GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

The next meeting of the Gloucestershire Hospitals NHS Foundation Trust Main Board will be held on **Thursday 11 July 2019** in the **Lecture Hall, Sandford Education Centre, Cheltenham General Hospital** commencing at 12:30

(PLEASE NOTE DATE AND VENUE FOR THIS MEETING)

Peter Lachecki
Chair

26 June 2019

AGENDA

				Approximate Timings
1.	Welcome and Apologies			12.30
2.	Declarations of Interest			
3.	Patient Story			12.31
4.	Organ Donation Annual Report	**PAPER** (Mark Pietroni, Mark Haslam)	**For information**	13.00
5.	Minutes of the meeting held on 13 June 2019	**PAPER**	**For Approval**	13.10
6.	Matters Arising	**PAPER**	**For assurance**	
7.	Chair's Update	**PAPER** (Peter Lachecki)	**For information**	13.15
8.	Chief Executive's Report	**PAPER** (Deborah Lee)	**For information**	13.20
9.	Trust Risk Register	**PAPER** (Lukasz Bohdan)	**For assurance**	13.30
10.	**Quality and Performance:**			13.40
	- Assurance Report of the Chair of the Quality and Performance Committee - meeting held on 26 June 2019	**PAPER** (Alison Moon)	**For assurance**	
	- Quality and Performance Report	**PAPER** (Steve Hams, Rachael de Caux, Mark Pietroni)	**For assurance**	
	- Learning from Deaths Report	**PAPER** (Mark Pietroni)	**For assurance**	
	- CNST Incentive Scheme Report	**PAPER** (Steve Hams)	**For approval**	
11.	**Finance and Digital:**			14.00
	- Assurance Report of the Chair of the Finance and Digital Committee - meeting held on 27 June 2019	**PAPER** (Rob Graves)	**For assurance**	
	- Financial Performance Report	**PAPER** (Sarah Stansfield)	**For assurance**	

12.	**People and Organisational Development:**			14.10
	- Assurance Report of the Chair of the People and Organisational Development Committee - meeting held on 17 June 2019	**PAPER** (Balvinder Heran)	**For assurance**	
	- People and Organisational Development Report	**PAPER** (Emma Wood)	**For assurance**	
	- People and Organisational Development Strategy	**PAPER** (Emma Wood)	**For approval**	
	- Equality Report	**PAPER** (Emma Wood)	**For assurance**	
13.	Annual Medical Revalidation and Appraisal Report	**PAPER** (Mark Pietroni)	**For assurance**	14.30
14.	**Audit and Assurance:**			14.40
	- Assurance Report of the Chair of the Audit and Assurance Committee – meeting held on 2 July 2019	**PAPER** (Claire Feehily)	**For assurance**	
15.	Assurance Report of the Chair of the Estates and Facilities Committee – meeting held on 8 July 2019	**VERBAL** (Mike Napier)	**For assurance**	14.45
	Governor Questions			
16.	Governors' Questions – A period of 10 minutes will be permitted for Governors to ask questions			14.50
	Staff Questions			
17.	A period of 10 minutes will be provided to respond to questions submitted by members of staff			15.00
	Public Questions			
18.	A period of 10 minutes will be provided for members of the public to ask questions submitted in accordance with the Board's procedure.			15.10
19.	New Risks Identified	**VERBAL** (All)		15.20
20.	Items for the Next Meeting	**VERBAL** (All)		
21.	Any Other Business			15.25
	Close			**15.30**

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 12 September 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
Balvinder Heran	Rachael de Caux, Chief Operating Officer
Alison Moon	Steve Hams, Director of Quality and Chief Nurse
Mike Napier	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

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

Report Title
Organ Donation Activities Report
Sponsor and Author(s)
Prof Mark Pietroni, Director of Safety and Medical Director Dr Mark Haslam, Consultant in Anaesthesia and Intensive Care Medicine
Executive Summary

Purpose

To update the Board on the positive progress in respect of organ donation activities.

Key issues to note

- The NHSBT report (Appendix I) documents the success of our embedded processes for identification of potential organ donors within the Trust, timely referral and provision of support for clinical teams and families by specialist nurses.
- In 2014/2015 82% of identified potential donors were referred for consideration of organ donation, we now refer 100% of potential donors (UK 94%).
- In 2014/2015 80% of families approached to offer organ donation were supported by a specialist nurse, in 2018/2019 this was 100% (UK 91%).
- In 2018/2019 25 people received a life-saving or life-changing transplant as a result of donation from patients cared for in our Trust.

Implications and Future Action Required

1. Maintaining 100% referral and specialist nurse involvement
2. Training/education for junior doctors as critical care rotations become shorter
3. Public engagement re Deemed Consent (Spring 2020)
4. Medical education re Deemed consent (Spring 2020)

Recommendations
The Board is asked to receive this report as a source of assurance regarding the quality of organ donation activities in the Trust.
Impact Upon Strategic Objectives
N/A
Impact Upon Corporate Risks

N/A
Regulatory and/or Legal Implications
N/A
Equality & Patient Impact
N/A

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

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

APPENDIX I

Actual and Potential Deceased Organ Donation 1 April 2018 - 31 March 2019

NHS Blood and Transplant

Gloucestershire Hospitals NHS Foundation Trust

Taking Organ Transplantation to 2020

In 2018/19, from 16 consented donors the Trust facilitated 11 actual solid organ donors resulting in 25 patients receiving a life-saving or life-changing transplant. Data obtained from the UK Transplant Registry.

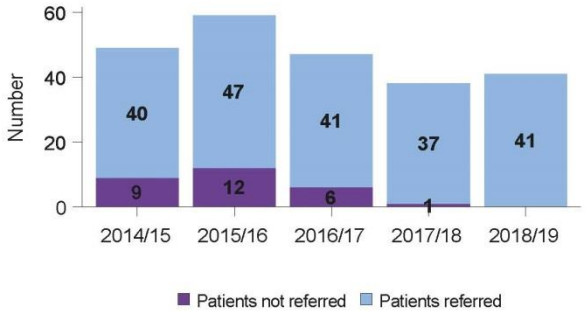
In addition to the 11 proceeding donors there were 5 consented donors that did not proceed.

Best quality of care in organ donation

Referral of potential deceased organ donors

Goal: Every patient who meets the referral criteria should be identified and referred to NHS Blood and Transplant's Organ Donation Service

Aim: There should be no purple on the chart

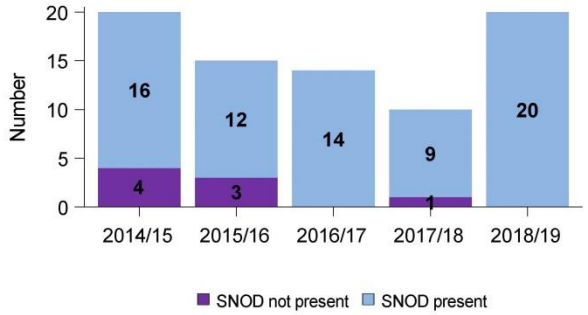


The Trust referred 41 potential organ donors during 2018/19. There were no occasions where potential organ donors were not referred.

Presence of Specialist Nurse for Organ Donation

Goal: A Specialist Nurse for Organ Donation (SNOD) should be present during every organ donation discussion with families

Aim: There should be no purple on the chart



A SNOD was present for 20 organ donation discussions with families during 2018/19. There were no occasions where a SNOD was not present.

Why it matters

- If suitable patients are not referred, the patient's decision to be an organ donor is not honoured or the family does not get the chance to support organ donation.
- The consent rate in the UK is much higher when a SNOD is present.
- The number of patients receiving a life-saving or life-changing solid organ transplant in the UK is increasing but patients are still dying while waiting.

Regional donors, transplants, waiting list, and NHS Organ Donor Register (ODR) data

	South West*	UK
1 April 2018 - 31 March 2019		
Deceased donors	124	1,600
Transplants from deceased donors	317	3,943
Deaths on the transplant list	26	403
As at 31 March 2019		
Active transplant list	418	6,083
Number of NHS ODR opt-in registrations (% registered)**	2,681,510 (49%)	26,496,220 (41%)

*Regions have been defined as per former Strategic Health Authorities
** % registered based on population of 5.47 million, based on ONS 2011 census data

Further information

Further information on potential donors after brain death (DBD) and potential donors after circulatory death (DCD) at the Trust are shown below, including a UK comparison. Data obtained from the Potential Donor Audit (PDA).

Key numbers comparison with UK data, 1 April 2018 - 31 March 2019

	DBD		DCD		Deceased donors	
	Trust	UK	Trust	UK	Trust	UK
Patients meeting organ donation referral criteria[1]	7	2004	34	5974	41	7728
Referred to Organ Donation Service	7	1982	34	5539	41	7287
Referral rate %		*99%*		*93%*		*94%*
Neurological death tested	7	1715				
Testing rate %		*86%*				
Eligible donors[2]	7	1635	26	4180	33	5815
Family approached	7	1493	13	1752	20	3245
Family approached and SNOD present	7	1423	13	1527	20	2950
% of approaches where SNOD present		*95%*		*87%*		*91%*
Consent ascertained	6	1082	10	1099	16	2181
Consent rate %		*72%*		*63%*		*67%*
Actual donors (PDA data)	5	970	6	612	11	1582
% of consented donors that became actual donors		*90%*		*56%*		*73%*

[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

Note that a patient that meets both the referral criteria for DBD and DCD organ donation is featured in both the DBD and DCD data but will only be counted once in the deceased donors total

For further information, including definitions, see the latest Potential Donor Audit report at www.odt.nhs.uk/statistics-and-reports/potential-donor-audit/

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE TRUST BOARD HELD IN THE LECTURE HALL, REDWOOD EDUCATION CENTRE, GLOUCESTERSHIRE ROYAL HOSPITAL ON THURSDAY 13 JUNE 2019 AT 12:30

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

PRESENT	Peter Lachecki	PL	Chair
	Deborah Lee	DL	Chief Executive
	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
	Mark Pietroni	MP	Director of Safety and Medical Director
	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
	Balvinder Heran	BH	Non-Executive Director
	Alison Moon	AM	Non-Executive Director
	Mike Napier	MN	Non-Executive Director
APOLOGIES	Rachael De Caux	RD	Chief Operating Officer
	Sarah Stansfield	SS	Director of Finance
IN ATTENDANCE	Marie-Annick Gournet	MAG	Associate Non-Executive Director
	Suzie Cro	SC	Deputy Director of Quality
	Bilal Lala	BL	Associate Non-Executive Director
	Craig Macfarlane	CM	Head of Communications and Marketing
	Jonathan Shuter	JS	Director of Operational Finance
	Felicity Taylor-Drewe	FTD	Director of Planned Care and Divisional Director Surgery
			Matrons

PUBLIC & PRESS 2 members of the public

The Chair welcomed all to the meeting with a special introduction to Balvinder Heran who has recently joined the Trust as a Non-Executive Director.

145/19 DECLARATIONS OF INTEREST **ACTIONS**

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

146/19 PATIENT STORY

SH introduced the Matrons who had come to the Board to present their story. SH said he was very proud to officially 'launch' the Matrons and handed over to Fran Wilson, Jo Harvey and Claire Powell, who described their role and presented some of the work the team had been doing over the last 12 months.

