GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

The next meeting of the Gloucestershire Hospitals NHS Foundation Trust Main Board will be held on **Thursday 13 June 2019** in the **Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital** commencing at 12:30

(PLEASE NOTE DATE AND VENUE FOR THIS MEETING)

Peter Lachecki
Chair

29 May 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 9 May 2019	**PAPER**	**For approval**	13:00
5.	Matters Arising	**PAPER**	**For assurance**	
6.	Chief Executive's Report	**PAPER** (Deborah Lee)	**For information**	13:05
7.	Trust Risk Register	**PAPER** (Lukasz Bohdan)	**For assurance**	13:15
8.	Quality and Performance:			13:25
	- Assurance Report of the Chair of the Quality and Performance Committee - meeting held on 29 May 2019	**PAPER** (Alison Moon)	**For assurance**	
	- Quality and Performance Report	**PAPER** (Steve Hams, Felicity Taylor-Drewe, Mark Pietroni)	**For assurance**	
	- Learning from Patient Stories	**PAPER** (Suzie Cro)	**For assurance**	
9.	Finance and Digital:			13:55
	- Assurance Report of the Chair of the Finance Committee - meeting held on 30 May 2019	**PAPER** (Rob Graves)	**For assurance**	
	- Financial Performance Report	**PAPER** (Jonathan Shuter)	**For assurance**	
10.	Audit and Assurance Committee			14:15
	- Assurance Report of the Chair of the Audit and Assurance Committee - meeting held on 21 May 2019	**PAPER** (Rob Graves)	**For assurance**	
	- Governance Documents o Revised Committee Terms of Reference o Scheme of Delegation	**PAPER** (Lukasz Bohdan)	**For approval**	

	Governor Questions		
11.	Governors' Questions – A period of 10 minutes will be permitted for Governors to ask questions		14:30
	Staff Questions		
12.	A period of 10 minutes will be provided to respond to questions submitted by members of staff		14:40
	Public Questions		
13.	A period of 10 minutes will be provided for members of the public to ask questions submitted in accordance with the Board's procedure.		14:50
14.	New Risks Identified	**VERBAL** (All)	
15.	Items for the Next Meeting	**VERBAL** (All)	
16.	Trust Board Work Plan	**PAPER** (Lukasz Bohdan)	
17.	Any Other Business		
	Close		**15:00**

COMPLETED PAPERS FOR THE BOARD ARE TO BE SENT TO THE CORPORATE GOVERNANCE TEAM NO LATER THAN 17:00 ON TUESDAY 4 JUNE 2019

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

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

Board Members

Peter Lachecki, Chair

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

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE TRUST BOARD HELD IN THE LECTURE HALL, SANDFORD EDUCATION CENTRE, CHELTENHAM GENERAL HOSPITAL ON THURSDAY 9 MAY 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
	Lukasz Bohdan	LB	Director of Corporate Governance
	Rachael De Caux	RD	Chief Operating Officer
	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
	Deborah Lee	DL	Chief Executive
	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
APOLOGIES	Balvinder Heran	BH	Non-Executive Director
IN ATTENDANCE	Suzie Cro	SC	Deputy Director of Quality *(for item 124/19)*
	Marie-Annick Gournet	MAG	Associate Non-Executive Director
	Bilal Lala	BL	Associate Non-Executive Director
	Craig Macfarlane	CM	Head of Communications and Marketing
	Katie Parker	KP	Head of Quality *(for item 124/19)*
	Simon Pirie	SP	Guardian for Safe Working *(for item 131/19)*
	Cecilia Price	CP	Corporate Governance Graduate Trainee
	Emma Rawlinson	ER	Patient *(for item 124/19)*
	Chantal Sunter	CS	Head of Research and Development *(for item 135/19)*

PUBLIC & PRESS One member of the public and one member of Staff.

The Chair welcomed all to the meeting.

124/19 DECLARATIONS OF INTEREST **ACTIONS**

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

125/19 PATIENT STORY

ER introduced herself as the Chair of the Gloucestershire Maternity Voices Partnership (GMVP) and described her organisation's work on personalisation of maternity services. ER spoke about her personal experiences of maternity services in Gloucestershire and what personalisation should looked like.

PL thanked ER for sharing her story.

In response:

- SH said that the Trust was part of Gloucestershire's *Better Births Programme* for which patient choice was a key focus. SH explained that the programme aimed for mothers to see one carer or midwife consistently from start to finish and asked ER how this would have affected her experience. ER responded that without the same point of contact, she was often repeating her story to new people, which was frustrating and concerned her. Had she seen the same midwife consistently, she believed that decisions would have been made earlier, that she would have been less worried about the decisions and that she would have been able to build a personal relationship with the individual, which would facilitate sharing of information and concerns.
- SH asked how the GMVP were listening to those in deprived areas and groups that were adversely affected by health inequalities. ER said the GMVP had yet to do work in this respect, but were keen to get representation from across the county and to hear voices from all sections of the community. Their aim was to get mothers and babies groups involved on the GMVP website, to meet with different groups and to work with health visitors.
- CF said her impression was that ER had negotiated her personal experience of care through the use of nuanced, subtle and personal language. She asked whether ER had learnt anything about how the Trust could best service people whose first language was not English, and may therefore lack the confidence and nuance in negotiating and exploring the possibilities of their care. ER replied that GMVP were looking to get feedback regarding this through engagement with different groups. DL said that whilst it was good to get contemporary views, she noted that Healthwatch had worked with Polish and Eastern European communities previously, to get their insight and recommended looking into existing reports to see what had been done. SC said that this was in-hand.
- AM commented that in maternity services personalisation was being done in an environment where planning was possible as patients began from a healthier view point. AM asked how personalisation could be achieved for patients who did not have the ability to plan their experience with the Trust. MP added that a barrier to personalisation was the perception of risk. ER replied that it was important to have the personalisation conversations early on. In response to AM, SH said there were examples of personalisation in the Trust, such as emergency plans and plans for respiratory patients. He felt the challenge was undertaking personalisation at scale. SH noted that midwives were able to build relationships with mothers in order to understand their needs, a 'luxury' that other services did not have. DL noted the importance of deciding to create plans and building this into practice. SH agreed, and referred to the health and wellbeing plans for patients with cancer or who were on an end of life pathway. MP explained that time of day or confidence of the individuals on shift could be barriers to implementation. He felt the new Electronic Patient Record (EPR) would be an enabler for personalisation plans by creating templates and prompts to support good plans but also provide a single source of comprehensive planning information about a patient and their wishes.

- RD asked what feedback ER had received concerning post-natal care, particularly for mothers who had a traumatic experience. ER replied that post-natal care was seen as an area requiring improvement, as some mothers felt abandoned because underlying mental health issues were not always picked up. DL noted that the value of the *Better Births Programme* being system-wide was that it sought to improve handover and prevent silo working through the involvement of organisations such as 2gether and voluntary partners. SH added that post-natal care was part of the Better Births programme and recognised as an area that needed further focus and development.

The Board were informed that Patrick Collins, the chaplaincy volunteer who had spoken to the Board previously, had passed away. Despite being unwell Mr Collins had been an enthusiastic and committed volunteer at the Trust. The Board recognised his courage in volunteering to come and speak to the Board while battling serious illness. The Board conveyed their condolences to Mr Collins' family.

126/19 MINUTES OF THE MEETING HELD ON 11 APRIL 2019

RESOLVED: That the minutes of the Board meeting held on 11 April 2019 be agreed as a correct record and signed by the Chair.

127/19 MATTERS ARISING

FEBRUARY 2019 052/19 REVISED GOVERNANCE DOCUMENTS - PL FELT FURTHER DISCUSSIONS WERE NEEDED AS TO THE ROLE OF THE GMS/ESTATES COMMITTEE
Ongoing: Updated governance documents to return to Board in June.

APRIL 2019 115/19 CF ASKED WHETHER THE QUALITY AND PERFORMANCE COMMITTEE COULD RECEIVE INFORMATION ON HOW THE 2019/20 PLAN WOULD IMPACT PERFORMANCE AND RECOVERY ASSUMPTIONS.
SS answered that she would take granular analysis of contract settlements through both the Finance and Digital Committee and the Quality and Performance Committee.
Completed: To be presented to the Finance and Digital Committee and the Quality and Performance Committee at their May meetings.

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 would be developed by the end of the financial year. LB added that a template had been agreed which built on the format used by the Audit and Assurance Committee, for us by all Committees. LB would be writing to all Committee Chairs and inviting members and attendees to complete the questionnaire.
Completed: Survey to be circulated electronically 8 May 2019.

LB said that the questionnaire had been sent to all the Committees, with the exception of the Audit and Assurance, which would receive an extended questionnaire on 10 May 2019; a similar questionnaire would be circulated to the Board.

128/19 CHIEF EXECUTIVE'S REPORT

DL presented the Chief Executive's report to the Board.

In response:

- CF asked whether pre-existing networks such as GMVP could provide valuable opportunities for engagement. DL said that this was underway, with engagement with the Stroke Association well embedded. DL added that it was also necessary to generate a co-ordinated communication and engagement plan to map those stakeholders to identify where diversity of opinion could come from.
- PL asked whether DL anticipated any problems or opportunities as a result of the integration of NHS England (NHSE) and NHS Improvement (NHSI). DL felt the newly appointed South West Regional Director would make a positive impact. RD added that the disruption would be minimal because many team members in the South West had remained the same.

129/19 TRUST STRATEGY

SL presented the Trust Strategy and requested:

- feedback on the whole document, and in particularly Sections 2, 5 and 6 and;
- approval of the proposed 12 Strategic Objectives.

In response:

- EW noted that the People and Organisational Development (P&OD) Committee had discussed the organisational cultural ambition and recognised it needed to be owned by the Board; the Committee suggested including the cultural ambition under the purpose, vision and values. The Board agreed a simple statement could be included in the Executive Summary.
- AM suggested the amber colour of the 'Caring' value should be changed; the Board agreed.
- DL explained that the Trust Leadership Team (TLT) had discussed changing 'improving' to 'excelling' because the former was not ambitious enough. The Board agreed to use 'Excelling' as the Trust's value.
- PL asked when further work on values would take place. EW replied that the values were in place and that the Head of Leadership and Organisation Development was working on underlying behaviours. PL asked whether there would be a launch. EW responded that it would be incorporated into the P&OD Strategy. PL asked EW to give further thought to how we might give greater profile to this aspect of the strategy given its fundamental importance to shaping the future culture of the organisation. **EW**
- MN noted a number of typos in Section 3 and suggested the headers be re-ordered. He commented that the strategy mentioned benchmarking but did not describe what the benchmarking revealed and asked for this to be included.
- DL pointed out that Section 3 looking back on 2018/19, did not say that the Trust had achieved most of its Strategic Objectives and requested this information be included.
- In relation to Section 5, SH acknowledge that in the April Quality and Performance Committee meeting it was agreed that a fifth programme - Responsiveness - would be added to the Quality Strategy.

- Referring to the Estates Strategy description in Section 5, PL questioned the reference to 'one public sector estate' and said that it should be clear that this did not mean one physical geographical location. DL agreed adding that even this strand of strategy had not been endorsed and asked for it to be removed.
- DL commented that primary care networks (PCNs) should be referenced in Section 3 as part of the analysis of the environment and Section 5 should describe the Trust's response to them.
- DL noted that it was incorrect to say the Trust had no plans to merge with other organisations in the next 5 years because the Board had not explicitly considered this point, therefore this line should be removed.
- MN commented that there were no references to the shared services, or to Gloucestershire Managed Services (GMS), in Section 5 and asked whether the Trust had intentions concerning the two. DL commented that place markers about strategic conversations would need to be included.
- RG asked who the audience of the document was. SL responded that the document would be refined then shared internally and with the public. DL added that while it was not a requirement to share the strategy with NHSI, it would nonetheless be available to regulators as information; further, the content of the Strategic Plan would be presented to stakeholders in a number of ways, including consideration of blogs, social media, simplified written materials and an infographic
- AM asked whether the CCG had published their strategy and whether there were strategic commissioning intentions the Trust should be aware of. SL responded that the CCG were currently engaging on the Long Term Plan (LTP); the ICS strategy would be generated following this. SL noted that amendments could be made to the strategy, which would be a live document but confirmed that the strategy had itself been informed by the LTP and the CCG current strategic commissioning intentions.
- Regarding the estates strategy, MN suggested the point concerning alternative routes to capital should refer to addressing maintenance backlog which may include exploring various routes to capital.
- SL agreed to align the clinical strategy's format with other strategies'.

SL invited comments on the proposed Strategic Objectives (SOs):

- PL commented that SO 5 was not phrased like a strategic objective.
- PL suggested 'set by the NIHR' be removed from SO 11 for consistency.
- RD commented on the use of 'we' instead of 'colleagues'. EW said this change was discussed at the P&OD Committee.
- CF questioned the use of 'talent' as a noun in SO 4. EW clarified that everybody was perceived as having talent and described the Trust's approach to talent through the Accelerated Development Pool (ADP) model. DL observed that if the Trust doesn't identify and nurture the most talented, then evidence suggests they will move on. She further commented that supporting the most talented did not detract from ensuring that every member of staff was supported to realise their full potential. The Board agreed to a re-phrasing of SO 4 to remove the current risk of misinterpretation.
- RG asked for clarification regarding SO 12. SL replied that it was a holding statement as work looking into whether the Trust should aim to become a university hospital was continuing. DL suggested incorporating this ambition into a different SO. It was agreed that SL would review SO 12.

- DL commented that SOs 2 and 8 overlapped as both related to the ICS. RG responded that SO 8 was created in order to have an objective relating specifically to the Estates Strategy. DL suggested the ICS component of SO 8 was removed. It was agreed that SL would review SOs 2 and 8.
- DL noted that SO 4 required rewording.
- DL suggested the SOs be reworded to sound more ambitious and bold to reflect the Trust's ambition to exceed the expectations of patients. She also felt they were quite jargon loaded and could be phrased using more lay language to widen accessibility. MN suggested reordering the SOs to make them more impactful, e.g. SO 3 could come first. It was agreed that SL, CM and DL would amend the language in light of the feedback. **CM/SL**
- SH noted that the Trust was defining what 'outstanding' meant and that the CQC rating was just a gateway. SH suggested the SO expresses ambition to be outstanding, which would implicitly include the CQC rating.
- SL asked for comments on the timescales. The Board agreed to remove the mid-term timescale as the operational plan would have yearly targets.
- CF suggested placing the SOs at the beginning of the document. The Board agreed.
- RG commented on the various degrees of specificity in the outcomes of the SOs. DL noted that 'soft' language could be used as long as there were 'hard' measures behind the objectives.
- PL thanked SL's team for their hard work. He noted that the strategy was appropriately ambitious and the Board should consider how it would be communicated. DL suggested a launch event with an external individual to endorse the strategy. CM and SL agreed to consider the options and make a proposal to the Trust's Leadership Team. **CM/SL**

RESOLVED: That the Board approve the Strategic Objectives, subject to agreed amendments.

130/19 TRUST RISK REGISTER

LB presented the Trust Risk Register, noting that following the last meeting of the Trust Leadership Team (TLT):

- No risks had been approved for addition to the Trust Risk Register.
- One risk had been downgraded within the reporting period:
  GMS2378Est -'Risk of loss of local power to Tower Block basement due to the deterioration of existing aluminium cables supplying electrical circuits' was downgraded from a consequence of Catastrophic (5) x likelihood of Rare (1) to consequence Minor (2) x likelihood Rare (1) = 2 for Safety. A review led by Deputy Director of Estates and Capital Development found that the risk consequence was over scored; the implication was that a failure of the aluminium cabling in the basement could affect the whole Tower Block. This was found not to be the case, a failure would only affect the local area, predominately lighting circuits and is being patch repaired as issues occur.
- No risks had been upgraded within the reporting period.
- No risks had been closed.
- No risk had the wording changed

AM explained that the P&OD Committee had discussed how most workforce risks did not reach the Board as they did not meet the criteria for inclusion on the Trust Risk Register. AM asked whether there was a wider risk around workforce, considering this was acknowledged to be a major concern for the Board. DL responded that the workforce risks could be articulated within the Board Assurance Framework, which should include the risks to the achievement of the Strategic Objectives (SOs). LB noted that the June Board Strategy and Development meeting would look at risks to the SOs.

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 and approve the changes to the Trust Risk Register as set out.

131/19 QUALITY AND PERFORMANCE:

ASSURANCE REPORT OF THE CHAIR OF THE QUALITY AND PERFORMANCE COMMITTEE - MEETING HELD ON 24 APRIL 2019

CF presented the assurance report from the April Quality and Performance Committee.

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

QUALITY AND PERFORMANCE REPORT

RD, SH and MP presented the Quality and Performance report (QPR). SH highlighted that the number of Clostridium Difficile (C.Diff) cases had reduced from 72 to 56 compared to last year, which was good progress but the Trust could, and should, be more ambitious in aiming to reduce infections. SH highlighted that the first faecal transplant had been completed in April 2019 and thanked MP's team and the Infection Control Team for their work as the Trust was one of the few to do this globally.

RD highlighted that the next planned care update would highlight contract negotiations, the money ring-fenced to tackle the follow-up issue and the 52-week wait recovery plan. RD noted that they would look at incorporating aggregated patient delay as a more realistic measure than 4 hour performance.

In response:

- DL asked about the status of the action for the QPR to monitor the proposed new performance measures currently being piloted. SH said that the Quality and Performance Committee had discussed the new format which would include the new standards in shadow form. The new format and data would be presented to the Board in June.
- DL mentioned a recent discussion at the Executive Team meeting concerning the Sustainability Transformation Partnership (STP) performance data, which compared the Gloucestershire system to the other 43 in England. She explained that the data highlighted the very poor performance of our STP compared to others and believed the degree of under-performance had not previously been understood. She asked for the STP benchmarking information to be incorporated into the report. **SH**

- MN complimented the new QPR format. He pointed out that 'caring' on the summary score card only had two boxes, which felt too light. MN also said it would be helpful to see the how demand and activities e.g. GP referrals and ED attendances, changed over time and how the Trust benchmarked. SH replied that a 'Plot the Dots' Board development session in September could lead to further changes to the report format, which would show changes over time and RAG rating would be replaced by Statistical Process Control (SPC) charts. EW agreed it should be a dynamic dashboard. She added that the new P&OD dashboard would have new measures and discussions were needed to decide where these measures would be reported.
- AM praised the amended report cover sheets and requested that the cover sheet be filled out fully to capture key points from Committee discussions. NJ would raise it with authors. **NJ**

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

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

SP presented the Quarterly and Annual Guardian Report on Safe Working Hours for Doctors and Dentists in Training.

In response:

- EW asked whether the exception reports were reported to Specialty Directors. SP replied that they were.
- CF asked what the aspirations were. SP responded that engagement with the consultant body was improving and trainees' confidence in reporting was growing. The aspiration was not to be levying any fines and to see a reduction in the number of exception reports. He added that the Trust's figures were comparable to those of Trusts of similar size and that exception reporting showed the challenging areas which also mirrored the national picture to a large degree. The numbers of exception reports were highest in the medicine specialty, which reflected the division's high medical vacancy rate. Consequently, work was noted to be underway on the medical rota, which would hopefully reduce exception reports. MP added that work was underway to get a more sophisticated understanding of the information relating to the different cultures around reporting in different grades.
- Given the number of rota gaps, MP was not surprised by the number of exception reports and noted that high levels of exception reports were not necessarily negative as it was important that the Trust could solve problems before they would be escalated to the General Medical Council (GMC). PL asked whether there would be no exception reports if there were no vacancies. MP replied that he expected exception reports to increase as more juniors become confident in reporting incidents and then decrease as rota gaps fill.
- MP noted that non-deanery posts were excluded from the data. DL asked whether this was a national requirement. SP replied that non-training doctors could still exception report but the number of vacant slots came from deanery data. DL asked that consideration be given to developing the same approach and reporting across both staff groups.
- In terms of short term solutions, MP indicated junior doctor rotas were being investigated as there were increased sickness rates in the third week of 3-week blocks of work; however surveys showed mixed opinions concerning the optimal rotas. **MP**

- PL asked where the information was captured and where it was reported to. MP answered that the information was captured in GMC surveys and DL replied that it was reported to the Medical Education Board, which reports to Workforce Delivery Group and then to the P&OD Committee. DL noted that she did not feel assured that the 7 habitual vacancies in the S3-S8 level were being attended to and suggested the report should describe what was being done in response to exception reports and therefore move from providing insight to providing assurance. DL requested that MP provides assurance that actions are being undertaken by the Chiefs of Service, Specialty Directors and Clinical Leads in response to the insights in the report, for the next report to the Board. **MP**

RESOLVED: That the Board note the report.

132/19 FINANCE AND DIGITAL

ASSURANCE REPORT OF THE CHAIR OF THE FINANCE COMMITTEE - MEETING HELD ON 25 APRIL 2019

RG reported the key messages from the April Finance and Digital Committee Chair's report.

DL updated the Board that decision making regarding EPMA funding had been further delayed until the end of summer.

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 draft financial position of the Trust as at the end of Month 12, highlighting that this was being audited and the final position would be ready at the end of May. SS noted that the Capital Control Group had agreed to use the £3.3m share of the Provider Sustainability Fund for the capital programme, which reduced the need for borrowing from £10m to £7m.

PL commented that the variance to plan had not come as a surprise, as the Board had been receiving monthly finance reports including year-end forecast. The Finance and Digital Committee reviewed the position in detail and provided assurance to the Board via its reports.

RESOLVED: That the Board note the report.

INFORMATION AND DIGITAL UPDATE

MH presented the information and digital update. He highlighted the work being done to raise awareness of the new Electronic Patient Record (EPR), both within and outside the organisation. He explained that staff were being shadowed in order to understand the baseline activity relating to paper patient records, notes and charts. Every ward had been visited over the previous two weeks to gauge the status of IT equipment on wards and to consider how to help teams report problems on time. Recruitment was underway in preparation for the new EPR.

In response:

- PL noted that in terms of nursing documentation this was a large undertaking and asked how the Board could be certain the EPR programme had what it needed in respect of resources. SH assured PL that a full list of documentation had been produced and that the Associate Chief Nurse and Deputy Director of Infection Prevention & Control (now Chief Nursing Information Officer) and MP were identifying the critical documents that would be prioritised for addition to an electronic format. MH added that the business case approved by the Board had included provision for programme and project management resource and he was confident this was appropriate however, if the programme scope or requirements changed he would revert to the Board as he was clear that no 'corners' should be cut to deliver this programme in light of the learning from the previous deployment of the Patient Administration System (PAS).
- CF commented that the connection between IT and business felt strong and welcomed that fact that the Finance and Digital Committee had heard from Business Intelligence and Information Governance teams.
- PL asked how the progress would be reported to Board. MH said he would bring an outline high level plan to the Board in June including the phases of the programme and an update on progress against enabling work but DL clarified that the action plan was not expected at Board but should be reference in the Finance and Digital Committee's report to the Board, once the Committee had reviewed it.

133/19 PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE

ASSURANCE REPORT OF THE CHAIR OF THE PEOPLE AND ORGANISATIONAL DEVELOPMENT (P&OD) COMMITTEE - MEETING HELD ON 15 APRIL 2019

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

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

PEOPLE AND ORGANISATIONAL DEVELOPMENT REPORT

EW presented the report, noting that since the last P&OD Committee meeting the first Health and Safety Executive (HSE) improvement notice had been complied with.

RESOLVED: That the report be noted.

EQUALITY DELIVERY SYSTEM (EDS2) REPORT AND NEW EQUALITY OBJECTIVES 2019-23

EW presented EDS2 report and new equality objectives, explaining that it was a national requirement to establish equality and diversity objectives every 4 years. It was also a requirement that this was reported to the Board for.

In response:

- PL noted that governors were involved in the process of establishing the objectives.

- Where the national target might not be ambitious, MAG asked how the Trust would challenge itself to be more ambitious. For example: issues concerning intersectionality were not captured at a national level but the Trust could make a difference in this respect. EW responded that this was discussed at the P&OD Committee and that the equality of opportunity plan included targets beyond the national ones. EW added that the data was currently not sufficient to assess intersectionality well and therefore the starting point would be data collection.

RESOLVED: That the Board note the report.

GENDER PAY GAP ANNUAL REPORT

EW presented the Gender Pay Gap Annual report.

A 'meaningful' gender pay gap had been identified amongst Specialty and Associate Specialist (SAS) doctors, which it was believed reflected the fact that SAS doctors did not receive their increment during parental leave, which adversely affected women. These terms and conditions were being looked at nationally and the Trust would input into this review. DL said that the Trust was unusual and very fortunate in the number and quality of SAS doctors in terms of their contribution to the workforce, therefore if the issue was slow to be picked up nationally then it should be investigated locally due to the value of SAS doctors and our priority to ensure that they felt valued and were fairly rewarded. DL asked that this issue be added to the People and OD Committee (P&ODC) to ensure that we took local action if this was not addressed through national work, in the next six months.

NJ for work plan

RESOLVED: That the Board note the report, accept the assurance that the national data upload is complete and ask the P&ODC to further review whether any local action is warranted in respect of the remuneration of SAS doctors who take parental leave.

134/19 AUDIT AND ASSURANCE COMMITTEE

ASSURANCE REPORT OF THE CHAIR OF THE AUDIT AND ASSURANCE COMMITTEE MEETING HELD ON 23 APRIL 2019

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

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

BOARD ASSURANCE FRAMEWORK

LB presented the Board Assurance Framework (BAF) report and highlighted that 10 Strategic Objectives (SOs) had been achieved, 5 SOs had been partially achieved and 6 SOs had not been achieved, however significant progress had been made against these.

The Board agreed that the year-end BAF update would be included in the Annual report and the Board would endorse it via the Annual Report. LB invited the Board to send comments via email by Thursday 16 May 2019.

RESOLVED: That the Board note the report.

135/19 RESEARCH REPORT

SL presented the research report to the Board.

SH commented that it was good to see a wider view of the research strategy and suggested that the report should incorporate research other than clinical trials. CS and SL agreed to include this information in future reports. **SL**

It was agreed that the research report would be presented to the Board on a 6-monthly basis and exception reports would come to the through P&OD Committee, and be reported to the Board as part of the P&OD Board report. **NJ** (for work plan)

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

136/19 MINUTES OF THE MEETING OF THE COUNCIL OF GOVERNORS HELD ON 19 DECEMBER 2018 AND 20 FEBRUARY 2019

RESOLVED: That the minutes be noted.

137/19 GOVERNOR QUESTIONS

There were none.

138/19 STAFF QUESTIONS

There were none.

139/19 PUBLIC QUESTIONS

There were none.

140/19 NEW RISKS IDENTIFIED

DL noted that the generic workforce risk discussed under Item 130/19 should be added to the Board Assurance Framework. **LB**

141/19 ITEMS FOR THE NEXT MEETING

There were none.

142/19 ANY OTHER BUSINESS

- DL reflected that she felt better sighted on some aspects of the Board depending on which sub-committees she attended. She suggested that each enabling strategy be brought to a Board Strategy and Development Session in order to understand each with some depth and so the strategies could be tracked through the committees against objectives. PL accepted this suggestion and SL agreed to ensure this was taken forward. **SL**
- LB informed the Board that the Corporate Governance Manager and the Lead Governor were attending the Governor Focus Conference in London and showcasing the Trust's work with governors.

- EW informed the Board that the official launch of the 2020 Staff Health and Well-being Hub was taking place on Tuesday 14 May 2019. The Hub is a telephone, physical and virtual service for staff support and advice in the areas of mental, physical and financial health and well-being.
- SH noted that DL had been wearing hearing moulds which simulated moderate hearing impairment, as part of the Deaf Awareness week. SH invited DL to share her experiences with the Board. DL said that she had felt quite vulnerable when wearing them, she had had to concentrate more and therefore had struggled to multi-task as she usually did which she noted may be a positive consequence (!), she was much more aware of air conditioning and background noise more generally, and finally she was aware of how much people 'mumbled', looked down and tapered off their speech. DL added that she was aware it was a fraction of the experience of being profoundly hearing impaired or deaf, as she had the luxury of being able to remove the moulds. PL urged Board members to point out if people mumbled at future Board meetings given they did not know who was, or was not, hearing impaired and especially so in respect of members of the public. DL mentioned the number of staff advocates who were themselves hearing impaired, particularly the number in the audiology service. SS confirmed she herself was hearing impaired and noted that lip-reading and touching people on the shoulder were helpful; however background noises were often harder to overcome. PL suggested the Board endeavour to address this, for example by cooling the room in advance and switching off the air conditioning during the meeting. DL suggested considering where the Trust had hearing loops, noting that the estate was largely ill-equipped in this respect.

143/19 DATE OF NEXT MEETING

The next **Public** meeting of the **Trust Board** will take place at 12:30 on **Thursday 13 June 2019** in the **Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital**

144/19 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 15:30.

