outcomes

We have a Diversity Network which is open for all staff to join. Our network collaborates with the Trust to eliminate unlawful discrimination experienced by staff. It also provides a signposting and support function where issues can be discussed in a safe and confidential environment. 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. The Trust revisited Equality and Diversity objectives in Q4 2018/19 for the next strategic planning period, and engaged with staff to ascertain their priorities.

Summary of system-wide workforce plans

The system-wide Local Workforce action board oversee a programme of work to support our transformational programme. The Gloucestershire workforce strategy is underpinned by both workforce and organisational development steering groups. There are a wide range of initiatives that have been funded during 2018/19 and the forward programme for 19/20 is currently being developed (further detail to be provided in April submission). The areas of focus during 2018/19 have been as follows, many of these are likely to continue into 2019/20.

- **Integrating roles and teams:** Integrated Supervision for Specialist and Advancing Practice and Changing Roles to support bringing health and social care specialists together from across the different organisations.
- **Multi-professional roles and teams:** a number of initiatives aimed at broadened the skills of the clinical workforce to work in professional diverse teams including the development of an approved educational framework to support the development of new roles and services to deliver the Gloucestershire's clinical priorities and pathways. Supporting advancing clinical practice through the provision of a 2 year Masters level modules.
- **Mental Health:** supporting the delivery of mental health crisis care within the urgent & emergency care pathway

[8] https://www.gov.uk/guidance/equality-act-2010-guidance
[9] https://www.england.nhs.uk/about/equality/equality-hub/eds/
[10] https://www.gloshospitals.nhs.uk/documents/5864/Equality_of_Opportunity_Plan_2018-19_v3.pdf

- **Maternity pathway:** directly upskill frontline perinatal team clinicians in psychological interventions and approaches.
- **Self-care and prevention:** better conversations training to widen the pool of our staff community who can support our enabling activity communities programme working with people on improving their health and staying well.
- **Leadership development:** we have system-wide leadership development and quality improvement programmes which support and develop our staff to work with a system-focus and quality improvement approach we will continue to roll-out this approach during 2019/20 with a widening scope for the leadership programme to encompass organisations who influence wider determinants of health including the police and the VCSE community.
- **Workforce planning:** support for increased workforce planning across system partners;
- **Recruitment:** joint initiatives to recruit for similar roles across ICS partners with a specific focus on improving BAME representation.

Planning for the withdrawal of the United Kingdom (UK) from the European Union (Brexit)

The Trust currently employees circa 300 staff from the EU, less than 4% of our entire workforce (excluding GMS, our subsidiary company). The number of EU recruits to our hard to fill vacancies, such as registered nurses, is negligible with pipelines from areas such as Spain and Portugal failing to produce candidates for the past four years. There is no evidence to suggest that our current workforce will leave the UK, especially given the assurance of their right to remain.

5. Financial Plan

5.1. Background and context

For the 2018/19 financial year the Trust accepted a control total of £18.8m deficit, including £8.1m of Provider Sustainability Funding (PSF). This was a challenging control total entered into post two years of significant financial recovery work.

The Trust negotiated a mixture of variable and block contracts with Gloucestershire CCG and Specialised commissioners which, whilst restricting some anticipated increases to income as part of our cost improvement plan, enabled us to continue progress with our financial recovery plan on a solid foundation.

In November 2018, after significant progress in the areas of both financial governance and CIP delivery in successive years, the Trust exited the Financial Special Measures regime. We continue to have an underlying deficit position still to address. For 2019/20 our financial recovery continues to be driven through operational and transformational cost improvement, to ensure we maintain and continuously improve quality and performance, during recovery and beyond.

5.2. Financial Forecasts and Modelling

Planning Assumptions

For the 2019/20 financial year the Trust is planning for a £1.5m deficit financial position (in line with the control total offered to it by NHS Improvement) based on the following key assumptions:

- A forecast 2018/19 outturn of a £27.9m deficit, which after adjusting for the impact of donated assets is revised to £29.1m on a control total basis. This position includes £5.2m of PSF and a further £12.7m of non-recurrent or full-year effect adjustments – leading to a recurrent underlying position of a £47.0m deficit.
- The impact of inflationary pressures is planned at £13.3m.
- As per planning guidance, pay expenditure excludes the impact of the increase in employer pension costs.
- Non-pay inflation includes provision for increases in drug and other non-pay costs.
- Total operating cost pressures of £4.1m, comprising: investment in approved pressures of £2.7m and £1.4m to address intolerable quality and safety risks.
- Based on the latest guidance from the Royal Institute of Chartered Surveyors (RICS) the Trust is exposed to the risk of an increased depreciation charge of £4.1m (not included in this plan) as a result of previously extended asset lives.
- 2019/20 CIP schemes of £22.4m (4% of turnover), including the full year effect of prior year's schemes.
- Where contract settlements have been reached with the Trust's commissioners they are reflected in this plan. These settlements which are subject to final agreement with commissioners assume significant income uplifts, reflecting NHS growth funds in the national tariff, activity increases for growth, and appropriate payment for non-tariff funded services.

2019/20 income assumptions:

Patient care income reflects the following assumptions:

- Agreement of a contract value of £345.4m with Gloucestershire CCG, which reflects the impact of the planning national tariff, activity growth, and appropriate payment for non-tariff and other services.

- Other operating income includes the following as notified within the Trust's control total, PSF (£8.5m), Marginal Rate Emergency Threshold (MRET) funding (£4m) and income from the newly established Financial Recovery Fund (FRF) (£7.3m).

Financial Summary

The table below summarises the 2019/20 financial plan for submission in the NHSI template on 4th April 2019:

Table 11 - Financial Plan Summary

Income/ cost area	2018/19 FOT £000	2019/20 Plan £000
Income from patient care activities	457,513	488,235
Other Operating Income	74,473	84,395
Total Income	531,986	572,630
Pay	(353,359)	(369,522)
Non-Pay	(186,890)	(182,630)
Total Expenditure	(540,249)	(552,152)
EBITDA	(8,263)	20,478
EBITDA %	(1.6%)	3.6%
Non-operating Income	98	98
Non-operating Costs	(19,784)	(21,472)
Surplus/ (Deficit)	(27,949)	(896)
Impairment		
Donated Assets impact	(1,130)	(604)
Adjusted Surplus/(Deficit)	(29,079)	(1,500)

The table above identifies planned delivery of the £1.5m deficit control total set by NHSI for the Trust. This plan is contingent on a significant uplift in income from the Trust's lead commissioner and a 4% CIP (2.4% in excess of the national planning assumption of 1.1% in tariff plus an additional 0.5% contained within control total offers).

Cash Flow Plan

The table below shows the cash flow plan based on the income and expenditure plan identified above; and a loan of £21.9m (including £10m confirmed in 2018/19) to fund the 2019/20 capital programme. The cash flow assumes that the Trust will receive borrowing to repay previous capital and revenue debt of £9.8m, and working capital debt of £12.9m, which is critical to ensuring that the Trust can continue to maintain its current working capital position and meet creditor commitments.