It was noted that back in December 2017, SH had met with the Matrons to discuss their role in terms of visibility, leadership and future ambitions but also to hear the concerns about lack of authority and lack of identify within the Trust at the time. In order to support this work, SH commissioned the Foundation of Nursing Studies to facilitate several sessions with the Matrons in order for them to realise their ambition and potential and agree upon their shared vision for their role.

CP presented the results of her research into the role of Matron, noting that:

- Matrons felt that the continually shifting operational boundaries within the NHS impact their ability to be effective
- The role is complex and unclear
- The extent of authority and resources they command is variable
- Administrative aspects of the role take up significant amount of time
- Matrons in the Trust are viewed as effective, supportive, approachable leaders

In response:

- MN asked whether the Operational Matrons Group (OMG) had had any success with eliminating or reducing non-value adding activities and if there was anything the Board or Executives could do to help. The matrons felt that it was early days but it has helped them to identify where the issues were and think about whether the meetings they were attending were essential or not. SH said that the matrons had agreed operational and quality priorities focusing on outstanding patient experience but it was up to the team to decide what the "drum beat" was and what it should feel like.
- LB praised the Matrons for their role in running the hospital when on the silver On-Call rota
- AM noted the power of the group to affect change and applauded the team on what they were trying to do. AM recognised that clarity on Matrons' authority, responsibility and decision making was really important. AM felt that there had to be divisional and executive buy-in to Matrons' visions. SH said that a discussion had already taken place to clarify that when matrons are in their divisions they had divisional responsibilities but when they come together at OMG they become an extended corporate team and the Chief Nurse's 'eyes and ears'.
- BH recognised the importance of visibility, which the new uniform provided. Referring to the Matrons' ambition to work better across sites, BH asked whether the next steps might include developing a digital matron concept. MH described the involvement of matrons in the digital programme and the Chief Nurse Information Officer role.
- PL made three observations: Firstly, the Matrons' ambition, their constructive dissatisfaction with the status quo and the ambition to step up and lead was excellent. Secondly, PL acknowledged Matrons visibility and involvement in leadership events and activities of the Trust. Thirdly, PL encouraged the team to make sure they get to where they want to go; a lot of the hard work has been done and there will be both easy and tough conversations with the senior nursing team. PL said that the team had the Board's support and he looked forward to seeing the Matrons' vision become a reality.

PL thanked the team again for taking time to come to talk to the Board.

147/19 MINUTES OF THE MEETING HELD ON 9 MAY 2019

RESOLVED: That the minutes of the Board meeting held on 9 May 2019 be agreed as a correct record and signed by the Chair.

148/19 MATTERS ARISING

APRIL 2019 115/19 2019/20 PLAN – CF ASKED WHETHER THE QUALITY AND PERFORMANCE COMMITTEE COULD RECEIVE INFORMATION ON HOW THE 2019/20 PLAN WOULD IMPACT PERFORMANCE AND RECOVERY ASSUMPTIONS.

Completed: DL advised that this has been presented to the May Finance and Digital Committee.

MAY 2019 131/19 GUARDIAN REPORT ON SAFE WORKING HOURS FOR DOCTORS AND DENTISTS IN TRAINING

- **MP NOTED THAT NON-DEANERY POSTS WERE EXCLUDED FROM THE DATA**
- **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.**

Completed: The Board noted that there was further work still to be done in respect of the long-standing medical vacancies and it was agreed that this should be discussed in more detail at the People and Organisational Development Committee. MP advised that the biggest gap was around the surgical mid-grades which was structural; MP had asked the surgical division to come back with a plan but noted that this issue was at the heart of the reconfiguration proposals. **EW**

MAY 2019 143/19 PEOPLE AND OD STRATEGY

Completed: Agreed that the launch of the People and OD Strategy would take place at the next 100 Leaders. The Strategy was very well received at the Trust Leadership Team last week and importantly through the work that EW had led, which had created a template for future enabling strategies.

149/19 CHIEF EXECUTIVE'S REPORT

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

In response:

- PL congratulated DL on her third work anniversary and thanked her for her contribution to the significant development of the Trust in that time.
- AM recognised how well received the Health and Well Being Hub had been. AM was particularly keen to know whether the contacts made with the hub during the first month pointed to any particular trends. EW said that analysis had already commenced and the results would be discussed at the People and OD Committee; that said, over 70 people had contacted the Hub with around 50% were regarding mental health issues.
- AM asked how the Integrated Care System Board came up with the four priority areas (circulatory disease, respiratory care, diabetes and frailty including dementia) referenced in the report. DL said it was a combination of data and the views of Clinical Programme Board but importantly reflect the drivers of the long term plan to close the gaps around quality, outcomes, inequalities and finance. DL said that the ICS Board had acknowledged that there were additional "golden threads" which ran throughout all the priority areas in respect of learning disability, mental health and end of life care. PL noted that as yet the ICS had not resolved how the Health and Well Being Board priorities align to the ICS Board but this was under discussion.
- CF noted the feedback received from NHSI on its Operational Plan and in particular the 52ww challenge. CF asked what gave the executive team confidence that the challenge can be addresses. FT-D agreed that a lot of work had been done in terms of ensuring that we understand and can diagnose the issues. It had taken the Trust a considerable time but now the Trust had a drum beat in terms of the monthly reporting cycle and an understanding of stabilising our position in respect of our waiting lists. Through the contract negotiation the Trust had secured non-recurrent

funding to specifically target key specialties; additional, non–recurrent capacity for the key specialities of lower and upper GI will be put in place. There were some expected process issues and some of that is in a specific 52ww plan which is currently being reviewed by NHSI. NHSI had offered their support with appropriate critical challenge of the pathways.

- FTD added that the data quality issues were significantly improved however she noted the risk of long waiting patients being identified through on-going validation. DL said that the challenge was also a cultural one, as this scenario of long waiting patients had been potentially 'normalised' so the Trust's challenge now was how we ensure that clinicians and managers show complete intolerance of long waits. A session with clinical leaders and speciality directors would be taking place on 21st June wand will specifically focus on 52ww.
- PL had heard that the NHSI capital review would now not be part of the Autumn Spending Review. If it were to be the case, what would the implications be for the Trust? JS agreed that it was not a helpful outcome to the overall capital framework and presented a further period of uncertainty. In response, work was underway to look at alternative routes to capital and this was to be discussed further at the Finance and Digital Committee. DL said she had been recently advised by a senior colleague that the STP capital funding £39.5M was ring fenced and would remain so but she had written to Elizabeth O'Mahoney, Regional Director SW on this matter. DL felt that the digital capital funding (electronic prescribing - EPMA) that we are awaiting was more concerning as this is not ring fenced. **JS/SS**
- PL asked whether Elizabeth O'Mahoney would be developing a regional NHSE/I strategy. DL did not think so, as the regional directors operated within a centrally-set framework. That said, under Amanda Pritchard, new joint NHSE/I COO, it could all change; DL added that she could not recollect an era when a regional director produced a strategy because their role had always been to regulate, oversee etc. DL thought that while there might not be a regional strategy, hopefully what the Trust would get is some clarity around direction and priorities.

150/19 TRUST RISK REGISTER

LB presented the Trust Risk Register, noting that following the last meeting of the Trust Leadership Team (TLT) one new risk (updated from prior year) had been added 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.

LB further advised that the 2018/19 finance risks would be formally closed in the next reporting cycle.

In response:

- CF asked what the process was to keep updates current so that it confirmed the extent of regular executive, Trust Leadership Team and Risk Management Group's oversight. LB briefly described to the Board the risk management processes. LB said that the risks reflected the position agreed at TLT earlier this month. LB committed to working with risks owners to further update the controls and actions/mitigations. **LB**
- DL stated that the Trust had recently lost capacity within the risk management function, following the retirement of the previous Risk Manager, and she felt this was now becoming an issue. LB had been picking up work in this area but it was not his role. With LB leaving the Trust and the re-organisation of his portfolio, there was an opportunity to address the capacity issues.

- Referring to DL's update regarding capital funding, and in particularly the uncertainty of EPMA, BH asked whether those risks should be reflected on the Risk Register. DL said that the Trust had actually recognised the risks and found another source of funding in anticipation so the programme was not affected. She added, that the current programme also reflected priority setting to manage a scenario in which the NHSI loan application was not successful.

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 change to the Trust Risk Register as set out.

151/19 QUALITY AND PERFORMANCE:

ASSURANCE REPORT OF THE CHAIR OF THE QUALITY AND PERFORMANCE COMMITTEE - MEETING HELD ON 29 MAY 2019

AM presented the assurance report from the May Quality and Performance Committee, highlighting the following points:

- an important workforce review of adult inpatient staffing levels was presented by SH. It was an excellent report which provided significant assurance; it was well thought through in terms of the national context and the methodology around staffing levels, and SH's recommendation of priority areas and staffing investment. AM felt that the report needed to go to the People and OD Committee as well as the Quality and Performance Committee because of the staffing implications. **CP** for work plan

AM said that the Committee received a good briefing paper on the systems in place at the Trust to receive and act on national *Safety Alerts* which had provided welcome assurance.

The Quality and Performance report was discussed in detail; there had been an issue about out of date policies for some time now standing at 113 and the ambition to have no more than 50 was questioned. There was also a proposal for the extension (through negotiation) of complaint response times from 35 day standard to 65 days in a small number of the most complex cases. The Committee had sought assurance that would not become the norm and the Committee would retain oversight of this through monitoring of response times.

AM further advised of a discussion on the ICS Urgent and Emergency Care Summit and subsequent meeting to agree three opportunities for 'positive risk taking'. A session was being convened on the 1st July re this topic.

In response:

- SH clarified that the proposed change to complaints response times was for a very small number of the most complex complaints which often require a multi-specialty and sometimes multi agency response. SH advised that the Head of the Complaints reports weekly on activity generally so he will be assured through this route we do not have an adverse shift in our response times. DL asked for the number of 35+ responses, by time series, be included in the monthly quality dashboard. **SH**

RESOLVED: That the report be received as assurance of the scrutiny and challenge undertaken by the Committee.

QUALITY AND PERFORMANCE REPORT

SH said that the report was still developing and thanked FTD's and the

Business Intelligence teams for their support with improving the report.