Chair
13 June 2019

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

TRUST BOARD – JUNE 2019

MATTERS ARISING

CURRENT TARGETS

Target Date	Month/Minute/Item	Action with	Issue	Action	Update
May 2019	April 2019 115/19 2019/20 Plan	**SS**	CF asked whether the Quality and Performance Committee could receive information on how the 2019/20 Plan would impact performance and recovery assumptions.	SS answered that she would take granular analysis of contract settlements through both Finance and Digital Committee and Quality and Performance Committee	*Ongoing:* *This will be presented to May finance Committee*
June 2019	May 2019 131/19 Guardian Report On Safe Working Hours For Doctors And Dentists In Training	**MP**	MP noted that non-deanery posts were excluded from the data. DL asked whether this was a national requirement. SP replied that non-training doctors could still exception report but the number of vacant slots came from deanery data.	DL asked that consideration be given to developing the same approach and reporting across both staff groups.	*Ongoing:* *Under discussion with Specialty and Associate Doctor representatives.*
June 2019	May 2019 131/19 Guardian Report On Safe Working Hours For Doctors And Dentists In Training	**MP**	DL noted that she did not feel assured that the 7 habitual vacancies in the S3-S8 level were being attended to and suggested the report should describe what was being done in response to exception reports and therefore move from providing insight to providing assurance.	DL requested that MP provides assurance that actions are being undertaken by the Chiefs of Service, Specialty Directors and Clinical Leads in response to the insights in the report, for the next report to the Board.	*Ongoing:* *Under review by Chiefs of Service.*

June 2019	May 2019 140/19 New Risks Identified	**LB**	DL noted that the generic workforce risk discussed under Item 130/19 should be added to the Board Assurance Framework.	LB to action.	*<u>Ongoing:</u>* *New BAF, including principal risks, to be presented to Board in July.*
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.	*<u>Completed:</u>* *Updated governance documents to on the agenda.*
June 2019	May 2019 143/19 Trust Strategy	**EW**	PL asked when further work on values would take place. EW replied that the values were in place and that the Head of Leadership and Organisation Development was working on underlying behaviours. PL asked whether there would be a launch. EW responded that it would be incorporated into the P&OD Strategy.	PL asked EW to give further thought to how we might give greater profile to this aspect of the strategy given its fundamental importance to shaping the future culture of the organisation.	*<u>Completed:</u>* *The launch of the Trust Strategy and People and OD strategy is being considered inclusive of wider engagement regarding the Values and behaviours underpinning these. This action will form part of the Leadership and OD team remit and sits with this team and the Staff Patient Experience Improvement Group to execute. Updates on execution will be provided to the People and OD Delivery Group, Trust Leadership Team and People and OD committee.*

June 2019	May 2019 143/19 Trust Strategy	**CM/SL**	DL suggested the SOs be reworded to sound more ambitious and bold to reflect the Trust's ambition to exceed the expectations of patients. She also felt they were quite jargon loaded and could be phrased using more lay language to widen accessibility. MN suggested reordering the SOs to make them more impactful, e.g. SO 3 could come first.	It was agreed that SL, CM and DL would amend the language in light of the feedback.	*<u>Completed</u>* *Feedback incorporated into final Strategic Objectives with Chair, CEO and Exec input.*
June 2019	May 2019 143/19 Trust Strategy	**CM/SL**	PL thanked SL's team for their hard work. He noted that the strategy was appropriately ambitious and the Board should consider how it would be communicated. DL suggested a launch event with an external individual to endorse the strategy.	CM and SL agreed to consider the options and make a proposal to the Trust's Leadership Team.	*<u>Completed</u>* *New Strategy Comms & Engagement plan defined. To go to TLT for approval*
June 2019	May 2019 145/19 Quality and Performance Report	**SH**	DL asked about the status of the action for the QPR to monitor the proposed new performance measures currently being piloted. SH said that the Quality and Performance Committee had discussed the new format which would include the new standards in shadow form.	The new format and data would be presented to the Board in June.	*<u>Completed:</u>* *NHS Access Standards Review published in March 2019 by NHS Improvement Medical Director, proposing new measures for testing during 2019 and publication from Spring of 2020.* *Four key areas of focus and proposed number of measures are:* *Mental Health X 1* *Cancer X 3*

					Urgent and emergency care X 4 *Elective care X 4* *The business intelligence team are developing shadow reporting for Delivery Groups and the Executive Team initially to review stability of data, this will commence in July 2019.* *New measures will be added to the QPR once final national testing and approval has been given.*
June 2019	May 2019 145/19 Quality and Performance Report	**NJ**	AM praised the amended report cover sheets and requested that the cover sheet be filled out fully to capture key points from committee discussions.	NJ would raise it with authors.	*<u>Completed:</u>* *The Corporate Governance Office will work with authors to ensure cover sheets are completed, and will issue guidance alongside cover sheet templates moving forward.*
June 2019	May 2019 149/19 Research Report	**SL**	SH commented that it was good to see a wider view of the research strategy and suggested that the report should incorporate research other than clinical trials.	CS and SL agreed to include this information in future reports.	*<u>Completed</u>* *Action complete, final research strategy to go through People & OD process culminating in People & OD Committee in October and Board in November 2019.*

June 2019	May 2019 156/19 Any Other Business	**SL**	DL reflected that she felt better sighted on some aspects of the Board depending on which sub-committees she attended. She suggested that each enabling strategy be brought to a Board Strategy and Development Session in order to understand each with some depth and so the strategies could be tracked through the committees against objectives.	PL accepted this suggestion and SL agreed to ensure this was taken forward.	*Completed:* Enabling Strategy timeline developed and shared with Director of Corporate Governance to enable agenda planning.

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

TRUST BOARD - JUNE 2019

REPORT OF THE CHIEF EXECUTIVE

1. Our Trust

1.1 Operationally, things have eased although daily demand, particularly through our emergency departments, remains higher than at the same time last year. Referrals for cancer are also notably higher than last year (20%+) and whilst this was anticipated and reflected in our operational plan, it poses a risk to delivery of the cancer standards. As we've come to expect, staff are responding to this and it is pleasing to note that we have seen more patients in outpatient services this year than planned, a very positive start to the year in light of our goal to reduce waiting times for routine appointments.

1.2 Work on the *Centres of Excellence* is gathering pace and we achieve a notable milestone this month with the presentation of the pre-consultation business case to the Board. The case sets out a very compelling narrative, and associated evidence base, for the benefits this model of service would bring. The work to enable this, and other proposed developments, to be widely shared with our staff, patients and wider public is also progressing well and, as things stand, we are on track to commence our next phase of public engagement in July. For the Trust, this means we will enter a phase of dialogue and 'co-creation' where we develop and test the different options open to us within the context of *Centres of Excellence,* for example the model of care for urgent care in Cheltenham and the long term future for general surgery, both of which remain undetermined and will, no doubt, be significantly shaped by our engagement activities.

1.3 The Trust received feedback from NHS Improvement on its Operational Plan for 2019/20 and this was resubmitted as required on the 15th May 2019; to date we have received no further feedback. What is very clear however, from discussions with the regional and national teams, is the spotlight and expectations in respect of long waiting patients i.e. those who have waited more than 52 weeks. The national operating framework introduced a new regime of fining, for both providers and commissioners, this year and currently this is a significant risk to the Trust and wider system. However, most importantly, current Trust performance reflects a very poor experience for our patients and a huge source of frustration for our staff and so remedying this issue is one of our greatest waiting time priorities in the next six months. Our resubmitted plan commits to have eliminated 52 week waiters by September and to hold that position going forward.

1.4 The Trust's approach to organ donation and transplant has always been something that has stood out to me since I arrived in Gloucestershire three years ago. We are phenomenally lucky in both the professional staff that provide support to potential donors and their family members and to our volunteers that act as Trustees for the Organ Donation Committee. I was therefore especially pleased to receive a letter last week drawing my attention to another huge achievement in the guise of <u>not a single missed opportunity</u> for following best practice associated with the 61 patients who were potential donors.

This resulted in 11 donors transforming the lives of 25 patients and their families; this compares to 4 donors last year. This amazing achievement comes about from the profile of organ donation throughout the Trust and wider county and equally, the skills and courage of staff to have the most difficult of conversations, at the darkest of times. At our July public meeting we will be hearing from Ian Mean, Chair of the Organ Donation Committee and Mark Haslam, Clinical Director; we will be also taking the opportunity to share the very personal and moving story of one of our colleagues who has been touched by this important issue.

1.5 On 5th June the Trust welcomed Professor Brian Dolan to a full day event exploring best practice in respect of discharge from hospital. Brian is reputed for his inspiring delivery but, even by his own standards, he excelled and captured the hearts and minds of more than 100 staff from across the Trust and wider system of health and social care. Of note, aside from the volume of staff present, was the range of staff involved both by discipline and role. Colleagues involved in the day were asked to make a personal pledge for how they would change their practice to improve the discharge experience for our patients and their families. Brian was the originator of the *Last 1000 Days* and #EndPJparalysis campaigns and brought both of these to life on the day. The Trust Leadership Team embedded their monthly meeting into the event to ensure senior representation and this was also very well received by front line staff and I suspect has established a model for the future.

1.6 On the 14th May, Emma Wood and her team launched the long awaited *Health and Well-being Hub*. The Hub is our response to the feedback received from the last two National Staff Surveys, through which Trust staff told us that this was an area where the Trust needed to do more. After a period of further enquiry, the Hub was developed to reflect the three areas where staff, and those that manage others, said they wanted more support and resources, including sign-posting; these are physical health and well-being, emotional health and well-being and financial health. To date, the launch of the Hub intranet site has attracted more hits than any other site ever hosted on this platform, reflecting the interest and need for such a development. Huge thanks are due to Emma Wood, Director of People for her vision and leadership and Abby Hopewell and Michele Pashley for the hard work that turned this into a reality (in such short time).

1.7 This month, the Trust welcomes Ali McGirr to its senior leadership team as Divisional Director for Medicine and Deputy Chief Operating Officer. A nurse by background and most recently Divisional Director for Surgery at Moorfields Hospital, London Ali brings a wealth of relevant experience, alongside a track record of successful delivery and levels of energy and enthusiasm rarely seen! Regrettably, I also announced the resignation of Neil Jackson, Managing Director of our subsidiary company Gloucestershire Managed Services. Neil developed our estates and facilities function over his tenure as Divisional Director before his vision led to the creation and establishment of GMS. I am very grateful for Neil's contribution to the Trust and more latterly GMS; he has been a particularly popular leader with estates and facilities colleagues over the years and we I wish him every success for his future.

1.8 This month has been a very active period again in the Trust with many initiatives drawing attention to important issues and promoting the amazing things that my colleagues in the Trust do every day. Looking ahead, there are also more important initiatives and events taking place in the Trust:

- Dementia Awareness Week was a huge success and staff continue with their efforts; on Friday 14th June, staff working in our Care of the Elderly team (COTE) are hosting a Cup Cake Day to raise funds for the Alzheimer's Society. Do drop in to see them between 11am and 2pm on ward 9B, at Gloucestershire Royal Hospital.
- Deaf Awareness Week was another huge success. In my last message I committed to wear ear moulds to enable me to experience a simulated version of what it is like to be severely hearing impaired. This included wearing my moulds at last month's public board meeting; I wrote about my experience in my weekly blog and had some fabulous feedback from staff, as a result.
- The Trust celebrated National Clinical Trials Day and I was delighted to Chair this month's Clinical Research Network (CRN) Board which demonstrated that we have surpassed last quarter's performance when the CRN moved from 15th (bottom) to 10th nationally in the research 'league tables', moving to 7th place this quarter. In summary this means more patients in the West of England, including Gloucestershire, are getting access to the very best, novel and innovative treatments.

- Eight teams of six staff members competed in a mini-military challenge as hosts of the Army's Reservist Field Hospital. It was a huge success with participants not only having fun and stretching themselves, but learning about the armed forces approach to leadership and followership. As a result, I have secured several more recruits for the 'real thing' on Dartmoor, later this year.
- In May, the Trust was formally recognised for the support we provide to serving and former armed forces personnel and their families when we were awarded with *Veteran Aware Hospital* status. It's a huge accolade and has the potential to make the lives of this group of patients (and their families) so much easier. The government has pledged to ensure that armed forces personnel are not disadvantaged by their status, when it comes to healthcare but the evidence shows this isn't the case. I am, therefore, especially proud that through the sponsorship of Steve Hams, Chief Nurse and the phenomenal hard work of Natalie Bynorth, Jenny Yates and the growing band of Armed Forces Champions we have gained this recognition. We will be raising the awareness of this important issue, and our endeavours, later this month when we host our Veterans Aware event from noon on Sunday 30th June 2019, in Sandford Park, Cheltenham. Please do join us if you can, it is set to be a fabulous day; again thanks to Natalie Bynorth and team for arranging the day and our hospitals charity (and other sponsors) for their generous support

2 Our System and Community

2.1 The Integrated Care System (ICS) continues to shape and influence all matters health and care related on the patch. Of note the *One Place* business case is coming together and, with the help of the Consultation Institute and others, the approach to public involvement is developing especially well. Activities are scheduled to commence in earnest in July this year and will include a range of events from the more typical to the more unusual.

2.2 An important part of the ICS strategy for the coming years is to make considerable progress i.e. beyond the trend and national norm in a small number of priority areas. The ICS Board has determined that we will focus our efforts in four specific areas which are circulatory disease, respiratory care, diabetes and frailty (including dementia). This does not, of course, mean that we will not be making progress on the very many fronts we are already involved in but it will shape the nature of the focus and time devoted to these priorities by the ICS Board, leadership team and most importantly the work of the Clinical Programmes Board, which I Chair.

3 National and Regional

3.1 Yesterday, NHS Improvement (NHSI) and NHS England (NHSE) announced the successor to Ian Dalton. Amanda Pritchard will take up the newly defined role of NHS Chief Operating Officer, reporting to Simon Stevens but with responsibility for the regulatory dimensions of the newly 'merged' NHSI / NHSE. Amanda is currently Chief Executive of Guys and St Thomas NHS Trust (GSTNHST).

3.2 We are fortunate to have secured the time of Matthew Swindells, current Deputy Chief Executive, NHS England and National Director for Operations and Information to address our 100 Leaders Forum in July before he leaves the NHS later in the month. Matthew is an inspiring speaker and will share his reflections on the *NHS Long Term Plan* and his own leadership journey.

3.3 Last month I announced the arrival of Elizabeth O'Mahony as South West Regional Director, for NHSI and NHSE. Since then, I have had the opportunity to attend the SW Chief Executives Forum which Elizabeth led. I was delighted to hear the tone and content of Elizabeth's opening address to Chief Executives; it was clear, inspiring, ambitious and supportive – what more could a CEO ask of their regulator?

4 Happy Anniversary

On the day of the Board meeting, 13th June 2019, I will be celebrating my third anniversary as Chief Executive Officer of Gloucestershire Hospitals. For those that have travelled the journey with me from my arrival to today, you will know that it has been an eventful and, at times, unexpected journey but most of all it has been an exciting, reward and huge privilege to serve the Board and my 8,000 colleagues. I, therefore, wanted to take this opportunity on my special day to say "thanks for having me"!

Deborah Lee
Chief Executive Officer

7th June 2019

Gloucestershire Hospitals
NHS Foundation Trust

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

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

Purpose

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

Key issues to note

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

The Trust Leadership Team (TLT) met on 5 June 2019 and agreed one change to the Trust Risk Register:

One risk has been approved by TLT for addition to the Trust Risk Register:

> **F2927** - Risk that the Trust does not achieve the required cost improvement resulting in failure to deliver the Financial Recovery Plan for FY20. Operational and Executive Lead: Director of Finance.
>
> This risk was reviewed by the Finance and Digital Committee on 30 May 2019 and the risk rating agreed as a consequence 5 (catastrophic) x likelihood of 4 (Likely) =20 .

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

No risks have had the wording changed.

Please note: Following the completion of the audit process 2018/19 finance risks will be closed and where relevant, corresponding risks will be added to the register. Changes will be presented to the July TLT and subsequently the Board.

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

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 (Risk C2628COO)

Equality & Patient Impact

Potential impact on patient care, as described under individual risks on the register.

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)
						5 June 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** **June 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
F2927	Risk that the Trust does not achieve the required cost improvement resulting in failure to deliver the Financial Recovery Plan for FY20	1. PMO in place to record and monitor the FY20 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 Financial Sustainability Delivery Group 6. Monthly Finance and Digital Committee scrutiny 7. Monthly and 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** **June 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** **June 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)	f2775	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
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 MAIN BOARD – JUNE 2019

From Quality and Performance Committee Chair – Alison Moon, Non-Executive Director

This report describes the business conducted at the Quality and Performance Committee on 29 May 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
Adult Inpatient Nursing workforce Review	Comprehensive report detailing review of staffing levels, national context/guidance, methodology, 3 year plan with prioritised areas, risks and recommndations.	How achievable is the implementation, are there any significant risks to delivery. How would this report be received at the front line? How is the pace of delivery mapped against new Trust strategic objectives?	Excellent report and assurance of approach. Clear narrative, rationale for staffing levels, vision for the future and tangible recommendations to implement. Risks present and known, mitigations considered. Plans already tested with clinical areas, example given of positive response from Medicine Division. Similar timeline to align with strategic objectives.	Report needs to go to P and OD Committee as clear cross over of sub-committee interests. Update on delivery to be added to forward planner.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Management of Patient Safety Alerts	Briefing of system in place to receive and act on defined alerts from variety of sources Regular reporting into Quality Delivery Group. One alert overdue, plan for closure by 30.6.19	Why has compliance with overdue alert been delayed? Were there any surprises in the outputs of the review? How will checking on compliance be prioritised for auditing?	Assurance received on process for logging and disseminating alerts in good time. Evidence of audits to provide assurance on two areas which have had never events and serious incidents nationally. Limited assurance received regarding confidence of timeliness in response to all alerts, particularly which may need pulling of old medical notes. Positive that no surprises, timely to strengthen the systems and processes particularly in relation to evidence of actions completed. Prioritisation currently being developed.	Update on progress and updated system proposed for August 2019, needs to include detail of improved process for checking / auditing compliance, including process for prioritisation

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Quality and Performance Report	First presentation of new reporting format, noting a work in progress and will develop further. **Quality Delivery Group** Sepsis indicators not where needed consistently, recent workshop with national leader on sepsis, well attended and refreshed focus. Use of QI and electronic observations (Eobs) highlighted as important for change. Update on out of date policies improved, now standing at 113, ambition of no more than 50 Extension of complaint response times from 35-65 days in certain cases. Issue of availability of syringe drivers for palliative care **Cancer Delivery Group** Update on current position with cancer standards.	Why set 50 as ambition? Why not zero? What is the rationale for this? How do you know this will not become the norm? With a total of 30 patients breaching the 62 day standard, what actions would support achievement? What are the enablers to achieve?	Authority to extend the response time held centrally by complaints team and for agreed complex cases only Plans to work with community colleagues and support a system of equipment recovery. Detail known on what needs to happen in each specialty. Enablers set out in the plan on a page incorporated in the reports.	Update requested to committee in three months, also needs to go to Finance and Digital Committee re Eobs. Future report to include ambition and trajectory of improvement. Assurance on availability of equipment to be reported through future QDG escalation reports.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	Planned Care Delivery Group Includes RTT reporting, showing 79% as in previous months, demonstrating continuing stabilisation of reporting Focus on 52 week waits, with re focus on those actions which support achievement before March 2020.	Have the job planning reviews taken place to support achievement? When will we see the outputs of the outpatient transformation programme? Why has there been no movement in palliative medicine? What more can be done to support achievement of paediatric ENT?	Specialty plans included in the report to committee Job planning still a work in progress	More detail on these areas to be included in next reporting period Update planned for June meeting.
	Emergency Delivery Group Update on performance and plans	Is there enough lead in time for initiatives to be in place pre quarter 4? How well are the previous developments performing?	Plans progressing for Clinical Decision Making Unit business case for approval in July and if agreed for Q4 implementation. Assurance that these areas e.g. SAU are delivering very well on expectations.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Risk Register	Regular review with a focus on the risk of delayed follow up care (C1798COO) and proposed four areas of improvement ('areas of focus') Use of quality improvement approach for sustainable improvements	Are these areas of focus stand alone or rolled into existing programmes? The themes are very broad, how is the level of discussion being managed? Are there actions which need to change quickly balanced with a more medium term QI approach?	Assurance that these focus areas are part of the planned care delivery group work plan and will form part of exception reporting to Q and P Committee if required. Assurances given that this is covered through the work programme.	Future exception reports to ensure updates on the four areas are covered.
Contract settlement	Presentation on contract settlement	How is it linked to activity and planning trajectories? Where will the backlogs start and finish? Where are the inherent patient safety risks in the settlement? What will the £0.75 m 'buy' in terms of follow up progress?	Assurance received re specific plans already in place and use of the £0.75m	Further updates as part of routine reporting on progress and risks within the settlement.

Board to note: There was a discussion at Committee on the ICS Urgent and Emergency Care Summit and subsequent meeting to agree three system measures Opportunites for positive decison making,Home First,Streaming and signposting considered to be the right areas, detail needing to be progressed. Outstanding issue of work to understand underlying population behaviours

Alison Moon
Chair of Quality and Performance Committee
29 May 2019

Gloucestershire Hospitals
NHS Foundation Trust

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

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

Purpose

This report summarises the key highlights and exceptions in Trust performance for the December 2018 reporting period.

The Quality and Performance (Q&P) committee receives the Quality Performance Report (QPR) on a monthly basis. The QPR is being developed in its new format and May is the first month that a full version has been presented.

Key Issues to note

During April, the Trust did not meet the national standards or Trust trajectories for; A&E 4 hour standard, 2 week wait and 62 day cancer standard. The Trust has commenced re-reporting of 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 April 2019, the trust performance against the 4hr A&E standard was 86.01% with an average of 432 attendances per day (11.3% increase from April 18).

In respect of RTT, we have commenced re-reporting and have set out our recovery trajectory until March 2020. Operational teams continue to monitor and manage the long waiting patients on the Referral to Treatment pathways; a separate recovery plan for our longest waiting patients is provided within the exception reports.

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

Conclusions

Cancer delivery, with a particular focus on Urology recovery and backlog clearance continues, and sustaining A&E performance is the priority for the operational teams.

Quality delivery remains 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 Optimisation.
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							

Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report

Reporting period April 2019

to be presented at May 2019 Quality and Performance Committee

Contents Page

Executive Summary

Delivery of agreed action plans remains critical to restore operational performance to the expected levels. During April the Trust did not meet the national standards or Trust trajectories for 62 day cancer standard and the 4 hour standard.

The Trust performance (type 1) for the 4 hour standard in April was 86.01% against the STP trajectory at 85.32% against a backdrop of significant attendances. The STP met the delivery of 90% for the system in March.

The Trust has met the diagnostics standard for April at 0.54%.

The Trust has not met the standard for 2 week wait cancer at 87.9% in April, this is as yet un-validated performance at the time of the report. 2 week wait performance was impacted where Dermatology experienced high demand mixed with consultant capacity issues related to sickness. Due the referral numbers this quickly built a backlog of patients. This has now been cleared. Demand for endoscopy has been variable from referral numbers hovering around mean average to a number of weeks referral numbers being above 85th percentile. GLANSO lists are being held in May and June

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.

For elective care, the levels of validation across the RTT incompletes, Inpatient and Outpatient Patient Tracking List (PTL) is significant. Significant work is underway to reduce our longest waiting patients of over 52 weeks. The Trust has commenced re-reporting in April (March data) and is currently stabilising the reporting position.

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. There are improvement plans in place for any indicators that have consistently scored in the “red” target area.

- There has been 1 never event in April and this is currently being investigated.
- There has been a single month increase in unconfirmed serious Director of Safety incidents, these incidents will be reviewed and brought forward to SI panel. There doesn't appear to be any particular pattern or trend. The longitudinal data shows no real change.
- Clinical Audit results in the last quarter showed 95% compliance
- Better Births, as a programme of work, is continuing to improve our maternity services and also the indicators that have been reported.
- The dementia indicator continues to be reviewed and an audit is underway.
- For VTE the clinical audit results in the last quarter showed 95% compliance
- This is the first time we have been able to report on our real time survey data and we are working on how this can be viewed by our staff. The data from April was collected as a pilot, with the Real-Time Survey being implemented from May 2019. The data collected in April shows that across divisions patients are not being provided the right amount of information to meet their needs. Our actions include that we need to align Real Time survey and FFT contracts, to give divisions access to all their patient experience data on one platform that can be used to highlight areas of best practice and improvement. Launch Best Care Programme, embedding patient experience improvement within the divisions, using Real Time Survey data and other patient experience improvement methodologies to identify areas for improvement
- The inpatient FFT remains stable and we are waiting for the NHS England guidance for updating the system.

Performance Against STP Trajectories

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.
* = unvalidated data

Indicator		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
ED: % total time in department – under 4 hours (type 1)	Trajectory	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	85.32%
	Actual	91.98%	91.58%	93.33%	91.34%	90.26%	89.01%	90.54%	91.59%	87.55%	84.46%	86.08%	87.13%	86.01%*
ED: % total time in department – under 4 hours (types 1 & 3)	Trajectory													90.00%
	Actual	94.59%	94.20%	95.33%	93.65%	93.45%	92.47%	93.60%	93.98%	91.29%	89.02%	90.21%	91.00%	90.39%*
Count of handover delays 30-60 minutes	Trajectory													52
	Actual	30	25	44	58	68	66	74	33	61 *	75 *	72	58 *	57
Count of handover delays 60+ minutes	Trajectory													0
	Actual	1	3	1	0	2	2	2	1	1 *	0 *	0	1 *	0
Referral to treatment ongoing pathways under 18 weeks (%)	Trajectory													76.00%
	Actual												79.75%	79.46%
Referral to treatment ongoing pathways over 52 weeks (number)	Trajectory													95
	Actual	95	92	98	113	125	105	103	105	97	89	97	95	93
% 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%	0.98%
	Actual	0.56%	1.26%	0.52%	0.55%	1.27%	0.63%	0.03%	0.35%	0.20%	0.67%	0.21%	0.45%	0.54%*
Cancer – urgent referrals seen in under 2 weeks from GP	Trajectory	93.00%	93.00%	93.00%	93.00%	93.10%	93.00%	93.10%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%
	Actual	86.60%	86.30%	88.60%	90.40%	88.90%	82.80%	91.80%*	90.60%*	94.30%*	92.00%*	93.80%*	95.30%*	87.90%*
2 week wait breast symptomatic referrals	Trajectory	93.20%	93.30%	93.40%	93.40%	93.30%	93.20%	93.40%	93.40%	93.10%	93.00%	93.50%	93.10%	93.10%
	Actual	91.30%	91.90%	95.10%	96.00%	97.80%	98.90%	99.20%*	94.50%*	97.60%*	95.50%*	97.00%*	95.60%*	96.90%*
Cancer – 31 day diagnosis to treatment (first treatments)	Trajectory	96.10%	96.30%	96.10%	96.20%	96.30%	96.20%	96.20%	96.30%	96.20%	96.40%	96.20%	96.40%	96.10%
	Actual	96.70%	96.90%	97.10%	96.80%	96.90%	93.50%	93.20%*	94.00%*	93.80%*	92.30%*	91.00%*	91.90%*	93.30%*
Cancer – 31 day diagnosis to treatment (subsequent – drug)	Trajectory	98.50%	100.00%	98.80%	98.10%	100.00%	98.40%	98.00%	98.10%	100.00%	100.00%	100.00%	98.40%	98.10%
	Actual	100.00%	100.00%	100.00%	100.00%	100.00%	98.80%	100.00%*	100.00%*	100.00%*	100.00%*	100.00%*	100.00%*	100.00%*
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	Trajectory	95.50%	95.80%	94.60%	95.10%	94.60%	95.00%	94.30%	94.70%	94.50%	94.40%	94.20%	94.40%	94.90%
	Actual	100.00%	100.00%	100.00%	98.70%	100.00%	100.00%	98.60%*	98.60%*	98.60%*	100.00%*	98.90%*	97.20%*	94.90%*
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	Trajectory	95.10%	95.00%	94.20%	95.90%	94.60%	95.30%	94.30%	95.00%	94.80%	94.30%	94.60%	94.20%	94.00%
	Actual	94.90%	96.60%	94.50%	96.00%	95.70%	94.30%	98.30%*	96.60%*	92.50%*	94.80%*	96.40%*	96.40%*	93.60%*
Cancer 62 day referral to treatment (screenings)	Trajectory	92.00%	94.70%	90.50%	90.00%	91.20%	92.10%	92.90%	92.90%	90.90%	92.90%	92.90%	90.90%	90.30%
	Actual	100.00%	94.10%	100.00%	100.00%	100.00%	85.50%	93.50%*	93.50%*	100.00%*	93.90%*	96.30%*	100.00%*	79.20%*
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	76.50%	100.00%	84.60%	53.30%	100.00%	75.00%	77.80%*	58.80%*	70.00%*	69.20%*	60.00%*	76.20%*	30.00%*
Cancer 62 day referral to treatment (urgent GP referral)	Trajectory	82.80%	84.40%	85.30%	79.70%	77.10%	81.70%	82.00%	83.70%	82.80%	80.90%	82.60%	85.40%	81.80%
	Actual	80.30%	79.90%	66.90%	74.70%	76.30%	69.00%	68.00%*	78.40%*	72.50%*	75.90%*	64.60%*	76.00%*	79.20%*

Demand & Activity

Measure	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	% change from previous year Monthly (Apr)	YTD
GP referrals	13,735	14,183	14,033	13,418	13,332	12,842	15,690	14,814	11,965	14,521	13,202	14,044	13,094	-4.67%	-4.67%
OP attendances	12,669	13,619	13,642	13,983	12,721	12,318	14,284	14,707	11,084	14,083	12,474	13,525	12,663	-0.05%	-0.05%
Day cases	5,202	5,641	5,886	6,392	6,127	5,793	6,828	6,766	5,833	6,167	5,995	6,318	5,815	11.78%	11.78%
All electives	6,194	6,818	7,086	7,524	7,125	6,831	7,901	7,877	6,837	7,124	6,955	7,465	7,255	17.13%	17.13%
ED attedances	11,637	12,961	12,533	13,482	12,200	12,488	12,610	12,230	12,639	12,962	11,701	13,245	12,949	11.27%	11.27%
Non electives	4,712	4,838	4,559	4,823	4,602	4,668	4,878	5,088	5,081	5,132	3,085	4,900	4,696	-0.34%	-0.34%

Summary Scorecard

The following table shows the Trust's current monthly 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.