Table 12 - Cash Flow Plan

Cash flow	£000
Operating surplus/(deficit)	10,086
Add back non-cash items	9,392
Movements in working capital	(19,990)
Net cash inflow from operating activities	(512)
Interest received	36
Land receipts	
Capital purchases	(25,003)
Net cash from investing activities	(24,967)
PDC Received	1,500
Capital Financing	21,934
Revenue Loans	8,321
Working capital loan	12,879
Loan repayments	(9,791)
Capital element of lease and PFI payments	(6,681)
Interest paid	(4,504)
PDC payable	(2,375)
Interest element of lease and PFI payments	(456)
Net cash inflow/(outflow) from financing	20,827
Net movement in cash	(4,652)
Opening cash balance	7,306
Closing cash balance	2,654

Income Plan 2019/20

For commissioned services the starting point for the income plan is the 2018/19 forecast outturn activity, adjusted for counting and coding changes as they are agreed with our commissioners, including maternity and non-Payment by Results tariff changes. The income plan is then adjusted for estimated growth in demand based on historical trends, specific business cases, and risks identified in securing contract settlement.

Expenditure Plan 2018/19

Budget setting meetings with Clinical Divisions and Corporate Directorates have been undertaken based on the following key principles:

- Inflation for pay and non-pay expenditure budgets is applied in line with detailed planning assumptions. Non-pay inflation has been provided where clearly demonstrated (e.g. contractual commitments, and drugs and consumable increases).
- For ***pay expenditure, non-pay expenditure and non-clinical income*** budgets for 2019/20 are based on forecast expenditure for 2018/19 as signed off by Divisions.

The baseline is then adjusted to take account of:

- Non-recurrent income and expenditure items, including non-recurrent delivery of expenditure CIPs in 2018/19.
- The income and expenditure impact of 2018/19 service developments that may only have had a partial impact on the forecast outturn position or that were approved to commence in 2019/20. The uplift reflects the 2019/20 full or part-year effect as appropriate.
- The income and expenditure impact of 2018/19 service disinvestments similarly has a full or part-year effect applied as appropriate.

5.3. Efficiency Savings

The Cost Improvement Programme plan for 2019/20 is £22.4m. The 4% savings target is made up of the 1.1% national tariff requirement, 0.5% requirement for Trusts in deficit, and an additional 2.4% applied by the Trust as a response to local pressures. Currently savings of £10.2m have been identified by Divisions. Divisions have proposed internal targets and work continues to identify further schemes to move towards delivery of the target.

The table below shows the current split of 2019/20 CIP scheme identification:

Table 13 - Status of 2019/20 CIP scheme identification (March 2019)

Type	Plan £m	Identified £m	Unidentified £m
Pay	10.71	4.61	6.10
Non-Pay	11.63	5.53	6.10
Other operating income	0.02	0.02	0.00
TOTAL	22.36	10.16	12.20

We continue to find opportunities to improve efficiency across all service lines, including regular review against the 'Model Hospital'[11] and the 'Carter Review'. We are also committed to continuing the *Getting It Right First Time* (*GIRFT*) programme, building on our success in the last two years, and as featured in the NHS Long Term Plan (p.75) with our Trauma and Orthopaedics service line. We also anticipate significant improvements from our ongoing work with ICS partners as this develops through 2019/20, and PMO reviews of other surgical service lines are already underway.

5.4. Agency rules

The Trust has continued to operate above the overall annual NHSI cap for agency expenditure; this is in part due to market forces and our geographical position that constrains the availability of agency staff, thereby imposing a cost premium to ensure we attract staff to work for us instead of surrounding metropolitan centres. We face a challenging recruitment market, and focus on achieving increased levels of compliance with the NHSI capped rates continues to be a priority. We have created a new internal bank (search Twitter for *#FlexibleOurs*) which attracts staff to work unfilled shifts and reduces reliance on agency. This is a challenging target and we have made significant progress towards the cap reducing spend in absolute terms from £21.8m (2016/17) to £16.7m (2017/18). The initiatives outlined support further reduction in spend and drive towards compliance with NHSI agency caps.

[11] https://improvement.nhs.uk/resources/model-hospital/

5.5. Capital Planning

The 2019/20 capital plan reflects critical capital expenditure that is required to ensure the effective operational running of the Trust, and is based on a risk prioritisation process using the following themes:

- Ongoing and committed schemes from 2018/19
- Priority Health & Safety schemes
- Essential backlog maintenance
- Essential equipment replacement

The levels of funding provision for each theme takes account of historical spend, but are based on assessed requirements. Health & Safety risks take highest priority, then significant risk of failure, before schemes that support guaranteed savings or additional income. This approach ensures prioritisation of our quality agenda and plan. Existing contractual commitments are also prioritised to ensure delivery of existing contract liabilities.

Table 14 - Capital Plan summary

Application of Funds 2019/20	£000
Expenditure	
Buildings & environment	17,700
Medical Equipment (including MEF)	3,000
IM&T	4,300
Other	
Donated assets (including imaging equipment)	1,000
Total Expenditure	26,000
Funding	
Depreciation	10,392
Capital Repayments	(2,970)
PDC	1,500
Charitable funding	1,000
Internal cash reserves	
Finance Leases	(5,856)
Loan requirement	21,934
Total Funding	26,000

6. Digital plan

Led by our Chief Executive and our highly experienced Executive Chief Digital Information Officer, we have committed to creating a culture that embraces digital technology. The strategy that will span 2019-24 is a bold and dynamic statement of our ambition to deliver digitally-enabled best care for everyone. To support the delivery of our strategy we intend to apply for *Global Digital Exemplar* (GDE)[12] fast follower status during 2019/20. This status and endorsement by NHS Digital will provide the trust support and funding to deliver our roadmap to high digital maturity. The improvement in digital maturity over the next year will be delivered through the priorities within the digital strategy described below.

Digital Landscape

We are moving at pace to be a Trust where the environment provides digital means of working. This includes having the infrastructure and hardware necessary to provide digital solutions, and readily available skilled staff to deploy and support digital solutions that improve patient care. Some of these key infrastructure/hardware improvements planned for 2019/20 (subject to funding) are: upgrade of our Wi-Fi, replacement of Fax machines, implementation of video-conferencing, and upgrading some of our core clinical information systems

Following the implementation of our Patient Administration System (PAS) *TrakCare* in 2016, we returned to reporting our RTT position in March 2019, and we will continue to improve and optimise *TrakCare* through 2019/20. The next - and most exciting - stage of our digital development is the implementation of advanced clinical functionality in an Electronic Patient Record (EPR) system. This will allow clinicians to view patient information (including diagnostic results), capture clinical documentation, prescribe electronically and be supported in their decision making.

In addition to day-to-day patient care, an EPR enables us to securely share information with colleagues involved in a patient's care both within and outside the Trust where appropriate, e.g. our ICS partners. An EPR will enable and enhance the benefits of transformation projects and new models of care such as the delivery of *Centres of Excellence* and *Urgent Treatment Centres*.

Digital Intelligence

We aim to provide an insight-driven culture which embeds analysis, data and intelligence to enhance decision making, outcomes and quality improvement. This includes a major overhaul of the way our data is managed through a single data warehouse, ensuring we report consistently and proactively as needed by operational teams and external stakeholders. There is a significant amount of work planned for 2019/20 that will enable this including both hardware and software upgrades and replacements, and a redesign of our underlying data structure.