SH advised the Board of his concerns in relation to pressure ulcers; this would be reviewed at the Quality and Performance Committee in due course and the Board would be assured on the actions. **CP** for work plan

In response:

- Commenting on the development of the report, CF said that the analysis, particularly of the summary scorecard data, was still missing. CF was reviewing the material to see if it was internally consistent; for example, in the effective domain on the summary scorecard (page 6), the Trust rated itself 'Amber moving into Green' based on the selected indicators. However, CF felt there were quite a substantial number of reds, which seemed to be significant care areas. CF felt they did not feed up in to the summary. CF asked SH to make sure the summary judgements were consistent with the underlying data and to make clear the key messages. SH said that an algorithm produced the summary ratings. SH thanked CF for her observations which were very helpful and that the Trust would give further though to how the information is pulled through to the summary scorecard.
- DL asked about the dementia metric and the recorded poor performance and asked how the Trust was addressing this given it was a legacy from the 2016 TrakCare deployment. SH said that despite fairly extensive conversations over the past 18 months, the Trust was still struggling to be able to put the dementia screening into the 'workflow' which meant that the information was not easily captured. Currently, we were capturing this through a paper form. The Trust changed the medical staffing form to ensure that every patient who met the criteria would have the assessment. Moving forward the Trust would be doing a monthly audit rather than using TrakCare which would provide information more reflective of practice. DL asked why we do not report from the paper audit; SH replied that we had had some guidance from NHS England which cautioned against it. DL suggested that the Trust needed to understand how many patients had been screened and not how many were put on to Trak as this was a completely different question; this should be done even if the Trust had to have a second report. SH to brief DL outside of the Board in respect of the NHSI guidance but in interim, data to be included in Board report from monthly audit. **SH**
- RG commended the evolution of the Quality and Performance Report. RG queried why some of the trend charts had little data. RG also suggested it would be helpful for the report to detail the status of key enablers. RG asked whether in a situation where a major indicator is consistently not met for 'x' number of months, should it be subject to review as a point of principle. SH responded that this had been done in the previous year, for example deep dives were performed for indicators that had three months of red rating. SH mentioned the performance framework being established as part of the executive review process, which would generate the information necessary to prompt data reviews for indicators that have fluctuated. SH noted that moving forward Statistical Process Control (SPC) or 'run' charts would be the next iteration which would indicate whether changes were statistically significant. SH added that there were 'to be confirmed' (TBC) tags for some standards on the report and he explained that some indicators had no national standard and that we were recording our own data to get a sense of the Trust's performance and to inform a future trajectory.
- AM seconded RG's observation. Regarding stroke services and bed capacity on the stroke unit, she expressed concern about the equity of how the Trust considers patients who have had a stroke, patients who have had

a heart attack or patients who need another form of intensive care; unlike the reporting concerning stroke patients, the report did not detail the amount of patients who have had an acute cardiac event but did not get into the cardiac unit. SH advised that access to a stroke bed was a nationally defined standard reflecting the evidence base but similar standards did not yet exist for other conditions. He also added that the opening of the Community Specialist Stroke Unit was expected to reduce the pressure on acute stroke beds.

- DL noted that it was good to see the benchmarking and ranking. PL said he would like to see more detail on understanding, perhaps through exception reports to the committee, on what had been done in the peer groups who were high performing. FTD confirmed that this was done at a number of levels and she noted that through the shadow indicators they were already trying to benchmark against other Trusts to see how much improvement was necessary, for example, the urology pathway from the Marsden was now being adopted in the Trust following a review of their approach.
- BL asked why some data in the report was un-validated. FTD said that it was a timing issue: the 62 day wait had a time lag. DL clarified that previously un-validated data should be refreshed in subsequent months' reports which is was not currently. FTD agreed to address. **FTD**

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

LEARNING FROM PATIENT STORIES

SC presented the learning from patient stories, highlighting the following points:

- The aim of the paper was to indicate how the stories had fed into the Trust's improvement work.
- The improvement within the Patient Advice and Liaison Service (PALS), the re-framing of their role as improving patient experience in real time, and the improved relationship between PALS and divisions.
- Following the February session on achieving 'Good', SC noted the importance of telling positive stories. She noted her work with the chaplaincy team to promote the service as a listening service.
- The story from a local GP would be filmed.

In response:

- MN thanked SC and said that he was not surprised to see the PALS team moving form strength to strength. He noted that there was a discussion about rebranding the PALS team as 'Patient Feedback Hub' which he thought sounded too passive. DL agreed. SC said that the PALS name would remain but Patient Feedback Hub would be an aspect of the team's work. MN challenged the service to have a name that was more bold and action-orientated. SC said it would be discussed with patients and their view would be paramount. **SC**
- CF commended the report for honouring the stories. Referring to the ligature risks, CF asked whether there was confidence that ligature risks are captured and that the Trust responds appropriately. SH said that the ligature risk was subject of a Patient Safety Alert and that through Carole Webster's leadership, a risk assessment was being carried out; the national requirement was to identify wards with high risk patients (which included AMU). SH acknowledged there was more work to do but the Trust was moving forward with respect to ligature risks; SH also noted the strategic aspects of this work, namely safety by design in future buildings.

- PL thanked SC for her contribution and for taking a holistic approach; he said it was unusual for patient stories to drive improvement to such an extent. PL invited the Board and governors to make suggestions to SC if there were any topics they would like to see covered in future sessions.

RESOLVED: That the Board note the report.

152/19 FINANCE AND DIGITAL

ASSURANCE REPORT OF THE CHAIR OF THE FINANCE COMMITTEE - MEETING HELD ON 30 MAY 2019

RG presented the assurance report, highlighting the following points:

- Financial performance in the first month of 2019/20 was on target, but advised against complacency as the achievements required over the next 11 months were significant. Referring to budget-setting, he acknowledged that the involvement of the whole organisation in the process had increased significantly.
- He recognised the magnitude of the challenge of the Cost Improvement Programme (CIP), which had a reasonable target for 2019/20 but current CIP delivery and identification was concerning.
- He commended the summary of the commissioning contracts and the supporting data. He said it was a useful tool for the committee and suggested reviewing the progress against mid-way through year to test the underlying assumptions - variance in that area could impact the outturn.
- Finally, he noted the disappointing and unusual situation concerning the Trust's external audit of the 2018/19 accounts, which had not been signed off by the external auditors yet. This had required the finance team to have undertaken a lot of additional work. This reflected performance issues within EY, and not any issues with the Trust's finance team. The Trust will be considering its response in due course but the current priority was to secure an audit opinion.

RESOLVED: That the report be received as assurance of the scrutiny and challenge undertaken by the Committee.

FINANCIAL PERFORMANCE REPORT

JS presented the financial performance report, highlighting the following points:

- The Trust reported a positive position against the plan with a £4.3m deficit, which was £0.1m better than the plan. This largely reflected an underspend on pay but there was risk that this wouldn't continue as recruitment kicked in.
- The CIP was also ahead of plan but he noted that the challenge was located predominantly in the second half of the year and he was very concerned about the low level of CIP delivery currently predicted.
- Concerning cash, there was a constant conversation with NHS Improvement (NHSI) around the drawdown of cash to ensure the Trust could meet its commitments and service the capital programme. He had no concerns about cash at the moment.
- The Trust was slightly behind plan in month 1 concerning capital: reporting a position of £0.7m against a plan of £1.6m. This was largely due to the timing of capital commitments and it was expected the plan would recover. He also advised that the Capital Control Group had been 'refreshed' and there was a clear focus on spend profile.
- The capital plan was contingent on a loan application of approximately £7.5m. However, a significant part was self-financed, which was being progressed.

- In terms of the budget setting progress, a large effort had been made regarding budget holder engagement. 97% had been signed off and the team were committed to resolving the remaining 3% in June and were meeting with budget holders to understand concerns. This had been a very positive process.

In response:

- Referring to page 6 of the report, BL noted the current liabilities of £53-54m, which were growing. He asked what was in there and what provided assurance that there would not be a future cash flow problem. JS responded that outstanding creditors were listed in there, whether trade creditors or other. JS said that the Finance and Digital Committee had discussed the financial plan and the ability to drawdown cash. JS said that the plan was underpinned by working capital and there was a monthly process to drawdown cash to meet the commitments, so the cash position was constantly reviewed. BL asked whether any issues were foreseen as the drive continues to adhere to the Better Payment Practice Code. JS expressed confidence in the process with NHSI and that the Trust would continue to service and meet its obligations. DL added that the Trust had moved from a historic position of 30% being achieved in terms of the payment code to 90% +. JS noted that there was the odd month where cash flow had been managed through slight manipulation of payment periods and that this was very openly reported to the Finance and Digital Committee if it occurred.
- PL commended the improvement in the budget setting process. Regarding CIP, he asked whether more support was needed from the Board or Executive colleagues to put together a plan to address the scale of the challenge. JS expressed confidence in the processes in place, led by Jo Burrows, to drive it through the organisation. JS noted that the challenge had been addressed through TLT and divisions, and the plan was reported to the Finance and Digital Committee. DL reflected that the previous two years of having 6% CIP targets would always make year 3 difficult and there was a sense of 'having hit a brick wall' within divisions. Additional interim CIP delivery support had been retained and Mr Phil Church would be joining the team in July. DL noted that divisions were moving away from over reliance on the Model Hospital benchmarks - as these opportunities had been exploited - and towards reference costing indices. DL noted that, although the Trust reference cost indices (RCI) were favourable, showing the Trust to be a relatively efficient organisation, there were service lines with a high RCI. DL added that a mitigation plan had been requested to address a scenario where the full CIP plan was not delivered. This would be discussed at the Finance and Digital Committee in June.
- Regarding culture, DL noted the 13 people were still engaged in the conversation to understand their budget and said that it was testament to the impact of the 'Count me in' programme and the improved culture that the staff felt able to debate their budget. MN added that high level sign off and engagement was considered best practice in the private sector.

RESOLVED: That the Board note the report.

153/19 AUDIT AND ASSURANCE COMMITTEE

ASSURANCE REPORT OF THE CHAIR OF THE AUDIT AND ASSURANCE COMMITTEE MEETING HELD ON 21 MAY 2019

RG reported the key messages from the May Audit and Assurance Committee

Chair's report. He highlighted the following points:

- The Internal Auditor's annual opinion was 'moderate assurance'. RG explained that this was encouraging and should be recorded favourably for a number of reasons: the opinion was 'limited' the year before; the committee had worked with the auditors to direct them to areas that the Trust believed merited closer investigation; it reflected work done by the executive team to make changes as there had been a historical backlog of unimplemented changes which was now addressed.
- The internal audit on divisional governance, whilst it had a reasonable rating, pointed to inconsistencies across the organisation which the Executives were already addressing.
- The external auditors were relatively favourable at the meeting; however this has since changed for reasons covered in the Chair's report from the Finance and Digital Committee. From an assurance point of view, there was no suggestion that the audit would come up with anything other than a positive opinion, it was just not finished yet.
- There was a report from Gloucestershire Managed Services (GMS), which represented a more formal process involving a paper from the Finance Director of GMS. RG noted this was a positive step forward in terms of oversight as a Group Audit and Assurance Committee.

PL thanked RG for his contribution as Chair of Audit and Assurance Committee and welcome CF to the role.

RESOLVED: That the report be received as assurance of the scrutiny and challenge undertaken by the Committee.

GOVERNANCE DOCUMENTS

LB presented the governance documents for approval, highlighting the following points:

- 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 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 Scheme of Delegation was approved in February with the exception of the sections relating to the Estates and facilities Committee.

The Board was 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)

In response:

- AM noted that there was no reference to University Hospital status in the People and OD Terms of Reference. DL said that this reflected the fact that there was no business case yet regarding this and that it was aspirational. The People and OD Committee would receive the business case for this in August.
- MAG asked whether a reference to staff wellbeing should be included in the People and OD Terms of Reference. EW agreed and would add. **EW**
- SH noted that the Estates and Facilities Committee did not have an executive with a clinical background as member, unlike the other Board committees. The Board agreed this should be considered and DL agreed to discuss this with the Executive team. **DL**
- CF asked whether the Board was content with the wording around the oversight of external audit performance in the Audit and Assurance Committee Terms of Reference; the ToR mentioned an annual review and CF questioned whether more detail was needed. RG replied that the annual review was typically conducted once the audit was over. DL noted that the language did not specify the timescale. She added that there were key relationships between three executives and the auditors which provided the opportunity for a constant dialogue about performance if there were any concerns, which would then be escalated to the committee. Agreed no change required.
- In relation to the Remuneration Committee powers referenced in the Scheme of Delegation, DL queried whether 9.1 reflected the Constitution as it did not reflect practice: in practice the Remuneration Committee did not appoint candidates for executive positions; appointment panels did. The Board agreed that this practice was correct and the ToRs should be amended. LB agreed to ensure the Constitution reflected this point and LB would update the Scheme of Delegation accordingly. **LB**
- PL thanked LB and RG thanked Cecile Price, Corporate Governance Trainee for the work on the governance documents.