 Safe	 Effective	 Caring	 Responsive	 Well-led
% of adult inpatients who have received a VTE risk assessment	% C-section rate (planned and emergency)	ED % positive	% of ambulance handovers that are over 60 minutes	% sickness rate
Number of never events reported	Emergency re-admissions within 30 days following an elective or emergency spell	Maternity % positive	% waiting for diagnostics 6 week wait and over (15 key tests)	% total vacancy rate
Number of trust apportioned Clostridium difficile cases per month	Hospital standardised mortality ratio (HSMR)	Number of breaches of mixed sex accommodation	Cancer 62 day referral to treatment (screenings)	% turnover
Number of trust apportioned MRSA bacteraemia	Hospital standardised mortality ratio (HSMR) – weekend	Outpatients % positive	Cancer 62 day referral to treatment (upgrades)	Cost Improvement Year to Date Variance
Safety thermometer – % of new harms		Count of complaints received per month per 1,000 patient contacts (TBC)	Cancer 62 day referral to treatment (urgent GP referral)	NHSI Financial Risk Rating
Number of falls per 1,000 bed days (TBC)			Did not attend (DNA) rates	Trust total % mandatory training compliance
Total number of pressure ulcers acquired as in-patient (TBC)			ED: % total time in department – under 4 hours (type 1)	Trust total % overall appraisal completion
			ED: % total time in department – under 4 hours (types 1 & 3)	YTD Performance against Financial Recovery Plan
			Referral to treatment ongoing pathways over 52 weeks (number)	Overall % of nursing shifts filled with substantive staff
			Referral to treatment ongoing pathways under 18 weeks (%)	

Trust Scorecard

*** = unvalidated data**

SAFE

	18/19	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	18/19 Q4	19/20	Standard	Threshold
Infection Control																		
Number of trust apportioned MRSA bacteraemia	6	1	0	0	1	1	2	0	0	0	0	0	1	0 *	1	0 *	0	
MRSA bacteraemia – infection rate per 100,000 bed days														0 *		0 *	TBC	
Number of trust apportioned Clostridium difficile cases per month	56	5	9	2	7	6	3	4	4	1	6	5	4	7 *	15	7 *	<=8	
Clostridium difficile – infection rate per 100,000 bed days														24.7 *		24.7 *	<30.2	
Number of MSSA bacteraemia cases	164	9	9	10	13	8	14	9	4	2	25	30	31	0 *	86	0 *	TBC	
MSSA – infection rate per 100,000 bed days														0 *		0 *	TBC	
Number of ecoli cases	295	17	15	24	23	28	32	25	4	3	39	41	44	5 *	124	5 *	N/A	
Number of pseudomona cases	59	2	1	3	8	3	3	3	1	0	11	12	12	1 *	35	1 *	N/A	
Number of klebsiella cases	135	6	6	1	9	7	10	7	3	2	25	28	31	1 *	84	1 *	N/A	
Number of bed days lost due to infection control outbreaks														40 *		40 *	<10	>30
Patient Safety Incidents																		
Number of patient safety alerts outstanding	0 *													0 *	0 *	0 *	0	
Number of falls per 1,000 bed days		8.3 *	7.6 *	8.3 *	6.9 *	6.3 *	7.5 *	7.3 *	6.8 *	7.2 *	6.8 *	7.1 *	6 *	6.6 *			TBC	
Number of falls resulting in harm (moderate/severe)	8 *	10 *	8 *	7 *	11 *	6 *	9 *	8 *	6 *	8 *	8 *	2 *	7 *	3 *			TBC	
Number of patient safety incidents – severe harm (major/death)	1 *	2 *	1 *	1 *	1 *	1 *	2 *	1 *	0 *	1 *	0 *	3 *	7 *	13 *			TBC	
Medication error resulting in severe harm													0 *	0 *			TBC	
Medication error resulting in moderate harm													1 *	1 *			TBC	
Medication error resulting in low harm													12 *	10 *			TBC	
Number of category 2 pressure ulcers acquired as in-patient		35 *	31 *	43 *	31 *	31 *								43 *			TBC	
Number of category 3 pressure ulcers acquired as in-patient		9 *	8 *	7 *	11 *	7 *								10 *			TBC	
Number of category 4 pressure ulcers acquired as in-patient		0 *	0 *	0 *	0 *	0 *								0 *			TBC	
Number of unstagable pressure ulcers acquired as in-patient														3 *			TBC	
Number of deep tissue injury pressure ulcers acquired as in-patient													6 *	10 *			TBC	
Total number of pressure ulcers acquired as in-patient														66 *			TBC	
RIDDOR																		
Number of RIDDOR		4 *	0 *	1 *	2 *	2 *	5 *	4 *	1 *	4 *	1 *	3 *	3 *	2 *			SPC	
Safety Thermometer																		
Safety thermometer – % of new harms		98.0% *	97.8% *		98.4% *	97.7% *	98.6% *	98.5% *	97.9% *	97.3% *	97.3% *	97.7% *	97.2% *	96.2% *			>96%	<93%
Sepsis Identification and Treatment																		
Proportion of emergency patients with severe sepsis who were given IV antibiotics within 1 hour of diagnosis											88.00% *	81.00% *	82.00% *				>=90%	<50%
Serious Incidents																		
Number of never events reported	1 *	1 *	0 *	0 *	0 *	0 *	0 *	0 *	0 *	0 *	0 *	0 *	1 *	1 *			0	
Number of serious incidents reported		3 *	10 *	5 *	0 *	4 *	4 *	2 *	1 *	1 *	3 *	0 *	3 *	2 *			0	
Serious incidents – 72 hour report completed within contract timescale		100.0% *	100.0% *	100.0% *	100.0% *	100.0% *	100.0% *	100.0% *	100.0% *	100.0% *	100.0% *	100.0% *	100.0% *	100.0% *			>90%	
Percentage of serious incident investigations completed within contract timescale		100% *	100% *	100% *	100% *	100% *	100% *	100% *	100% *	100% *	100% *	100% *	100% *	100% *			>80%	
VTE Prevention																		
% of adult inpatients who have received a VTE risk assessment	93.2% *	79.9% *	96.6% *	91.7% *	94.8% *	94.6% *	93.8% *	94.8% *	95.4% *	90.7% *	96.6% *	94.2% *	94.8% *	95.4% *	95.2% *	95.4% *	>97%	<=95%

EFFECTIVE

	18/19	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	18/19 Q4	19/20	Standard	Threshold
Dementia Screening																		
% of patients who have been screened for dementia (within 72 hours)	1.9% *	0.7%	1.6%	1.6%	1.7%	3.5%	2.3%	1.8%	2.6%	3.3%	1.9%	0.8% *	0.6%	0.4% *	1.2%	0.4% *	>=90%	<70%
% of patients who have scored positively on dementia screening tool that then received a dementia diagnostic assessment (within 72 hours)	27.9% *	50.0%	16.7%	33.3%	11.1%	41.2%	18.2%	33.3%	22.2%	26.3%	40.0%	0.0% *	33.3%	100.0% *	30.4%	100.0% *	>=90%	<70%
% 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)	2.8% *	0.0%	0.0%	0.0%	0.0%	12.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0% *	0.0%	0.0% *	0.0%	0.0% *	>=90%	<70%
Maternity																		
% C-section rate (planned and emergency)	26.78% *												29.71% *	28.93% *	28.59% *	28.93% *	<=25%	>=27%
% emergency C-section rate	14.13% *												16.11% *	16.31% *	15.66% *	16.31% *	<=14%	
% of women that have an induced labour	29.19% *												31.17% *	29.13% *	30.68% *	29.13% *	<=20%	>25%
% stillbirths as percentage of all pregnancies > 24 weeks	0.26% *												0.21% *	0.39% *	0.21% *	0.39% *	<0.52%	
Mortality																		
Summary hospital mortality indicator (SHMI) – national data	102.6 *			103.3			102.6										Dr Foster	
Hospital standardised mortality ratio (HSMR)	97.2 *	98.3	95.2	96	96.4	98.1	99.8	100.8	99.1	97.7	97.2						Dr Foster	
Hospital standardised mortality ratio (HSMR) – weekend	101.3 *	101.1	97.3	97.1	97.9	96.6	98.4	101.7	101.4	99.3	101.3						Dr Foster	
Number of inpatient deaths													168 *	162 *		162 *	N/A	
Number of deaths of patients with a learning disability													2	4		4 *	N/A	
Readmissions																		
Emergency re-admissions within 30 days following an elective or emergency spell	6.9% *	7.1% *	6.9% *	7.2% *	7.2% *	7.2% *	6.8% *	7.1% *	6.1% *	7.1% *	6.7% *	6.9% *	6.3% *		6.6% *		<8.25%	>8.75%
Research																		
Research accruals	1,621 *	64 *	136 *	406 *	149 *	147 *	121 *	199 *	96 *	84 *	71 *	81 *	91 *	103 *	267 *		TBC	
Stroke Care																		
Stroke care: percentage of patients receiving brain imaging within 1 hour	36.9% *	36.7%	50.0%	40.6%	37.8%	47.0%	41.5%	34.3%	26.6%	31.9%	37.1%	32.7%	22.4%	23.4%	31.7%	23.4% *	>=50%	<45%
Stroke care: percentage of patients spending 90%+ time on stroke unit	90.8% *	90.4%	95.1%	95.6%	94.1%	97.2%	93.4%	80.7%	87.7%	91.9%	88.7%	84.1%	87.7%		86.9%		>=80%	<70%
% of patients admitted directly to the stroke unit in 4 hours													51.70%	68.10%			>=80%	<72%
% patients receiving a swallow screen within 4 hours of arrival													70.70%	52.10%			>=90%	<80%
Trauma & Orthopaedics																		
% of fracture neck of femur patients treated within 36 hours	76.0% *	72.2% *	79.4% *	68.3% *	74.2% *	88.7% *	85.5% *	67.7% *	70.1% *	75.0% *	83.9% *	85.6% *	77.8% *	80.2% *	82.6% *		>=90%	<80%
% fractured neck of femur patients meeting best practice criteria													77.78% *	77.78% *	79.80% *		>=65%	<55%

CARING

	18/19	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	18/19 Q4	19/20	Standard	Threshold
Friends & Family Test																		
Inpatients % positive	91.2% *	90.2%	91.4%	91.7%	91.7%	90.7%	91.9%	92.2%	90.9%	91.5% *	91.9% *	89.2% *	91.5% *	89.1% *	90.9% *	89.1% *	>=96%	<93%
ED % positive	83.1% *	83.1%	83.2%	84.6%	83.6%	82.0%	85.9%	82.7%	82.7%	81.0% *	82.7% *	82.8% *	82.7% *	82.7% *	82.7% *	82.7% *	>=84%	<81%
Maternity % positive	96.7% *	97.4%	94.0%	95.6%	93.3%	94.7%	0.0%	100.0%	98.2%	100.0% *	100.0% *	93.5% *	97.5% *	96.6% *	97.0% *	96.6% *	>=97%	<94%
Outpatients % positive	92.6% *	92.0%	92.3%	92.3%	93.3%	91.9%	92.3%	93.0%	92.5%	92.9% *	93.4% *	92.5% *	93.1% *	92.8% *	93.0% *	92.8% *	>=94%	<91%
Total % positive	91.2%	90.6%	91.2%	91.3%	91.6%	90.3%	91.6%	91.8%	91.2%	90.9% *	91.9% *	90.7%	91.4%	90.6% *	91.3% *	90.6% *	>=93%	<90%
Inpatient Questions (Real time)																		
How much information about your condition or treatment or care has been given to you?														71.57%			>=90%	
Are you involved as much as you want to be in decisions about your care and treatment?														94.06%			>=90%	
Do you feel that you are treated with respect and dignity?														93.07%			>=90%	
Do you feel well looked after by staff treating or caring for you?														96.97%			>=90%	
Do you get enough help from staff to eat your meals?														95.96%			>=90%	
In your opinion, how clean is your room or the area that you receive treatment in?														96.88%			>=90%	
Do you get enough help from staff to wash or keep yourself clean?														96.97%			>=90%	
Linked Patient and Staff Experience																		
National Inpatient Survey Q72 overall rated experience as 7 out of 10 or more	83%																<=90%	
MSA																		
Number of breaches of mixed sex accommodation	68 *	8	8	20	5	6	0	7	2	6	2	1	3	4	6	4 *	<=10	>=20

RESPONSIVE

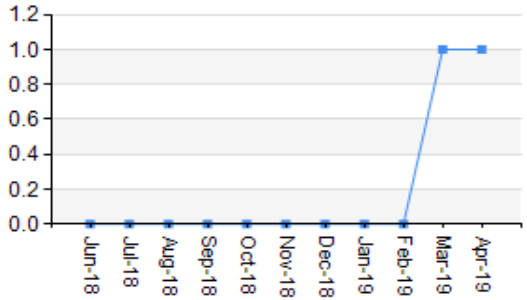
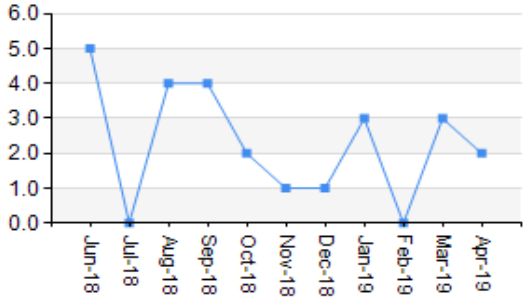
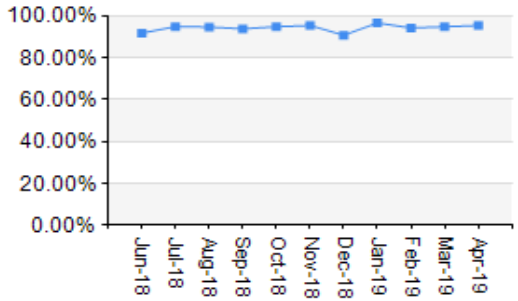
	18/19	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	18/19 Q4	19/20	Standard	Threshold
Cancer																		
Cancer – urgent referrals seen in under 2 weeks from GP	90.0% *	86.6%	86.3%	88.6%	90.4%	88.9%	82.8%	91.8% *	90.6% *	94.3% *	92.0% *	93.8% *	95.3% *	87.9% *	93.8% *	87.9% *	>=93%	<90%
2 week wait breast symptomatic referrals	95.8% *	91.3%	91.9%	95.1%	96.0%	97.8%	98.9%	99.2% *	94.5% *	97.6% *	95.5% *	97.0% *	95.6% *	96.9% *	96.0% *	96.9% *	>=93%	<90%
Cancer – 31 day diagnosis to treatment (first treatments)	94.6% *	96.7%	96.9%	97.1%	96.8%	96.9%	93.5%	93.2% *	94.0% *	93.8% *	92.3% *	91.0% *	91.9% *	93.3% *	91.6% *	93.3% *	>=96%	<94%
Cancer – 31 day diagnosis to treatment (subsequent – drug)	99.9% *	100.0%	100.0%	100.0%	100.0%	100.0%	98.8%	100.0% *	100.0% *	100.0% *	100.0% *	100.0% *	100.0% *	100.0% *	100.0% *	100.0% *	>=98%	<96%
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	95.3% *	94.9%	96.6%	94.5%	96.0%	95.7%	94.3%	98.3% *	96.6% *	92.5% *	94.8% *	96.4% *	96.4% *	93.6% *	95.8% *	93.6% *	>=94%	<92%
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	99.3% *	100.0%	100.0%	100.0%	98.7%	100.0%	100.0%	98.6% *	98.6% *	98.6% *	100.0% *	98.9% *	97.2% *	94.9% *	98.8% *	94.9% *	>=94%	<92%
Cancer 62 day referral to treatment (urgent GP referral)	74.8% *	80.3%	79.9%	66.9%	74.7%	76.3%	69.0%	68.0% *	78.4% *	72.5% *	75.9% *	64.6% *	76.0% *	79.2% *	72.5% *	79.2% *	>=85%	<80%
Cancer 62 day referral to treatment (screenings)	96.5% *	100.0%	94.1%	100.0%	100.0%	100.0%	85.5%	93.5% *	93.5% *	100.0% *	93.9% *	96.3% *	100.0% *	100.0% *	96.8% *	100.0% *	>=90%	<85%
Cancer 62 day referral to treatment (upgrades)	68.9% *	76.5%	100.0%	84.6%	53.3%	100.0%	75.0%	77.8% *	58.8% *	70.0% *	69.2% *	60.0% *	76.2% *	30.0% *	70.2% *	30.0% *	>=90%	
Number of patients waiting over 104 days with a TCI date	141 *	9	12	6	8	22	26	7	13	8	8	8	14	20	30	20 *	0	
Number of patients waiting over 104 days without a TCI date	347 *	18	18	22	28	24	30	39	37	27	42	37	25	19	104	19 *	0	
Diagnostics																		
% waiting for diagnostics 6 week wait and over (15 key tests)	0.45% *	0.56%	1.26%	0.52%	0.55%	1.27%	0.63%	0.03%	0.35%	0.20%	0.67%	0.21%	0.45%	0.54%	0.45%	0.54% *	<=1%	>2%
The number of planned / surveillance endoscopy patients waiting at month end	726 *	188	223	260	311	407	576	630 *	680 *	686 *	639 *	600 *	726 *	835	726 *	835	TBC	
Discharge																		
Number of patients delayed at the end of each month	37 *	37	27	36	47	44	41	44 *	40 *	34 *	29 *	24 *	43	45	32 *	45	TBC	
Patient discharge summaries sent to GP within 24 hours	50.7% *	50.1% *	50.2% *	51.7% *	52.6% *	49.7% *	51.9% *	51.7% *	49.2% *	47.4% *	52.4% *	49.9% *	51.3% *		51.2% *		>=88%	<75%
Emergency Department																		
ED: % total time in department – under 4 hours (type 1)	89.60%	91.98%	91.58%	93.33%	91.34%	90.26%	89.01%	90.54%	91.59%	87.55%	84.46%	86.08%	87.13%	86.01% *	85.89%	86.01% *	>=95%	<90%
ED: % total time in department – under 4 hours (types 1 & 3)	92.78%	94.59%	94.20%	95.33%	93.65%	93.45%	92.47%	93.60%	93.98%	91.29%	89.02%	90.21%	91.00%	90.39% *	90.09%	90.39% *	>=95%	<90%
ED: % total time in department – under 4 hours CGH	96.40%	97.80%	98.10%	96.30%	96.90%	96.00%	96.40%	96.90%	96.94% *	95.47%	93.70%	95.50%	96.10%	94.66% *	95.10%	94.66% *	>=95%	<90%
ED: % total time in department – under 4 hours GRH	86.20%	89.10%	88.10%	91.80%	88.40%	87.40%	85.20%	87.30%	89.06% *	83.82%	80.10%	81.60%	82.80%	81.89% *	81.50%	81.89% *	>=95%	<90%
ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission)	0	0	0	0	0	0	0	0	0	0 *	0	0	0	0 *	0	0 *	0	
ED: % of time to initial assessment – under 15 minutes	87.4%	90.5%	90.3%	90.8%	88.6%	90.7%	87.3%	88.8%	89.6%	85.4%	85.2% *	83.6%	78.4%	75.8% *	82.3%	75.8% *	>=95%	<92%
ED: % of time to start of treatment – under 60 minutes	33.5%	36.8%	33.6%	34.1%	31.4%	34.3%	29.0%	36.7%	34.5%	32.1%	34.9% *	32.4%	32.6%	32.0% *	33.3%	32.0% *	>=90%	<87%
% of ambulance handovers that are over 30 minutes													7.90% *	1.44% *		1.44% *	TBC	
% of ambulance handovers that are over 60 minutes													0.10% *	0.0% *		0.0% *	0%	>2%
Operational Efficiency																		
Number of patients stable for discharge	73 *	67	66	71	71	75	80	75	76	69 *	74 *	72 *	77 *	82 *	74 *	82 *	TBC	
% of bed days lost due to delays														4.74% *		4.74% *	<=3.5%	>4%
Number of stranded patients with a length of stay of greater than 7 days	384 *	384	395	369	373	382	376 *	374 *	382 *	374 *	399 *	412 *	397 *	393 *	402 *	393 *	TBC	
Average length of stay (spell)	4.94 *	5.18 *	4.73 *	4.71 *	4.64 *	4.95 *	4.8 *	4.88 *	5.13 *	4.83 *	5.14 *	5.35 *	4.99 *	4.58 *	5.15 *	4.58 *	TBC	
Length of stay for general and acute non-elective (occupied bed days) spells	5.51 *	5.72 *	5.27 *	5.34 *	5.17 *	5.4 *	5.31 *	5.48 *	5.76 *	5.29 *	5.7 *	6.07 *	5.67 *	5.56 *	5.8 *	5.56 *	<=5.4	
Length of stay for general and acute elective spells (occupied bed days)	2.71 *	2.82 *	2.78 *	2.52 *	2.61 *	3 *	2.75 *	2.47 *	2.84 *	2.89 *	2.6 *	2.67 *	2.56 *	1.78 *	2.61 *	1.78 *	<=3.4	>4.5
% day cases of all electives													84.60% *	80.00% *		80.00% *	>80%	<70%
Intra-session theatre utilisation rate														87.80% *			>85%	<70%
Outpatient																		
Outpatient new to follow up ratio's													1.93 *	1.91 *		1.91 *	TBC	
Did not attend (DNA) rates													6.40% *	6.80% *		6.80% *	<=7.6%	>10%
RTT																		
Referral to treatment ongoing pathways under 18 weeks (%)	79.75%												79.75% *	79.46%	79.75%	79.46% *	>=92%	
Referral to treatment ongoing pathways 35+ Weeks (number)	2,352												2,352	2,163	2,352	2,163 *	TBC	
Referral to treatment ongoing pathways 40+ Weeks (number)	1,860												1,860	1,699	1,860	1,699 *	TBC	
Referral to treatment ongoing pathways over 52 weeks (number)	95 *	95	92	98	113	125	105	103	105	97	89	97	95	93	95	93 *	0	
SUS																		
Percentage of records submitted nationally with valid GP code	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% *	100.0% *	100.0% *	100.0% *	>=99%	
Percentage of records submitted nationally with valid NHS number	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% *	99.8% *	99.8% *	99.8% *	>=99%	

WELL-LED

	18/19	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	18/19 Q4	19/20	Standard	Threshold
Appraisal and Mandatory Training																		
Trust total % overall appraisal completion	79.0% *			74.0%	74.0%	75.0% *	79.0%	80.0% *	79.0% *	79.0% *	79.0%	79.0%	81.0% *	80.0% *	81.0%	80.0% *	>=90%	<70%
Trust total % mandatory training compliance	89% *			87%	87%	88%	90%	91% *	91% *	91% *	89%	89%	91% *	91% *	91%		>=90%	<70%
Finance																		
NHSI Financial Risk Rating		4	4	4	4	4	4	4	4	4	3	4	4	4				
YTD Performance against Financial Recovery Plan		.05	.07	.09	.18 *	.2	.2	.2	.4	.04	-3	-6.6	-14.1	.2				
Total PayBill Spend		28.4	28.5	28.05	28.5	30.5	27.5	29.5	29.03	29.7	29.4	29.9	33.3	31.8				
Agency – Performance Against NHSI Set Agency Ceiling		2	2	2	2	2	3	3	3	3	3	3	3	3				
Cost Improvement Year to Date Variance		-51	121	1,116	2,365	2,342	2,975	2,994	2,013 *	1,593	0	-1,784	-3,378	0				
Capital service		4	4	4	4	4	4	4	4	4	4	4	4	4				
Liquidity		4	4	4	4	4	4	4	4	4	4	4	4	4				
Safe Nurse Staffing																		
Overall % of nursing shifts filled with substantive staff														96.55%		96.55%	>=75%	<70%
% registered nurse day														97.86%		97.86%	>=90%	<80%
% unregistered care staff day														97.17%		97.17%	>=90%	<80%
% registered nurse night														94.11%		94.11%	>=90%	<80%
% unregistered care staff night														100.33%		100.33%	>=90%	<80%
Care hours per patient day RN													6.2 *	4.61 *		4.61 *	TBC	
Care hours per patient day HCA													3.2 *	2.78 *		2.78 *	TBC	
Care hours per patient day total	7 *	7	7	8	7	7	7	7	7	7 *	7 *	7 *	8 *	7 *	7 *	7 *	TBC	
Staff Engagement																		
Number of concerns raised with freedom to speak up guardian per month	65 *														11 *		TBC	
Vacancy and WTE																		
% total vacancy rate														11.46%			<=11.5%	>13%
% vacancy rate for doctors														8.07%			<=5%	>5.5%
% vacancy rate for registered nurses														12.09%			<=5%	>5.5%
Staff in post FTE														6142.0900 *			TBC	
Vacancy FTE														792.7200			TBC	
Starters FTE														10.1200 *			TBC	
Leavers FTE														5.1700 *			TBC	
Workforce Expenditure and Efficiency																		
% turnover	12.3% *	12.0%	11.8%	12.3%	12.3%	12.0%	12.1%	11.9%	11.6%	11.7%	11.7%	11.9%	12.2%	0.9% *			<=11%	>15%
% turnover rate for nursing														1.09% *			<=11%	>15%
% sickness rate	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%	3.9% *			<=3.5%	>4%

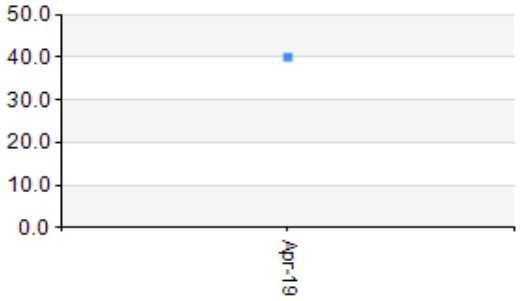
Exception Reports

SAFE

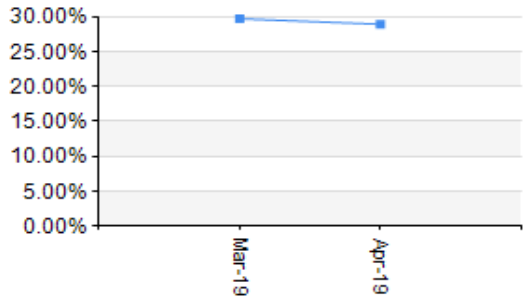
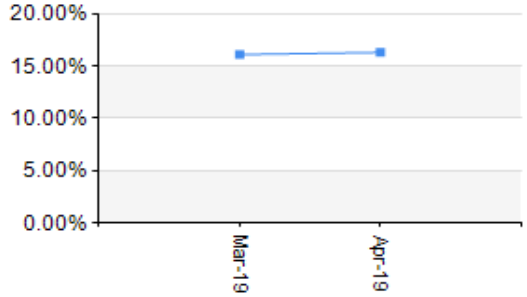
Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of never events reported **Standard: 0**		There has been one Never Event reported in April involving a wrong injection into the eye. A full RCA is underway.	Director of Safety
Number of serious incidents reported **Standard: 0**		There has been a single monthl increase in unconfirmed serious incidents, these incidents will be reviewed and brought forward to SI panel. There doesn't appear to be any particular pattern or trend. The longitudinal data shows no real change.	Director of Safety
% of adult inpatients who have received a VTE risk assessment **Standard: R<=95% A96% G>97%**		Clinical Audit results in the last quarter showed 95% compliance	Director of Safety

Exception Reports

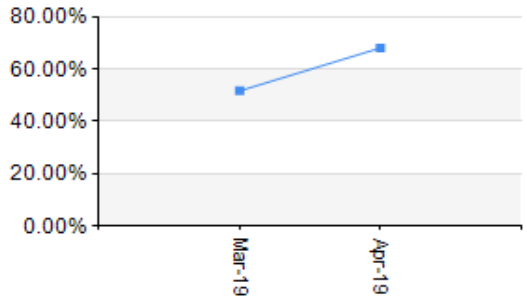
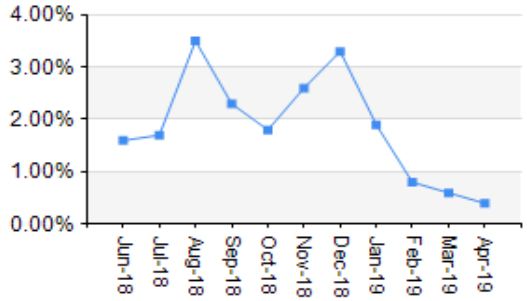
SAFE

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of bed days lost due to infection control outbreaks **Standard: R>30 A11-30 G<10**		There were a number of outbreaks either caused by Norovirus or Influenza during April. As a mean to control the outbreak bays and/or wards were closed to prevent ongoing transmission of infection to other patients. The Infection Prevention and Control team and Site team worked together closely on a daily basis to control the outbreak and re-open beds when it was safe to do.	Associate Chief Nurse and Deputy Director of Infection Prevention and Control

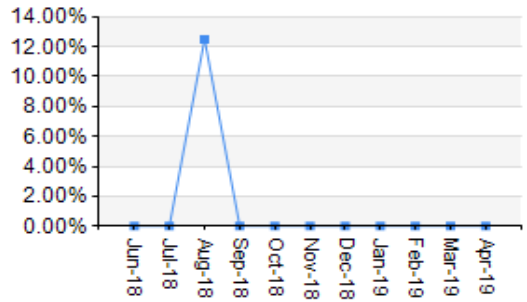
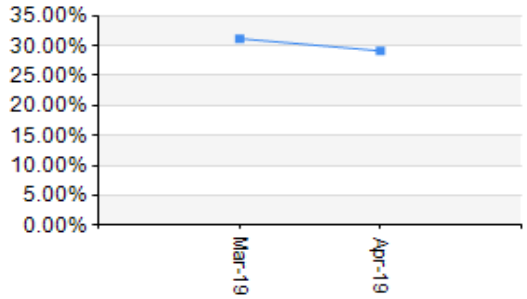
EFFECTIVE

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% C-section rate (planned and emergency) **Standard: R>=27% A26% G<=25%**		National and regional benchmarking to be undertaken.	Divisional Chief Nurse and Director of Midwifery
% emergency C-section rate **Standard: R>14% G<=14%**		National and regional benchmarking to be undertaken.	Divisional Chief Nurse and Director of Midwifery

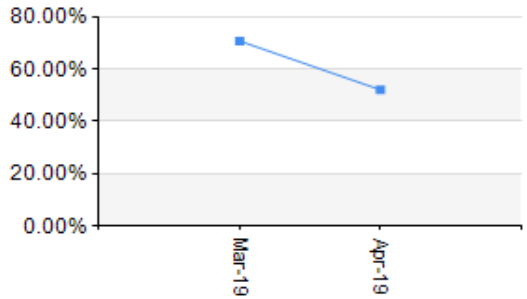
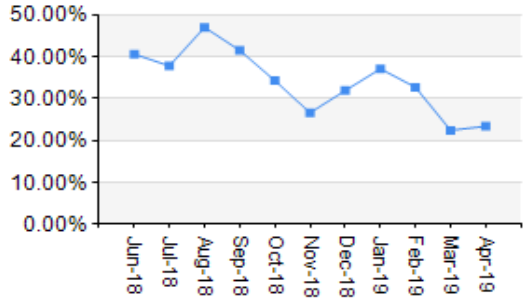
EFFECTIVE