Digital Workforce

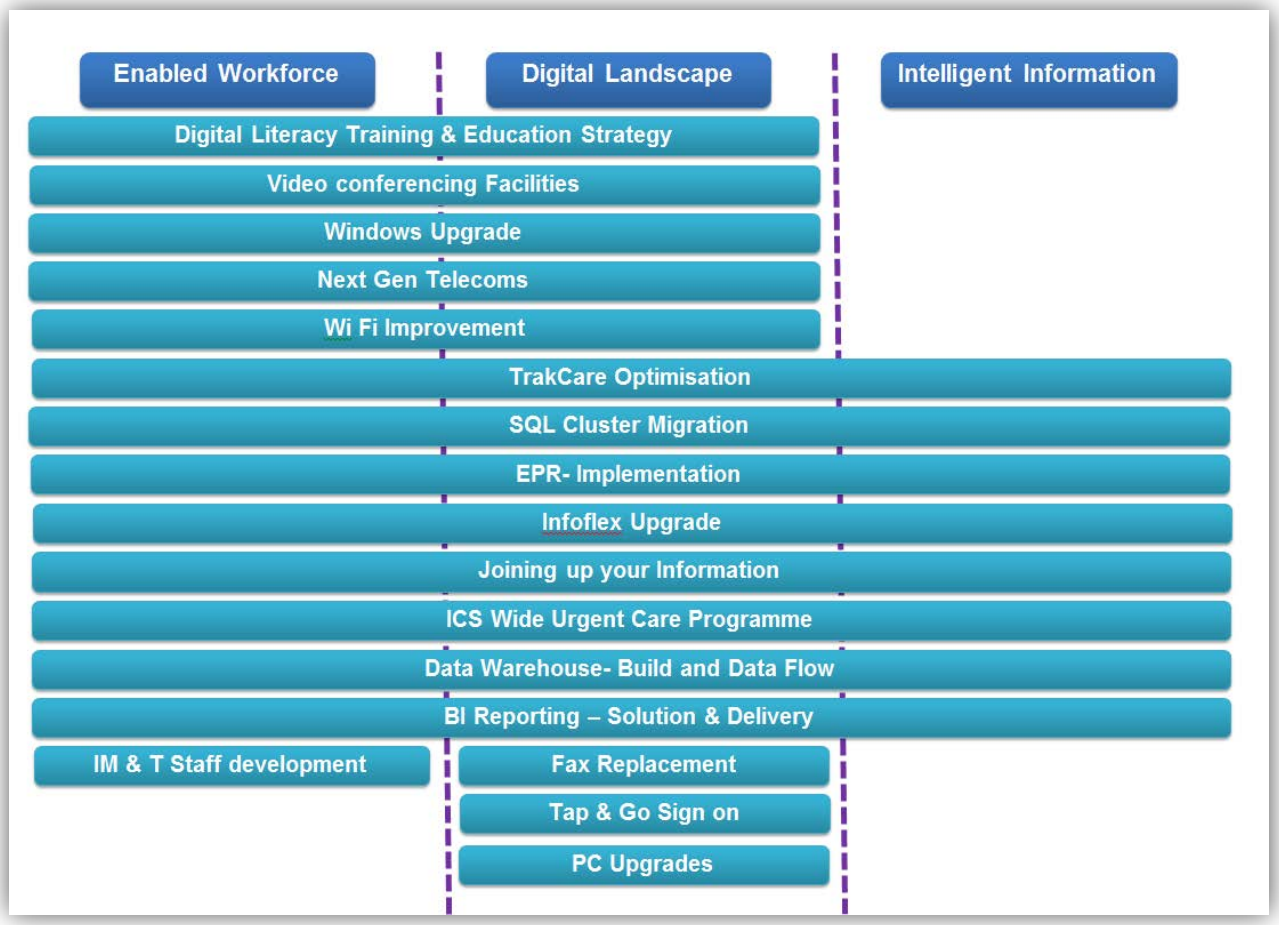
We are committed to developing staff digital literacy skills to ensure confidence and competence in using technology tools. From emails to accessing electronic pay slips to using a clinical system, digital ways of working will continue to develop across all departments and become integral over the next five years. This will involve collaborative working between our digital specialists, HR team and line managers, to ensure that digital literacy is assessed and reviewed as needed within colleagues' personal development conversations, to identify staff that require support and those that may be gifted and talented in the digital arena.

Within the Digital and IT workforce the Trust is also working to become an employer of choice and an organisation that individuals seek to work in. Alongside some of our exciting plans, ambitions

[12] https://www.england.nhs.uk/digitaltechnology/connecteddigitalsystems/exemplars/

and projects, we are running an in-house development programme within our Business Intelligence service, utilising the ICS skill base to provide local training in an effort to both 'grow our own' experts, and provide staff with development opportunities that aid retention and working with NHS Digital and ICS colleagues to ensure we have a consistent and effective approach to Digital workforce planning. This also includes ensuring we have an approach to upskilling the leaders within our Trust to ensure that they understand the art of the digitally possible, and think digitally for all possible solutions.

Figure 4 - Our Digital Maturity Model



7. The *One Gloucestershire* Integrated Care System (ICS)

Or ICS is building on strong and positive partnerships to ensure that we make the best use of local resources with and for the benefit of our population. 2018/19 was the first year of all organisations working more closely together as a shadow ICS and we have made good progress on the journey towards a full ICS as laid out in our system operational plan. During 2019/20 we will consolidate our ICS ensuring that our partnership results in us going further and faster with integrating care.

The ICS vision is *"to improve health and wellbeing, we believe that by all working better together, in a more joined up way, and using the strengths of individuals, carers and local communities, we will transform the quality of care and support we provide to local people"*. The ICS's four priority transformational programmes and four enabling programmes (Appendix 7) remain our focus and we believe they will set a good foundation for our delivery against the first five years of the NHS Long-Term Plan. The Gloucestershire Strategic Forum has reviewed ICS priorities for 2019/20, and emphasised:

- **Improving mental health:** including improving dementia care and a renewed focus on mental health and wellbeing, and support for regular users of health and care services.
- **Urgent & Emergency Care:** the One Place programme remains central to delivering our new model of care within Gloucestershire
- **Focus on proactive care in partnership with local communities:** including building capacity in primary, community and VCSE care, reducing demand for acute services and improving end of life care
- **Improve population health:** rapid delivery of place-based integrated working through Integrated Locality Partnerships and a focus on wellbeing, prevention and self-care. Increasingly we will influence the wider determinants of health including loneliness and isolation whilst also improving or use and application of population health management.
- Focus on **enabling conditions** including: a culture that fosters engagement and co-creation; existing enabling programmes of workforce, estates and digital; maturing the system approach to allocation of resources to ensure investments are used to create greatest improvement; effective governance that facilitates shared decision making

All partner organisations are essential to delivering these priorities; we are governed through distributed leadership so that all partners are represented across the scope of the system, including within programme leadership and senior responsible owner roles. Gloucestershire Hospitals is Senior Responsible Owner for the Clinical Programme Approach, and provides programme leadership for the Centres of Excellence.

Critical milestones

Our system operational plan gives full details on the governance structure and priorities at programme level. The most critical milestones for 2019/20 are detailed below.

Clinical Programme Approach: the clinical programmes have expanded to encompass 13 pathways and the transformation approach is being to bear fruit within the system. Some of the top level milestones in 2019/20 will be.

- **Pathway integration** across a number of pathways including musculoskeletal, diabetes and respiratory - implementation throughout 2019/20
- **Peri-natal mental health** services will continue to develop, including the introduction of a new specialist mental health team and expansion of the community support offer.
- **Children's and Young People Mental Health Trailblazer** - four Mental Health Support Teams (MHSTs) to develop models of early intervention on mild to moderate mental health

issues; beginning May 2019 and will be fully embedded from November 2019. We have been selected to trial a four-week waiting time for referral to treatment for specialist children and young people's mental health services by spring 2020.