RESOLVED: That the Board approve the governance documents subject to the above amendments.

154/19 GOVERNOR QUESTIONS

- AT congratulated DL on her third anniversary and reflected on her very positive contribution.
- AT remembered, the chaplaincy volunteer who had recently passed away; the volunteer presented his patient story to the Board earlier this year but had sadly passed away.
- AT said the quarterly patient story update was a very useful document, as it showed something was done in response to the stories. AT asked whether Joining Up Your Information (JUYI) had been implemented in Accident and Emergency as regards mental health information. MH confirmed that JUYI was being used successfully. DL cited an example of when she witnessed an ED practitioner using JUYI to see the mental health records of a patient being cared for by 2gether Trust.
- With regards to PALS, AT noted that was good to talk to patients but it was also good to listen to patients.
- AT had some concerns around the complaints response time changes from 35 to 65 days, however he was reassured that it was just for complex cases. However, AT was further concerned that there were 1-2 such cases a week, which seemed a high number. AT asked for assurance that patients/complainants in complex cases would be

informed at some point that a response would take longer than might be expected. SH confirmed that it would be the case, adding that the time for response would be negotiated with the patient and it would be clear that the response time would not exceed 65 days but every effort would be made to respond sooner. DL reiterated that she had asked for a measure of this to be included in the quality and performance report.

- AT raised a concern that governors of both Foundation Trusts in Gloucestershire were not represented in the Integrated Care System (ICS) structures. AT had previously raised this issue but he was yet to receive a response. AT requested backing from the Board that governors, the only elected representatives of the public, should be at least part of this system which was determining priorities for the next 5-10 years. AT was also disappointed not to see any reference to mental health amongst the priorities. PL said that he had raised the issue of governor representation, with the ICS Board and at a strategic stakeholder event. PL agreed to raise it again with Nick Relph, ICS Chair, and Ellen Rule, ICS Programme Director, at the July Board Strategy and Development session. DL added that she had assumed that governors were on the stakeholder group that meets quarterly and asked if this was correct. AT replied that Governors were not formally involved. DL said that at a OnePlace Business Case system meeting the previous week, the Consultation Institute noted that two ICS partners were Foundation Trusts, and as such had an obligation to reflect both governors' and members' voices in the governance arrangements. DL agreed to take this back to the ICS Executive, where governor involvement could be discussed prior to going to the ICS Board. AT said that he felt that the two Lead Governors should be involved in the ICS decisions concerning priorities. PL mentioned the NHS Providers' blog described the role of governors in ICSs and pointed out that he had brought it to the ICS leaders' attention.
- Referring to the discussion about external audit, AT said that it was the governors' responsibility to appoint and remove, if necessary, the external auditors. He noted the responsibility of external auditors to report to the Council of Governors, which had not happened for a couple of years. AT would discuss with PL the external auditors' attendance at the Council of Governors or Annual Members Meeting. RG noted that the external auditors had presented to the Council of Governors last year and that the Audit and Assurance Committee Chair would approach the Governors to discuss any action that the Trust intended to take in response to the audit delay; this would be done in concert with the Executive leads.

155/19 STAFF QUESTIONS

There were none.

156/19 PUBLIC QUESTIONS

PL advised the Board that a public question was received from Bren McInerney. The question and the Trust response were included in the papers.

PL noted that congratulations were in order to Mr McInerney who had been recognised in Her Majesty's Birthday Honours list for his services to volunteering.

157/19 NEW RISKS IDENTIFIED

There were none.

158/19 ITEMS FOR THE NEXT MEETING

There were none.

159/19 TRUST BOARD WORK PLAN

LB advised the Board that following the approval of the corporate strategy, enabling strategies would be presented to relevant committees for approval and then the Board for information. The work plans have been updated to reflect this.

160/19 ANY OTHER BUSINESS

EW mentioned the junior doctors' contract being refreshed and renegotiated, which would go live in August 2019 although national publication suggested it would be phased implementation until August 2020. Her team was working through the implications for the Trust regarding changing rotas and pay enhancements; she was unsure how the changes would be funded yet but would keep the Board informed on any risks that arose.

EW noted that the Interim NHS People Plan was published last week. The Plan outlined what would be done in 2019/20 from the 'centre' and system perspective. There was nothing in the Plan which EW believed the Trust had not considered.

DATE OF NEXT MEETING

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

EXCLUSION OF THE PUBLIC

RESOLVED: That in accordance with the provisions of 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
11 July 2019

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

TRUST BOARD – JULY 2019

MATTERS ARISING

CURRENT TARGETS

Target Date	Month/Minute/Item	Action with	Issue	Action	Update
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.	*Completed. Principal risk added and discussed at June Board Strategy and Development session. New BAF on the agenda.*
July 2019	June 2019 – 148/19 Matters Arising	**EW**	The Board noted that there was further work still to be done in respect of the long-standing medical vacancies.	It was agreed that this should be discussed in more detail at the People and Organisational Development Committee.	*Completed: The long term vacancies are included in the People and OD performance dashboard and in August a paper on 'sustainable workforce' will be presented to provide further in depth assurance on the actions we will take and their impact on this position.*
July 2019	June 2019 – 149/19 Chief Executive's Report	**JS/SS**	PL had heard that the NHSI capital review would now not be part of the Autumn Spending Review. If it were to be the case, what would the implications be for the Trust? JS agreed that it was not a helpful outcome to the overall capital framework and presented a further period of uncertainty.	In response, work was underway to look at alternative routes to capital and this was to be discussed further at the Finance and Digital Committee.	
July 2019	June 2019 – 150/19 Trust Risk Register	**LB**	CF asked what the process was to keep updates current so that it confirmed the extent of regular executive, Trust Leadership Team and Risk Management Group's oversight.	LB committed to working with risks owners to further update the controls and actions/mitigations.	*Completed. Changes made and agreed at the Trust leadership Team on 3rd July – see Trust Risk Register paper.*

			LB briefly described to the Board the risk management processes. LB said that the risks reflected the position agreed at TLT earlier this month.		
July 2019	June 2019 – 151/19 Assurance Report of the Chair of the Quality and Performance Committee – Meeting Held on 29 May 2019	**SH**	SH advised that the Head of the Complaints reports weekly on activity generally so he will be assured through this route we do not have an adverse shift in our response times.	DL asked for the number of 35+ responses, by time series, be included in the monthly quality dashboard.	*<u>Completed:</u>* *The data is being collected and dashboard development in progress, expected completion in August.*
July 2019	June 2019 – 151/19 Quality and Performance Report	**SH**	DL asked why we do not report from the paper audit; SH replied that we had had some guidance from NHS England which cautioned against it. DL suggested that the Trust needed to understand how many patients had been screened and not how many were put on to Trak as this was a completely different question; this should be done even if the Trust had to have a second report.	SH to brief DL outside of the Board in respect of the NHSI guidance but in interim, data to be included in Board report from monthly audit.	*<u>Completed:</u>* *Monthly manual audit agreed to be completed by Quality Improvement and safety team*
July 2019	June 2019 – 151/19 Quality and Performance Report	**FTD**	BL asked why some data in the report was un-validated. FTD said that it was a timing issue: the 62 day wait had a time lag. DL clarified that previously un-validated data should be refreshed in subsequent months' reports which is was not currently.	FTD agreed to address.	*<u>Completed:</u>* *Included in the Quality and Performance Report.*

July 2019	June 2019 – 151/19 Learning from Patient Stories	**SC**	MN noted that there was a discussion about rebranding the PALS team as 'Patient Feedback Hub' which he thought sounded too passive. DL agreed. SC said that the PALS name would remain but Patient Feedback Hub would be an aspect of the team's work. MN challenged the service to have a name that was more bold and action-orientated.	SC said it would be discussed with patients and their view would be paramount.	*<u>Completed:</u>* *The service manager is currently doing some market research around the name "PALs" with patients and SC will report at the next Patient Experience Board Story update.*
July 2019	June 2019 – 153/19 Governance Documents	**EW**	MAG asked whether a reference to staff wellbeing should be included in the People and OD Terms of Reference.	EW agreed and would add.	*<u>Completed:</u>* *People &OD ToR updated.*
July 2019	June 2019 – 153/19 Governance Documents	**DL**	SH noted that the Estates and Facilities Committee did not have an executive with a clinical background as member, unlike the other Board committees.	The Board agreed this should be considered and DL agreed to discuss this with the Executive team.	*<u>Completed:</u> Discussed Executive Triumvirate and agreed that priority for clinical representation is GMS Contract Management Group and given current Chief Operating Officer is a clinical professional, it was agreed that current arrangements are satisfactory.*
July 2019	June 2019 – 153/19 Governance Documents	**LB**	In relation to the Remuneration Committee powers referenced in the Scheme of Delegation, DL queried whether 9.1 reflected the Constitution as it did not reflect practice: in practice the Remuneration Committee did not appoint candidates for executive positions; appointment panels did. The Board agreed that this practice was correct and the ToRs should be	LB agreed to ensure the Constitution reflected this point and LB would update the Scheme of Delegation accordingly.	*<u>Completed.</u>* *The Constitution does not describe the role of the Remuneration Committee in detail; it states: "The Trust shall establish a committee of Non-Executive Directors to decide the remuneration and allowances and the other terms and conditions of office of the executive Directors."*

			amended.		*However, the Remuneration Committee Terms of Reference agreed by the Board in February 2019 state that the Committee: 'Appoint[s] candidates to fill all the Executive Director positions on the Board.* *This provision has now been removed from the ToR and the Scheme of delegation has been amended accordingly.*

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

TRUST BOARD – July 2019

CHAIR'S ACTIVITIES UPDATE

In order to present a snapshot of the wider perspective of Chair activities undertaken, a written summary is presented at Public Trust Board meetings on a quarterly basis. This excludes regular meeting attendances at Board, Council of Governors, Board Committees and 1:1s with Directors and Governors. Period from 2nd April to 3rd July 2019.