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of patients admitted directly to the stroke unit in 4 hours **Standard: R<72% A73-79% G>=80%**		In April 85.7% of patients were admitted directly to the Stroke unit within 4 hours of admission. This fell short of the target by 4.3% compared to previous month achievement of 90.6%. On further analysis a number of patients were not admitted directly to the Stroke unit but were awaiting a bed on AMU which then led to a knock on delay to admission to the Stroke unit. - 5 patients had a difficult diagnosis which led to observation on AMU before diagnosis of Stroke could be confirmed and then follow the appropriate Stroke pathway. - 2 patients were delayed in transfer over from CGH and Community Hospital which led to failure of the target. - 1 patient was too unwell to move from AMU to the Stroke unit. - 11 patients could not get a bed on the Stroke unit due to medical patients on the ward and therefore a lack of beds. This is symptomatic of the wider patient flow issues evident during April; greater ED attendances per day on average and a higher number of MOFD remaining on an inpatient ward.	Director of Unscheduled Care and Deputy Chief Operating Officer
% of patients who have been screened for dementia (within 72 hours) **Standard: R<70% A70-89% G>=90%**		Monthly manual audit of clinical pathway in place in unscheduled care areas. plan for EPR solution longer term.	Deputy Chief Nurse

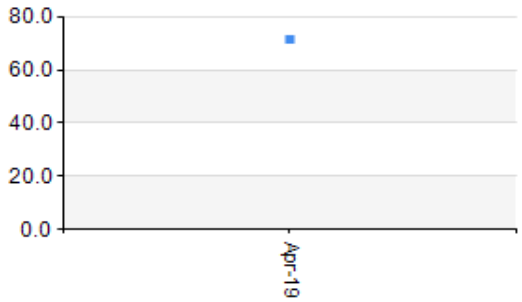
EFFECTIVE

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of patients who have received a dementia diagnostic assessment with positive or inconclusive results that were then referred for further diagnostic advice/FU (within 72 hours) **Standard: R<70% A70-89% G>=90%**		Monthly manual audit of clinical pathway in place in unscheduled care areas. plan for EPR solution longer term.	Deputy Chief Nurse
% of women that have an induced labour **Standard: R>25% A21-25% G<=20%**		Induction rates have been static at @30% for last 12-18 months. This is favourable regionally and nationally and unlikely to fall significantly as it reflects a global change in obstetric practice. However the new Saving Babies Care Bundle V2 will help in that it suggests IOL should not be offered for reduced fetal movements before 39 weeks gestation. It also provides useful data which can be used to counsel women about the adverse effects of early intervention. A new IOL guideline will be written which will be consistent with a regional consensus approach from South West Obstetric Network. New induction of labour guideline to be written GAP analysis of saving babies lives care bundle V2 to be undertaken	Divisional Chief Nurse and Director of Midwifery

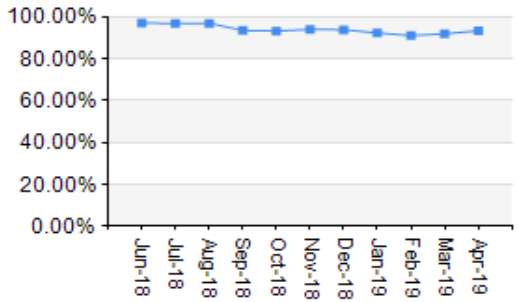
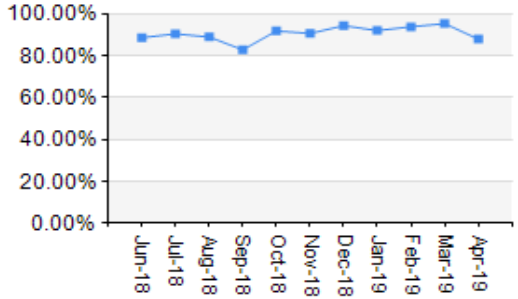
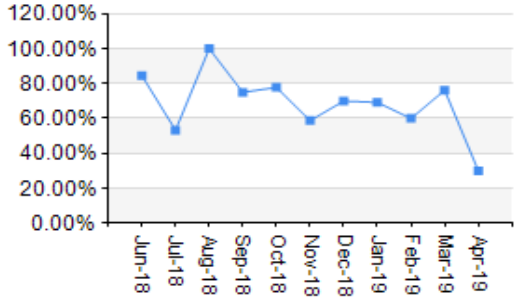
EFFECTIVE

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% patients receiving a swallow screen within 4 hours of arrival **Standard: R<80% A81-89% G>=90%**		April was a difficult month for capacity linked to increased attendances and bed pressures. Over the month 21 patients failed to receive a swallow screen within the expected timeframe; the target was achieved in the previous month (90.6% in march 2019). Themes are as follows: 4 patients were too unwell / difficult diagnosis 4 patients were delayed transfers from CGH 3 patients were delayed on 6th floor due to reduced staffing (Bank Holiday) 2 patients had a delayed scan (Radiology capacity, not late referral) which then had a knock on impact on swallow screen 8 patients had a delayed admission to 6th floor due to medical patients in beds 1 patient had a delay as Stroke Specialist Nurse was already dealing with another patient. Overall the common theme that contributed most to failure of this target is lack of 6th floor beds	Director of Unscheduled Care and Deputy Chief Operating Officer
Stroke care: percentage of patients receiving brain imaging within 1 hour **Standard: R<45% A45-49% G>=50%**		The target was marginally improved in April 2019 (23.4% achievement) versus March 2019 (22.4% achievement). Key themes remain the same in regards to either lack of pre-alert to the Stroke Specialist Nurse team within hours to come and pick the patient up in ED or patients arriving out of hours currently covered by Stroke Specialist Nurse team. Recovery will focus on two key elements; pre-alert to SSN team and SSN team cover in ED. 2.0 WTE additional Stroke Specialist Therapists were recruited successfully in April 2019 and will commence in post July / August 2019.	Director of Unscheduled Care and Deputy Chief Operating Officer

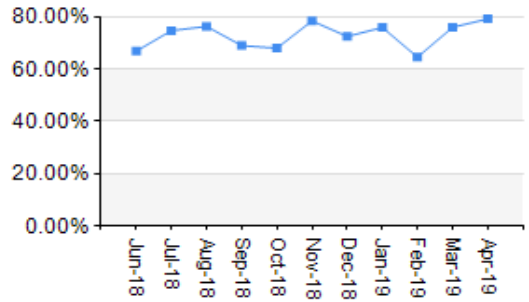
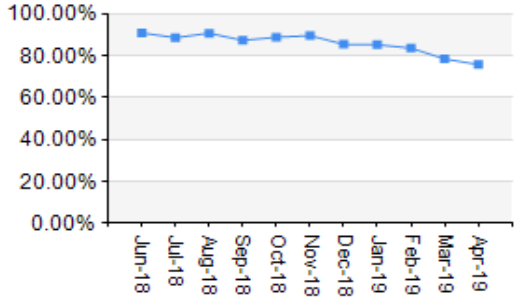
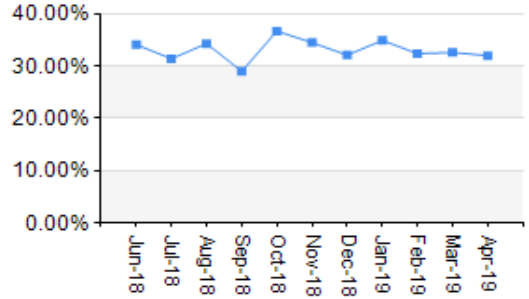
CARING

Metric Name & Standard	Trend Chart	Exception Notes	Owner
How much information about your condition or treatment or care has been given to you? **Standard: TBC**		The data from April was collected as a pilot, with the Real Time Survey being implemented from May 2019. The data collected in April shows that across divisions patients are not being provided the right amount of information to meet their needs. Actions: Align Real Time survey and FFT contracts, to give divisions access to all their patient experience data on one platform that can be used to highlight areas of best practice and improvement. Launch Best Care Programme, embedding patient experience improvement within the divisions, using Real Time Survey data and other patient experience improvement methodologies to identify areas for improvement	Head of Patient Experience Improvement

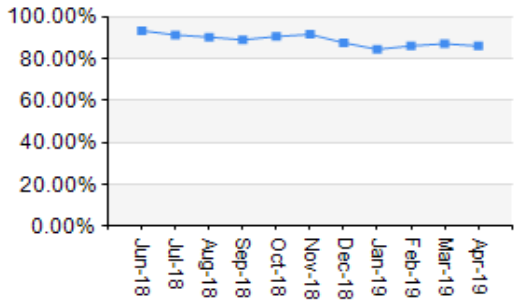
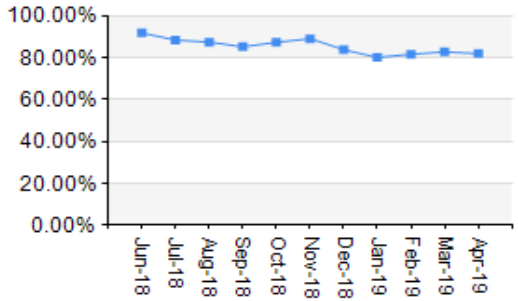
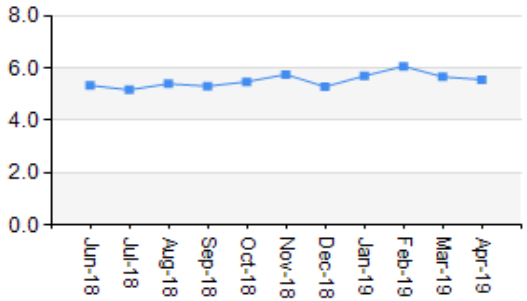
RESPONSIVE

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Cancer – 31 day diagnosis to treatment (first treatments) **Standard: R<94% A94-95% G>=96%**		Performance - 93.2% 266 tx and 18 breaches Target - 96% National performance - 96.5% Uro 9 Gynae 4 H&N 2 Skin 2	Director of Planned Care and Deputy Chief Operating Officer
Cancer – urgent referrals seen in under 2 weeks from GP **Standard: R<90% A90-92% G>=93%**		2ww performance - 1991 DFS 241 breaches - 87.9% National performance - 91.8% LGI 66 Skin 131 UGI 19	Director of Planned Care and Deputy Chief Operating Officer
Cancer 62 day referral to treatment (upgrades) **Standard: >=90%**		Performance - 30% % 5 tx's 3 breaches Target - No target National performance - 85% UGI 2 Lung 0.5 Gynae 1	Director of Planned Care and Deputy Chief Operating Officer

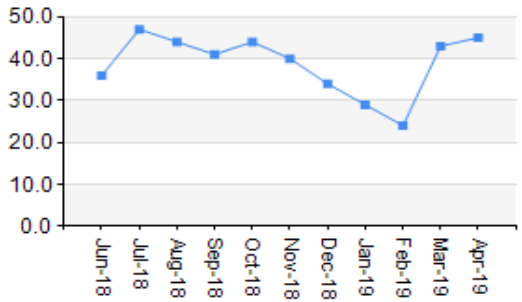
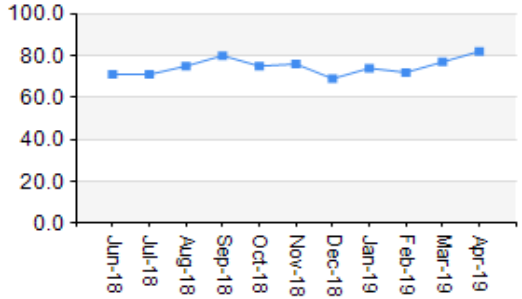
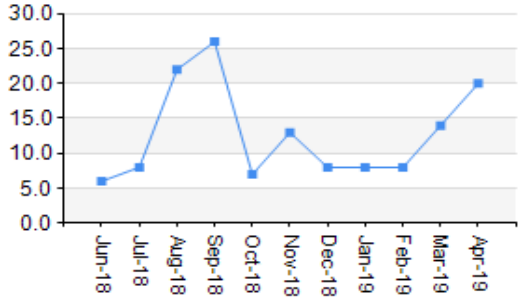
RESPONSIVE

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Cancer 62 day referral to treatment (urgent GP referral) **Standard: R<80% A80-84% G>=85%**		Performance - 79.6% (162 tx 33 breaches) exc urology performance - 84.1% Target - 85% National performance - 79.7% Urology - 11.5 Gynae 5 H&N 4 Haem 4	Director of Planned Care and Deputy Chief Operating Officer
ED: % of time to initial assessment – under 15 minutes **Standard: R<92% A92-94% G>=95%**		ENP enhanced triage pilot kicked off 13th May 2019 for 14 days. Following this a 14 day trial of medical triage is planned to provide a comparative analysis of effectiveness.	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%**		Emergency Care Delivery Group & Unscheduled Care Leaders reinvigorated to meet in their respective capacities as the weekly assurance and operational delivery groups from June 2019. This will include breach analysis and trends contemporaneously to measure success of recovery plan actions as they kick in. Clinical Decision Unit plan being produced for Medicine Divisional Board in June 2019.	Director of Unscheduled Care and Deputy Chief Operating Officer

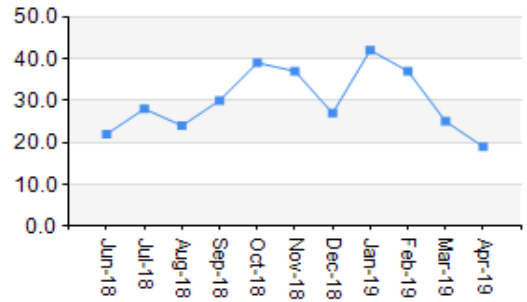
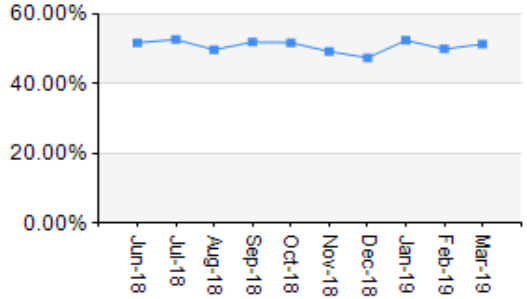
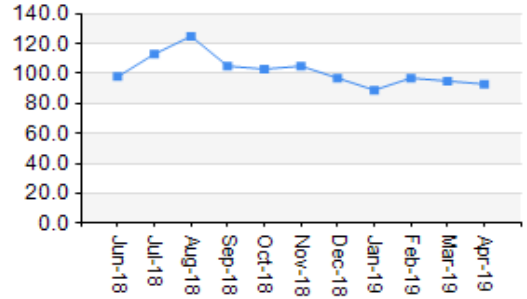
RESPONSIVE

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % total time in department – under 4 hours (type 1) **Standard: R<90% A90-94% G>=95%**		Full exception report detailing a number of actions provided.	Director of Unscheduled Care and Deputy Chief Operating Officer
ED: % total time in department – under 4 hours GRH **Standard: R<90% A90-94% G>=95%**		Full exception report detailing a number of actions provided.	Director of Unscheduled Care and Deputy Chief Operating Officer
Length of stay for general and acute non-elective (occupied bed days) spells **Standard: TBC**		Review at speciality level and benchmarking with ‘ best in class’ to be reviewed in the next 3 months.	Deputy Chief Operating Officer

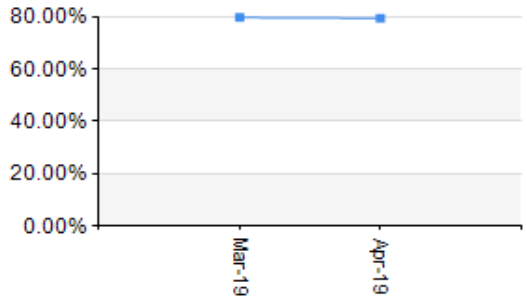
RESPONSIVE

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of patients delayed at the end of each month **Standard: TBC**		CEX Summit held and key priorities agreed to address system issues & internal focus through LOS Steering Group system wide.	Director of Unscheduled Care and Deputy Chief Operating Officer
Number of patients stable for discharge **Standard: TBC**		CEX Summit held and key priorities agreed to address system issues & internal focus through LOS Steering Group.	Director of Unscheduled Care and Deputy Chief Operating Officer
Number of patients waiting over 104 days with a TCI date **Standard: 0**		Cancer Category Total Gynaecological 1 Haematological 1 Lower GI 4 Urological 23 Grand Total 29	Director of Planned Care and Deputy Chief Operating Officer

RESPONSIVE

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of patients waiting over 104 days without a TCI date **Standard: TBC**		Cancer Category Total Gynaecological 2 Lower GI 7 Skin 1 Upper GI 2 Urological 6 Grand Total 18	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%**		Performance remains static despite improvement plans in place over the last 6 months and daily reporting to clinical leaders. Currently considering whether we can make it mandatory on Trakcare.	Medical Director
Referral to treatment ongoing pathways over 52 weeks (number) **Standard: 0**		Recovery plan in place and trajectory set, key specialities are GI and ENT.	Deputy Chief Operating Officer

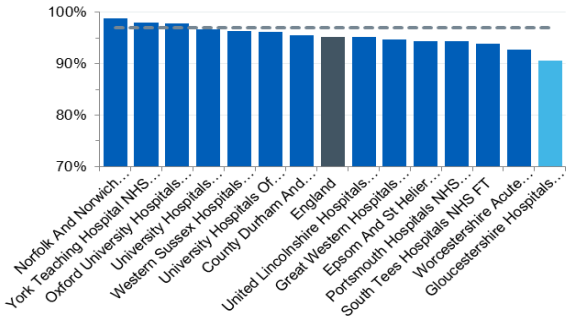
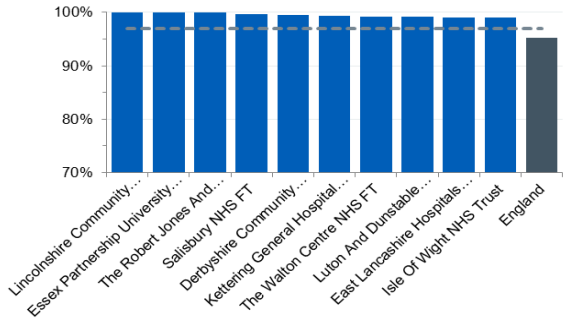
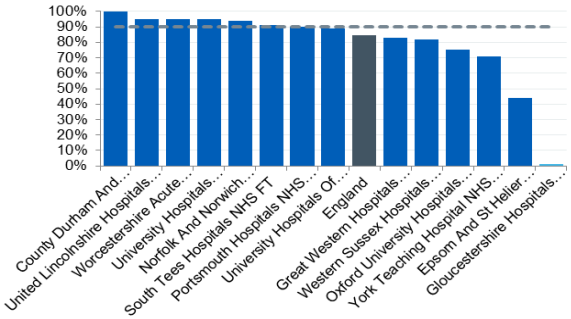
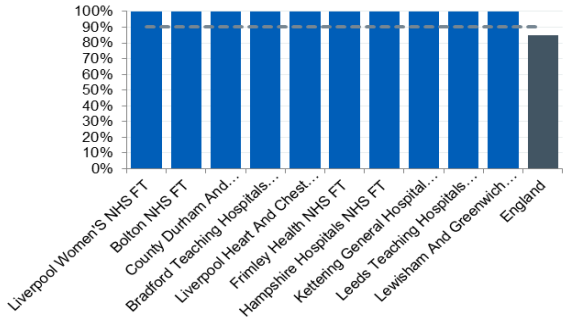
RESPONSIVE

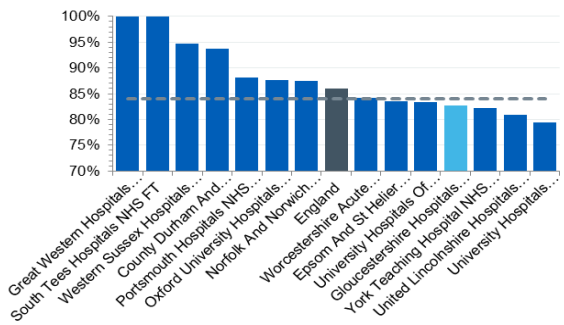
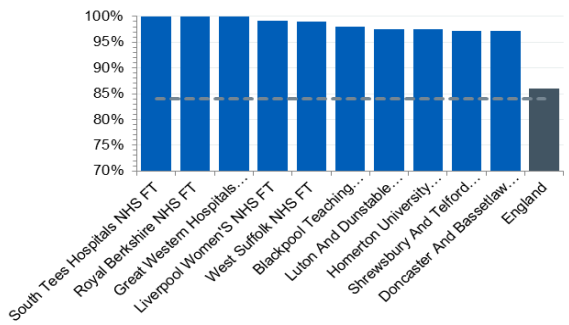
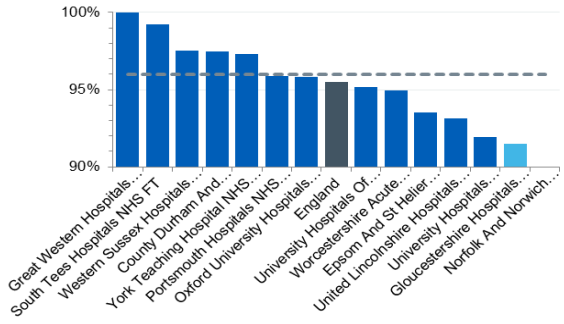
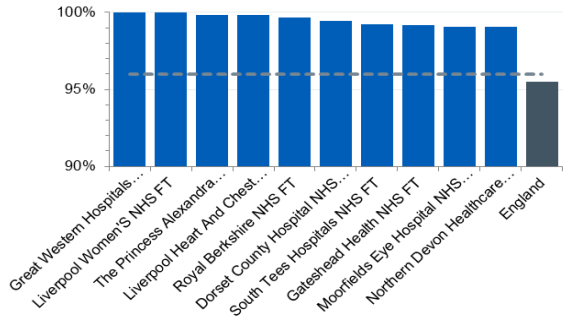
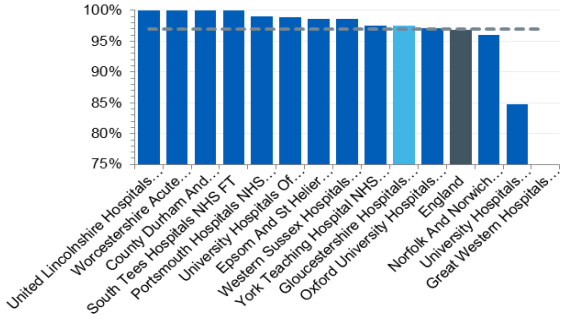
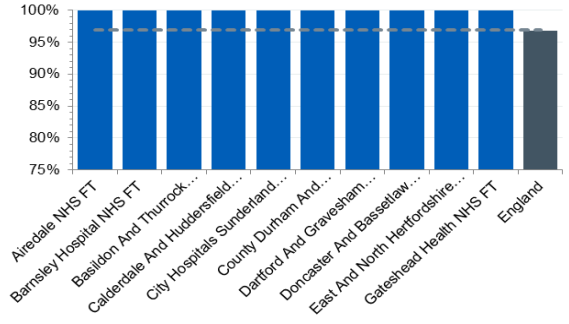
Metric Name & Standard	Trend Chart	Exception Notes	Owner
Referral to treatment ongoing pathways under 18 weeks (%) **Standard: >=92%**		Re-reporting has commenced and RTT position is in line with trajectory, full delivery plan accompanies the exception report.	Deputy Chief Operating Officer

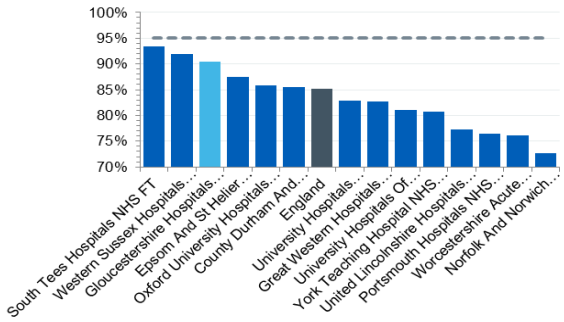
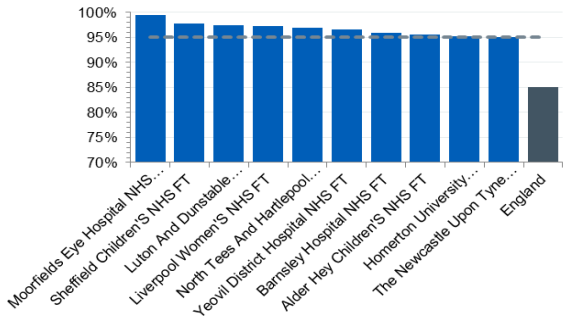
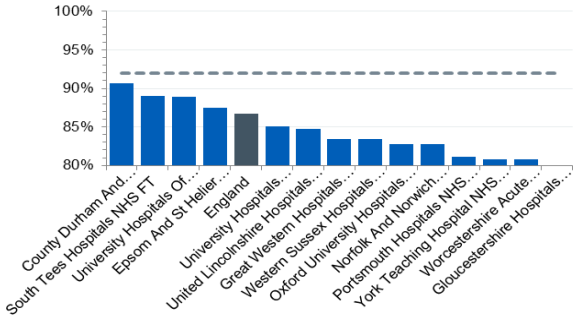
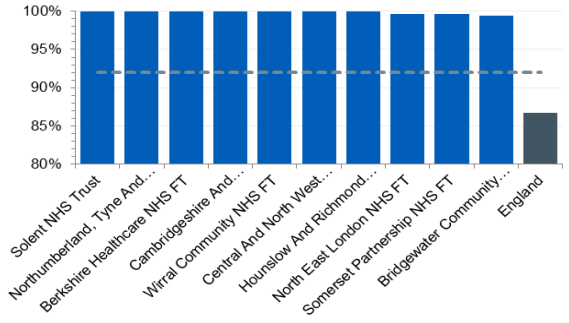
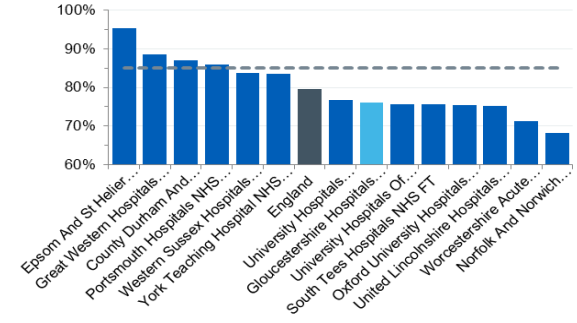
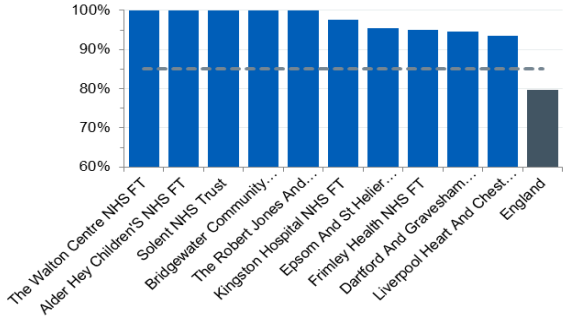
Benchmarking – Selected Measures

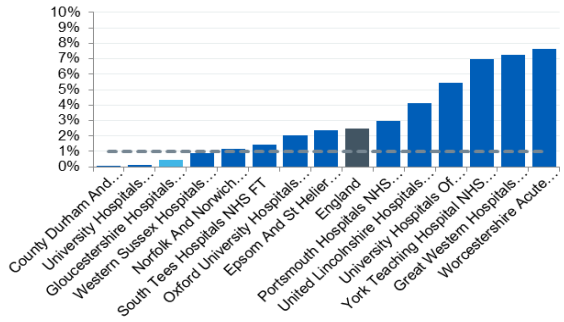
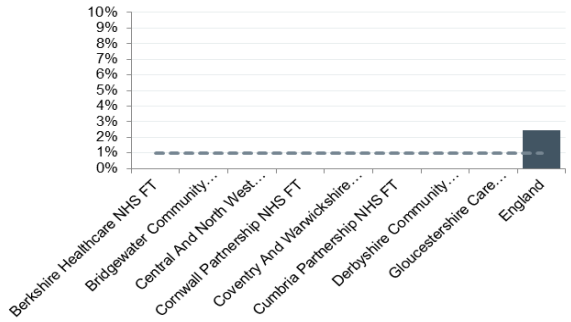
Standard
GHT

England
Other providers

Metric	Period	Peer Group	Best in Class	Rank	Quartile
VTE	Dec-18			139/150	4th
Dementia	Feb-19			131/132	4th

Metric	Period	Peer Group	Best in Class	Rank	Quartile
FFT - ED	Mar-19			106/134	4th
FFT - Inpatient	Mar-19			136/147	4th
FFT - Maternity	Mar-19			77/123	3rd

Metric	Period	Peer Group	Best in Class	Rank	Quartile
ED 4 Hour (Type 1 & Type 3)	Apr-19			34/134	1st
RTT	Mar-19			167/183	4th
Cancer 62 Days GP Referrals	Mar-19			103/147	3rd

Metric	Period	Peer Group	Best in Class	Rank	Quartile
Diagnostics	**Mar-19**			**63/174**	**2nd**

Gloucestershire Hospitals
NHS Foundation Trust

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

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

Purpose

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

Key issues to note

Our stories are told by individuals, who choose to come to Board, to tell us their story from their own perspective. The stories provide us with an opportunity to understand their experience of the care they have received – what was good, what did not meet their needs and what could be done to improve their experience.

We use patient stories: -

- To get a better understanding of individuals' experiences and perspectives on a specific issue or service.
- Alongside other data sources to gain powerful insight into what is happening with our services and/or systems.
- To improve our services.
- To enable Board members to step into the shoes of the patient and see our care through the eyes of our patients.

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

NHS

It's fundamental and its everyone's business

Conclusions

The developing emphasis on service user involvement in our Trust health is a powerful asset in our quality improvement work.