- Increased focus on cross-cutting requirements of vulnerable groups, **including Learning Disabilities**, and how we increase support in these areas, the scoping of this work will take place in Quarter 1 of 2019/20.

Reducing Unwarranted Clinical Variation: whilst continuing to deliver on our successful medicines optimisation work the progress around diagnostic and outpatient optimisation will be accelerated supported by improved benchmarking and analytics.

Urgent & Emergency Care: The One Place and Centres of Excellence Programmes are working on our central priority of increasing out of hospital and same day emergency care. They will also ensuring our system can be organised to deliver better health outcomes and more efficient care pathways for our population, through a fully integrated urgent care system and the delivery of 'centres of excellence' for elective care. It is anticipated that

- Public engagement will take place between now and Summer 2019
- A citizen's jury approach will be used to facilitate the decision making process
- Public consultation anticipated in autumn 2019 moving towards implementation in 2020/21.
- Continuing focus on delivery of Clinical Assessment Services and Urgent Treatment Centre test and learn sites for impact as early as possible and for winter 2019/20.
- Risk stratification and support of regular users of services will begin to deliver with a pilot in two localities in the first six months of the year followed by evaluation and potential roll-out.

Place based primary care & community partnerships: our system has 100% coverage of primary care networks. This year we will build on this to ensure that the Integrated Locality Partnership (ILP) model is in place for our whole population by summer 2019. Place based prioritisation supported by population health analytics will be a priority for the end of 2019/20. The ILPs will be supported by specialists in managing complex frail patients, and those with complex long term conditions creating a "channel shift" from hospital based to community based care. The merger of two of the main community-based partners, Gloucestershire Care Services NHS Trust and 2gether NHS Foundation Trust in autumn 2019 is a critical milestone for our system as we more closely align our objectives particularly around our integrated locality teams.

Enablers: good progress is being made by these programmes and they will have increased priority in 2019/20. Our digital programme went live with the joint care record in 2018/19 and this will be further expanded during 2019/20 with primary care and acute trust information becoming available. Our first full population health management cycle will be complete by April 2019 and embedding this further into our business as usual will take place through the year to maximise opportunities for prevention, supported self-management and enhanced community activation.

Efficiency: Overall the ICS transformation schemes are aimed at ensuring sustainability for our system with an emphasis on sustainable, high quality models of care and shifting care out of hospitals wherever possible. We are committed to an open book approach to financial and activity planning and have moved to a model of full involvement from all partners in prioritising investments and agreeing areas of efficiency. As we move our partnership forwards we will increase the responsibility on the system to deliver against the first year of our 5 year plan towards achieving the NHS Long-Term plan. Gloucestershire Hospitals NHS Foundation Trust is committed to fully contributing to further development and delivery of system-wide transformational programmes to ensure that we can deliver on our commitments to our population and contribute towards improving health and well-being across our county.

8. Membership and Elections

8.1. Membership

At the end of 2017/18 the Trust's public membership stood at 10,928, a slight increase from 2016-17. Our current strategy focuses on meaningful engagement with existing members as a priority over recruitment of new members. Members have had the opportunity to:

- Review patient information through the regular patient experience report shared with the Council of Governors
- Deliver patient stories to Board
- Attend three seminars
- Become more involved in staff training
- Become patient advisors on Research and Development become a Governor including attending a Prospective Governor evening
- Attend the Annual Members Meeting
- Become Patient Assessors for Patient Led Assessments of the Care Environment (PLACE)
- Continue to be involved in the Leading Together project
- Participate in a survey on NHS funded patient transport
- Workshops and training provided by the National Institute for Health Research

Our **Membership Strategy** was developed and agreed by the Council of Governors in June 2017, with Governors retaining ownership of the strategy. Objectives for 2017-2020 are:

To build and maintain membership numbers	To effectively engage and communicate with members
➢ Maintain an accurate membership database ➢ Successfully recruit and retain membership numbers, including planned targeted membership drives. ➢ Take steps to ensure that our membership is representative of the diversity of the population that we serve. ➢ Establish a connection and a relationship between the Trust and the membership by communicating our strategic objectives clearly. ➢ Develop and support potential Governors.	➢ Promote the work of the Trust and the Governors. ➢ Identify opportunities for two-way communication between members and Governors, ensuring the views of members are heard, understood and acted upon. ➢ Ensure that a wide range of communication media and methods are explored to aid effectiveness ➢ Offer *gold*, *silver* or *bronze* membership so that members can choose how much they wish to be involved.