Trust Activities

DATE	EVENT
3 4 19	Meeting with Nick Relph – Interim Chair of Integrated Care System (ICS)
17 4 19	Gloucestershire Royal Hospital Volunteers' lunch with Bishop Rachel
23 4 19	Renal Consultants recruitment panel
29 4 19	Board Development day
30 4 19	100 Leaders event
10 5 19	Non-Executive Director vacancy candidate meeting
22 5 19	Trust Governors' and Non-Executive Directors' – University of Gloucestershire evening
30 5 19	Chief Executive's appraisal and development meeting
6 6 19	Volunteers' Tea at Cheltenham General Hospital
12 6 19	Non-Executive Director recruitment shortlisting panel
17 6 19	Part attendance at Brian Dolan workshop re. discharge improvement
2 7 19	Non-Executive Director recruitment panel interviews

Gloucestershire Health Economy

DATE	EVENT
8 4 19	Attendance at HRH visit to Stroud General Hospital – League of Friends
8 4 19	Chairing Research4Gloucestershire Task and Finish Meeting
17 4 19	Integrated Care System (ICS) Chairs' meeting
26 4 19	Chairing Research4Gloucestershire Task and Finish Meeting
30 4 19	ICS Board meeting
30 4 19	Business West Advisory Board meeting
14 5 19	Gloucestershire Health and Wellbeing Board meeting
14 5 19	ICS Strategic Stakeholder Group meeting
20 5 19	Chairing Rsearch4Gloucestershire Steering Group meeting
21 5 19	Health Overview and Scrutiny meeting
21 5 19	Integrated Care System (ICS) Chairs' meeting
28 5 19	ICS Board meeting
18 6 19	Opening of Stroke Unit at The Vale Community Hospital, Dursley
19 6 19	Chairing Research4Gloucestershire Task and Finish Meeting
25 6 19	ICS Board meeting
26 6 19	Meeting with Chair and Chief Executive of Pied Piper charity
30 6 19	Armed Forces Day event – Sandford park, Cheltenham

National Stakeholders + others

DATE	EVENT
8 5 19	Meeting with Worcester Acute Hospitals Chair and Chief Executive
18 6 19	Informal visit to Trust by members of CQC Board

Peter Lachecki
Trust Chair - 3rd July 2019

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

TRUST BOARD - JULY 2019

REPORT OF THE CHIEF EXECUTIVE

1. Our Trust

1.1 Operationally, we ended the quarter with a number of positive achievements. Despite the numbers of patients attending our hospital A&E departments increasing and referrals to our specialist teams rising, we achieved 91.06% as a system against the 90% trajectory for the 4 hour A&E waiting standard – a huge achievement and one of the strongest performances nationally. We are beginning to make noticeable inroads into the numbers of patients who are overdue their follow up care and yet again delivered the 6/52 diagnostic waiting standard for which we are now recognised as the highest performing Trust in the region.

1.2 The Trust's leadership team presided over another significant milestone last week when it endorsed the shortlisted options for our major capital development schemes on the Gloucestershire Royal and Cheltenham General sites. The scheme, which will result in c£40m of investment in our two sites will develop state of the art acute care, day surgery and theatre facilities. The next steps will include detailed development and costing of the three shortlisted options to support development of the Outline Business Case.

1.3 Following on from our recent successful Care Quality Commission (CQC) inspection, the Board of the CQC visited the Trust to hear more about our approach to quality improvement, which was one of the things that the inspectors singled out for praise during their inspection last year. Ted Baker, Chief Inspector of Hospitals and Ian Trenholme, Chief Executive were accompanied by CQC executive and non-executive directors to hear from our Gloucestershire Safety and Quality Improvement Academy (GSQIA) team, as well as staff who have graduated from the academy. They were incredibly impressed with what has been achieved and particularly the reach and embedded nature of the QI philosophy and practice throughout our hospitals.

1.4 Building on our work to use social media to bring to life the work of our hospitals, we ran a very successful second *Cancer Insights* day when we shared the work of more than 40 different staff groups involved in delivering cancer care to a typical patient. As last time, public engagement was very positive with more than 18,000 members of the public engaging via Facebook and a further 100,000 'impressions' through Twitter – a hugely successful campaign bringing understanding of what we do and the challenges we face every day. Without a doubt, campaigns such as this raise important awareness in the public's mind of our hospitals and the amazing staff that work in them and, I'm sure, contribute to other successes such as the raising of more than £2.4m of charitable donations to our recent CT Scanner appeal.

1.5 In June, the Trust welcomed Professor Brian Dolan to the organisation to speak with staff from across our system about the importance of valuing every patient day and, as a result, ensuring no patient spends more time in hospital than is dictated by their clinical needs. Professor Dolan, who is the 'originator' of the two hugely successful campaigns *The Last 100 Days* and *#endPJparalysis* passionately addressed the issues which affect our ability to prevent unnecessary admissions and promptly discharge patients who no longer need hospital based care. The sessions, held on our two sites, resulted in hundreds of staff making a personal pledge to support our 'home first' philosophy of care.

1.6 As the largest employer in the County, I have always believed we have an important civic role to play alongside our core role as a healthcare provider and June saw two

great examples of the Trust playing a wider role in the local community. On Friday 14th June a number of staff from the Trust, and the wider system, spent a morning with teachers and pupils of St James Church of England Primary School in Tredworth. This school supports one of the County's most deprived communities and the typical pupil will be living in poverty, around a quarter will have social work input, 45% will have English as their second, third or even fourth language and many would be at risk of malnutrition without school meals. Thanks to local volunteer and community activist, Bren McInerney, staff ran a careers fayre for children in years 5 and 6 with the theme of *Dare To Dream;* staff from GHFT, 2Gether, Gloucestershire Care Services and the South West Ambulance Service came along to share their personal career journeys and give children the chance to learn more about these roles and practice some key activities through play such as learning resuscitation, calculating and dispensing medicines, injecting teddy bears, driving ambulances and even palpating pregnant bellies! It was the most joy filled morning listening to children talk about their ambition; in a Tweet on the day, I described the staff as 'modern day saints' and my view hasn't changed. The challenge now is how to follow through meaningfully so that we don't become a group of leaders who raise expectations or are able to be accused of tokenism; we are already giving thought to this and for my own part, I am scoping out the germ of an idea about a piece of research following the lives of these children and seeing whether regular (meaningful) contact with the NHS and the career opportunities it affords everybody, whatever their ability and circumstances, results in more of these children pursuing NHS careers.

1.7 On the 30th June, we continued our engagement with our local communities when we hosted *Veterans Aware Day* in Sandford Park, Cheltenham where a whole array of colleagues and supporters came along to celebrate national *Armed Forces Day* and the Trust's recent accolade of having been awarded *Veteran Aware Status* as part of the Veteran Healthcare Alliance Covenant. There were many highlights in the day but spending time talking with five local World War ll veterans was the stand out moment for me. The very serious dimension to a fun filled day was the recognition, by all the healthcare providers involved, of the unique needs of veterans and serving personnel which require the NHS to respond differently and I am delighted that our own volunteer 'Veteran Champions workforce is developing so well with 15 staff now able to meet and support armed forces personnel, past and present, to ensure that at Gloucestershire Hospitals we meet the commitments set out by Government, through the Covenant. HUGE thanks to Nathalie Bynorth and Jenny Yates (and there many helpers) for organising such a superb event.

1.8 This month, we received the exciting news that the prospective *Three Counties Medical School* (based at Worcester University) has just been informed that it has passed the third important stage of approvals and is on its way to the final round of applications. If established, the School will offer a post-graduate medical degree (completed in four years) and as part of their offer would like to place students in our hospitals. This initiative is part of the government's pledge to increase the supply of doctors into the NHS, a pledge that applies equally to nurses too. I am equally pleased, therefore, that our Education and Learning Team have secured funding for additional Practice Educator Facilitators to enable us to increase the number of student nurses that we take on placement. We know that nurses and doctors are considerably more likely to take up their first role in a Trust that they have trained in, so very good news for our future pipeline of these vital colleagues.

1.9 On the night of 1st to 2nd July, the Trust took a major upgrade of its Patient Administration System (PAS) TrakCare. Given our digital history and notably the original deployment of the system, considerable time and effort was put into the planning for the event. The upgrade went very well and huge thanks are owed to very many staff who went above and beyond to ensure this success. Personal thanks to Mark Hutchinson, Executive Chief Information & Digital Officer for his leadership (and forgoing of much sleep).

2 Our System and Community

2.1 On the 25th June, myself and Chief Nurse, Steve Hams joined system partners at the three year anniversary celebrations of the *Gloucestershire Better Births* programme. A hugely exciting strategy for childbirth, published in 2016 the *Better Births* programme aims to reduce still births and neonatal deaths by 20% by 2021 and a massive 50% by 2025, from the 2010 baseline. This is hugely ambitious given the impact of its predecessor *Changing Childbirth,* accomplished less than half of this in the two decades following its publication, however, it reflects the fact that, despite being part of the developed world, our rates of these adverse events (including brain damage during birth) continue to exceed many of our European neighbours. Positively, the interventions for care set out in the strategy are evidence based and if achieved should, of themselves, deliver these reductions, However, implementing them sets us some huge challenges such as the one which requires continuity of carer during pregnancy, childbirth and the first days beyond. The thing that sets this strategy apart from previous approaches is its focus on whole system working and I was delighted to hear that we are the first health system in England to implement a system wide maternity safety strategy, which we heard about on the day. I was equally delighted to be present for the launch of *Maternity Voices,* a representative organisation established to ensure that voice of parents is at the heart of our approach to ensuring a better, safer birthing experience for all our parents and their families throughout Gloucestershire. Their Chair, Emma Rawlinson, was a recent attender at the Trust Board.

2.2 Many, myself included, have wanted to be able to point to more tangible benefits of being an Integrated Care System and delivering the wholly grail of truly joined up care provided by multiple organisations, working together. On the 18th June, the Chair and I had the pleasure of attending the official opening of the new community based specialist stroke service at the Vale Community Hospital run by Gloucestershire Care Services. It was fantastic to meet with staff, patients and their families and, whilst the quality of the environment was superb, what stood out the most was the philosophy enabled through a dedicated unit such as this. All of the patients I spoke with had spent time on the 6th floor at GRH and whilst they were extremely grateful for the care they had received whilst in the acute phase of their stroke, 100% of them believed that their recovery – physical and emotional – had been hugely enhanced through rehabilitation at the community unit.

3 National and Regional

3.1 Brexit preparations for a 'no-deal' scenario have come back up the agenda with the National Strategic Commander, Keith Willetts leading preparations again. The risks remain largely as perceived earlier in the year and the Trust's Executive Lead remains Sarah Stansfield, Director of Finance although this will change shortly. A briefing will be provided to the Board at its next meeting.

3.2 Winter planning has commenced both nationally and regionally with early concerns about the implications of an already difficult influenza season in Australia. The Trust's own planning will commence in earnest later this month.

3.3 We were fortunate to secure the time of Matthew Swindells, current Deputy Chief Executive, NHS England and National Director for Operations and Information to address our 100 Leaders Forum on the 4th July, before he leaves the NHS later in the month. Matthew was an inspiring speaker and shared his reflections on the *NHS Long Term Plan* and his own leadership journey. His patient centred approach was refreshing and set an important tone for our own thinking about our local response to the plan.

Deborah Lee
Chief Executive Officer

4th July 2019

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Strategic Plan 2019–2024

Executive Summary

This is our 'Journey to Outstanding'… It is a five year strategic plan that defines the context in which we operate and the challenges we expect to face. It describes the framework we will use to deliver our vision, Best Care for Everyone, and the strategic objectives we have prioritised to achieve that vision by April 2024.

This strategy marks the end of a period of uncertainty that included regulatory intervention, governance concerns and performance and technology challenges. We will build on recent successes, such as our Care Quality Commission (CQC) rating of Good, to take control by defining the scale and pace of our ambition and priorities.

The journey will include significant and exciting change, including:

- Launching our new clinical strategy built around centres of excellence
- Designing and implementing integrated models of health and social care
- More focus on looking after each other's physical and emotional wellbeing
- Investing in and using digital technology to help us deliver the best care for everyone
- Utilising the Gloucestershire Safety and Quality Improvement Academy (GSQIA) to progress more services to Outstanding
- A renewed focus on research
- Investment in our estate
- Financial sustainability within the first three years of the period

This strategy is ambitious and realistic. It has been developed through an internal and external engagement programme spanning 12 months (see appendix 1), when we asked teams to define what outstanding care means to them and their patients (see appendix 2), and finished at our senior leadership event in April 2019 where we confirmed our strategic priorities and objectives.