Implications and Future Action Required

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

Recommendations
The Board are asked to note the contents of this report.
Impact Upon Strategic Objectives
Outstanding rating by CQC.
Impact Upon Corporate Risks
Listening to stories helps identify our risks and where improvements can be made. Bringing people to tell their stories from areas where experience risks have been identified enables members of the Board to 'walk in the shoes of the patient'.
Regulatory and/or Legal Implications
None.
Equality & Patient Impact
Improvement work being carried out in response to stories.

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	
		None	√

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							

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

TRUS BOARD - JUNE 2019

PATIENT EXPERIENCE IMPROVEMENT IN RESPONSE TO BOARD STORIES

1 Patient Experience Improvement Work

The aim of this paper is to give the Board an update on the patient experience improvement work that has been initiated in response to the stories that have been presented to Board from November 2018 - May 2019.

2 Patient Experience Stories

2.1 In **November 2018** the Deputy Director of Quality introduced Janice Payne, Sarah Sharp and Kate Williams, the Trust's Patient Advice and Liaison Service (PALS) Officers, who gave a presentation on the background of the team and recent and proposed service developments.

Their staff experience story touched on:

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

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

In response to the Board Story:

Issues discussed at Board (positive and areas for improvement)	Achievements since the Board meeting
Improved level of service for PALS as raised as an issue by Healthwatch	We have now increased the establishment to 4 band 4 staff. In addition 1 member of staff has left the team and we are now out to recruit for 2 more staff. We had 49 applicants and we hope to have a fully established team of 4 by the end of July.
Working to reduce complaints	The PALs team continue to have a close working relationship with the Complaints Team and help to resolve issues for our

Issues discussed at Board (positive and areas for improvement)	Achievements since the Board meeting
	patients in a timely manner. Anything that does not have resolution within 5 days is escalated to the service manager.
Resilience of PALs team	Since Jan 2019 the team have regular team meetings and every Friday they discuss the cases that they need additional support with and now have a system of escalation.
More administrative support	The PALs manager has secured volunteers 5 days a week to answer phones and to do basic admin for the team.
Relaunch of the service on Cheltenham site.	Every day one member of the team is allocated to provide support on the Cheltenham site (this is on hold until the new members of staff have been recruited).
Digital solutions	Each member of staff requires a laptop to be able to log data whilst they are on the wards. The Deputy Director of Quality is working with the team to look at how we convert to all the team having laptops so that they can work away from the office and next to patients (wards or outpatient services).
Focus on positive feedback and compliments	The team are working with the Divisions to develop improved systems for capturing positive feedback about care and services. A plaudit email address has been suggested.
Recurrent themes raised were collated	Their new way of working with a PALs advisor working closely with a Division has led to better knowledge of themes/trends within the Division.
PALs service development	The fact that the PALs team were invited to the Board to talk about their role and function was hugely motivating for the PALs team. They felt valued by the Board. The PALs team have many ideas about how they would like to improve their services and things to watch out for… - Rebranding the service as a "Patient Feedback Hub" - Painting the walls so they have an inviting and attractive office for patients to visit. - Setting up a plaudits email address so that patients and their families can provide specific feedback for a member of staff. The team are very motivated who have very innovative ideas about how they want to lead and develop their service.

2.2 In **January 2019** the Deputy Director of Quality Suzie Cro (SC) gave a presentation on being #Equally Outstanding – how well do people from protected groups fare (human rights, equality and diversity inclusion)? within patient stories and described some of the improvement work in this area.

Issues discussed at Board (positive and areas for improvement)	**Achievements since the Board meeting**
Completion of Equality Delivery System with staff and patients	We now have chosen 2 objectives to work on throughout the next 4 years - Conversations with our community - Developing a person centred care charter
Decision to bring stories and look through a protected characteristic lens	Each story in 2019/20 to have a protected characteristic focus.

A recording was then played of a patient story narrated by one of the Communications Team on behalf of a mother whose daughter attempted suicide and was subsequently admitted into the emergency department (ED) and then was admitted to the Acute Medical Unit.

The story touched on:

- The kind care received from a staff nurse and junior doctor.
- The Mental Health Liaison Team (MHLT) and the fact that they would not see the patient as she was already under a psychiatrist's care.
- Access to the Acute Medical Unit and the lack of direction and supervision of visitors.
- A lack of assessment of ligature risks in the single room her daughter was in.
- Lack of checks by nursing staff and healthcare assistants for long periods of time.
- How the doctors on the ward round spoke *about* her daughter (in her presence), not *to* her daughter.
- The unsympathetic demeanour of one the agency nurses on the Acute Medical Unit (AMU) and the attitude of some agency staff.

Issues discussed at Board (positive and areas for improvement)	**Achievements since the Board meeting**
Enhanced Care Programme	The Deputy Chief Nurse is leading on this programme of improvement work in this area as there is a need for one-to-one nursing care, also known as special observation or specialling, for critically ill **or vulnerable patients** in hospital. The person in this story required closer observation that should have engaged a very person-centred relationship between her and her care givers. Realtime feedback has started on AMU as one of the pilot wards and one of the questions focuses on was asking "Are you being treated with kindness and respect?"
Ligature risk assessments	These have now been completed across the organisation.
Safer staffing – agency nurses	AMU has a lot of agency staff there has been:- - A vacancy review and pipeline planning - Review of recruitment processes

Issues discussed at Board (positive and areas for improvement)	Achievements since the Board meeting
	- Block booking of agency staff for continuity - Exclusions of individuals if feedback is poor.
Excellent care from the staff nurse and junior doctor in ED	We are looking at setting up a feedback mechanism so that patients can feedback if they have been provided with excellent care – Plaudits email.
Talking as though not there	We have checked or National Survey results and we scored well on Adult wards and no so well on Children's wards. This is now a focused area for improvement for the Matron in charge of AMU.
Mental Health history	Joining Up Your Information (JUYI) project will soon be going live in the A&E
Audio of recording be used as part of training	The story has been taken to the Divisional Medical Board and the Matron has a copy to use in her staff meeting.
Quality and Performance Committee	The story was discussed with the Chair of the Committee and the improvement work plan was provided for assurance that we were taking the right steps for the improvement work.

2.3 In **February 2019** In recognition of the Trust's recent 'Good' rating by the Care Quality Commission (CQC), the Board dedicated this portion of the agenda to celebrating the Trust's achievements:

- SC gave a presentation highlighting some of the recent positive feedback received by the Trust via social media and in telephone calls. The feedback praised a range of areas across both sites and echoed the feedback presented in the CQC's inspection report.

- Susan Macklin (SM) presented projects undertaken on the Avening Ward, highlighting the NHS70 Award for their project to address device-related pressures, the "Cheers Ears" campaign, which became part of NHS Improvement's overall national strategy.

- DL recognised the contribution of staff across all levels of the organisation and thanked them for the large part they had played in securing recent rating which was undoubtedly an organisation-wide achievement.

2.4 In **March 2019** the Deputy Director of Quality SC introduced KM, the 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.

The following comments and queries were raised by the Board:

Issues discussed at Board (positive and areas for improvement)	Achievements since the Board meeting
Spiritual Care – promotion of service to clinical staff	The work of the Chaplaincy team is promoted and highlighted.
Listening service	The PALs team are going to meet with the

Issues discussed at Board (positive and areas for improvement)	Achievements since the Board meeting
	Chaplaincy team to see how they can promote each other's services.
Worship space at Cheltenham	Work under way to improve the prayer facilities on the Cheltenham site but access to additional space was a constraint
Access to Trackcare to identify patients who requested spiritual care	The Deputy Chief Nurse is working on this issue with the Chaplaincy team.

2.6 In **April 2019** the Deputy Director of Quality introduced RC who described his experience as a patient of the Trust, reflecting on the importance of kindness, genuine patient engagement and a positive attitude amongst hospital staff, in particular the difference this makes amongst health care assistants (HCAs). RC has already presented his story to staff attending a HCA study day.

In response:

Issues discussed at Board (positive and areas for improvement)	Achievements since the Board meeting
As a patient you don't like to raise concerns	PALs staff are now visiting to the wards and talking to patients so this enables patients to raise concerns with staff that are not providing direct care to them.
Film story for training purposes	Completed - there is now a filmed version of this story and the patient experience team are looking at how we can have a library of stories that staff can use for co-design improvement work. We have a new patient experience improvement collaborative (based Sweeney Programme) starting in July 2019 called "Best Care for Everyone – Patient Experience Improvement Collaborative". This film will be shown there to start the day.
Recruitment - importance of behaviour, care and empathy and ability to learn	Values based recruitment will be a focus within our new People and Organisational Development Strategy for 2019-23.

3 Recommendation

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

Author: Suzie Cro, Deputy Director of Quality & Freedom to Speak Up Guardian
Presenting Director: Steve Hams Director of Quality and Chief Nurse
Date: June 2019

REPORT TO TRUST BOARD – JUNE 2019

From Finance and Digital Committee Chair – Rob Graves, Non-Executive Director

This report describes the business conducted at the Finance Committee held 30 May 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	Month 1 results – actual deficit of £4.3 million, £0.099 million favourable v. budget. Activity predominantly on plan - variances reviewed.	When in the year does the deficit reverse?	Detailed year's budget by month has been prepared and will be presented at next meeting	
		What is driving agency expenditure to higher than planned levels?	Analysis provided – prime areas capacity and pressures in Emergency and Medical Divisions are being challenged	
		How is non-pay overspend being addressed?		Increased emphasis required by Divisional Finance Managers
	Budget Setting Process – status of sign offs with 97% achieved and 13 remaining.	How is the revised process working?	100% sign off expected by June. Positive feedback from Divisions on the process.	
		What is the correlation between sign off and ownership?	Executive input that ownership is high particularly in areas generating the highest number of questions	

		Could a Division Finance Manager attend the Committee to give first hand input on the process? How is the unidentified element of the CIP target reflected in budgets? What training is available to budget holders?	Yes Divisions have a choice how they cascade this to individual budgets or hold centrally New budget holder training has been rolled out and 84% of participants report improved understanding. Additional initiatives planned	To be scheduled
Capital Programme Update	Year's programme initially set at £26 million with £18 million secured funding. Funding of balance to be kept under review and commitments managed accordingly.	What is the prioritisation process?	Clear prioritisation exercised in the capital planning group. Funding alternatives under consideration.	

Cost Improvement Programme	Month 1 performance delivered £1.05 million against a target of £0.733 million with vacancy factor savings the prime over achiever. For the year £14.7 million of CIP savings identified – a very challenging shortfall of £7.7million from target.	Do the divisions have a clear understanding of what is needed? Do the divisions have the right expertise and skill sets available to do what is needed? What are the CIP numbers for GMS?	Progress is slow in some areas. Project Management Office working with divisions to identify outstanding needs. GMS numbers included in Group totals.	Strong focus and close scrutiny required as risk of shortfall is high. CIP visibility to be emphasised at GMS Board.
Clinical Productivity Update	Job Plan review rate of 896% achieved with 80% signed off. Specialties with less that 75% sign off to provide exception reports.			Topic to remain on Committee agenda until 100% achieved sustainably.
Risk Register (Finance)	Report reviewed and minor corrections proposed. Cost Improvement Programme non-achievement risk added.			
Contract Update	High level review of 19/20 contract review outcomes.	What is the process for reviewing actual activity against planning assumptions used.		Comparative analysis to be brought to Committee in November (part of the Financial Performance Report).

IM & T Programme Board Report	Summary update on all active projects highlighting significant actions. PC Refresh completed and closed, new telephone system to go live in being rolled out completion expected by end of calendar year– preparations complete.			
Smartcare Programme Board Report - **Note to be re-named Digital Care Board**	Status report highlighting: - Infoflex viewer project had lacked a clear scope & plan – now resolved - Focus on going live with 2018 Trakcare update in July - OPMAS (now Chemo Care) planned for go live in October 2019	What is the performance of the supplier Intersystems?	Discussion taking place on how best to ensure consistent, adequate attention is provided and maintained.	Keep under review.

Sunrise EPR Update	Report delivered highlighting - Allscripts the chosen supplier - Recruitment to critical technical project vacancies remains a priority during this pre mobilisation period. - Key lesson learnt from Trakcare programme was the importance of user engagement; positively received engagement including benefits workshop held - Enabling projects being tracked through EPR project, currently on track including site audits to determine additional device needs for clinical areas. - Formal project mobilisation planned for July 2019	What is the structure of the workshop session planned for June 17th? Are we ensuring early engagement with ward clerks and medical secretaries? What are the best devices to use with the system – laptops v tablets? What is the cost and risk profile of the project and what are the project budgets?	Confirmed the supplier would also be running a "drop-in" session to maximise opportunity to engage wider staff outside of targeted blueprint session Communications and engagement plans to cover all stakeholders across the organisation, ensuring engagement sessions include ward clerks and medical secretaries as appropriate.	To be reviewed at the Digital Care Board. Project status reporting to committee to include resource and finance profiles.

Risk Register (Digital)	Risk Register reviewed – no significant changes in last month, some revised (reduced) scores.	Has the analysis been completed to separate risks and issues?	Work in progress.	Update in June.
2018/19 Year End Accounts Update	FD reported that the external auditors had encountered an operational difficulty and had yet to complete their year-end tests. Additional and unexpected work for the Trust's Finance team but all questions answered satisfactorily			

Rob Graves
Chair of Finance and Digital Committee
30 May 2019

Gloucestershire Hospitals
NHS Foundation Trust

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

Report Title
Financial Performance Report – Month 1 2019/20
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 30th April 2019.

Key issues to note

- At Month 1 the Trust reported a cumulative deficit of £4.3m (£0.1m favourable to plan).
- Commissioner income is showing a favourable variance to budget of £0.1m.
- Private and paying patients' income is £0.1m favourable to plan.
- Other NHS patient related income is on plan.
- Other operating income (including Hosted Services) is adverse by £0.2m.
- Pay expenditure is showing a favourable variance of £0.5m.
- Non-pay expenditure is showing an adverse variance of £0.4m.
- Non-operating costs are on plan.

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
Supports Trust to deliver Strategic Objectives around financial position and sustainability
Impact Upon Corporate Risks
Risks around CIP delivery and budget management.
Regulatory and/or Legal Implications
Potential for regulatory action if the financial position is not delivered as planned.
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 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

The position was previously reported to Finance & Digital Committee in May.

Gloucestershire Hospitals NHS
NHS Foundation Trust

Report to the Trust Board

Financial Performance Report
Month Ended 30th April 2019

Introduction and Overview

Gloucestershire Hospitals NHS
NHS Foundation Trust

The Trust submitted a revised budget for the 2019/20 financial year to NHSI on 15th May 2019 reflecting a deficit of £1.5m on a control total basis (after removing the impact of donated asset income and depreciation). This plan forms the basis for reporting in month 1. As part of the planning process budget holders were requested to sign off their 2019/20 budgets; 97% have been signed off by number and value of cost centres.

The financial position as at the end of April 2019 reflects the Group position including Gloucestershire Hospitals NHS Foundation Trust and Gloucestershire Managed Services Limited, the Trust's wholly-owned subsidiary company. The Group position in this report excludes the Hospital Charity.

In April the Group's consolidated position shows a year to date deficit of £4.3m. This is £0.1m favourable against plan. The Group's forecast year end position remains a deficit of £1.5m.

Statement of Comprehensive Income (Trust and GMS)

	TRUST POSITION			GMS POSITION			GROUP POSITION *		
Month 01 Cumulative Financial Position	**Budget £000s**	**Actuals £000s**	**Variance £000s**	**Budget £000s**	**Actuals £000s**	**Variance £000s**	**Budget £000s**	**Actuals £000s**	**Variance £000s**
SLA & Commissioning Income	38,397	38,480	83	0	0	0	38,397	38,480	83
PP, Overseas and RTA Income	400	476	76	0	0	0	400	476	76
Other Income from Patient Activities	38	27	(11)	0	0	0	38	27	(11)
Operating Income	6,081	5,827	(254)	3,833	3,872	39	13,423	13,208	(214)
Total Income	**44,916**	**44,810**	**(106)**	**3,833**	**3,872**	**39**	**52,258**	**52,192**	**(67)**
Pay	30,733	30,068	665	1,543	1,689	(146)	32,304	31,757	547
Non-Pay	16,678	17,096	(419)	2,089	2,043	46	22,248	22,648	(400)
Total Expenditure	**47,411**	**47,164**	**247**	**3,632**	**3,732**	**(100)**	**54,551**	**54,404**	**147**
EBITDA	**(2,494)**	**(2,353)**	**141**	**202**	**141**	**(61)**	**(2,293)**	**(2,213)**	**80**
EBITDA %age	**(5.6%)**	**(5.3%)**	**0.3%**	**5.3%**	**3.6%**	**(1.6%)**	**(4.4%)**	**(4.2%)**	**0.1%**
Non-Operating Costs	1,942	1,984	(42)	202	141	61	2,144	2,125	19
Surplus/(Deficit) with Impairments	**(4,437)**	**(4,338)**	**99**	**0**	**0**	**0**	**(4,437)**	**(4,338)**	**99**
Excluding Donated Assets	37	37	(0)	0	0	0	37	37	(0)
Control Total Surplus/(Deficit)	**(4,400)**	**(4,301)**	**99**	**0**	**0**	**0**	**(4,400)**	**(4,301)**	**99**

* Group Position excludes £3.6m of intergroup transactions including dividends

Group Statement of Comprehensive Income

Gloucestershire Hospitals NHS
NHS Foundation Trust

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

In April the Group's consolidated position shows an in month deficit of £4.3m on a control total basis, which is favourable against plan by £0.1m.

Month 01 Financial Position	Annual Budget £000s	M01 Budget £000s	M01 Actuals £000s	M01 Variance £000s	M01 Cumulative Budget £000s	M01 Cumulative Actuals £000s	M01 Cumulative Variance
SLA & Commissioning Income	482,404	38,397	38,480	83	38,397	38,480	83
PP, Overseas and RTA Income	4,802	400	476	76	400	476	76
Other Income from Patient Activities	456	38	27	(11)	38	27	(11)
Operating Income	84,330	13,423	13,208	(214)	13,423	13,208	(214)
Total Income	**571,992**	**52,258**	**52,192**	**(67)**	**52,258**	**52,192**	**(67)**
Pay	365,118	32,304	31,757	547	32,304	31,757	547
Non-Pay	182,089	22,248	22,648	(400)	22,248	22,648	(400)
Total Expenditure	**547,207**	**54,551**	**54,404**	**147**	**54,551**	**54,404**	**147**
EBITDA	**24,785**	**(2,293)**	**(2,213)**	**80**	**(2,293)**	**(2,213)**	**80**
EBITDA %age	**4.3%**	**(4.4%)**	**(4.2%)**	**0.1%**	**(4.4%)**	**(4.2%)**	**0.1%**
Non-Operating Costs	25,727	2,144	2,125	19	2,144	2,125	19
Surplus/(Deficit) with Impairments	**(942)**	**(4,437)**	**(4,338)**	**99**	**(4,437)**	**(4,338)**	**99**
Excluding Donated Assets	(558)	37	37	(0)	37	37	(0)
Control Total Surplus/(Deficit)	**(1,500)**	**(4,400)**	**(4,301)**	**99**	**(4,400)**	**(4,301)**	**99**

Detailed Income & Expenditure

Gloucestershire Hospitals NHS
NHS Foundation Trust

Month 01 Financial Position	M01 Budget £000s	M01 Actuals £000s	M01 Variance £000s	M01 Cumulative Budget £000s	M01 Cumulative Actuals £000s	M01 Cumulative Variance £000s
SLA & Commissioning Income	38,397	38,480	83	38,397	38,480	83
PP, Overseas and RTA Income	400	476	76	400	476	76
Other Income from Patient Activities	38	27	(11)	38	27	(11)
Operating Income	13,423	13,208	(214)	13,423	13,208	(214)
Total Income	**52,258**	**52,192**	**(67)**	**52,258**	**52,192**	**(67)**
Pay						
Substantive	30,571	29,411	1,160	30,571	29,411	1,160
Bank	703	995	(292)	703	995	(292)
Agency	1,030	1,351	(321)	1,030	1,351	(321)
Total Pay	**32,304**	**31,757**	**547**	**32,304**	**31,757**	**547**
Non Pay						
Drugs	5,473	5,570	(97)	5,473	5,570	(97)
Clinical Supplies	3,599	3,825	(226)	3,599	3,825	(226)
Other Non-Pay	13,176	13,253	(77)	13,176	13,253	(77)
Total Non Pay	**22,248**	**22,648**	**(400)**	**22,248**	**22,648**	**(400)**
Total Expenditure	**54,551**	**54,404**	**147**	**54,551**	**54,404**	**147**
EBITDA	**(2,293)**	**(2,213)**	**80**	**(2,293)**	**(2,213)**	**80**
EBITDA %age	**(4.4%)**	**(4.2%)**	**0.1%**	**(4.4%)**	**(4.2%)**	**0.1%**
Non-Operating Costs	2,144	2,125	19	2,144	2,125	19
Surplus/(Deficit)	**(4,437)**	**(4,338)**	**99**	**(4,437)**	**(4,338)**	**99**
Excluding Donated Assets	37	37	(0)	37	37	(0)
Surplus/(Deficit)	**(4,400)**	**(4,301)**	**99**	**(4,400)**	**(4,301)**	**99**

SLA & Commissioning Income – is broadly on plan, reflecting over performance on Gloucestershire CCG and Specialised Commissioning, offset by under performance on other commissioners.

PP / Overseas / RTA Income – is reporting an over performance of £0.1m, reflecting private patients in D&S.

Pay – expenditure is showing an underspend of £0.5m reflecting an underspend on substantive budgets (£1.2m), offset by overspends on bank (£0.3m) and agency budgets (£0.3m).

Non-Pay – expenditure is showing an £0.4m overspend, reflecting overspends on drugs and clinical supplies. The position within other non pay is £0.1m adverse to plan which relates to outsourced clinical services through Glanso and B.Braun (renal dialysis).

Cost Improvement Programme

Gloucestershire Hospitals NHS
NHS Foundation Trust

1. At Month 1 the trust has delivered £1.05m of CIP against the in-month NHS Improvement target of £733k.
Within the month, this is a positive variance of £317k which is due to vacancy factor (i.e. underspend against pay budgets).

2. To date £14.7m has been identified in cost improvement schemes against a target of £22.4m.
£2m of this is Operational Growth margin. £2.5m relates to a review of Business Rates and is very high risk and has been profiled into month 12 and as such has only been captured in the Trust's CIP plan submission but has not been assumed within the internal CIP plan.

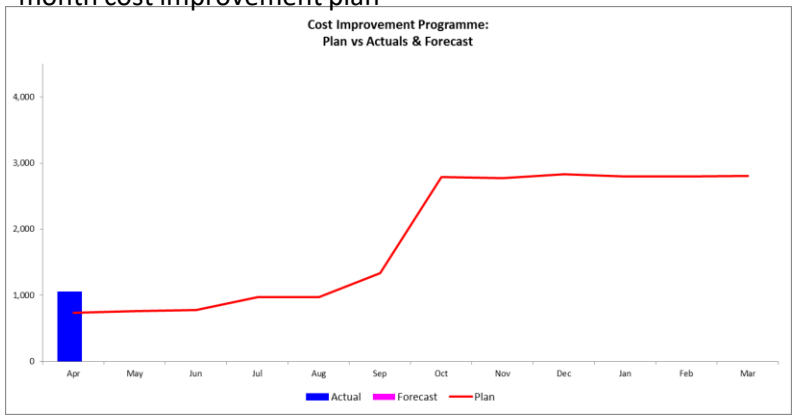
3. Work continues with the Divisions to progress planning and mobilisation for the 19/20 Cost Improvement Programme. The CIP target for 19/20 is £22.4m (4%). The interim operational consultant continues to support identification, mobilisation and delivery of further schemes to close the gap.

4. Additional in-year measures are being progressed. Stock take against the NHSI grip and control measures to identify top high value opportunities per Division incl. Corporate. Additional theatres opportunities as identified using national benchmarking. Outpatients transformation programme uncovering opportunities through better efficiency.

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

Trust Total	Annual Plan £000s	Year To Date Plan £000s	Year To Date Actual £000s	Year To Date Variance £000s
Local Divisional Schemes	2,472	39	37	(2)
Trustwide - Income Improvement	2,000	167	167	0
Agency	900	73	0	(73)
Theatre	300	20	0	(20)
Medicines Optimisation	228	19	29	10
Workforce Pay Grip	0	0	0	0
Procurement	1,850	73	45	(28)
Vacancy Factor	1,653	112	698	586
Trustwide	0	0	0	0
FYE	1,954	230	75	(155)
Phasing	0	0	0	0
Unidentified	11,001	0	0	0
Total	**22,357**	**733**	**1,050**	**317**

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



Balance Sheet (1)

Gloucestershire Hospitals NHS
NHS Foundation Trust

Trust Financial Position	Opening Balance 31st March 2019 £000	GROUP Balance as at M1 £000	B/S movements from 31st March 2019 £000
Non-Current Assests			
Intangible Assets	10,412	10,412	0
Property, Plant and Equipment	232,217	230,762	(1,455)
Trade and Other Receivables	4,640	4,640	0
Total Non-Current Assets	**247,269**	**245,814**	**(1,455)**
Current Assets			
Inventories	7,571	7,684	113
Trade and Other Receivables	25,964	27,408	1,444
Cash and Cash Equivalents	7,317	4,876	(2,441)
Total Current Assets	**40,852**	**39,968**	**(884)**
Current Liabilities			
Trade and Other Payables	(54,315)	(53,831)	484
Other Liabilities	(5,837)	(5,686)	151
Borrowings	(12,527)	(12,897)	(370)
Provisions	(160)	(160)	0
Total Current Liabilities	**(72,839)**	**(72,574)**	**265**
Net Current Assets	**(31,987)**	**(32,606)**	**(619)**
Non-Current Liabilities			
Other Liabilities	(6,860)	(6,860)	0
Borrowings	(135,294)	(137,558)	(2,264)
Provisions	(1,434)	(1,434)	0
Total Non-Current Liabilities	**(143,588)**	**(145,852)**	**(2,264)**
Total Assets Employed	**71,694**	**67,356**	**(4,338)**
Financed by Taxpayers Equity			
Public Dividend Capital	172,676	172,676	0
Equity			
Reserves	24,554	24,554	0
Retained Earnings	(125,536)	(129,874)	(4,338)
Total Taxpayers' Equity	**71,694**	**67,356**	**(4,338)**

The table shows the M01 balance sheet and movements from the 2018/19 closing balance sheet, supporting narrative is on the following page.

Balance Sheet (2)

Gloucestershire Hospitals NHS
NHS Foundation Trust

The commentary below reflects the Month 1 balance sheet position against the 2018/19 outturn

Current Assets

- Inventories have increased in month and are £0.1m higher than closing 2018/19 values.
- Trade receivables are £1.4m above the closing March 2019 level, largely reflecting NHS commissioner income.
- Cash has decreased by £2.4m since the year-end, reflecting the deficit income and expenditure position, offset by borrowing and the movement in working balances.

Non-Current Liabilities

- Borrowings have increased by £2.3m, reflecting working capital loan support.

Retained Earnings

- The retained earnings reduction of £4.3m reflects the impact of the in year deficit.

Better Payment Practice Code (BPPC)

Gloucestershire Hospitals NHS
NHS Foundation Trust

	Cumulative for Financial Year		Current Month April	
	Number	£'000	Number	£'000
Total Bills Paid Within period	10,089	24,094	10,089	24,094
Total Bill paid within Target	8,590	19,880	8,590	19,880
Percentage of Bills paid within target	85%	83%	85%	83%

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

It should be noted that whilst driving down creditor days as far as possible the Trust are not compliant with 30 day terms across all suppliers.

Liabilities – Borrowings

Analysis of Borrowing	As at 30th April 2019 £000
<12 months	
Loans from ITFF	2,988
Distress Funding	7,743
Obligations under finance leases	1,598
Obligations under PFI contracts	568
Balance Outstanding	**12,897**
>12 months	
Loans from ITFF	22,593
Capital Loan	3,018
Distress Funding	89,311
Obligations under finance leases	17,917
Obligations under PFI contracts	4,719
Balance Outstanding	**137,558**
Total Balance Outstanding	**150,455**

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 £2.4m of additional in-year borrowing from the DoH.

Cashflow : April

Gloucestershire Hospitals NHS
NHS Foundation Trust

Cashflow Analysis	Apr-19 £000s
Surplus (Deficit) from Operations	**(3,464)**
Adjust for non-cash items:	
Depreciation	1,229
Other operating non-cash	0
Operating Cash flows before working capital	**(2,235)**
Working capital movements:	
(Inc.)/dec. in inventories	113
(Inc.)/dec. in trade and other receivables	1,444
Inc./(dec.) in current provisions	0
Inc./(dec.) in trade and other payables	(2,349)
Inc./(dec.) in other financial liabilities	0
Net cash in/(out) from working capital	**(792)**
Capital investment:	
Capital expenditure	(1,129)
Capital receipts	0
Net cash in/(out) from investment	**(1,129)**
Funding and debt:	
PDC Received	0
Interest Received	3
Interest Paid	(124)
DH loans - received	2,442
DH loans - repaid	0
Finance lease capital	(488)
Interest element of Finance Leases	(12)
PFI capital element	(68)
Interest element of PFI	(38)
PDC Dividend paid	
Net cash in/(out) from financing	**1,715**
Net cash in/(out)	**(2,441)**
Cash at Bank - Opening	**7,317**
Closing	**4,876**

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

Cashflow Key movements:

The Cash Position – reflects the Group position. The Trust has drawn down loan support of £2.4m in 2019/20.

The closing position includes £3.6m of committed cash.

Capital Programme

This report provides an overview of the capital programme for 2019/20. Adverse and favourable movements are highlighted along with the risks and opportunities in delivering the programme.

Capital Programme Expenditure Summary position at 30th April 2019

Capital Summary	Internal YTD £k	YTD Spend £k	YTD Var £k	19/20 Full Year Plan £k	FOT 19/20 Spend £k	Forecast Variance £k
Health & Safety Projects	173	221	48	2,605	2,605	0
Environmental Works	23	0	(23)	350	350	0
Non Health & Safety Projects	79	109	30	975	975	0
Committed Schemes	31	38	7	460	460	(0)
Service Reconfiguration	1	0	(1)	9	9	0
Major Equipment Replacement	1	0	(1)	1,020	1,020	0
IM&T	737	283	(454)	9,883	9,883	0
MEF	166	0	(166)	2,490	2,490	0
Other Schemes	399	35	(365)	6,908	6,908	0
Contingency/Leases Capitalisation	0	0	0	1,300	1,300	0
Overspend/(Underspend)	**1,610**	**685**	**(925)**	**26,000**	**26,000**	**(0)**

The table summarises (at a high level) the capital plan expenditure (not cash flow) position.