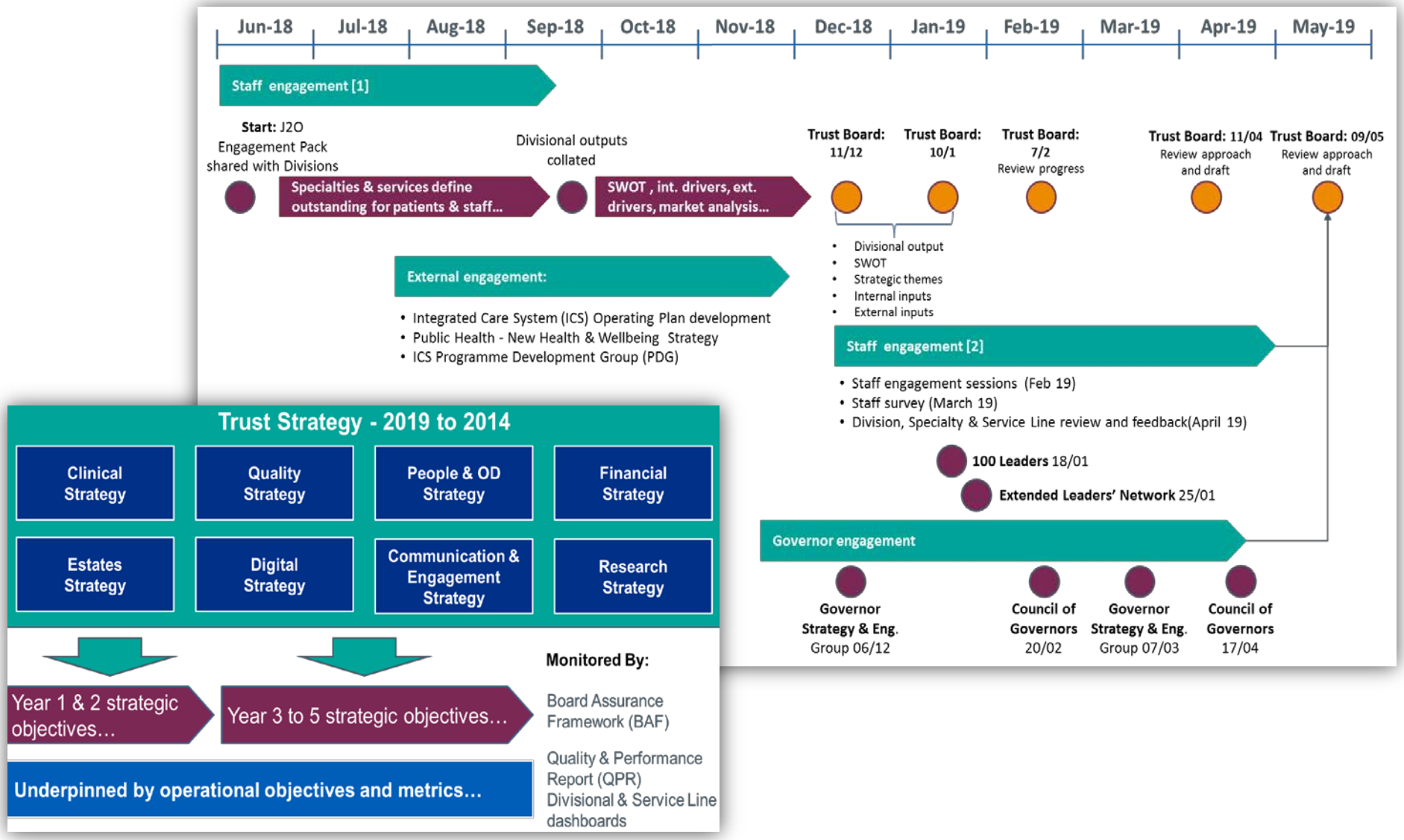
8.2. Elections

Elections were held in 2018 to fill vacancies in six of the seven public constituencies where the Governors' terms of office came to an end. Five of those Governors were eligible for re-election; two stood and were duly elected. There were elections in four staff constituencies with five vacancies to fill. Two were eligible for re-election and one was duly elected. A new Governor was appointed by Gloucestershire County Council. For the 2017-18 elections an open evening was held for potential Governors to provide an opportunity to hear about the work of the Trust, the role of Governors and to meet existing Governors and Board members in an informal setting. This event was well attended and lead to an increase in the total number of Governors seeking election. There are no planned elections during 2018-19

New Governors are encouraged to attend various inductions, and are offered two half-day Development Sessions per year to provide training on specific topics, such as the statutory role of holding Non-Executive Directors to account for the performance of the Board.

Appendices

Appendix 1 – 2019-24 Strategic Objectives timeline and approach



Draft 2019-24 Strategic Objectives

✓ = Lead Strategy ● = Enabling Strategy

Draft – work in progress

Strategic Objective	Lead & enabling strategies							
	Clinical	Quality	People & OD	Research	Comms & Engagement	Finance	Digital	Estates
1. We have established Centres of Excellence for urgent and emergency care, obstetrics and paediatrics, planned care and oncology	✓	●	●	●	●	●	●	●
2. We have worked with our Integrated Care System partners to design and implement integrated models of care across Gloucestershire	✓	●	●		●		●	
3. We are rated *outstanding* by the Care Quality Commission	●	✓	●	●	●	●	●	●
4. We have a workforce which meets the needs of the Trust, its partners, staff and patients; is future proofed and focuses on attraction, development and retention of talent.	●	●	✓	●				
5. Our staff recognise the trust as an outstanding employer and want to work with us to deliver best care for everyone.	●	●	✓	●				
6. Our staff are equipped and inspired to do things differently to deliver improved services to our community.	●	●	✓	●	●			
7. We have a high quality research portfolio, which is visible to staff and patients, embedded alongside routine care, and is achieving the standards set by the National Institute for Health Research (NIHR).	●			✓			●	
8. We have defined the benefits University Hospital status can deliver for patients and staff and can demonstrate progress towards delivering those benefits	●	●	●	✓	●			●
9. Public, patient and carers are involved in the co-design of new care pathways and services and help us to define, monitor and communicate measures of success	●			●	✓			
10. We are rated *outstanding* by NHS Improvement for how we use our resources	●	●				✓	●	●
11. We use accurate quality, workforce, performance and financial information to inform our operational and strategic decision making			●			✓	●	
12. We have achieved Healthcare Information and Management Systems Society (HIMSS) Level 6 status due to our digital maturity and successful implementation of an electronic patient record, electronic prescribing, digital pathology and secure linkages with other partner systems.	●	●	●				✓	
13. We have a Trust site development plan that is helping us to implement our clinical strategy	●					●	●	✓
14. We are working with our Integrated Care System partners to improve the quality and optimise the use of public estate across Gloucestershire	●					●	●	✓

Appendix 2 – Operational Trajectories

Diagnostic test waiting times trajectory

Item	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oc-19t	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
No. waiting <6 weeks	8,699	8,458	8,322	8,001	7,281	7,318	7,971	8,324	7,600	7,998	7,998	7,998
Total no. waiting	8,785	8,542	8,405	8,081	7,353	7,391	8,050	8,407	7,675	8,077	8,077	8,077
%	0.98%	0.98%	0.99%	0.99%	0.98%	0.99%	0.98%	0.99%	0.98%	0.98%	0.98%	0.98%

Referral To Treatment (RTT):

Item	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oc-19t	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
18 week	73.0%	72.9%	72.8%	73.1%	73.5%	73.9%	74.2%	74.6%	75.0%	75.4%	75.8%	76.2%
No. >52 weeks	60	40	20	0	0	0	0	0	0	0	0	0

Ambulance Handovers to meet improvement plans:

Item	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oc-19t	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Type 1,2,3 arrivals	3,814	4,171	4,026	4,130	4,026	4,071	4,278	4,353	4,663	4,522	4,156	4,365
Delays 15-30 min	1,441	1,583	1,528	1,571	1,533	1,554	1,635	1,664	1,785	1,730	1,587	1,669
Delays 30-60 min	52	50	48	46	43	40	40	40	40	40	40	40
Delays 60+ min	0	0	0	0	0	0	0	0	0	0	0	0

Cancer Waiting Times (2 Week Wait):

Item	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oc-19t	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
No. seen <2 weeks	1,933	2,224	2,083	2,049	1,944	1,985	2,057	2,097	1,908	2,031	2,031	2,031
Total no. seen	2,078	2,391	2,239	2,203	2,090	2,134	2,211	2,254	2,051	2,183	2,183	2,183
%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%

Cancer Waiting Times (2 Week Wait – Breast Symptoms):

Item	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oc-19t	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
No. seen <2 weeks	215	207	234	238	182	187	253	229	221	218	218	218
Total no. seen	231	222	251	255	195	201	272	246	237	234	234	234
%	93.1%	93.2%	93.2%	93.3%	93.3%	93.0%	93.0%	93.1%	93.2%	93.2%	93.2%	93.2%

Cancer Waiting Times (31 Day First Treatment):

Item	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oc-19t	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
No. treated <31 days	347	355	353	359	381	341	365	342	307	350	350	350
Total no. treated	361	369	367	373	396	355	380	356	319	364	364	364
%	96.1%	96.2%	96.2%	96.2%	96.2%	96.1%	96.1%	96.1%	96.2%	96.2%	96.2%	96.2%

Cancer Waiting Times (31 Day Surgery):

Item	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oc-19t	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
No. treated <31 days	63	63	61	55	51	39	63	62	43	55	55	55
Total no. treated	67	66	64	58	54	41	66	65	45	58	58	58
%	94.0%	95.5%	95.3%	94.8%	94.4%	95.1%	95.5%	95.4%	95.6%	94.8%	94.8%	94.8%

Cancer Waiting Times (31 Day Drugs):

Item	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oc-19t	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
No. treated <31 days	101	113	111	89	102	98	97	98	86	99	99	99
Total no. treated	103	115	113	90	104	100	98	100	87	101	101	101
%	98.1%	98.3%	98.2%	98.9%	98.1%	98.0%	99.0%	98.0%	98.9%	98.0%	98.0%	98.0%