Teams and individuals can recognise their influence and input upon this strategy and our objectives; our approach has remained focused on ensuring these objectives are meaningful and that staff find them compelling.

The basis of the eight enabling strategies that form our strategic framework have also been shaped by our engagement approach and these enabling strategies will all be defined, approved and live by April 2020.

This strategy will be used by our decision making groups, leaders, teams and individuals to inform and prioritise operational and strategic decision making. The intention is that a well-worn, well annotated copy will be present and visible in all clinical and support function areas.

Simon Lanceley

Director of Strategy and Transformation

Our Purpose, Vision and Values

Our Purpose

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

We exist to treat illness and injury as traditional forms of healthcare but also to improve the physical and emotional wellbeing of our patients and each other.

This means not only caring for them clinically, but also ensuring their experiences of our services are the best they can be.

We strive to see the 'whole patient', not just the ailment or condition presented to us.

Compassion and kindness are critical to patient experience.

Outstanding is the term used by the Care Quality Commission, whose assessments of our care describe the experiences and outcomes patients should have with us, and is therefore the term we also use to describe our strategic intention for care, although our definition of outstanding goes beyond that used by the CQC.

Our Vision

Best Care For Everyone

We have retained our vision statement as staff told us it is meaningful and memorable.

Achieving 'best' means it becomes the new norm, so needs continuously redefining to set ourselves new challenges.

It is also inclusive as we not only care for our patients but for their families and carers, and each other.

Our Values

Caring, Listening, Excelling

Our values are the foundation of our purpose and vision.

They are not the 'what' of our work, but the 'how', and are the words we want our patients and staff to use to describe their experience with us.

Our engagement programme told us we need to simplify our values so that they are easier to understand, adopt and recognise day to day.

Our three core values are:

Caring – Patients said: "Show me that you care about me as an individual. Talk to me, not about me. Look at me when you talk to me."

Listening – Patients said "Please acknowledge me, even if you can't help me right now. Show me that you know that I'm here."

Excelling – Patients said: "I expect you to know what you're doing, be good at it, and continuously improve standards."

We will co-design and embed behaviours to reflect our core values and culture as we progress towards Outstanding. We will recognise where colleagues deliver care to the standard we expect and hold each other to account when this does not happen. The standard we see and walk past is the standard we set.

Trust Strategy
2019 to 2024

Outstanding care

We are recognised for the excellence of care and treatment we deliver to our patients, evidenced by our CQC Outstanding rating and delivery of all NHS Constitution standards and pledges.

Compassionate workforce

We have a compassionate, skilful and sustainable workforce, organised around the patient, that describes us as an outstanding employer who attracts, develops and retains the very best people.

Quality improvement

Quality improvement is at the heart of everything we do; our staff feel empowered and equipped to do the very best for their patients and each other.

Care without boundaries

We put patients, families and carers first to ensure that, in partnership with our local health and social care partners, care is delivered and experienced in an integrated way 'without boundaries'.

Involved people

Patients, the public and staff tell us that they feel involved in the planning, design and evaluation of our services.

Our Strategic Objectives: 2019 to 2024

The objectives have been derived from a process of combining national, regional and local context and how we plan to respond, our strategic analyses, and the messages we heard from our engagement programme. They have been tested with members of staff from across the Trust, who have confirmed they articulate the scale and pace of our collective ambition.

Centres of Excellence

We have established Centres of Excellence on our hospital sites that provide urgent, planned and specialist care to the highest standards, and ensure as many Gloucestershire residents as possible receive care within the county.

Financial balance

We are a Trust in financial balance, with a sustainable financial footing evidenced by our NHSI Outstanding rating for Use of Resources.

Effective estate

We have developed our estate and are working with our local health and social care partners to ensure services are accessible and delivered from facilities that enable us to deliver our vision of Best Care for Everyone.

Digital future

We use technology to drive safe, reliable and responsive care. Our electronic patient record is embedded and has released staff time that is being used to treat and care for patients; it links to our partners in the health and care system to ensure care for the patients is joined up.

Driving research

We are a research active Trust providing innovative and ground breaking treatments; staff from all disciplines contribute to tomorrows evidence base enabling the Trust to be one of the best University Hospitals in the UK.

What Patients Say

"I know that I receive the best care in the county and couldn't be in safer hands"

"I was kept informed at every stage of my pathway and treated very quickly by the right person in the right place"

"I see the hospital has improved its facilities for patients which is welcomed"

"I didn't have to wait long to get an appointment date, referral or be seen"

"It is comforting to see the same team when I come in for my treatment"

"I enjoy being engaged in conversations about the future of my local hospital"

"Staff really care and show compassion"

"It is great to get specialist treatment on my doorstep"

"It is good to know I live in a County where the hospitals perform well and if I need to attend I will be looked after"

"I know if I have an idea on how to improve standards in the hospital I will be listened to"

"I know my care is provided by many organisations but it feels seamless to me"

"I am so excited to be involved in the Trusts clinical trials and look forward to benefiting from the results"

"It is a relief not to repeat my medical history as I moved around the hospital and community for treatment"

"My thoughts and feelings on my care are listened to and acted upon"

"I know the Trust have the best skilled staff available and I am in expert hands"

What Colleagues Say

"I see colleagues doing the best they can and being inspire by working in a Trust which focuses on continuous improvement and research"

"I am well led and enjoy my job"

"I am glad to work in a hospital that really places the patient at the centre of all it does"

"I know I work with colleagues who are enthusiastic and keen to be the very best they can be"

"I am developed and motivated to ensure the care I provide is individualised to patient needs"

"I am excited by the technological changes which make it easier to care for patients and demonstrates to them that we know who they are and what their health concerns may be"

"It is fantastic to see the investments made in our facilities and equipment. It makes my job easier to be given the right tools to deliver my services"

"Ot is great to work in a county where care transcends organisational borders"

"I am proud to work here"

"I am proud we are delivering timely quality care for our patients and it is satisfying to work in an organisation where patient outcomes are at the heart of what we do"

How We Will Deliver Our Strategy

Strategic Intent

Our strategic intent is to provide **outstanding care through two thriving but distinct main hospital sites** and, as a lead provider within an Integrated Care System (ICS), through a range of community facilities (including our community maternity suite) and integrated models of care. We will be a Hospitals Trust that **patients, families and carers recommend and staff are proud to be part of**.

We will be a **collaborative ICS partner** to ensure patients, families, carers, staff and other stakeholders benefit from the value a high performing, high energy acute Trust can bring to this partnership.

We recognise that as the ICS develops, **partners may need to adapt their organisational form** to ensure opportunities to improve patient experience and outcomes, staff experience and value for money do not get delayed. For example by ensuring the timescale and flexibility of our decision making processes align.

We will continue to provide acute and specialist care for residents of Gloucestershire and adjacent regions; Herefordshire, South Worcestershire, Wiltshire, and where it is the right thing to do for patients, and this can be supported by a strong clinical and financial business case, **we will work with commissioners, providers and clinical networks in these regions to secure and extend our clinical service offer**.

We want the quality of care we provide to be rated **Outstanding by the Care Quality Commission (CQC)** and our use of resources to be rated **Outstanding by NHS Improvement**.

We believe becoming an accredited **University Hospital Trust** will increase our capacity and capability to deliver 'Best Care for Everyone' and are committed to exploring the best way to achieve this.

Strategic Framework: Our Eight Enabling Strategies

Our strategy will be delivered through eight enabling strategies as shown below. By April 2020 all enabling strategies will have been defined and approved by Trust Board (see appendix 3 for timeline).

See appendix 4 to see the methodologies used (SWOT, PESTLEC, market analysis, benchmarking) and a range of national, regional and local publications to inform our approach.

Clinical Strategy

Our new Clinical Strategy will be designed around Centres of Excellence that enable a greater separation between emergency and planned care. Our work in this area has already been recognised nationally and we want to build on this so that we are recognised for delivering excellence across urgent and emergency care, obstetrics and paediatrics, planned and specialist care and oncology. We want this recognition to come from patients and their families and carers, staff, partners, regulators, professional bodies and benchmarking organisations. We will work closely with emergent **Primary Care Networks** and **Integrated Locality Partnerships** to ensure we maintain conversations with our communities and ensure our focus continues to be with the patient.

Quality Strategy

Quality standards described in the NHS Constitution, the Care Quality Commission's (CQC) quality and safety standards and the National Quality Board's 'Shared Commitment to Quality' will inform the Quality Strategy that will get us from a CQC rating of Good' (February 2019), to Outstanding by April 2021. The strategy will describe our 'Journey To Outstanding' and will put the needs of patients and service users, their families and carers first.

The Gloucestershire Safety and Quality Improvement Academy (GSQIA) will be a key enabler to us achieving our Quality Strategy and drive the implementation of a new Quality Model, that will ensure staff are equipped and inspired to improve services.

We will continue to expand the way we use data to drive quality and our Digital Strategy will be another key enabler to improving quality.

Our Quality Strategy will be designed around five key programmes:

- **Well led** – Our leadership, governance and culture will be used to drive and improve the delivery of high-quality person-centred care
- **Improve experience** – People will be truly respected and valued as individuals and empowered as partners in their care, practically and emotionally.
- **Improve safety** – People will be protected by a strong comprehensive safety system, and a focus on openness, transparency and learning when things go wrong
- **Improve outcomes & effectiveness** – Outcomes for people who use services will be consistently better than expected when compared with other similar services
- **Responsiveness** – Services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care

People & Organisation Development (OD) Strategy

Collectively we, 'our staff', will determine whether we are successful in delivering this strategy. Our People & OD Strategy will ensure we have the right number of staff with the required skills to be successful, through effective recruitment, retention, education, recognition & reward.

Our People & OD Strategy will be designed around three key programmes:

- **Workforce sustainability** – We will attract, develop and retain staff that are best in their field, the ambition described in our Clinical, Quality, Digital and Research Strategies will help us here. We will ensure we anticipate and close capacity and capability gaps and provide career pathways that build and retain the knowledge, skills and experience we need
- **Staff experience** – Our engagement programme told us we need to simplify our values so they are easier to understand, adopt and recognise day to day so will focus on three core values; Caring, Listening and Excelling. We will define and embed a new set of behaviours that reflect these values and will use these to shape our culture as we progress towards outstanding. We will be an outstanding employer and we will support colleagues to maintain and sustain emotional and physical health and wellbeing. The principles of equality, diversity and inclusion will continue to underpin our vision of Best Care for Everyone and we remain committed to becoming an exemplar of the requirements defined in The Public Sector Equality Duty and The Equality Delivery System (EDS2)
- **Transformation** – Our staff will be equipped and inspired to do things differently to deliver Best Care for Everyone. We will provide an education and development programme that ensures individuals and teams have the skills and confidence to collectively achieve our strategic objectives

Financial Strategy

Our Financial Strategy will ensure we become a financially sustainable organisation that provides efficient and effective services supported by an outstanding finance team that is recognised nationally and supports the Trust to deliver this strategy.

We will be a financially literate organisation with all staff who have a budgetary responsibility receiving training to enable them to make the best decisions for their patients and teams.