The year to date spend is behind plan as schemes are being worked up and put out to tender.

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. The work should be complete by August 2019.
- The Apollo theatre refurbishment is progressing well and is due to complete by the end of June. Following hand-over and commissioning, it is due to go live on 8th July. Work on the adjoining air handling unit will complete within the same timetable.
- The planned work on the lifts across the two hospital sites is close to completion and will be within budget.
- The enabling works at Victoria Warehouse and Pullman Court continues and is estimated to complete within budget.

Recommendations

Gloucestershire Hospitals NHS
NHS Foundation Trust

The Board is asked to note:

- The Trust is reporting an actual income and expenditure deficit on a control total basis of £4.3m at April 2019. This is £0.1m favourable against plan.
- That budgets have been signed off by Budget Holders for 97% of cost centres (97% by value).

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

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

Date: **May 2019**

Gloucestershire Hospitals
NHS Foundation Trust

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

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

Purpose

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

- Audit and Assurance Committee Terms of Reference
- Estates and Facilities Committee Terms of Reference
- People and Organisational Development (OD) Committee Terms of Reference
- Schedule of decisions reserved to the Board and the scheme of delegation (Scheme of Delegation)

Key issues to note

General

- Undertaking periodic review of governance arrangements and documents is considered good practice and ensures that the Trust's governance arrangements remain fit for purpose.
- The revised governance documents (including the Standing Orders, Standing Financial Instructions, Scheme of Delegation and the Terms of Reference (ToRs) of the Board Committees and the Trust Leadership Team) were presented to the Board for approval in February 2019.
- The Board approved the revised governance documents presented in February:
  - with the exception of the Estates Committee Terms of Reference (and the corresponding section within the Scheme of Delegation); and
  - with the following amendments:
    - Removal of the reference to the research programme oversight from the Quality and Performance Committee Terms of Reference pending a decision on the oversight of the research portfolio
    - Replacing the reference to the 'patient governor' with 'public governor' in the People and Organisational Development Committee Terms of Reference.
- Since the February Board discussion, changes to the Estates and Facilities Committee's role and remit has been agreed and endorsed by the Committee at its May meeting. The Board should note that the agreed changes to the functions of the Estates and Facilities Committee mean a repatriation of certain GMS audit-related functions to the Audit and Assurance Committee. Further, it has been agreed that the People and OD Committee will have a role in the oversight of the Trust's research portfolio.
- The Director of Corporate Governance had undertaken a final review and edit to ensure consistency and completeness across the whole suite of governance documents, including those agreed at the February Board.

Estates and Facilities Committee Terms of Reference

- Changes to the Terms of Reference reflecting the expansion of the Committee's remit to cover strategic estates issues and the re-positioning of the Committee as a Board assurance committee.
- Change of the Committee name from 'GMS Committee' to 'Estates and Facilities Committee'

Audit and Assurance Committee Terms of Reference

- Changes to the Terms of Reference reflect a repatriation of certain functions to the Audit and Assurance Committee from the GMS Committee, namely:
  - Oversight of the Trust's subsidiaries' audit arrangements to
    - Gain assurance that any subsidiaries set up and owned by the Trust have appropriate and effective audit arrangements.
    - Appoint or remove the external auditor for Gloucestershire Managed Services (GMS).
    - Appoint or remove the internal auditor for GMS.
    - Approve any change to GMS' accounting reference date.

People and OD Committee Terms of Reference

- Changes to the Terms of Reference reflect the revised governance arrangements relating to the Trust's research portfolio:
  - Inclusion of "Obtain assurance that the research programme and governance framework is implemented and monitored" into the Committee's Responsibilities
  - Inclusion of Head of Research and Development as an attendee

Scheme of Delegation

- Amendments to the Scheme of Delegation reflect the changes to the Terms of Reference described above and the changes to the *GMS Schedule of Matters Reserved and Delegated*.
- For ease of reference, changes are marked with TrackChanges.

Implications and Future Action Required

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

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

The amended GMS Schedule of Matters Reserved and Delegated will be agreed by the Trust and GMS.

The documents will be reviewed annually.

Recommendations

The Board is asked to approve:

- revised Committee Terms of Reference;
- amendments to the Schedule of decisions reserved to the Board and the scheme of delegation (Scheme of Delegation)

Impact Upon Strategic Objectives

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

Assurance on the delivery of Strategic Objective 10 'Driving Research' will now be obtained through the People and OD Committee.

Impact Upon Corporate Risks

Not applicable.

Regulatory and/or Legal Implications
Compliance with NHS Foundation Trust Code of Governance and best practice.

Equality & Patient Impact
Not applicable

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

Date the paper was presented to previous Committees and/or TLT							
Audit and Assurance Committee	**Finance and Digital Committee**	**GMS Committee**	**People and OD Committee**	**Quality and Performance Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
		May 2019					

Outcome of discussion when presented to previous Committees/TLT
ToRs endorsed; changes now reflected in the attached documents.

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

ESTATES AND FACILITIES COMMITTEE

TERMS OF REFERENCE – JUNE 2019

1. Purpose and status

The Estates and Facilities Committee (the Committee) has been established by the Board of Directors (the Board) of Gloucestershire Hospitals NHS Foundation Trust (the Trust).

The purpose of the Committee is to:

- Provide the Board with assurance concerning the development and delivery of the Estates Strategy and associated capital programmes to ensure our estate contributes to securing the best clinical outcomes and experience for our patients and staff, within the resources set out in the annual Operational Plan.
- Provide the Board with assurance that its subsidiary company, Gloucestershire Managed Services (GMS), is performing effectively and delivering its annual business plan, within its resources. (*GMS is a company limited by shares which is wholly-owned by, and provides estate management services to, the Trust. GMS is managed by its board of directors (the GMS Board)).*
- *Provide the Board with assurance that GMS is fulfilling its contractual obligations to its key customers.*

2. Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request by the Committee.

The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

These Terms of Reference (TOR) are subject to the Standing Orders and other relevant governance documents that apply to the Committee.

3. Responsibilities

The Committee will:

- Ensure that the Trust's Estates Strategy is aligned to and responds to the Trust's Clinical Strategy and other enabling strategies and operational plans.
- Ensure that the Trust's Estates Strategy takes account of and, where appropriate, is aligned to the Integrated Care System (ICS)'s estates strategy.
- Provide assurance and oversight of the delivery of the Trust's major capital schemes, defined as those in excess of £5m and any smaller scheme considered to be 'high risk' as determined by the Trust's Capital Control Group.
- Ensure that the estates maintenance and refurbishment programmes are aligned to Trust strategy and the risks and impact on service delivery are understood and actively managed.
- Maintain oversight of risks related to the estate and facilities function and provide assurance to the Board that risks are being comprehensibly assessed, controlled and mitigated effectively, including clarity with respect to ownership of risks between Trust and GMS

- Obtain assurance on the effectiveness of the corporate governance arrangements in respect of GMS, both within the Trust and within GMS, to ensure that they comply with regulatory requirements, adopt relevant good practice, and are effective.
- Obtain assurance on the effectiveness of the Trust's arrangements for managing its contract(s) with GMS, including the oversight of GMS' performance against key indicators or other measures of service delivery on an exceptions basis.
- Approve GMS' corporate strategy/strategic direction and obtain assurance that the corporate strategy for GMS addresses the Trust's requirements of GMS and is consistent with relevant Trust strategies.
- On behalf of the Board, review and approve the GMS Business Plan for each financial year, and any subsequent business cases for new or changed services, (even if they are outlined in the Plan) where the proposal's impact is deemed 'significant' , ensuring that they addresses the Trust's objectives so far as they are relevant to the business of GMS and any other content that the Committee requires.
- Subsequently obtain assurance from the Trust Executive Directors that delivery is in line with the GMS Plan. (*NB the delivery of the contracted service will be overseen by the Contract Management Board*). This assurance will also include financial performance, including the GMS contribution to the Trust's CIP plans (*NB This is more specific than the review of Group financial performance performed at the Finance and Digital Committee)*.Further, this assurance will also cover the realisation of the benefits set out in the March 2018 GMS business case).
- Exercise Trust's responsibilities as the GMS owner/shareholder, as set out in the *Schedule of matters reserved and delegated*.
- Advise and make recommendations to the Board as necessary on the exercise of its responsibilities and authority as shareholder/owner and client/customer of GMS.

For the avoidance of doubt:

- *The Trust Leadership Team is the Trust decision-making forum for GMS, where the Trust governance arrangements (e.g. Scheme of Delegation/Standing Financial Instructions etc.) envisage a role for the Trust Leadership Team (e.g. business plan and business cases approval), unless the* Schedule of matters reserved and delegated *states otherwise.*
- *The Estates and Facilities Committee is the single Trust Committee with the assurance remit in respect of GMS and the single Committee approval step, where required (NB Trust Board approval may additionally be required, in limited number of cases, as per the* Schedule of matters reserved and delegated*).*
- *Notwithstanding the above, the Audit and Assurance Committee has a Group role with regard to the GMS and the Finance and Digital Committee has a similar role as regards capital, finance and IM&T.*

4. Membership

Members

The Committee shall comprise:

Three Trust Non-Executive Directors, one of whom shall be the Committee Chair

Trust Chief Executive

Trust Director of Finance

Trust Chief Operating Officer (executive lead for facilities and GMS contract management)

Trust Director of Strategy and Transformation (executive lead for strategic estates)

Any member who is unable to attend a meeting of the Committee may appoint a suitably qualified and senior substitute. Any substitute appointed for the Non-Executive Director member of the Committee must also be a Non-Executive Director of the Trust.

Attendees

Attendees

The Committee may decide that any other person must attend one or all of its meetings to contribute to discussions, but no such person shall form part of the quorum nor have decision-making authority. The following post-holders have a standing invitation to attend the Committee meetings:

GMS Chair

GMS Managing Director

Trust Associate Director of Estates

One Governor of the Trust may attend any meeting of the Committee as an observer.

5. Accountability and Reporting

Accountability

After each of its meetings the Committee shall report to the Board, via the Chair's report, such issues as it considers should be brought to the Board's attention or require a decision from the Board, including on the matters in respect of which authority is reserved to the Board (as defined in the *GMS Schedule of matters reserved and delegated*).

The Committee shall provide such information and other support as the Board requires in order for the non-executive directors of the Trust to give account to the Council of Governors in respect of the Committee's remit.

The Committee will review its effectiveness at least annually.

Reporting in
The following groups will report into the Committee:

Trust Contract Management Group (*via exception report; 'line' reporting is to the Trust Leadership Team*)

6. Conduct of business and administrative matters

The Committee shall conduct its meetings in accordance with these Terms of Reference and any other Trust governance requirements that apply to it (subject to below).

Any member who has a conflict of interests in respect of any matter shall not count in the quorum for the Committee's discussions and any decisions in respect of that matter.

The quorum for the Committee's meetings shall be three members, two of whom must be Non-Executive Directors of the Trust.

The Committee shall determine the frequency of its meetings. It is expected the Committee shall meet bi-monthly.

The Chair may request an extraordinary meeting at any time if they consider one to be necessary.

The agenda and any papers for the Committee's meetings shall be issued not less than five working days before each meeting.

Minutes shall be taken of each of the Committee's meetings and shall be circulated to the members within seven working days of the Committee.

The Committee may agree that its members can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

Administrative support, including retention of meeting papers and other relevant documents, shall be provided by the Corporate Governance Officer.

7. Approval and Review

These ToR were approved by the Board on [13 June 2019].

These ToR were adopted by the Committee at its meeting on [8 July 2019].

These ToR shall be reviewed at least annually.

Version Control			
Version	**Author**	**Date**	**Changes**
0.1	Lukasz Bohdan	08-01-2019	First draft
0.2	Lukasz Bohdan	08-02-2019	Amendments made following Audit and Assurance Committee feedback
0.3	Lukasz Bohdan	08-03-2019	Amendments made following Board, GMS Committee Chair and CEO feedback
0.4 and 0.5	Lukasz Bohdan	03-05-2019	Amendments made following Trust/ GMS Committee workshop and subsequent feedback
0.6	Lukasz Bohdan	16-05-2019	Amendments made following 14 May 2019 GMS Committee feedback

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

AUDIT AND ASSURANCE COMMITTEE

TERMS OF REFERENCE – JUNE 2019

1. Purpose and status

The Audit and Assurance Committee (the Committee) has been established by the Board of Directors (the Board) of Gloucestershire Hospitals NHS Foundation Trust (the Trust).

The purpose of the Committee is to:

- Monitor the integrity of the financial statements
- Assist the Board in its oversight of risk management and the effectiveness of internal control, oversight of compliance with corporate governance standards and matters relating to the external and internal audit functions
- Provide the Board with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Trust's activities both generally and in support of the annual governance statement

The scope of the Audit and Assurance Committee's remit covers the Gloucestershire Hospitals NHS Foundation Trust and any subsidiary companies thereof (the Group).

2. Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request by the Committee.

The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

3. Responsibilities

The Committee will:

Integrated governance, risk management and internal control

- Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical), that supports the achievement of the organisation's objectives.
- Review the adequacy and effectiveness of:
    - All risk and control related disclosure statements (in particular the annual governance statement), together with any accompanying head of internal audit opinion, external audit opinion or other appropriate independent assurances, prior to submission to the Board;
    - The underlying assurance processes that indicate the degree of achievement of the organisation's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
    - The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications;

  - The policies and procedures for all work related to counter fraud, bribery and corruption as required by the NHS Counter Fraud Authority (NHSCFA).
- Utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources.
- Seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.
- Maintain effective relationships with other key committees, for example, the Quality and Performance Committee so that it understands processes and linkages. However, these other committees must not usurp the Committee's role.
- Monitor compliance with Standing Orders and Standing Financial Instructions.
- Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Director of Finance (for losses and special payments).
- Approve the terms of reference and membership of its sub-committees (as may be varied from time to time at the discretion of the Committee) and oversee their work, receiving reports for consideration and action as necessary.
- Review the Single Tender Action Report.

Internal and External Audit

- Oversee internal and external audit services.
- Ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards, 2017 and provides appropriate independent assurance to the Committee, Accountable (or Accounting) Officer and the Board.
- Review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process.
- Review the work and findings of the external auditors and consider the implications and management's responses to their work.
- Provide feedback to the Council of Governors for the appointment of external auditors and assess the external (financial) auditors on an annual basis in terms of the quality of their work.

Clinical Audit

- Ensure that there is an appropriate and effective clinical audits programme. The remit of the Committee will cover the processes for clinical audits, whereas the outcomes of clinical audits will be considered by the Quality and Performance Committee.

Other assurance functions

- Review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation. These will include, but will not be limited to, any reviews by Department of Health and Social Care arm's length bodies or regulators/Inspectors for example, the Care Quality Commission, NHS Resolution, etc. and professional bodies with responsibility for the performance of staff or functions- for example, Royal Colleges, accreditation bodies, etc.
- Review the work of other committees within the organisation, whose work can provide relevant assurance to the Committee's own areas of responsibility. In particular, this will include any clinical governance, risk management or quality committees that are established.
- Review the work of the clinical governance committee and issues around clinical risk management and gain assurance regarding the clinical audit function

Counter Fraud

- Gain assurance that the organisation has adequate arrangements in place for counter fraud, bribery and corruption that meet NHSCFA's standards and shall review the outcomes of work in these areas.
- Refer any suspicions of fraud, bribery and corruption to the NHSCFA.

Management

- Request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.
- Request specific reports from individual functions within the organisation (for example, clinical audit).

Financial reporting

- Monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance.
- Ensure that the systems for financial reporting to the Board including those of budgetary controls are subject to review as to the completeness and accuracy of the information provided.
- Review the annual report and financial statements before submission to the Board.

Whistleblowing

- Review the adequacy and security of the Trust's arrangements for its employees and contractors to raise concerns, in confidence, about possible wrongdoing in financial reporting or other matters and ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow up action.
- Review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently.
- Ensure that the Trust has appropriate and effective Freedom to Speak Up arrangements. The remit of the committee will cover the processes, whereas the issues and themes will be considered by the People and Organisational Development Committee.

Oversight of the Trust's subsidiaries' audit arrangements

- Gain assurance that any subsidiaries set up and owned by the Trust have appropriate and effective audit arrangements.
- Appoint or remove the external auditor for Gloucestershire Managed Services (GMS).
- Appoint or remove the internal auditor for GMS.
- Approve any change to GMS' accounting reference date.

4. Membership

Members

The Committee shall comprise:

One Non-Executive Director (who shall be the Committee Chair)

Two further Non-Executive Directors (one of whom should also be a member of the Finance Committee).

At least one Committee Member should have financial qualification (i.e. qualified accountant: ACCA/CIMA/ACA/IPFA).

The Chair of the Trust shall not be a member of the Committee.

Any member (with the exception of the Chair) who is unable to attend a meeting of the Committee may appoint a substitute. Any substitute appointed for the Non-Executive Director member of the Committee must also be a Non-Executive Director of the Trust.

Attendees

The Committee may decide that any other person must attend one or all of its meetings to contribute to discussions but no such person shall form part of the quorum nor have decision-making authority. The following post-holders have a standing invitation to attend the Committee meetings:

Chief Executive
All Executive Directors
All Non-Executive Directors
Director of Safety
Director of Operational Finance
Representatives of the External Auditors
Representatives of the Internal Auditors
A representative of the Local Counter Fraud Service

One Governor of the Trust may attend any meeting of the Committee as an observer.

Access

Representatives of internal audit and external audit have right of direct access to the Chair of the Committee.

5. Accountability and Reporting

Accountability

After each of its meetings the Committee shall report to the Board, via the Chair's report, such issues as it considers should be brought to the Board's attention or require a decision from the Board.

The Committee shall provide such information and other support as the Board requires in order for the non-executive directors of the Trust to give account to the Council of Governors in respect of the Committee's remit.

The Committee will reviews its effectiveness and report to the Board at least annually on its work in support of the Annual Governance Statement.

The annual report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they are addressed.

Reporting in
The following groups will report into the Committee:

Not applicable.

6. Conduct of business and administrative matters

The Committee shall conduct its meetings in accordance with these Terms of Reference and any other Trust governance requirements that apply to it (subject to below).

Any member who has a conflict of interests in respect of any matter shall not count in the quorum for the Committee's discussions and any decisions in respect of that matter.

The quorum for the Committee's meetings shall be any two members or their duly appointed substitutes.

The Committee shall determine the frequency of its meetings to allow it to discharge all of its responsibilities. It is expected the Committee shall meet at least bi-monthly, including at least one meeting a year with both the internal and external auditors but without executive Board members.

The external auditors or internal auditors may request a meeting if they consider that one is necessary.

The Chair may request an extraordinary meeting at any time if they consider one to be necessary.

The agenda and any papers for the Committee's meetings shall be issued not less than five working days before each meeting.

Minutes shall be taken of each of the Committee's meetings and shall be circulated to the members within timescales agreed by the Committee.

The Committee may agree that its members can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

Administrative support, including retention of meeting papers and other relevant documents, shall be provided by the Executive Assistant to the Director of Finance.

7. Approval and Review

These ToR were approved by the Board on 14 February 2019.

These ToR were adopted by the Committee at its meeting on 19 March 2019.

These ToR shall be reviewed at least annually.

Version Control			
Version	**Author**	**Date**	**Changes**
0.1	Lukasz Bohdan	08-01-2019	First draft
0.2	Lukasz Bohdan	08-02-2019	Amendments made following Audit and Assurance Committee feedback
1.0	Lukasz Bohdan	14-02-2019	Version approved by the Trust Board at its 14 February 2019 meeting
1.1	Lukasz Bohdan	04-06-2019	Amendments made to align with GMS Schedule of matters reserved and delegated

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE

TERMS OF REFERENCE – JUNE 2019

1. Purpose and status

The People & Organisational Development (OD) Committee (the Committee) has been established by the Board of Directors (the Board) of Gloucestershire Hospitals NHS Foundation Trust (the Trust).

The purpose of the Committee is to assure the Trust Board that the People and OD function is delivering upon the Workforce and associated People strategies.

2. Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request by the Committee.

The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

3. Responsibilities

The Committee will:

- Obtain assurance that there are practices in place which ensure the sustainability and affordability of workforce supply on a short, medium and long term basis including workforce planning, development, redesign, recruitment and retention.
- Obtain assurance that the Trust attracts and retains a high performing workforce capable of delivering the Trust's operational clinical strategies.
- Obtain assurance that the Trust implements effective and equitable reward packages that positively impact on performance and meet national and legislative parameters.
- Obtain assurance that strategic education issues and external relationships which impact on supply and engagement are included in Trust planning.
- Obtain assurance that the Trust delivers services which are fair and equitable promoting diversity and equality of opportunity.
- Obtain assurance that the Trust is driving improved employee engagement, ensuring appropriate mechanisms for the employee voice to ensure that rapid action is taken to improve staff experience.
- Obtain assurance that the research programme and governance framework is implemented and monitored.
- Agree the Trust Workforce Strategy and establish, monitor and report to the Trust Board on an annual programme of work to implement the strategy.
- Agree annual objectives for Health and Safety.
- Agree (where necessary) People and Organisational Development reports prior to publication and review implications of national reports that have been published.
- Identify risks associated with People and Organisational Development issues ensuring ownership with mitigating actions, escalating to Trust Board as required.
- Approve the terms of reference and membership of its sub-committees (as may be varied from time to time at the discretion of the Committee) and

oversee their work, receiving reports for consideration and action as necessary.
- Consider and approve action plans, programmes of work and strategic objectives as a result of national audit related to protected characteristics and provide assurance to the Board on progress.
- Work with the Quality and Performance Committee to obtain assurance on safer and optimal staffing and that education, learning and development is aligned with the Trust's quality priorities.

4. Membership

Members

The Committee shall comprise:

One Non-Executive Director (who shall be the Committee Chair)

Two further Non-Executive Directors

Director of People and OD and Deputy Chief Executive

Director of Quality and Chief Nurse

Medical Director

Any member who is unable to attend a meeting of the Committee may appoint a substitute. Any substitute appointed for the Non-executive Director member of the Committee must also be a Non-Executive Director of the Trust.

Attendees

The Committee may decide that any other person must attend one or all of its meetings to contribute to discussions but no such person shall form part of the quorum nor have decision-making authority. The following post-holders have a standing invitation to attend the Committee meetings:

Deputy Director of People and OD

~~Deputy~~ Director of Operational Finance

Head of Research and Development

Head of Leadership and OD

Associate Director of Education and Development

One Public ~~or Patient~~ Governor of the Trust and one Staff Governor of the Trust may attend any meeting of the Committee as an observer.

5. Accountability and Reporting

Accountability

After each of its meetings the Committee shall report to the Board, via the Chair's report, such issues as it considers should be brought to the Board's attention or require a decision from the Board.

The Committee shall provide such information and other support as the Board requires in order for the non-executive directors of the Trust to give account to the Council of Governors in respect of the Committee's remit.
The Committee will review its effectiveness at least annually.

Reporting in

N/A
~~The following groups will report into the Committee:~~
- ~~Health and Safety Committee~~
- ~~Strategic Education and Sustainable Workforce Group~~
- ~~Equality Steering Group~~

6. Conduct of business and administrative matters

The Committee shall conduct its meetings in accordance with these Terms of Reference and any other Trust governance requirements that apply to it (subject to below).

Any member who has a conflict of interests in respect of any matter shall not count in the quorum for the Committee's discussions and any decisions in respect of that matter.

The quorum for this Committee is three members, two of whom must be Non-Executive Directors.

The Committee shall determine the frequency of its meetings to allow it to discharge all of its responsibilities. It is expected the Committee shall meet at least bi-monthly.

The Chair may request an extraordinary meeting at any time if they consider one to be necessary.

The agenda and any papers for the Committee's meetings shall be issued not less than five working days before each meeting.

Minutes shall be taken of each of the Committee's meetings and shall be circulated to the members within timescales agreed by the Committee.

The Committee may agree that its members can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

Administrative support, including retention of meeting papers and other relevant documents, shall be provided by the Executive Assistant to the Director of People and Organisational Development and Deputy Chief Executive.

7. Approval and Review

These ToR were approved by the Board on 14 February 2019.

These ToR were adopted by the Committee at its meeting on 4 March 2019.

These ToR shall be reviewed at least annually.

Version Control			
Version	**Author**	**Date**	**Changes**
0.1	Lukasz Bohdan	08-01-2019	First draft
0.2	Lukasz Bohdan	08-02-2019	Edits made following Audit and Assurance Committee
1.0	Lukasz Bohdan	14-02-2019	Version approved by the Trust Board at its 14 February 2019 meeting
1.1	Cecilia Price	31-05-2019	Edits made to reflect governance arrangements for research portfolio

GLOUCESTERSHIRE HOSPITALS

NHS FOUNDATION TRUST

SCHEDULE OF DECISIONS RESERVED TO THE BOARD AND THE SCHEME OF DELEGATION

Version Control			
Version	**Author**	**Date**	**Changes**
0.1	Lukasz Bohdan	08-01-2019	First draft
0.2	Lukasz Bohdan	08-02-2019	Amendments made following January 2019 Audit and Assurance Committee feedback
1.0	Lukasz Bohdan	14-02-2019	Version approved by the Trust Board at its 14 February 2019 meeting with the exception of Section 3.2 'Estates Committee'
1.1	Cecilia Price & Lukasz Bohdan	31-05-2019	Amendments made following February 2019 Board feedback and changes to Committee ToRs

Contents

1 Introduction

1.1 Reservation of powers

Subject to a provision in the authorisation or the Constitution, the Board may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee, appointed by virtue of Standing Order 5 or by a Director or an officer of the Trust in each case subject to such restrictions and conditions as the Board thinks fit. The NHS Foundation Trust Code of Governance and the Code of Accountability requires the Board of Directors to draw up a schedule of decisions reserved to itself and to ensure that management arrangements are in place to enable the clear delegation of its other responsibilities. This document sets out the powers reserved to the Board of Directors and the Scheme of Delegation including financial limits and approval thresholds. However, the Board of Directors remains accountable for all of its functions, including those which have been delegated, and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

1.2 Role of the Chief Executive

All powers of the Foundation Trust, which have not been retained as reserved by the Board of Directors or delegated to a Board committee or sub-committee, shall be exercised on behalf of the Board of Directors by the Chief Executive. The Scheme of Delegation identifies any functions which the Chief Executive shall perform personally and those able to be delegated to other directors or officers. All powers delegated by the Chief Executive can be re-assumed by them should the need arise.

1.3 Caution of the use of delegated powers

Powers are delegated to directors and officers on the understanding that they would not exercise delegated power in a manner which could be a cause for public concern.

1.4 Absence of directors or officers to whom powers have been delegated

In the absence of a director or officer to whom powers have been delegated, those powers shall be exercised by that director or officer's superior unless alternative arrangements have been approved by the Board of Directors. If the Chief Executive is absent, powers delegated to them may be exercised by the Deputy Chief Executive and in their absence a nominated officer acting in their absence after taking appropriate advice from the Executive Director of Corporate Governance. In the absence of the Executive Director of Corporate Governance, appropriate advice should be sought from the Director of Finance.

1.5 Review and awareness of delegated powers

The Scheme of Delegation is reviewed annually. As part of ensuring a sound system of corporate governance prevails, there is a requirement for staff with budgetary and/or senior managerial responsibility to sign a statement acknowledging awareness of this document and the Standing Financial Instructions and Standing Orders, and agreeing to apply them to their everyday approach to carrying their work for the Trust. This approach promotes compliance and effectiveness.

2 Schedule of Decisions Reserved to the Board

REF[1]	Decisions reserved to the Board of Directors
	General Enabling Provision The Board of Directors may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers.
	Regulations and Control
	1 Approve Standing Orders (SOs) and Reservation of Powers to the Board.
	2 Suspend SOs, subject to SOs 3.30-3.34.
	3 Amend SOs, subject to SO 3.3.5.
	4 Approve Standing Financial Instructions (SFIs), including Financial Delegation Limits.
	5 Ratify the exercise of powers, which the Board has retained to itself, by the Chief Executive and the Chair in emergency, subject to SO 4.2.
SO 4.4 SO 5.5	6 Approve a scheme of delegation of executive powers from the Board of Directors to committees or sub-committees, which it has formally constituted, and authorise the delegation of a committee's executive powers to a sub-committee.
	7 Require and receive the declaration of Directors' interests that may conflict with those of the Trust and determining the extent to which that Director may remain involved with the matter under consideration in accordance paragraph 11 of the Constitution.
	8 Receive reports from committees including those that the Trust is required by the Secretary of State or other regulation to establish and to take appropriate action on such reports.
	9 Confirm or otherwise the recommendations of the Trust's committees where the committees do not have executive powers.
	10 Establish terms of reference and reporting arrangements of all committees that are established by the Board of Directors.
SFI 17.1 SO 2.2	11 Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust.
C 19.1 SO 11.2	12 Authorise the use of the seal and agree a policy to define those documents that must be sealed.
	13 Ensure the quality and safety of healthcare services, education, training and research delivered by the NHS Foundation Trust and applying the principles and standards of clinical governance set out by the Department of Health, the CQC, and other relevant NHS bodies.
	Appointments/ Dismissal
C 9.7	1 Appoint one of the independent Non-Executive Directors to be the Senior Independent Director in consultation with the Council of Governors.
SO 5.6	2 Approve the appointments to each of the committees, which it has formally constituted, and approve the terms of such appointments.
	3 Confirm appointment of members of any committee of the Trust as representatives on outside bodies.
SFIs 9.1.3 & 9.1.4	4 Approve proposals of the Remuneration Committee regarding the remuneration and terms of service of Directors.
	Strategy, Plans and Budgets
SFI 1.3.1	1 Define the strategic aims and objectives of the Trust each year.
	2 Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust, having regard to any guidance issued by NHS Improvement (Monitor).