Cancer Waiting Times (31 Day Radiotherapy):

Item	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oc-19t	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
No. treated <31 days	75	85	73	83	63	78	77	78	77	77	77	77
Total no. treated	79	90	77	88	67	82	81	82	81	81	81	81
%	94.9%	94.4%	94.8%	94.3%	94.0%	95.1%	95.1%	95.1%	95.1%	95.1%	95.1%	95.1%

Cancer Waiting Times (62 Day GP Referral):

Item	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oc-19t	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
No. treated <62 days	165	176	193	167	153	177	196	197	170	183	180	227
Total no. treated	135	145	159	138	129	151	167	167.5	145	156	153	193
%	81.8%	82.3%	82.4%	82.6%	84.3%	85.0%	84.9%	85.0%	85.0%	85.0%	85.0%	85.0%

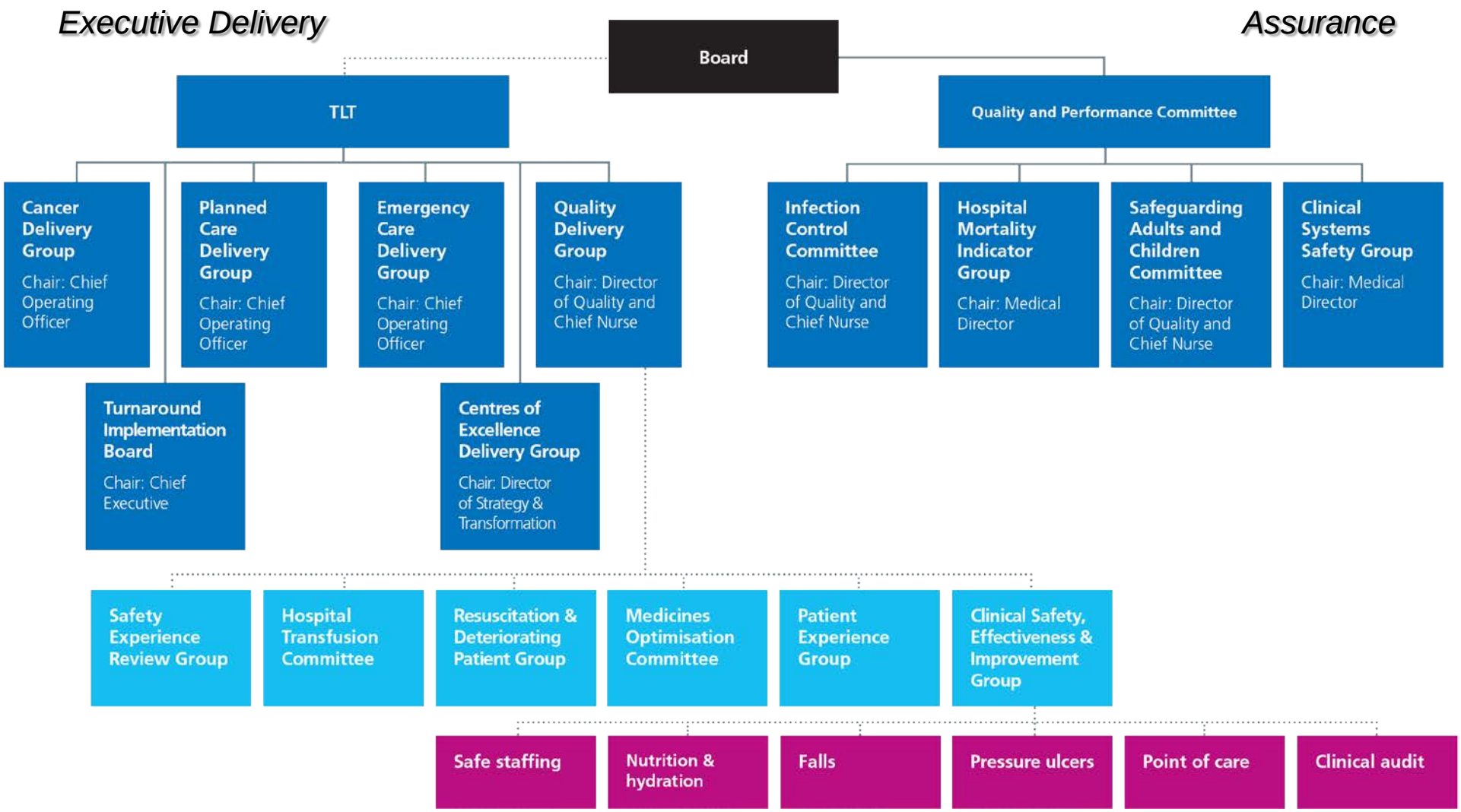
Cancer Waiting Times (62 Day Screening):

Item	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oc-19t	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
No. treated <62 days	28	20	22	20	32	44	32	32	36	29	29	29
Total no. treated	31	22	24	22	35	48	35	35	39	32	32	32
%	90.3%	90.9%	91.7%	90.9%	91.4%	91.7%	91.4%	91.4%	92.3%	90.6%	90.6%	90.6%

Cancer Waiting Times (62 Day Upgrade):

Item	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oc-19t	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
No. treated <62 days	9	8	7	8	4	7	5	9	11	8	8	8
Total no. treated	9	8	7	8	4	7	5	10	12	8	8	8
%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	90.0%	91.7%	100.0%	100.0%	100.0%

Appendix 3 – Quality Governance Structure



Appendix 4 – Quality Framework Model

What do we need to improve?

GSQIA – Inspiring, coaching, facilitating – Expert capability- Gold

Patient involvement/co-design/shadowing

Improvement Plan – Improvement monitoring

Celebrating, Engaging, Networking

Things we should always monitor

Locally identified measures (SPC/Variation)

National indicators (SPC/Variation)

National Clinical Audit/Surveys data

NCEPOD/NICE Guidance key metrics

Specialty level

What is important for our patients and staff?

Assurance

Proactive

Reactive

Are we safe today?

Real time safety/Quality – Day to day management

Escalation Plans/policy

Staffing –Professional standards-Nursing metrics

Risk assessment

Effective learning

Competent Investigation – Duty of Candour-5Cs-claims/Inquests

Lessons learnt – Error proofing – Human Factors, Effective staff feedback – Patient Feedback