We will use national productivity programmes and tools, for example Getting It Right First Time (GIRFT), Model Hospital, Carter Review to identify unwarranted variation and efficiency improvements and support our clinical teams and support functions across the Integrated Care System (ICS) to implement opportunities.

We will work with ICS partners and other stakeholders to explore alternative routes to capital and investment that will enables us to provide an infrastructure that matches our ambition to deliver Best Care for Everyone through centres of excellence.

Our financial strategy will be designed around four programmes:

- **A medium term financial plan** that outlines the route to sustainability
- **Outstanding business partnering** to support and challenge divisions to deliver the best financial performance
- **Financial reporting** that provides assurance and is easy to understand, including **Patient Level Information Costing (PLICs)** to support clinical and service decision making
- A **finance department improvement plan** (#ghftcountmein), which will deliver a Future Focussed Finance accredited department of which the trust can be proud

The long-established shared NHS financial and procurement service in Gloucestershire will be a key enabler in achieving these programmes, and those in the ICS, as we increasingly automate transactional functions to reinvest on our transformational programmes.

Estates Strategy

Our Estates Strategy is a key enabler to the delivery of our Clinical Strategy. Our Estates Strategy will describe how we need to respond to planned and anticipated changes in activity, efficiency, models of care, ways of working and demographics.

We will work with our Integrated Care System (ICS) partners to ensure estates development plans and decisions are taken as a system to optimise the way we use public estate across Gloucestershire to deliver organisation and ICS objectives.

We will explore the concept of moving to **one public sector estate** so that staff can move between sites as required to deliver the right care at the right place at the right time as part of an integrated health and social care system. This concept could be extended to include academic facilities as part of our Research strategy and University Hospital aspiration.

We will use our new Estates Strategy to describe how we plan to maintain and develop our estate with our subsidiary organisation GMS to address **backlog maintenance**, operational risk and a need to invest so that we can deliver Best Care For Everyone in an **environment that reflects our centres of excellence** concept.

We recognise the pace at which we can invest in our estate is not always in our control, due to the availability of capital and we will explore **alternative routes to securing capital** investment through a range of models, for example Managed Equipment Service (MES), joint ventures and shared use with integrated care partners.

We will deliver our £39.5M **Strategic Site Development Programme** to improve acute care facilities at Gloucester Royal and day surgery and theatre capacity at Cheltenham General and ensure we achieve the return on investment we have committed to.

Digital Strategy

Our Digital Strategy will be a key enabling component of our Trust strategy and will be a bold and dynamic statement of our ambition to deliver digitally-enabled Best Care for Everyone. We are committed to creating a culture that embraces digital technology.

We will apply for Global Digital Exemplar (GDE) fast follower status as with this NHS Digital endorsement comes support and funding that will enable us to achieve high digital maturity.

Our Digital Strategy will be built around three key programmes:

- **Digital Landscape** – We will provide infrastructure and hardware necessary to provide digital solutions that improve patient care and readily available skilled support staff. We will continue to optimise the use of TrakCare and continue our digital development with the implementation of an Electronic Patient Record (EPR), that will enable and enhance our ability to implement new models of care and more efficiency and safer ways of working
- **Digital Intelligence** – We will provide an insight-driven culture which embeds analysis, data and intelligence to enhance decision making, outcomes and quality improvement. We will report consistently and proactively as needed by operational teams and external stakeholders
- **Digital Workforce** – We will develop our digital literacy skills to ensure confidence and competence in using technology tools. We want to become an employer of choice for people with Digital and IT skills. We will continue our in-house development programme within our Business Intelligence service to provide local training in an effort to both 'grow our own' experts, and provide staff with development opportunities that aid retention and ensure we have a consistent and effective approach to digital workforce planning

Communications & Engagement Strategy

Our engagement programme told us that this is an area we need to improve, particularly how and when we involve patients, families and carers in the process of exploring and designing new ways of working, and as a result it is a key part of our strategic thinking going forward.

Our new Communications and Engagement Strategy will ensure that when we are communicating or asking for engagement it is clear how the message or request relates to our strategic priorities.

We will adapt our language to meet the needs of our different stakeholder groups and use a range of methods to engage, recognising that different groups respond to different approaches and techniques.

We will work closely with communication and engagement colleagues from other health and social care organisations to reinforce the concept of One Gloucestershire.

Research Strategy

Our Research Strategy will ensure we are able to build on our existing good practice and extend our research portfolio so that more patients benefit from improved experience and outcomes and we all benefit from improving recruitment and retention evidenced in research-active hospitals and specialties.

We will continue to support the development of the Research 4 Gloucestershire initiative to develop an integrated approach to research across Gloucestershire, particularly given the opportunities we can offer to commercial and non-commercial studies as an Integrated Care system.

We are committed to exploring whether becoming an accredited University Hospital Trust would increase our capacity and capability to deliver Best Care for Everyone and collectively our People & OD and Research teams will define the best way to achieve this. If in order to meet accreditation criteria we need to enhance our clinical and/ or educational research capacity and capability, we will produce a compelling business case to prioritise investment.

Our Research Strategy will be designed around four key programmes:

- **Increasing visibility & awareness** – Improving how we communicate our research activity to patients, staff, ICS partners, National Institute for Health Research (NIHR) and commercial partners
- **Celebrating success** – Demonstrate how research is improving patient care, outcomes and experience and staff experience, recruitment and retention
- **Increasing equity of access** – Improving access to trials for patients with the aim that every patient can access a trial or be offered one
- **Growing our collaborations** – Increasing the number and variety of organisations we work with

How We Will Implement This Strategy

2019 to 2024 Strategic Objectives

Progress Reporting → **Board Assurance Framework (BAF)**

Clinical Strategy

Programmes:
- Centres of Excellence
- Integrated health & social care
- Upper quartile performance

Quality Strategy

Programmes:
- Well led
- Improve experience
- Improve safety
- Improve outcomes, effectiveness & responsiveness

People & OD Strategy

Programmes:
- Workforce sustainability
- Staff experience
- Transformation

Financial Strategy

Programmes:
- Medium term financial plan
- Outstanding business partnering
- PLICS & financial reporting
- Dept. improvement plan

Estates Strategy

Programmes:
- Site development plan
- Strategic Site Development Programme
- Addressing backlog maintenance

Digital Strategy

Programmes:
- Digital Landscape
- Digital Intelligence
- Digital Workforce

Communication & Engagement Strategy

Programmes:
- Co-design
- Engagement model
- One Gloucestershire

Research Strategy

Programmes:
- Increasing visibility & awareness
- Celebrating success
- Increasing equity of access
- Growing our collaborations

Enabling Strategy Operational Objectives & Metrics

Progress Reporting → **Quality & Performance Report (QPR) –** Committees, TLT, Divisions

Appendix 1: How We Developed Our New Strategy

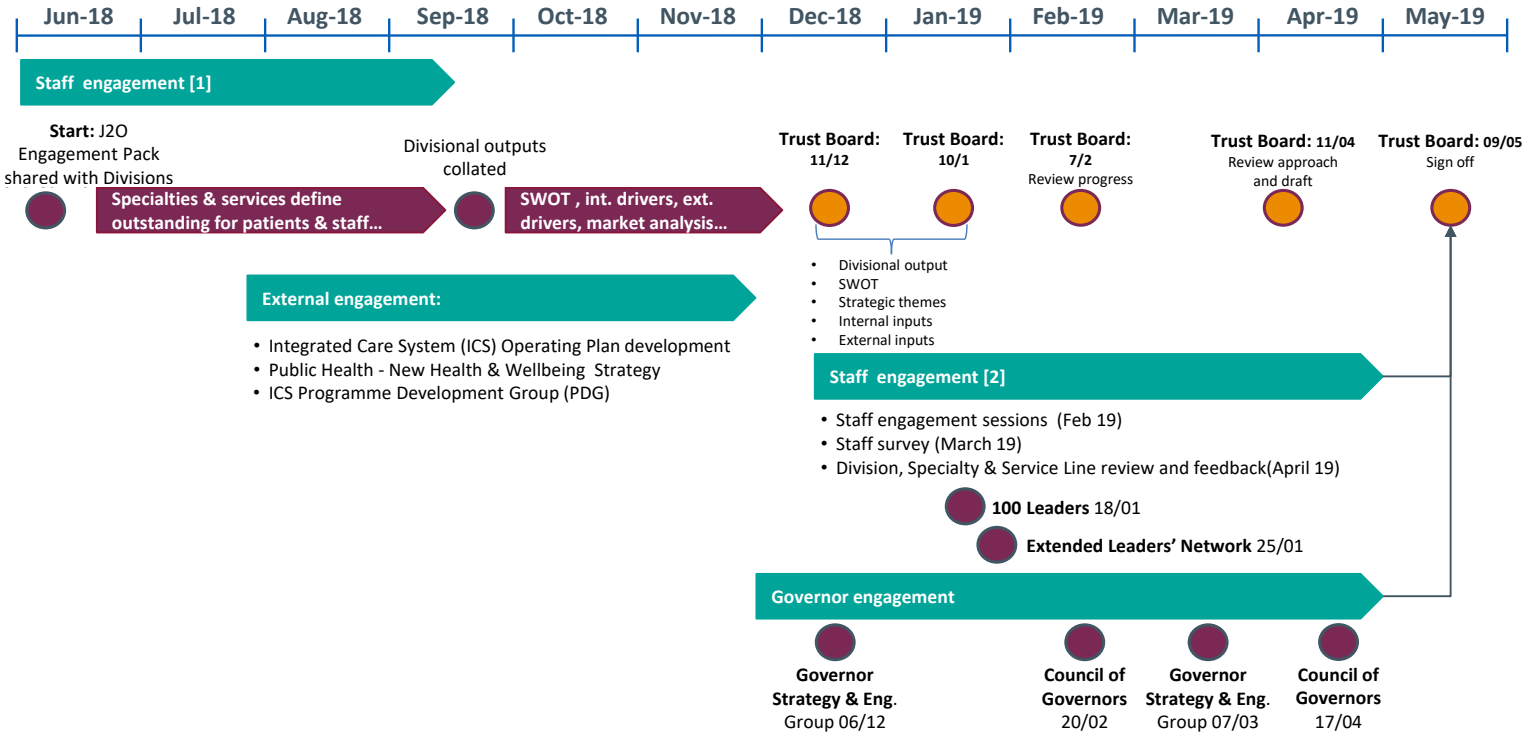
How We Developed Our New Strategy

Approach

The approach we took to develop this strategy started in June 2018 and is shown in the diagram opposite. We started our engagement programme by asking staff three questions:

1. What will providing an outstanding service mean for your patients (or customers if you are a support function)?
2. What will working in an outstanding service look and feel like to you?
3. What support do you need to get there – what does the Journey to Outstanding programme need to provide?

The output from this engagement formed the basis of our new strategy which was supplemented by a number of methodologies (SWOT, PESTLEC, market analysis, benchmarking), and a range of national, regional and local publications.