[1] Reference Key: Constitution (C), Standing Financial Instructions (SFIs), SFI Appendix (SFI A) and Standing Orders (SOs).

SFI 20.1 SFI 4.1.5 SFI 12.2.1 SFI A1.5.2 SFI A1.1.3 SFI A1.1.3 SFI A1.3 SFI 8.5 SFI 2.1.1 SFI 10.1.1 SFI 11.1	3 Approve and monitor the Trust's risk management strategy. 4 Approve the Trust's financial plan and annual budget. 5 Approve the Trust's capital programme. 6 Approve annually the Trust's Operational Plan. 7 Approve Private Finance Initiative proposals (subject to any guidance issued by the Regulator). 8 Approve the opening of bank or investment accounts. 9 Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to, over £5,000,000. 10 Approve capital expenditure, business cases and PFI schemes, including approval of variations, amounting to over £1,000,000. 11 Approve of increases in the real terms cost of revenue or capital developments identified specifically in the financial plans of the Trust, or reported individually in any Board agenda, provided that the cost increase can be funded within one of the approved provisions or reserves where the increase is >10% of the value in the agreed financial plan. 12 Approve purchase orders amounting to over £500,000. 13 Approve participation in a tendering exercise where retaining a service provided by the Trust amounts to over £50,000,000 and where acquiring a new service amounts to over £25,000,000. 14 Approve individual compensation payments. 15 Approve the level of non-pay expenditure on an annual basis. 16 Approve long term and short term borrowing facilities.
	Policy Determination 1 Determine insurance policy.
	Audit 1 To provide feedback to Governors to inform the appointment (and, where necessary, dismissal) of the External Auditor. 2 Approve the appointment (and where necessary, dismissal) of the Internal Auditors. 3 Receive reports of the Audit and Assurance Committee meetings, highlighting significant internal and external audit issues, and take appropriate action. 4 Receive the annual management letter received from the external auditor and agreement of proposed action, taking account of the advice of the Audit and Assurance Committee where appropriate.
	Annual Reports and Accounts 1 Approve the Trust's Annual Report, the Quality Account and Annual Accounts.
	Monitoring 1 Receive Board Assurance Framework reports and reports from committees in respect of their exercise of powers delegated such as the Board of Directors sees fit. 2 Continuous appraisal of the affairs of the Trust by means of the provision of information to the Board as the Board may require from Directors, committees and officers of the Trust as set out in management policy statements. All monitoring returns required by NHS Improvement (Monitor) shall be reported, at least in summary, to the Board of Directors. 3 Receive reports on all aspects of the Trust's performance, and particularly those covering performance against budget, financial plans, performance improvement plans, internal or national targets, and measures of activity and quality.

GMS Schedule of Matters Reserved and Delegated	**Matters concerning GMS** 1 Responsibilities of the Trust as shareholder of GMS as defined in company law. 2 Admission of additional shareholders for GMS. 3 Approval to issue any shares in GMS or grant any options or other right to subscribe for shares in GMS. 4 Approval to consolidate, sub-divide, convert, cancel, reduce, redesignate, purchase or redeem any share capital of GMS. 5 Approval of any change to the registered or trading name(s) of GMS, or to its brand. 6 Approval to change the location of GMS' registered office or its principal place of business. 7 Engage, carry on or establish any business outside of the United Kingdom or provide for the payment of any monies other than in good faith for the purposes of or in connection with the carrying on of such business outside of England and Wales. 8 Dissolution of GMS. 9 Approval and amendment of GMS' articles of association. 10 Appointment and removal of directors and the company secretary for GMS. 11 Appointment of a director to act as ~~chairman~~ Chair of the GMS Board of Directors. 12 Approval of the terms and conditions of appointment for directors and the company secretary of GMS. 14 Approval of the GMS' schedule of matters reserved and delegated. 16 Approval of the membership and responsibilities of the Trust Estates and Facilities Committee. 24 Oversight and approval to issue, defend or settle any litigation, claim or other legal proceedings (other than actions to recover debts in the ordinary course of business) for fees and other costs in excess of £10,000. 30 Change the nature of GMS' business or commence any new business which is not ancillary or incidental to the business (otherwise than in accordance with approved business plan). 34 Approval to acquire or to dispose of assets with a value exceeding £1,000,000. 35 Enter into a loan agreement with another lender, including any mortgage or other charge with a value exceeding £1,000,000.~~.~~ 36 Approval to create issue or allow to come into being any encumbrance over the whole or any part of the undertaking or assets of GMS (save for charges arising by operation of law in the ordinary course of business or under retention of title covenants with suppliers to GMS). 37 Approval to make any capital distributions or dividend distributions. 45 Enter into or to renew a contract or series of connected revenue or capital contracts for any material for consideration payable being in excess of £5,0000,000; or consideration receivable represents on average in excess of £5,0000,000; per annum. 46 Approval of capital transactions or contracts not within the approved Trust capital plan for the year. 47 Providing parent company guarantees for new GMS contracts. 51 Approval of staffing establishment and structure that could adversely affect services provided to a client or have significant impact on the staffing structure (e.g. redundancies). 52 Approval of changes to terms and conditions, excluding non-contractual policies, for employees who transfer from the Trust to GMS. 54 Approval of pension scheme arrangements for employees who transfer from the Trust to GMS.

3 Decisions/Duties delegated by the Board to Committees

3.1 Audit and Assurance Committee

Audit and Assurance Committee Terms of Reference	**The Audit and Assurance Committee will:**
	Integrated governance, risk management and internal control
	• Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical), that supports the achievement of the organisation's objectives.
	• Review the adequacy and effectiveness of:
	  ○ All risk and control related disclosure statements (in particular the annual governance statement), together with any accompanying head of internal audit opinion, external audit opinion or other appropriate independent assurances, prior to submission to the Board;
	  ○ The underlying assurance processes that indicate the degree of achievement of the organisation's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
	  ○ The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications;
	  ○ The policies and procedures for all work related to counter fraud, bribery and corruption as required by the NHS Counter Fraud Authority (NHSCFA).
	• Utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources.
	• Seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.
	• Maintain effective relationships with other key committees, for example, the Quality and Performance Committee so that it understands processes and linkages. However, these other committees must not usurp the Committee's role.
	• Monitor compliance with Standing Orders and Standing Financial Instructions.
	• Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Director of Finance (for losses and special payments).
	• Approve the terms of reference and membership of its sub-committees (as may be varied from time to time at the discretion of the Committee) and oversee their work, receiving reports for consideration and action as necessary.
	
	Internal and External Audit
	• Oversee internal and external audit services.
	• Ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards, 2017 and provides appropriate independent assurance to the Committee, Accountable (or Accounting) Officer and the Board.
	• Review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process.

- Review the work and findings of the external auditors and consider the implications and management's responses to their work.
- Provide feedback to the Council of Governors for the appointment of external auditors and assess the external (financial) auditors on an annual basis in terms of the quality of their work.

Clinical Audit

- Ensure that there is an appropriate and effective clinical audits programme. The remit of the Committee will cover the processes for clinical audits, whereas the outcomes of clinical audits will be considered by the Quality and Performance Committee.

Other assurance functions

- Review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation. These will include, but will not be limited to, any reviews by Department of Health and Social Care arm's length bodies or regulators/Inspectors for example, the Care Quality Commission, NHS Resolution, etc. and professional bodies with responsibility for the performance of staff or functions- for example, Royal Colleges, accreditation bodies, etc.
- Review the work of other committees within the organisation, whose work can provide relevant assurance to the Committee's own areas of responsibility. In particular, this will include any clinical governance, risk management or quality committees that are established.
- Review the work of the clinical governance committee and issues around clinical risk management and gain assurance regarding the clinical audit function

Counter Fraud

- Gain assurance that the organisation has adequate arrangements in place for counter fraud, bribery and corruption that meet NHSCFA's standards and shall review the outcomes of work in these areas.
- Refer any suspicions of fraud, bribery and corruption to the NHSCFA.

Management

- Request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.
- Request specific reports from individual functions within the organisation (for example, clinical audit).

Financial reporting

- Monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance.
- Ensure that the systems for financial reporting to the Board including those of budgetary controls are subject to review as to the completeness and accuracy of the information provided.
- Review the annual report and financial statements before submission to the Board.

Whistleblowing

- Review the adequacy and security of the Trust's arrangements for its employees and contractors to raise concerns, in confidence, about

	possible wrongdoing in financial reporting or other matters and ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow up action. • Review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently. • Ensure that the Trust has appropriate and effective Freedom to Speak Up arrangements. The remit of the committee will cover the processes, whereas the issues and themes will be considered by the People and Organisational Development Committee. *Oversight of the Trust's subsidiaries' audit arrangements* • Gain assurance that any subsidiaries set up and owned by the Trust have appropriate and effective audit arrangements. • Appoint or remove the external auditor for Gloucestershire Managed Services (GMS). • Appoint or remove the internal auditor for GMS. • Obtain assurance and approve the proposals for the acquisition or disposal of assets (GMS). • Approve any change to GMS' accounting reference date.
GMS Schedule of Matters Reserved and Delegated	31 Appointment or removal of the external auditor for GMS 32 Appointment or removal of any internal auditor for GMS ~~34 Approval to acquire or to dispose of assets~~ 42 Approval of any change to GMS' accounting reference date

3.2 Estates and Facilities Committee

Estates and Facilities Committee Terms of Reference	**The Estates Committee will:** • Ensure that the Trust's Estates Strategy is aligned to and responds to the Trust's Clinical Strategy and other enabling strategies and operational plans. • Ensure that the Trust's Estates Strategy takes account of and, where appropriate, is aligned to the Integrated Care System (ICS)'s estates strategy. • Provide assurance and oversight of the delivery of the Trust's major capital schemes, defined as those in excess of £5m and any smaller scheme considered to be 'high risk' as determined by the Trust's Capital Control Group. • Ensure that the estates maintenance and refurbishment programmes are aligned to Trust strategy and the risks and impact on service delivery are understood and actively managed. • Maintain oversight of risks related to the estate and facilities function and provide assurance to the Board that risks are being comprehensibly

~~GMS Schedule of matters reserved and delegated~~	assessed, controlled and mitigated effectively, including clarity with respect to ownership of risks between Trust and GMS • Obtain assurance on the effectiveness of the corporate governance arrangements in respect of GMS, both within the Trust and within GMS, to ensure that they comply with regulatory requirements, adopt relevant good practice, and are effective. • Obtain assurance on the effectiveness of the Trust's arrangements for managing its contract(s) with GMS, including the oversight of GMS' performance against key indicators or other measures of service delivery on an exceptions basis. • Approve GMS' corporate strategy/strategic direction and obtain assurance that the corporate strategy for GMS addresses the Trust's requirements of GMS and is consistent with relevant Trust strategies. • On behalf of the Board, review and approve the GMS Business Plan for each financial year, and any subsequent business cases for new or changed services, (even if they are outlined in the Plan) where the proposal's impact is deemed 'significant' , ensuring that they addresses the Trust's objectives so far as they are relevant to the business of GMS and any other content that the Committee requires. • Subsequently obtain assurance from the Trust Executive Directors that delivery is in line with the GMS Plan. (*NB the delivery of the contracted service will be overseen by the Contract Management Board*). This assurance will also include financial performance, including the GMS contribution to the Trust's CIP plans (*NB This is more specific than the review of Group financial performance performed at the Finance and Digital Committee*).Further, this assurance will also cover the realisation of the benefits set out in the March 2018 GMS business case). • Exercise Trust's responsibilities as the GMS owner/shareholder, as set out in the *Schedule of matters reserved and delegated*. • Advise and make recommendations to the Board as necessary on the exercise of its responsibilities and authority as shareholder/owner and client/customer of GMS.
GMS Schedule of Matters Reserved and Delegated	13 On behalf of the Trust's Board of Directors, authorise any conflicts of interests for any directors of the Trust who are also directors of GMS. 17 Approval of the responsibilities of the GMS Board of Directors. 22 Approval of arrangements to ensure compliance with regulatory requirements. 26 Approval of GMS' corporate strategy/strategic direction. 27 Approval of the annual business plan and annual budget for GMS (including objectives and any other strategic measures of performance), and any amendments to them as well as any subsequent business cases for new or changed services (even if they are outlined in the Plan) where the proposal's impact is deemed 'significant' 28 Approval of the financial plan and annual budget for GMS. 29 Approval for any of GMS' services to be sub-contracted to another provider. 30 Change the nature of GMS' business or commence any new business which is not ancillary or incidental to the business (otherwise than in accordance with approved business plan) 34 Approval to acquire or to dispose of assets with a value exceeding £20,000 and up to £1,000,000. 35 Enter into a loan agreement [with GMS on behalf of the Trust, including

	any mortgage or other charge 36 Enter into a loan agreement on behalf of GMS with another lender, including any mortgage or other charge with a value exceeding £20,000 and up to £1,000,000. 39 Acquisition of any interest or share capital in another body corporate. 40 Making any loan or granting credit, other than trade credit in the normal course of business on arm's length terms, or granting any guarantee or indemnity of the obligations of any person. 41 Approval of accounting and financial policies and procedures, subject to compliance with the approved budget and financial plan. 43 Approval to open or close any bank account for GMS. 45 Enter into or to renew a contract or series of connected revenue or capital contracts for any material for consideration payable being in excess of £250,000 and up to £5,0000,000; or consideration receivable represents on average in excess of £250,000 and up to £5,0000,000; per annum. 49 Obtain assurance that the findings and recommendations of GMS-related internal audit reports have been addressed by the GMS. ~~49~~50 Approval of revenue transaction over £50,000 and not within the approved business plan for the year.

3.3 Finance and Digital Committee

Finance and Digital Committee Terms of Reference	**The Finance and Digital Committee will:** • **Finance** *Financial strategy and business planning:* • Ensure delivery of the financial aspects of the Operational Plan. • Ensure delivery of the annual and medium-term financial plans: income and expenditure plans/budgets, revenue investment, capital investment, working capital, statement of financial position and cash flow, and associated targets for savings to ensure sustainability going forward. The Committee shall assess the assumptions therein and the alignment with overall Trust objectives. • Approve the investment and borrowing strategy and associated policies. • Review in-year performance against financial plan, particularly gaining an understanding of key assumptions and risks within the Trust projections. • Review levels of contingency within the Trust financial plans and the phasing of key developments and efficiency schemes, ensuring that the full impact of any developments (including depreciation and cost of capital) have been appropriately included. • Review and develop reporting arrangements. • Ensure the availability and quality of financial management information (to ensure a consistent approach to financial management). • Ensure sustainable service commissioning from a financial and funding perspective. • Review and maintain an overview of financial and service delivery agreements and key contractual arrangements. • Oversee the development, management and delivery of the Trust's annual capital programme. • Review business cases and either: ○ approve as appropriate on behalf of the Board, if within the

	Committee's delegated authority; or o endorse prior to Board approval, if above the Committee's delegated authority. • Consider key financial policies e.g. investment policy, issues and developments to ensure that they are shaped, developed and implemented in the Trust appropriately. *Income and contracts management:* • Review the Trust contracting approach with key commissioners • Monitor in-year income against contract and levels of risk, including commissioner challenges, accrued income, fines and penalties, and income disputes. • Review arrangements for non-activity related income streams, particularly CQUIN, to understand alignment with Trust clinical priorities and levels of income risk. • Consider material opportunities to grow new income streams and market share of existing services. *Transformation and Efficiency:* • Set financial performance benchmarks and monitor the performance of investments. • Seek and consider evidence of organisational compliance with the Capital Investment Policy • Review proposed revisions to the Capital Investment Policy for approval by the Board each year. • Review the process for developing the CIP and for the oversight and delivery of the programme within the Trust. • Review the process for developing the transformation plan and for the oversight and delivery of the programme within the Trust. • Consider and recommend any major transformation programmes that the Trust should undertake. • Review the annual CIP and transformation plan to provide assurance that delivery risk is minimised and productivity and efficiency maximised, in particular that contingency, phasing and risk mitigation plans are appropriate and that savings programmes are realistic and deliverable. • Receive assurances regarding efficient and effective resource planning, particularly with respect to staffing and the deployment of agency staff. • Receive benchmarking and other information (for example from Carter metrics) to assess Trust productivity and ensure targeting or efficiency programmes. • Receive assurance that any process reviews are conducted using an appropriate methodology. *Procurement* • Review the Trust procurement strategy, systems and arrangements for obtaining best value. • Monitor progress against the NHS standards of Procurement within the Trust. *Other:* • Oversee funding arrangement for DH transaction deficit support. • Gain assurance that cash management arrangements are robust.

	• Approve the terms of reference and membership of its sub-committees (as may be varied from time to time at the discretion of the Committee) and oversee their work, receiving reports for consideration and action as necessary. • Review financial systems arrangements including those used for costing, income and service level reporting where appropriate. • Review and consider any bids for external capital. • Any other relevant matters as referred by the Board. The Duties of the Committee are to consider and examine:- • Key financial performance indicators. • Monthly/annual consolidated financial performance summaries and related plans/budgets. • Cost improvement plans. • The monthly/annual statement of financial position. • Working capital performance. • Cash flow status. • Capital Programme. • Risks associated with financial plans. • Financial relationships with Trust Commissioners. • Financial Risk Ratings applied by NHS Improvement. • Financial performance forecasts. • Cash flow forecasts. • Financial aspects of the Board Assurance Framework. • **Digital** *Digital Strategy and Delivery Plan* • Approve the Digital Strategy. • Oversee the delivery of the strategic and operational priorities set out in the Strategy through scrutiny of the Delivery Plan. • Make recommendations to the Board in respect of the annual IM&T capital budget. • Provide assurance in respect of budgetary control against the agreed annual budget. • Consider and examine risks associated with the digital strategy and delivery plan. • Obtain assurance in respect of the digital aspects of the Board Assurance Framework. *Information Governance* • Approve the Trust's information governance Policy on an annual basis. • Obtain assurance that the Trust's policies and procedures with respect to data privacy, covering patients, staff and members, are compliant with all relevant legislation and guidance including the Data Protection Act 1998. • Receive a quarterly report on information governance activities including: ▪ Serious reportable data breaches including assurance on incident investigation and lessons learnt ▪ Training compliance status ▪ Progress against national IG Toolkit Compliance

	Partnerships • Receive regular updates from the Integrated Care System on relevant programmes. • Ensure there is effective collaboration with partner organisations and other stakeholders in relation to the implementation of digital solutions and sharing of systems in a controlled manner. • Ensure the Trust is an effective host and partner in respect of the Countywide IT Service (CITS).

3.4 People and Organisational Development Committee

P&OD Committee Terms of Reference	**The People and Organisational Development Committee will:** • Obtain assurance that there are practices in place which ensure the sustainability and affordability of workforce supply on a short, medium and long term basis including workforce planning, development, redesign, recruitment and retention; • Obtain assurance that the Trust attracts and retains a high performing workforce capable of delivering the Trust operational clinical strategies; • Obtain assurance that the Trust implements effective and equitable reward packages that positively impact on performance and meet national and legislative parameters; • Obtain assurance that strategic education issues and external relationships which impact on supply and engagement are included in Trust planning; • Obtain assurance that the Trust delivers services which are fair and equitable promoting diversity and equality of opportunity; • Obtain assurance that the Trust is driving improved employee engagement, ensuring appropriate mechanisms for the employee voice to ensure that rapid action is taken to improve staff experience. • Obtain assurance that the research programme and governance framework is implemented and monitored. • Agree the Trust Workforce Strategy and establish, monitor and report to the Trust Board on an annual programme of work to implement the strategy; • Agree annual objectives for Health and Safety; • Agree (where necessary) People and Organisational Development reports prior to publication and review implications of national reports that have been published; • Identify risks associated with People and Organisational Development issues ensuring ownership with mitigating actions, escalating to Trust Board as required; • Approve the terms of reference and membership of its sub-committees (as may be varied from time to time at the discretion of the Committee) and oversee their work, receiving reports for consideration and action as necessary; • Consider and approve action plans, programmes of work and strategic objectives as a result of national audit related to protected characteristics and provide assurance to the Board on progress; and • Work with the Quality and Performance Committee to obtain assurance on safer and optimal staffing and that education, learning and development is aligned with the Trust's quality priorities.

3.5 Quality and Performance Committee

Quality and Performance Committee Terms of Reference	**The Quality and Performance Committee will:** *General Governance Arrangements:* • Ensure that all statutory elements of quality governance are adhered to within the trust. • Carry out statutory responsibilities on behalf of the Board (e.g. with regard to learning from deaths, safeguarding and infection control). • Agree the annual quality priorities and monitor progress and ensure that the Trust has reliable, real time, up-to-date information about what it is like being a patient and experiencing care administered by the Trust, so as to identify areas for improvement and ensure that these improvements are effected. • Review and approve the Trust's annual quality governance and Quality Account before submission to the Board. • Approve the terms of reference and membership of its sub-committees (as may be varied from time to time at the discretion of the Committee) and oversee their work, receiving reports for consideration and action as necessary. • Consider matters referred to the Committee by the Board. • Consider matters referred to the Committee by its sub-committees. • Obtain assurance that the Trust's policies and procedures with respect to the use of clinical data and patient identifiable information are compliant with all relevant legislation and guidance including the Caldicott Guidelines and the Data Protection Act 1998. • Make recommendations to the Audit and Assurance Committee concerning the annual programme of internal audit work, to the extent that it applies to matters within these terms of reference. • Receive internal audit reports relevant to the remit of the Committee and obtain assurance that findings recommendations are acted on. • Review outcomes of clinical and internal audits and obtain assurance findings recommendations are acted on. • Obtain assurance that all quality and performance-related contract performance notices (CPNs) have local recovery plans and that appropriate monitoring arrangements are in place at the Divisional and Trust. • Obtain assurance that the Trust has effective policies and procedures in the areas covered by the remit of the Committee, e.g.: • Infection prevention and control annual report and programme • Complaints policy • Claims policy • Incident reporting policy • Consent policy • Safeguarding children policy • Safeguarding adults policy *Quality and excellence in patient care:* • Shape and influence the Trust's Quality Strategy and framework and associate strategic objectives, including overseeing the development and production of the annual Quality Account. • Obtain assurance that the registration criteria of the Care Quality Commission continue to be met.

	• Support the Trust's objectives to strive for continuous quality improvement through the work for the Gloucestershire Safety and Quality Improvement Academy. • Promote the Trust's open and honest reporting culture. • Obtain assurance that robust arrangements are in place for the review of patient safety incidents from within the Trust and wider NHS (including near-misses, complaints, claims reports from HM Coroner, reports from the Healthcare Safety Investigation Branch). • Identify trends and areas for focused or organisation-wide learning from the review of patient safety incidents and to ensure that actions for improvement identified in incident reports, reports from HM Coroner and other similar documents are addressed. • Identify areas for improvement in respect of incident themes and complaint themes from the results of national patient survey/PALS and ensure appropriate action is taken. • Oversee the system within the Trust for obtaining and maintaining any licences relevant to clinical activity in the Trust (e.g. licences granted by the Human Tissue Authority or any successor organisation). • Monitor the Trust's compliance with the fundamental standards of quality of the Care Quality Commission, and monitor licence conditions that are relevant to the Committee's area of responsibility. • Provide assurance to the Board so that the Board may approve the Trust's annual declaration of compliance and corporate governance statement. • Obtain assurance that risks to patients are minimised through: • Considering areas of significant risk, setting priorities and agreeing actions using the assurance framework; • Obtaining assurance that the Trust incorporates the recommendations from external bodies and reports (e.g. the National Confidential Enquiry into Patient Outcomes and Death or Care Quality Commission, Care Quality Commission, commissioners) and those made internally (e.g. serious incident reports) into practice and has mechanisms to monitor their delivery; and • To ensure those areas of risk within the Trust are regularly monitored and that effective disaster recovery plans are in place. • Obtain assurance that there are processes in place that safeguard children and adults within the Trust. • Escalate to the Executive Team, Audit and Assurance Committee and/or Board any identified unresolved risks arising within the scope of these terms of reference that require executive action or that pose significant threats to the operation, resources or reputation of the Trust. *Operational performance and the NHS Constitution standards:* • Obtain assurance that the Trust delivers services which are consistently meeting nationally defined minimum standards and performance and notably the four key standards required by the Trust's regulator. Where performance is below the standard required, the Committee will ensure that robust recovery plans are developed and implemented (A&E four hour wait, Cancer waiting times, referral to treatment and 6 week diagnostic standards).

	Efficient and effective use of resources through evidence-based clinical practice: • In liaison with the Finance and Digital Committee, obtain assurance the Quality Impact Assessments are completed for proposals for cost improvement programmes and other significant service changes and that the assessment of their impact on the Trust's quality of care determines whether to proceed to implementation. • Ensure that care is based on evidence of best practice/national guidance. • Ensure that there is an appropriate process in place to monitor and promote compliance across the Trust with clinical standards and guidelines, including but not limited to NICE guidance and guidelines and radiation use and protection regulations (IR(ME)R). • Review the implications of confidential enquiry reports for the Trust and to endorse, approve and monitor the internal action plans arising from them. • Monitor trends in complaints received by the Trust and commission actions in response to adverse trends where appropriate. • Monitor the development of quality indicators throughout the Trust. • Identify and monitor any gaps in the delivery of effective clinical care ensuring progress is made to improve these areas, in all specialties. ~~• Obtain assurance that the research programme and governance framework is implemented and monitored.~~ • Obtain assurance that where practice is of high quality, practice is recognised and propagated across the Trust. • Obtain assurance that the Trust is outward-looking and incorporates the recommendations from external bodies into practice with mechanisms to monitor their delivery. The duties of the Committee will include: • Ensuring that staff effectively involve patients and their carers in the planning and evaluation of services so as to ensure that services meet the needs and preferences of patients, so far as is possible. • Working with the People and Organisational Development Committee to obtain assurance on safer and optimal staffing and that education, learning and development is aligned with the Trust's quality priorities. • Working with the Finance and Digital Committee to ensure that the availability of resources does not adversely impact upon the quality of services to the extent that patient safety is compromised or care is delivered that doesn't meet the required mandatory quality standards as defined by the CQC and NHSI. • Maintaining effective links to Divisions via exception reports (e.g. from the Quality Delivery Group; Planned Care Delivery Group; Cancer Delivery Group; and Emergency Care Delivery Group). • Triangulating data in support of its purpose.

3.6 Remuneration Committee

SFI 9.1	**The Remuneration Committee will:** **A. Appointments Role** • Periodically review the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board, making use of the output of the board evaluation process as appropriate, and make recommendations to the Board, and Governance and Nominations Committee of the Council of Governors, as applicable, with regard to any changes. • Give full consideration to and make plans for succession planning for the chief executive taking into account the challenges and opportunities facing the trust and the skills and expertise needed on the Board in the future. • Appoint candidates to fill all the executive director positions on the Board. • Consider any matter relating to the continuation in office of any board executive director including the suspension or termination of service of an individual as an employee of the trust, subject to the provisions of the law and their service contract. ***B. Remuneration Role*** • Monitor and evaluate the performance of the Chief Executive through the Chair's appraisal process. • Determine the remuneration and terms of service of Executive Directors. • Discuss and, if appropriate, confirm the assessments made of performance related pay by the Chair for the Chief Executive the Chief Executive for the other Executive Directors. • Determine pay rises and review the need for any other adjustments. If a performance related pay scheme is in operation then a meeting of the Committee will review the performance of individual directors prior to the award of any bonus payments. (If a group PRP scheme is in place covering the most senior managers as well as Executive Directors then the Committee will determine membership of the scheme and payments for the scheme as a whole). • Advise on and oversee appropriate contractual arrangements for Executive Directors, including any termination payments.

4 Scheme of Delegation of Powers from the Constitution

Constitution Ref	Delegated to	Authorities/Duties Delegated
7.4.3 & 7.4.4 & 7.4.5	Director of Corporate Governance	Make decisions regarding Members' and applicants' eligibility or disqualification.
7.7.9	Chair	Preside at the Annual Members' Meeting.
8.6.1	Chair	May veto the appointment of a Stakeholder Governor by serving notice in writing to the relevant sponsoring organisation where they believe that the appointment in question is unreasonable, irrational or otherwise inappropriate.
8.7.2	Director of Corporate Governance	Ensure NHS Improvement (Monitor) is provided with details of the serving Lead Governor.
8.11.2	Director of Corporate Governance	Request, where the vacancy arises amongst the appointed Governors, the appointing organisation appoints a replacement to hold office for the remainder of the term of office.
9.5	Chair	May exercise a second or casting vote where the number of votes for and against a motion is equal at a meeting of the Board of Directors.
17.5	Chair	Judge whether a transaction is "deemed to be high risk by its nature" or "of specific relevance to governor priorities".
Annex 2 3.4	Chair	Give such directions as they think fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the business of the meeting shall be conducted without interruption and disruption; exclude any member of the public or press from a meeting of the Council of Governors if they are interfering with, or preventing the proper conduct of the meeting.
Annex 2 3.7	Chair	Call a meeting of the Council of Governors at any time.
Annex 2 3.9	Chair	Serve notice of a Council of Governors meeting on governors.
Annex 2 3.17	Chair	Exercise a casting vote where the number of votes for and against a motion is equal at a meeting of the Council of Governors.
Annex 2 3.27	Chair	Decide questions of order, relevance, regularity and any other matters at a meeting of the Council of Governors.
Annex 2 3.33	Director of Corporate Governance	Keep records of all written resolutions of any matter determined by the Council of Governors.
Annex 2 5.1.1 & 5.1.2	Governors	Declare any actual or potential conflict of interest.
Annex 2 5.1.3	Chair	Determine what action to take if a Governor has a conflict of interest.
Annex 2 5.3.1	Director of Corporate Governance	Ensure a register of interests is established to record formally declarations of interests of Governors.