Trend analysis – Local level action -Risk register

Appendix 5 – 2019/20 Quality Priorities

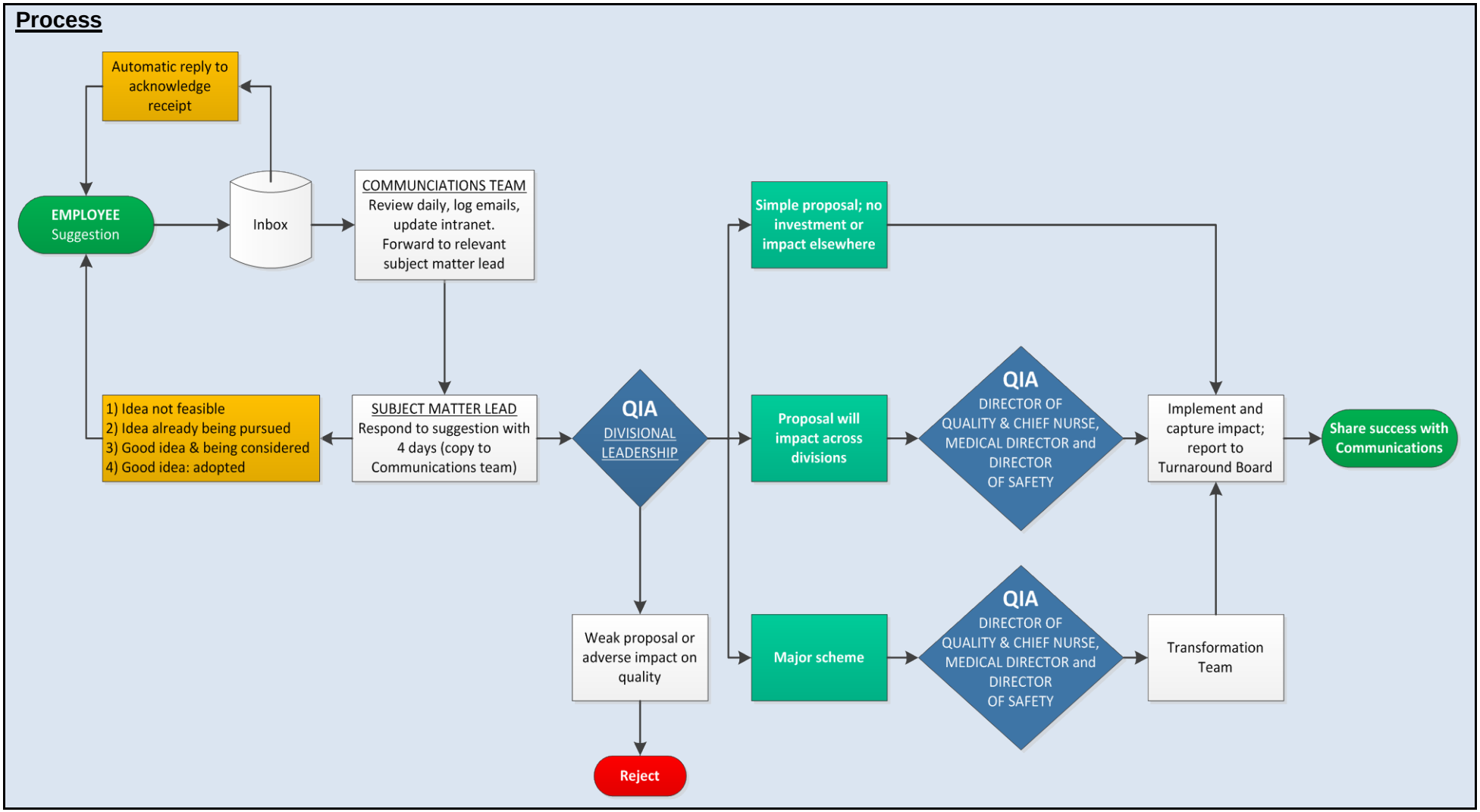
Priority quality indicator goals 2019/2020	Why we have chosen this indicator
Well Led	
Continuing and the development of quality improvement through the roll out of the new quality framework supported by Gloucestershire Safety and Quality Improvement Academy (GSQIA) and the Quality Team	To further embed our QI approach to enable us to be rated as a good and then outstanding organisation by CQC. CQC were impressed with our overall QI approach.
EXPERIENCE (Enhancing the way staff and patient feedback is used to influence care and service development)	
Bullying and harassment (Freedom to Speak Up)	Staff have recommended this as an area. This is an area that staff have indicated that they would like us to improve and after our consultation for our speaking up strategy and our results of our speaking up survey.
Safe and proactive discharge (Inpatient survey)	Our national inpatient survey indicates this as an area of improvement and our local data supports this.
Cancer patient experience improvement (Cancer Survey)	In order to achieve an Outstanding rating for Cancer Services we want to co-ordinate our improvement work to where it is most needed.
Outpatients experience improvement	Our local data supports that this is an area for improvement.
Improving mental health care for our patients coming to our acute hospital	Our CQC feedback from our most recent inspection advises us that we can make improvements in this area. Our local data and The Long Term Plan supports that this is an area for improvement.
Real Time Surveys	Our staff would like access to more real time patient experience data.
SAFETY	
Enhance our safety culture within the organisation	National driver with the consultation for the national patient safety strategy and also the CQC Never Events report.
Staff experience improvement – Violence and aggression	Our staff tell us that this is an area where they would like to see an improvement.
Improving the learning from our investigation into our serious medication errors	Our local data supports this as an area of focus.
CLINICAL EFFECTIVENESS / RESPONSIVENESS	
Improving our learning into action systems – including learning from national investigation reports as well as learning from our own local investigations (learning from deaths, complaints, Duty of Candour, serious incidents and legal claims).	National driver after Gosport Independent Panel findings. Our staff tells us that this is an area where they would like to see an improvement.

Priority quality indicator goals 2019/2020	Why we have chosen this indicator
CLINICAL EFFECTIVENESS / RESPONSIVENESS	
Preventing patients from deteriorating and delivering time critical care – (to include Stroke care, VTE and sepsis	National drivers – Long Term Plan. Local data supports that we need to fully embed our NEWS2 system and that the recognition, response and that we appropriately respond to our patients.
Improving our care for patients with diabetes	National Driver – Long Term Plan. Our local data supports that this is an area that we should focus on improvements.
Improving our dementia diagnosis and post diagnostic support for our patients and their carers	National drivers – Long Term Plan. Our local data supports that this is an area that we should focus on improvements.
Improve our nursing standards with Model Ward and continuation of Nursing Assessment and Accreditation Scheme (NAAS	Local data supports this as an area for improvement especially with the desire to be rated good and then outstanding by CQC.
Improving our infection prevention and control standards (reducing our Gram-negative blood stream infections by 50% by 2021)	National driver
Rolling out of Getting it Right First Time standards in targeted standards	National driver
Delivering the 10 standards for seven day services (especially 2, 8, 5, 6)	National driver; Board Assurance Framework; this should include the date by which we expect to achieve compliance and how links are being made between seven-day hospital services and improvements to patient flow, length of stay and patient outcomes

Divisional indicators	Why we have chosen this indicator
Diagnostics and Specialities Division	
Support and maintain our ISO standards	Patient, staff and commissioner assurance
Medicine	
Emergency readmissions (SHMI)	Local data supports this as an area for improvement
Surgical Division	
Reducing length of stay	National driver
Surgical site infections	Local data supports this as an area for improvement
Women and Children's	
Delivery of Better Births	National Driver
Implementing an ACES based approach in Maternity and Neonates	Local data supports this as an area for development.
Improving the pathway for young people in emotional distress/exhibiting self harming behaviours	National driver and local data supports this as an area for improvement

Appendix 6 – Our *Quality Impact Assessment* (QIA) Process, Format and Metrics

Process



Format

- Scheme name and overview (brief description)
- Project Owner and Lead
- Cross-divisional impact and approval (formal sign-off by divisions) with conditions, if any.
- Quality indicators, with appropriate benchmark, monitoring frequency, data collection method and governance function this reports to.
- Risk assessment of the following domains:
  - Patient or Staff Safety
  - Clinical Effectiveness
  - Care
  - Responsiveness
  - Mitigation for each risk expressed
- Sign-off by clinical leadership at appropriate organisational level:
  - Service Line - Specialty Director, Matron or Clinical Lead
  - Division – Chief of Service or Divisional Nursing Director
  - Executive – Medical Director
- Comments from Director of Safety and Deputy Director of Quality

All schemes, regardless of financial value, have to be agreed by Divisional Triumvirate (Tri) with involvement of their HR Business Partner and signed off by their Finance Business Partner. All schemes are then formally assessed and signed off by the Medical Director and Nursing Director with additional input by the Director of Safety in virtual QIA sessions. In addition, the CIP office uses a scorecard to make sure that the CIP plans are feasible and deliverable using the following categories:

- Project Initiation Document (PID) sign off
- Clear & realistic timeframes
- Financial scoping
- Risk assessment & QIA
- Evidence of engagement with stakeholders
- Availability of resource to deliver the scheme

All new schemes and (potential) issues with existing schemes are reported and escalated to the Turnaround Implementation Board, chaired by the Chief Executive. Additionally, all Divisional Operations Directors report the progress, concerns, risks and issues with their CIP schemes weekly during CIP 'Deep Dives' with the Director of Finance, Chief Operating Officer and CIP Director of Programme Management, HR Business Partners and Finance Business Partners

Metrics

1. **What is the potential impact of the service development on patient experience and their outcomes?**
2. **What do patients and carers say about the current service and what does current outcomes?**

   Triangulate and use our positive and negative feedback from:
   - PALS and complaints, and Patient Opinion
   - Social media comments
   - National Survey Programme data and local surveys
   - Real time feedback,
   - Focus groups, and
   - Feedback about our service from Healthwatch

   Review our outcomes and clinical effectiveness data

3. **Are there NICE Guidance and/or Quality Standards associated with this business case/service change/redesign?**

   Which NICE Quality Standards are identified?
   If there is no relevant Quality Standard, has other accredited evidence been sourced? If yes, please state which.
   If there is no relevant accredited evidence, will good practice be defined by carrying out research?
   Are there protocols or guidelines written which specifies good practice?

4. **Are the planned changes or service re-design in line with the most up-to-date guidance ensuring the business case is evidence-based?**

   Has a baseline assessment against the recommendations/indicators been undertaken?
   Does the plan reflect the Quality Standard Indicators?
   Are there gaps? If there are gaps, how will these be addressed?

5. **What plans are in place for clinical audit or evaluation once changes have been imbedded into practice?**

   Audit against standards outlined in NICE guidance or professional standards.

   Health Outcomes for patients

   What are the expected health outcomes for patients?
   How will the success against your expected health outcomes be measured?
   How do these compare with other available treatment or care pathway alternatives?

6. **How will the patient experience and outcomes data of the new service be monitored?**

   How will feedback and outcomes data be collected? Who will be analysing it and when?

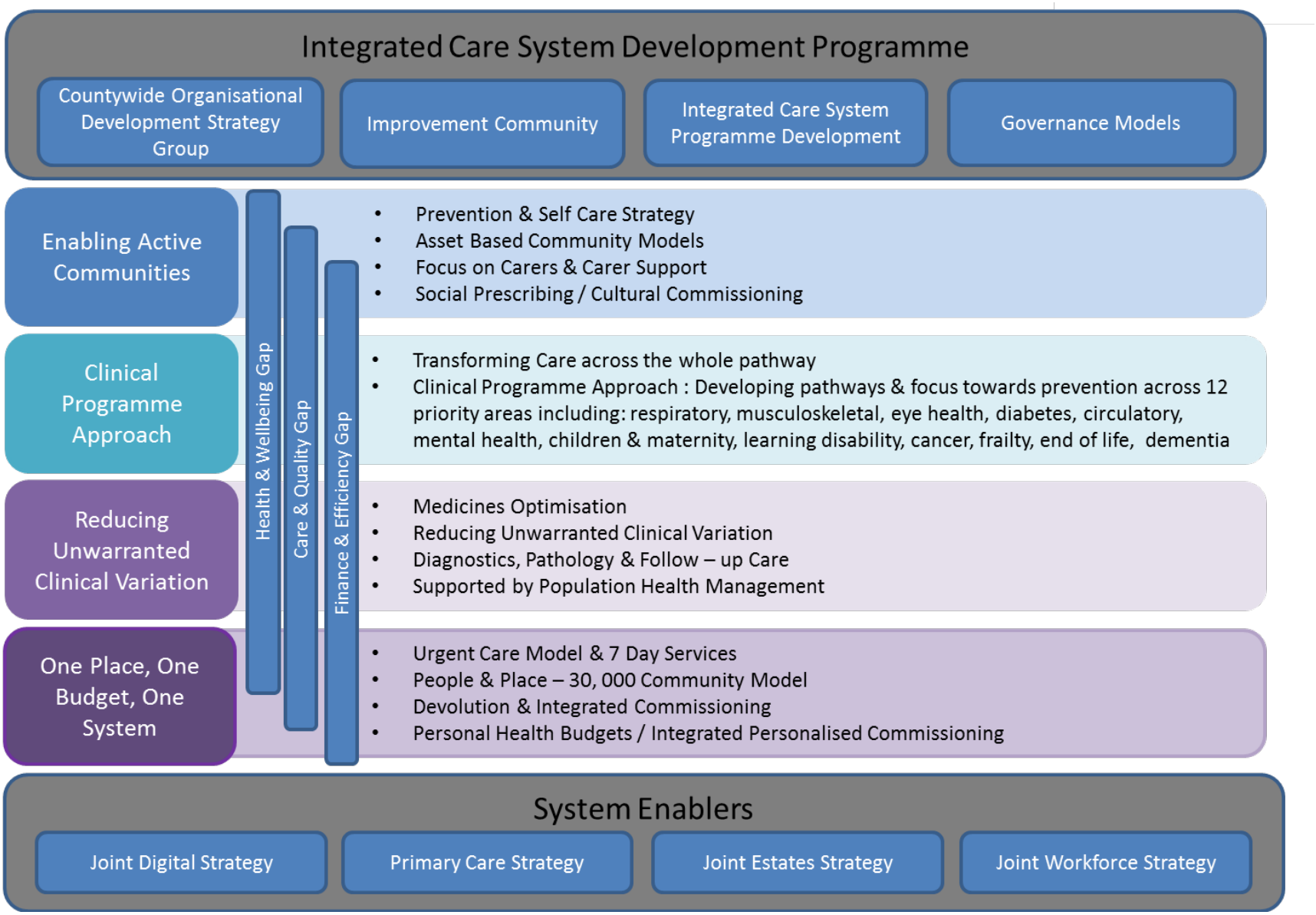
7. **Will patient choice be affected?**

   Will choice be reduced, increased or stay the same?
   Do the plans support the compassionate and personalised care agenda?

8. **What level of public support for this service development is anticipated?**

   Do you expect people to:
   - be supportive
   - be a little concerned or
   - contact their MP or the press as a result of their objections?

Appendix 7 – ICS Overview



ITEM 14

GOVERNOR QUESTIONS

Peter Lachecki
Chair

ITEM 15

STAFF QUESTIONS

Peter Lachecki
Chair

ITEM 16

PUBLIC QUESTIONS

Peter Lachecki
Chair

Gloucestershire Hospitals
NHS Foundation Trust

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.

Gloucestershire Hospitals
NHS Foundation Trust

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 17

NEW RISKS IDENTIFIED

VERBAL

ITEM 18

ITEMS FOR THE NEXT MEETING

VERBAL

ITEM 19

ANY OTHER BUSINESS

DISCUSSION