5 Scheme of Delegation of Powers from the Board Standing Orders (SOs)

SO Ref	Delegated to	Authorities/Duties Delegated
1.1	Chair	Be the final authority on the interpretation of the Standing Orders (on which they should be advised by the Chief Executive and/the Director of Corporate Governance).
3.4	Chair	Give such directions as they think fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted.
3.7	Chair	Call a meeting of the Trust Board at any time.
3.9	Chair	Serve notice of the meeting of the Trust to every Director.
3.16 & 3.26	Chair	Exercise a casting vote where the number of votes for and against a motion is equal.
3.25	Chair	Decide questions of order, relevance, regularity and any other matters at the meeting of the Trust.
4.2	Chief Executive and Chair	Exercise the powers which the Board has retained to itself within the Standing Orders in emergency.
4.5	Chief Executive	Determine which functions they will perform personally and nominate officers to undertake the remaining functions for which they will still be accountable to the Board.
4.6	Director of Corporate Governance	Prepare a Scheme of Delegation identifying their proposals which shall be considered and approved by the Board, subject to any amendments agreed during the discussion; and periodically propose amendment to the Scheme of Delegation.
6.3.5	Chair	Determine what action to take if during the course of a meeting of the Board a Director has a conflict of interest.
6.13	Director of Corporate Governance	Ensure a register of interests is established to record formally declarations of interests of Directors.
7.6	Directors, Governors and officers of the Trust	Disclose to the Chief Executive any relationship with a candidate for any staff appointment of whose candidature that Director or officer is aware.
7.6	Chief Executive	Report to the Trust any disclosure made by any Director, Governor and officer of the Trust concerning any relationship with a candidate of whose candidature that Director or officer is aware.
8.4	Director of Finance or nominated officer	Maintain a list of applicable exemptions from waivering competition.
8.5	Director of Finance	Waive competitive tendering/quotation procedures in specific circumstances as defined in SO 8.5.1-8.5.4.
8.6	Chief Executive and Director of Finance	Waive formal tendering procedures over £25,000 excluding VAT and under the thresholds of the EU Procurement Directives given specific circumstances as defined in SO 8.6.1-8.6.5.
8.16	Chief	Evaluate quotations and select the one which gives the best

	Executive or officer nominated by them	value for money.
8.18	Chief Executive	Ensure best value for money can be demonstrated for all services provided under contract or in-house.
8.19.1	Chief Executive	Demonstrate the use of private finance represents value for money and genuinely transfers risk to the private sector.
8.22 & 10.4	Chief Executive	Nominate an officer who shall oversee and manage each contract on behalf of the Trust.
8.22	Chief Executive	Nominate officers with delegated authority to enter into contracts for the employment of other officers, to authorise regrading of staff, and enter into contracts for the employment of agency staff or temporary staff.
8.23	Chief Executive	Nominate officers to assess the tax status on individuals/personal services companies to ensure compliance with HMRC Self-Employment/IR35 status, prior to entering into any contracts of this nature.
8.23	Director of Finance or Director of People or Head of Shared Services or Head of Procurement	Assess the tax status on individuals/personal services companies to ensure compliance with HMRC Self-Employment/IR35 status, prior to entering into any contracts of this nature.
8.25	Chief Executive	Nominate officers with power to negotiate for the provision of healthcare services with commissioners of healthcare.
11.1 & 11.5	Director of Corporate Governance	Keep the Common Seal of the Trust in a secure place and maintain a register of sealing.
11.3	Director of Finance	Approve and sign the sealing of any building, engineering, property or capital document.
11.3	Chief Executive	Authorise and countersign the sealing of any building, engineering, property or capital document.
11.4	Director of Corporate Governance	Witness and attest to the affixing of the seal.
12.1	Chief Executive	Sign any documents where the signature will be a necessary step in legal proceedings involving the Trust.
12.2	Chief Executive	Sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board or committee or sub-committee to which the Board has delegated appropriate authority.
13.1	Chief Executive	Ensure that existing Directors and officers and all new appointees are notified of and understand their responsibilities within Standing Orders and Standing Financial Instructions.
Annex A	Chief Executive	Perform tendering procedure as designated in Annex A of the SOs.

6 Scheme of Delegation of Powers from the Standing Financial Instructions (SFIs)

SFI Ref	Delegated to	Authorities/Duties Delegated
1 Introduction		
1.3.6 & 1.3.9	Chief Executive	Ensuring that all members of the Board, employees of the Trust and contractor are notified of and understand their responsibilities within SFIs.
1.3.7	Finance Director	1 Implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies; 2 Maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions; 3 Ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time; 4 Ensuring that good financial practice is followed in accordance with accepted professional standards and advice received from internal and external auditors; 5 Providing of financial advice to the Trust and its Directors and employees; 6 Designing, implementing and supervising of systems of internal financial control; and 7 Preparing and maintaining of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.
1.3.8 & 1.3.9	All directors, staff and contractors	Security of Trust property; avoiding loss; exercising economy and efficiency in the use of resources; conforming to the Constitution, Standing Orders, SFIs and the Scheme of Delegation; and reporting suspected theft or fraud to the Director of Finance.
2 Audit		
2.1.1	Audit and Assurance Committee	1 Overseeing Internal and External Audit services; 2 Reviewing systems of internal control and ensuring they are fit for purpose; 3 Monitoring compliance with Standing Orders and Standing Financial Instructions; and 4 Reviewing schedules of losses and compensations and making recommendations to the Board.
2.1.3	Director of Finance	Ensuring adequate internal audit service is provided
2.1.4	Audit and Assurance Committee	Making a recommendation to the Council of Governors to the appointment of external auditors; assessing the external (financial) auditors on an annual basis in terms of the quality of their work
2.2.1	Chief Executive / Director of Finance	Monitoring and ensuring compliance with the directions issued by the Secretary of State for Health and/or NHS Counter Fraud Authority on fraud, bribery and corruption.
2.2.4	Local Counter Fraud	Providing a written report at least annually on counter fraud work within the Trust.

	Specialist	
2.2.5	All staff	Informing the Finance Director or Local Counter Fraud Specialist if they discover or suspect a loss of any kind
2.3.1	Director of Finance	1 Ensuring that there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function; 2 Ensuring that the internal audit is adequate and meets the NHS mandatory audit standards; 3 In conjunction with the Counter Fraud and Security Management Service, deciding at what stage to involve the police in cases of misappropriation, and other irregularities; 4 Ensuring that an annual Internal Audit Report is prepared for the consideration of the Audit and Assurance Committee and the Board; 5 Ensuring that a three year strategic Internal Audit Plan is prepared for the consideration of the Audit and Assurance Committee and the Board; and 6 Ensuring that an annual Internal Audit Plan is produced for consideration by the Audit and Assurance Committee and the Board, which sets out the proposed activities for the function for the forthcoming financial year.
2.3.3	All staff	Notifying the Director of Finance or Local Counter Fraud Service whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature.
2.4.1	Director of Finance	Ensuring an Internal Audit function is in place and operates efficiently and effectively.
2.4.2	Internal Auditor	1 Providing assurances about the effectiveness of controls in place across all of the Trust's activities; 2 Reviewing the overall arrangements the Board itself has in place for securing adequate assurances and providing an opinion on those arrangements to support the Statement on Internal Control; and 3 Reviewing the way in which the Board has identified objectives, risks, controls and sources of assurance on these controls, and assessed the value of assurances obtained.
2.5.2	Council of Governors	Appointing (or removing) the external (financial) auditor on behalf of the Trust in accordance with the selection criteria in the Audit Code for NHS Foundation Trusts.
2.6.1	Chief Executive	Ensuring compliance with the Audit Code for NHS Foundation Trusts.
3 Financial Targets		
3.3	Chief Executive	Ensuring the Trust aims to maintain its financial viability and meets any specific financial targets set by the regulator; setting appropriate internal targets in order to ensure financial viability; signalling to the Finance and Digital Committee and the Board where the Trust's financial viability or key targets are at risk.
3.4	Director of Finance	1 Advising the Board and Chief Executive on progress in meeting these targets, recommending corrective action as appropriate; 2 Ensuring that adequate systems exist internally to monitor

		financial performance; 3 Managing the cash flow and external borrowings of the Trust; and 4 Providing the Regulator with such financial information as is necessary to monitor the financial viability of the Trust.
4 Business Planning, Budgets and Budgetary Control		
4.1.1	Council of Governors	Providing the Board with its views on the Trust's forward plans for each financial year.
4.1.1	The Board	Consulting the Council of Governors on the Trust's forward plans for each financial year.
4.1.2	Chief Executive	Compiling and submitting to the Board and the Council of Governors an annual business plan which takes into account financial targets and forecast limits of available resources.
4.1.3	Chief Executive	Submitting the approved Business Plan to the Regulator as required.
4.1.4	Chief Executive	Ensuring on behalf of the Board that the Council of Governors is consulted on any significant changes to the Business Plan in year.
4.1.5	Director of Finance	Preparing and submitting revenue and capital budgets for approval by the Board.
4.1.6	Director of Finance	Monitoring financial performance against budget and the Business Plan and report to the Board.
4.1.7	Budget holders	Providing information as required by the Director of Finance to enable budgets to be compiled and to explain variances.
4.1.8	Director of Finance	Ensuring adequate, on-going training is delivered to budget holders to help them manage their budgets successfully.
4.2.1	Director of Finance	Delegate the management of a budget to permit the performance of a defined range of activities.
4.2.1 & 4.3.2	Budget holders	The management of a budget to permit the performance of a defined range of activities.
4.3.1	Director of Finance	Devise and maintain systems of budgetary control including monthly financial reports to the Board containing sufficient information to ascertain financial performance.
4.3.3	Chief Executive	Ensuring the identification and implementation of cost improvements and income generation initiatives in accordance with the requirements of the annual Business Plan and agreed Control Total.
4.3.4	Director of Finance	Advising the Chief Executive and the Board on the financial consequences of any changes in policy, pay awards and other events impacting on budgets and also on the financial implications of future plans and developments proposed by the Trust.
4.5.1	Chief Executive	Providing the Regulator with the appropriate monitoring information.
4.5.2	Chief Executive	Ensuring the Trust contributes to standard national NHS data flows required for NHS policy development/ funding decisions as well as performance assessment by the Healthcare Commission.
5 Annual Accounts and Reports		
5.1	Director of Finance	1 Preparing annual accounts in accordance with the Regulator's Manual of Accounts and any other guidance from the same, the Trust's accounting policies and generally accepted accounting practice; 2 Preparing and submitting annual accounts to the Board and

		an audited summary of the Main Financial Statements to an Annual Members' Meeting convened by the Council of Governors, certified in accordance with current guidelines; and 3 Laying a copy of the annual accounts, and any report of the external (financial) auditor thereon, before Parliament and subsequently send them to the Regulator.
5.4.1	Director of Corporate Governance	Preparing and submitting annual reports to the Board and an audited summary to an Annual Members' Meeting convened by the Council of Governors.
6 Bank Accounts		
6.1.1 & 6.4.1	Director of Finance	Managing and regularly reviewing the Trust's banking arrangements and advising the Trust on the provision of banking services and operation of accounts.
6.2.1	Director of Finance	Responsible for bank accounts; establishing separate bank accounts for the Trust's charitable funds; ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made; and reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.
6.3.1	Director of Finance	Preparing detailed instructions on the operation of bank accounts.
6.3.2	Director of Finance	Advising the Trust's bankers in writing of the conditions under which each account will be operated.
7 Income, Fees and Charges and Security of Cash, Cheques and Other Negotiable Instruments		
7.1.1	Director of Finance	Designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.
7.1.3	Director of Finance	Banking of all monies received.
7.2.2	Director of Finance	Approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute.
7.3.1	Director of Finance	Take appropriate recovery action on all outstanding debts and provide the Finance and Digital Committee with a monthly analysis of debtors profiled by age and actions to recover.
7.4.1	Director of Finance	1 Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable; 2 Ordering and securely controlling any such stationery; 3 Providing adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and 4 Prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.
8 NHS Contracts for the Provision of Services		
8.1	Chief Executive	Ensuring that the Trust enters into suitable legally binding contracts with NHS commissioners both for the mandatory healthcare services specified in the Trust's Authorisation agreement with the Regulator and also other healthcare services.
8.2	Chief	Ensuring the Trust works will all partner agencies involved in

	Executive	both the delivery and the commissioning of the service required.
8.3	Director of Finance	Ensuring regular reports are provided to the Finance and Digital Committee and the Board detailing forecast/ budgeted and actual income from contracts with NHS commissioners, particularly highlighting the impact of differences between planned and actual numbers of patients treated and outline any action required to address such variances and periodically providing information on the impact of differences between the actual cost to the Trust of treating patients in individual service lines and the relevant national tariff.
9 Terms of Service and Payment of Directors and Employees		
9.1.2	Remuneration Committee	1 Periodically review the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board, making use of the output of the board evaluation process as appropriate, and make recommendations to the Board, and Governance and Nominations Committee of the Council of Governors, as applicable, with regard to any changes; 2 Give full consideration to and make plans for succession planning for the chief executive taking into account the challenges and opportunities facing the trust and the skills and expertise needed on the Board in the future; 3 Appoint candidates to fill all the executive director positions on the Board; 4 Consider any matter relating to the continuation in office of any board executive director including the suspension or termination of service of an individual as an employee of the trust, subject to the provisions of the law and their service contract; 5 Monitor and evaluate the performance of the Chief Executive through the Chair's appraisal process; 6 Determine the remuneration and terms of service of Executive Directors; 7 Discuss and, if appropriate, confirm the assessments made of performance related pay by the Chair for the Chief Executive the Chief Executive for the other Executive Directors; 8 Determine pay rises and review the need for any other adjustments. If a performance related pay scheme is in operation then a meeting of the Committee will review the performance of individual directors prior to the award of any bonus payments. (If a group PRP scheme is in place covering the most senior managers as well as Executive Directors then the Committee will determine membership of the scheme and payments for the scheme as a whole); and 9 Advise on and oversee appropriate contractual arrangements for Executive Directors, including any termination payments.
9.1.3	Remuneration Committee	Send recommendations in report to the Board.
9.2.2	Vacancy Control Panel	Authorise changes to the funded establishment.
9.3.1	Vacancy Control Panel	Authorise changes in any aspect of remuneration, unless the changes are within the limit of the employee's approved budget

		and funded establishment.
9.3.1	Budget holders	Recruit to vacancies provided that this is within their approved budget and funded establishment.
9.4.1	Director of Finance	1 Specifying timetables for submission of properly authorised time records and other notifications; 2 Authorising the final determination of pay; 3 Making payment on agreed dates; and 4 Agreeing method of payment.
9.4.2	Director of Finance	Issuing instructions regarding processing of payroll.
9.4.3	Nominated managers	1 Submitting time records, and other notifications in accordance with agreed timetables; 2 Completing time records and other notifications in accordance with the Director of Finance's instructions and in the form prescribed by the Director of Finance; and 3 Submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination or retirement. Where an employee fails to report for duty in circumstances that suggest they have left without notice, the Director of Finance must be informed immediately.
9.4.4	Director of Finance	Ensuring the chosen method for providing the payroll service is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.
9.5.1	Director of People and OD	1 Ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and 2 Dealing with variations to, or termination of, contracts of employment.
10 Non-pay Expenditure		
10.1.1	Chief Executive	Determine level of delegation to budget managers.
10.1.2	Director of Finance	Set out the list of managers who are authorised to place requisitions for the supply of goods and services; and the maximum level of each requisition and the system for authorisation above that level.
10.1.3	Director of Finance	Ensuring the Trust has clearly established arrangements for the purchase of goods and services.
10.1.4	Director of Finance	Ensuring the Trust makes optimum use of corporate, national or regional contracts for the acquisition of goods and services, in order to ensure best value for money.
10.2.1	Requisitioners	Obtain the best value of money for the Trust when choosing an item to be supplied, seeking the advice of the Procurement Shared Service.
10.2.2	Director of Finance	Paying accounts and claims promptly and paying contract invoices in accordance with contract terms or otherwise national guidance.
10.2.3	Director of Finance	1 Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed;

		2 Prepare procedural instructions on the obtaining of goods, works and services incorporating the thresholds; 3 Be responsible for the prompt payment of all properly authorised accounts and claims and for advising the Board on a monthly basis of performance against targets set under the Government's Better Payments Practice Code; 4 Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. 5 Be responsible for ensuring that payment for goods and services is only made once the goods and services are received, except in exceptional circumstances where prepayments are permitted.
10.2.4	Budget holders	Ensuring all items due under a prepayment contract are received and informing the appropriate manager if problems are encountered.
10.2.4	Director of Finance	Be satisfied with the proposed arrangements for prepayments before contractual arrangements proceed.
10.2.6	Managers	Ensure full compliance with the guidance and limits specified by the Director of Finance concerning contracts and other commitments which may result in a liability.
10.2.7	Director of Finance	Ensuring arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the appropriate guidance.
11 Treasury Management		
11.1.2	Director of Finance	Advise the Board concerning the Trust's ability to pay a dividend on, and repay Public Dividend Capital (PDC) and any proposed new borrowing, within the limits set by the Department of Health and report periodically to the Board concerning the PDC debt and all loans financing facilities and overdrafts,
11.1.3	Director of Finance	Make, or delegate an employee to make, any application for a loan, financing facility or overdraft.
11.1.4	Director of Finance	Prepare detailed procedural instructions concerning applications for loans, financing facilities and overdrafts.
11.1.5	Director of Finance	Authorise short term borrowing requirements.
11.2.2	Director of Finance	Advise the Board on investments and report periodically to the Board concerning the performance of investments held, other than short term temporary cash surpluses.
11.2.3	Director of Finance	Prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.
11.3.1	Director of Finance	Manage and monitor the overall cash flow of the Trust and provide reports thereon to the Finance and Digital Committee and the Board.
12 Capital Investment, Private Financing, Fixed Asset Registers and Security of Assets		
12.1.1	Chief Executive	Ensure adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans; be responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and ensure that the capital investment is not undertaken without consideration of the availability of resources to finance all revenue consequences, including capital charges.

12.1.2	Chief Executive	Ensure that for every capital expenditure proposal a business case is produced and the Director of Finance has certified to the costs and revenue consequences detailed in the business case which is approved by the Board subject to agreed delegated limits.
12.1.3	Director of Finance	Issue procedures for the management of capital schemes where the contracts stipulate stage payments; and issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.
12.1.4	Chief Executive	Issue necessary authority to the manager responsible for any capital programme and a scheme of delegation for capital investment management in accordance with "Estatecode" guidance and the Trust's Standing Orders.
12.1.5	Director of Finance	Issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.
12.2.1	Director of Finance	Demonstrate the use of private finance represents value for money and appropriately transfers significant risk to the private sector.
12.3.1	Responsible Officer	Maintain registers of assets and arrange a physical check of assets against the asset register to be conducted once every two years.
12.3.5	Director of Finance	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
12.4.1	Chief Executive	Control of fixed assets.
12.4.2	Director of Finance	Approve asset control procedures.
12.4.4	Directors and senior employees	Apply appropriate routine security practices in relation to NHS property.
13 Stores and Receipt of Goods		
13.2	Chief Executive	Delegate day-to-day responsibility for the control of stores of goods, subject to the responsibility of the Director of Finance for the systems of control.
13.3 & 13.7	Designated Manager / Pharmaceutical Officer	Define in writing the responsibility for security arrangements and the custody of keys for all stores and locations; be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles; and report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice.
13.4	Director of Finance	Set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.
13.5	Director of Finance	Agree stocktaking arrangements.
13.8	Director of Finance	Identify those authorised to requisition and accept goods supplied via the NHS Supply Chain central warehouses.
14 Disposals and Condemnations, Losses and Special Payments		
14.1.2	Director of Finance	Prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.
14.1.4	Director of	Authorise employees to condemn or otherwise all unserviceable

& 14.1.5	Finance	articles; approve the form in which this is recorded; and take appropriate action if there is evidence of negligence.
14.1.4 & 14.1.5	All staff	If authorised by the Director of Finance, condemn or otherwise all unserviceable articles; record in a form approved by the Director of Finance; and report any evidence of negligence in use to the Director of Finance.
14.2.1	Director of Finance	Prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.
14.2.2	All staff	Inform their head of department if they discover or suspect a loss of any kind, who must immediately inform the appropriate officer.
14.2.3	Director of Finance	Report losses apparently caused by theft, fraud, arson, neglect of duty or gross carelessness, except if trivial, to the Audit and Assurance Committee.
14.2.4	Director of Finance	Take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.
14.2.5	Director of Finance	Consider whether any insurance claim can be made for any loss.
14.2.6	Director of Finance	Maintain a Losses and Special payments Register.
15 Information Technology		
15.2	Director of Finance	Ensuring the accuracy and security of the computerised financial detail.
15.3	Director of Finance	Ensuring an appropriate Business Case is prepared and approved for a new financial system or significant amendment to a current financial system.
15.5	Director of Finance	Ensuring contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage.
16 Patients' Property		
16.2	Chief Executive	Ensuring patients or their guardians, as appropriate, are informed before or at admission that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.
16.3	Chief Operating Officer	Provide arrangements for the administration of patient property.
18 Acceptance of Gifts by Staff		
18.1	Director of Finance	Ensure staff are aware of the Trust's policy on acceptance of gifts and other benefits in kind by staff.
19 Retention of Documents		
19.1 & 19.3	Chief Executive	Maintaining archives for all documents required to be retained in accordance with Department of Health guidelines; instigating the destruction of these documents and maintaining a record of destroyed documents.
20 Risk Management & Insurance		
20.1	Chief Executive	Ensuring the Trust has a programme of risk management which is approved and monitored by the Board.
20.4	Director of Finance	Ensuring insurance arrangements exist where appropriate.

Appendix 1: Financial Delegation Limits

1.1 Revenue and Capital Expenditure (SFI Appendix 1.1.3)

Responsibility	**Board**	**Chief Executive, delegated to the Trust Leadership Team**
Approval of capital expenditure, business cases & PFI schemes, including approval of variations	>£1,000,000	<£1,000,000
Approval of increases in the real terms cost of revenue or capital developments identified specifically in the financial plans of the Trust, or reported individually in any Board agenda, provided that the cost increase can be funded within one of the approved provisions or reserves	If the increase is >10% of the value in the agreed financial plan	If the increase is equal to or >10% of the value in the agreed financial plan

1.1.1 Authorisation of Virement (SFI Appendix 1.1.4-1.1.5)

Executive Director	**Divisional Director**	**Budget holders**
<£100,000 between budgets with their control	<£25,000 within budgets in their control (but <£100,00 provided each of the three (four) DD's agree)	<£5,000 between budgets under their control (<£5,000 non-recurringly and <£1,000 recurringly between revenue budgets within their control)

1.2 Purchase Orders (SFI Appendix 1.3)

Expenditure range	**Authorised personnel**
Up to £1,000	Budget Holder
£1,000 to £10,000	Level 2 Approvers
£10,000 to £50,000	Level 3 Approvers
£50,000 to £100,000	Chief Executive & Director of Finance
£100,000 to £500,000	Trust Leadership Team
above £500,000	Board

1.3 Tendering Limits (SFI Appendix 1.4)

Expenditure range	**Action required**
Up to £5,000	Single supplier or quotations via Procurement Shared Services
£5,001 to £25,000	Competitive quotations/tenders via Procurement Shared Services
£25,001 to EU threshold	Formal tender procedure via Procurement Shared Service
Above EU threshold	Formal tender procedure via Procurement Shared Services under Public Contract Regulations

1.4 Authorisation to enter into and sign Contracts for goods and services (SFI Appendix 1.5)

	Level 3/4 Budget Holders	Trust Leadership Team	Finance and Digital Committee	Trust Board
Total contract value (over the lifetime of the contract including permitted extensions)	0 - £250k	>£250k - £1m	>£1m - £5m	>£5m

a. Delegated authority limits associated with tendering (SFI 8.5)

	Director of Finance (in consultation with Chief Executive)	**Trust Leadership Team**	**Trust Board**
Decision not to bid	No limit	Not applicable	Not applicable
Total or annual value range where services are provided by the Trust and tender is to retain the current provision	0 - £10m	>£10m - £50m	>£50m
Total or annual value range where services are not currently provided by the Trust and tender is to acquire provision	0 - £5m	>£5m - £25m	>£25m

b. Charitable Funds (SFI Appendix 1.6)

Expenditure range	**Authorised personnel**
Up to £1,000	Fund holders (unless a lower limit is specified by the Chief Operating Officer and Deputy Chief Executive.)
£1,001 to £5,000	Chief Operating Officer and Deputy Chief Executive (who may delegate as he/she judges appropriate to senior managers)
Above £5,000	Charitable Funds Committee

ITEM 11

GOVERNOR QUESTIONS

Peter Lachecki
Chair

ITEM 12

STAFF QUESTIONS

Peter Lachecki
Chair

ITEM 13

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

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

Since the introduction of the NHS Workforce Race Equality System (WRES) what approach/approaches have Gloucestershire Hospitals NHS Foundation Trust undertaken to achieve visible ethnic minority at senor leadership level, executive level, and at the board of Gloucestershire Hospitals NHS Foundation Trust. What have been the significant impact of this approach/approaches?

The Trust has sought to approach the agenda of improving visible ethnic minority at a senior level in a number of ways.
Recently the Trust introduced a new role of Associate Non-Executive Director (NED) with the aspiration to improve our visible BAME representation and voice at the Board. At the same time we also recruited for substantive NED's and specifically networked among diverse communities describing our ambition to have greater diversity of thought at the Board. The impact of a direct approach and honest conversation about our lack of visible diversity was successful and we have appointed two Associate NED's and one NED from a BAME background.

To assist in our personal development the Board will be undergoing unconscious bias training led by a national NHS lead for WRES.

The vast majority of recruiting managers have attended training in unconscious bias and the remainder are scheduled to attend in the near future. This year we will aim for interview panels for band 8a posts and above (typically leadership roles) to have a BAME interview panel member and we plan to train at least 20 colleagues to fulfil this role. (NOTE for you all FYI: We have received 31 Expressions of Interest from colleagues around the Trust and will be meeting with them all next month to explore taking this forward.

The Trust promotes the NHS England Stepping up programme aimed at aspiring BAME talent at bands 5-7. Six colleagues have or are participating in the programme and one has recently been accepted into our Trust Accelerated Development Programme.

The Board act as a champion for protected characteristics with an Executive and Non-Executive Director covering all 9 characteristics. The Executive lead for Race attends all national WRES conferences along with our staff lead representative for BAME who is a member of our Diversity Network.

We believe visible leadership of our BAME colleagues will help to break down barriers and the Chair of our Equality, Diversity and Inclusion Steering Group is from a BAME background. We also have BAME colleagues on the organising committee of the Trust's Diversity Network.

Overall our representation of staff at senior levels is positive in comparison to our staff and local populations and particularly so amongst clinical staff.

We have made some progress in staff survey results for our BAME colleagues and have new measures in the new 5 year People and OD strategy due to be published in July which will directly address the issues of visible ethnic minorities in senior leadership roles.

ITEM 14

NEW RISKS IDENTIFIED

VERBAL

ITEM 15

ITEMS FOR THE NEXT MEETING

VERBAL

PUBLIC BOARD PLANNER - 2019

PUBLIC BOARD MEETINGS	COMMENTS	Jan	Feb	Mar	Apr	May	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Standing Items							C							
Welcome & Apologies		X	X	X	X	X		X	X		X	X	X	X
Declarations of Interest		X	X	X	X	X		X	X		X	X	X	X
Patient Story		X	X	X	X	X		X	X		X	X	X	X
Review Minutes of the previous Board Meeting		X	X	X	X	X		X	X		X	X	X	X
Matters Arising from previous Board Meeting		X	X	X	X	X		X	X		X	X	X	X
Chief Executive's Report		X	X	X	X	X		X	X		X	X	X	X
Quality and Performance Report		X	X	X	X	X		X	X		X	X	X	X
Assurance Reports of the Chair of the Quality and Performance Committee		X	X	X	X	X		X	X		X	X	X	X
Trust Risk Register		X	X	X	X	X		X	X		X	X	X	X
Report of the Finance Director		X	X	X	X	X		X	X		X	X	X	X
Assurance Reports of the Chair of the Finance Committee		X	X	X	X	X		X	X		X	X	X	X
Report of the Director of People and Organisational Development		X		X		X			X		X		X	
Assurance Report of the Chair of the People and Organisational Development Committee		X	X	X	X	X		X	X		X	X	X	X
Report of the Chair of the Audit and Assurance Committee		X	X		X	X		X			X	X		X
Report of the Chair of the Gloucestershire Managed Services Committee		X	X	X	X	X		X	X		X	X	X	X
SmartCare Progress Report		X	X	X	X									
Review Minutes of the Meeting of the Council of Governors		X	X	X	X	X		X	X		X	X	X	X
Governors' Questions		X	X	X	X	X		X	X		X	X	X	X
Staff Questions		X	X	X	X	X		X	X		X	X	X	X
Public Questions		X	X	X	X	X		X	X		X	X	X	X
Any Other Business		X	X	X	X	X		X	X		X	X	X	X
Quarterly														
Chair's Update		X			X				X			X		
Board Assurance Framework			X			X					X			X
Guardian Report on Safe Working Hours for Doctors and Dentists in Training			X			X					X			X
Learning from Deaths		X			X				X			X		
Bi-Annually														
Learning from Patient Stories								X					X	
Research Report		X				X			X					
Annually														
Gender Pay Gap Annual Report						X								
Annual Organ Donation Report									X					
Annual Medical Revalidation and Appraisal Report									X					
Annual Safeguardying Reports (Safeguarding Adults and Safeguarding Children)											X			
Infection Control Annual Report											X			
GHNHSFT Annual Report											X			
Annual Audit Letter											X			
Annual Trust Seal Report					X									
Emergency Planning Resilience and Response Annual Report													X	
Modern Slavery Act Statement													X	
Equality Report		X							X					
Workforce Race Equality Standard (WRES)									X					
Workforce Disability Equality Standard (WDES)									X					
Equality, Diversity & Inclusion Action Plan						X					X			
Operational Plan (sign off)				X										
Non-recurring														
Financial Special Measures		X												
4 Year Equality Objectives 2019-2023						X								
Brexit Briefing			X								x			
Governance Documents for Review			X											
New Trust Strategy Approval					X									
One Place pre-consultation business case approval									X					
Strategic Site Development One Busines Case approval									X					
Governance Documents: Estates Terms of Reference, Scheme of								X						
Quality Strategy												X		
Estates Strategy											X			

ITEM 17

ANY OTHER BUSINESS

DISCUSSION