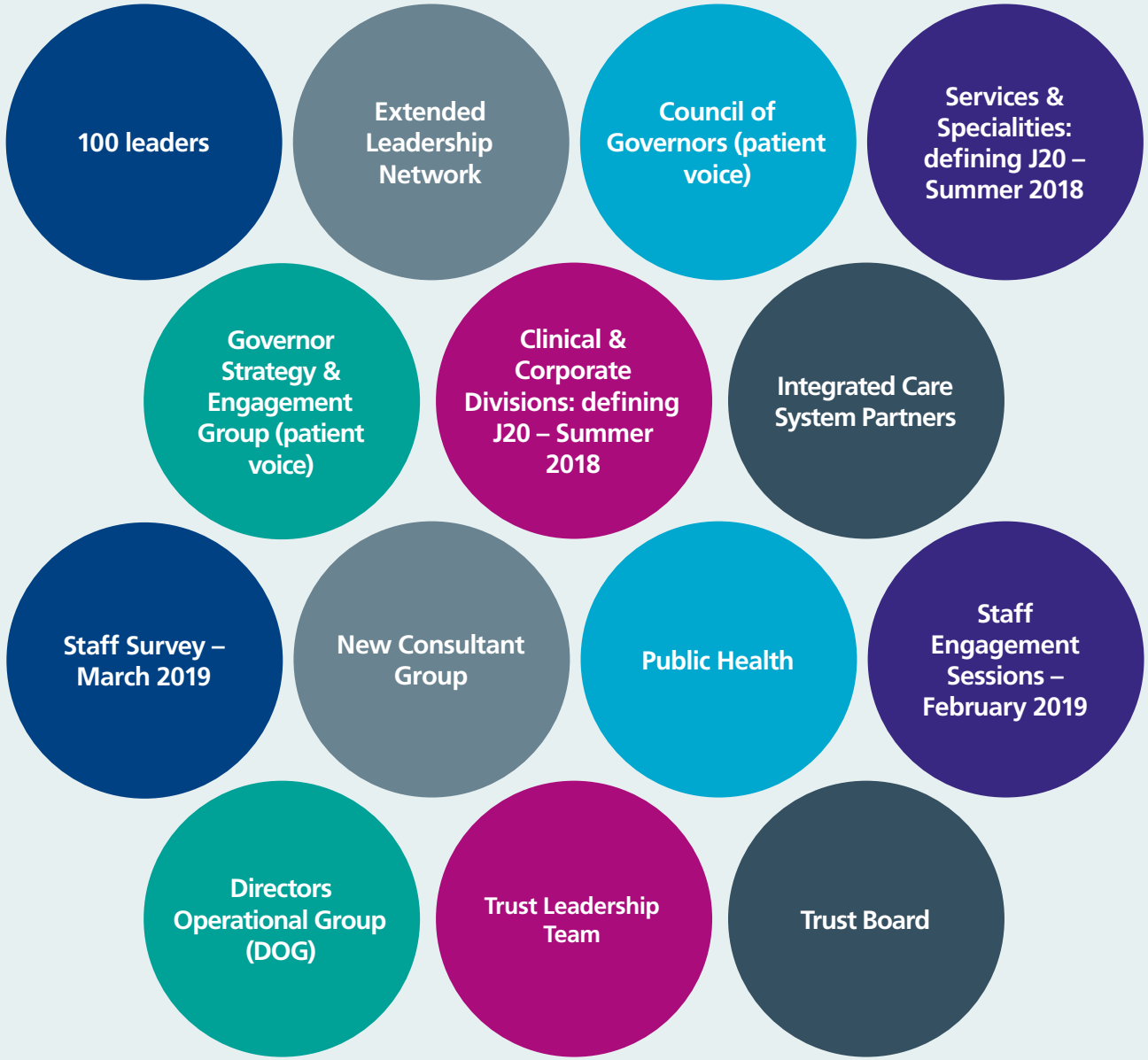


Approach (cont'd)

We used the engagement groups shown here to present, test and iterate our thinking and assumptions. We used a range of thought-provoking questions (Appendix 2) to help us understand the priorities and collective level of ambition of staff and stakeholders. We created a long list of objectives based on eight emergent enabling strategies, SWOT and PESTLEC analyses, and hundreds of votes and qualitative feedback.

The long list became a short list of 14 strategic objectives which addressed the context and challenges our analyses presented. These were issued to staff, governors, and Board for final feedback, resulting in 10 ambitious, compelling, realistic and achievable strategic objectives.

Engagement Groups



Appendix 2: Identifying Priorities and the Scale of our Ambition

Identifying Priorities and the Scale of our Ambition

Examples of the thought-provoking questions we used with our engagement groups to help us understand the priorities and collective level of ambition of our staff and other stakeholders:

Clinical

- What benefits must our emerging Centres of Excellence programme deliver for patients and staff?
- What should our role be in delivering integrated health and social care?
- What is our role in promoting and supporting population health across Gloucestershire?

Quality

- What role can we play in ensuring parity of esteem across physical & mental health
- What do we want our culture of improving & learning to look and feel like for patients and staff?
- Where are our opportunities to reduce variation (GIRFT)?
- How can we continue to build on the success of the Gloucestershire Quality & Safety Improvement Academy (GSQIA)?

People & Organisation Development

- How do we make this an organisation and system people want to work in?
- How can we ensure people with protected characteristics feel safe and valued?
- What standards do we want to set for supporting and encouraging professional development?

Financial

- How aspirational should we be in terms of performance – upper quartile, upper decile?
- What are the barriers that prevent us from living within our means?
- What do we want our culture of efficiency to look and feel like for patients and staff?

Estates

- How can we ensure our Estates Strategy reflects our ambition but remains realistic?
- What principles should we set for locating services on/ off-site?
- If you could focus on improving one area of our facilities service what would it be?

Digital

- What does outstanding digital healthcare look and feel like to you and your patients?
- How can we better use data to predict activity changes and inform decision making
- If you could focus on one area to improve our digital offer to patients, what would it be?

Communications & Engagement

- What does outstanding staff engagement look and feel like?
- What do we want to patients and stakeholder to say about how we have involved them?
- How should we define and measure effective engagement?

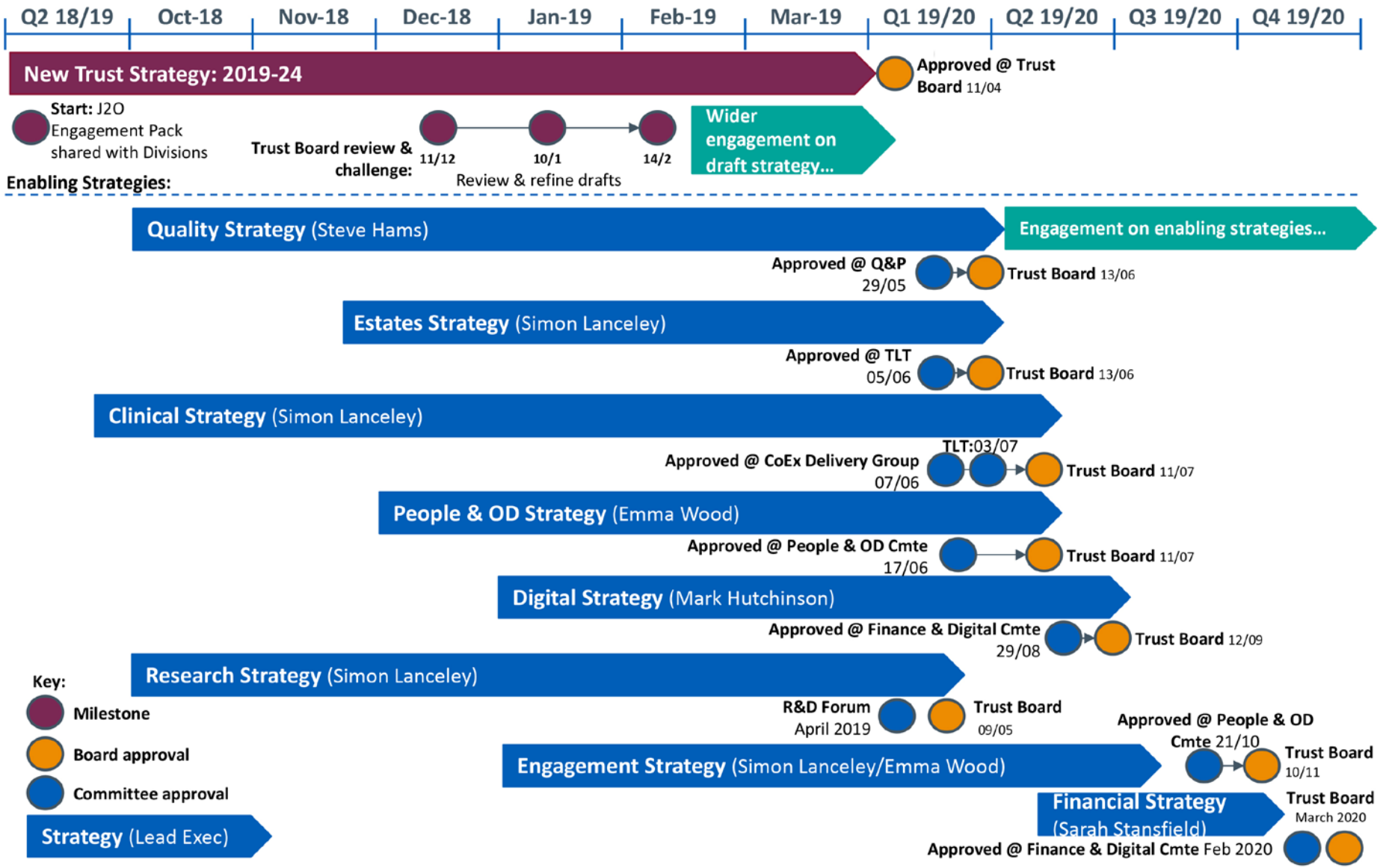
Research

- Should we prioritise achieving University Hospital status? What benefits would it bring to patients and staff?
- What is our aspiration for research across Gloucestershire?
- What statement/ change do we need to make to demonstrate research is a priority for this organisation?

Appendix 3: Enabling Strategies

Approval Timeline

Enabling Strategies Approval Timeline



Appendix 4: Context & Challenges

National, Regional, Local

Context and Challenges: National

We used a range of internal and external inputs, to define the national, regional and local context and identify future challenges so that this strategy ensures we are able to plan and respond accordingly.

The NHS Long Term Plan was published in February 2019, recognising both the ongoing successes of the NHS in its first 70 years, and the pressures, challenges and opportunities ahead. The Long Term Plan presents an ambition to accelerate the redesign of patient care based on three key factors:

- Secure and improved funding averaging 3.4% a year over the next five years, compared with 2.2% over the previous five years
- A wide consensus about the changes needed, confirmed by patient groups, professional bodies and frontline NHS leaders and staff
- Work generated by the NHS Five Year Forward View is beginning to bear fruit, providing practical experience of how to bring about the changes set out in the Long Term Plan – almost everything in the Plan is already being implemented successfully somewhere in the NHS

The Long Term Plan tackles the three major life stages and sets out broad action areas to overcome the challenges the NHS faces such as staff shortages and growing demand for services:

- Doing things differently: a new service model for the 21st century
- Preventing illness and tackling health inequalities
- Further progress on care quality and outcomes
- Backing our workforce
- Making better use of data and digital technology
- Getting the most out of taxpayers' investment in the NHS

The three major life stages set out in the NHS Long Term Plan

PESTLEC Analysis

To better understand the wider external context in which we operate we used the PESTLEC analysis model.
A summary of the external factors we used to inform our strategy is shown below.

Political	Economic	Social	Technological	Legal	Ecological	Competition
One or more general elections	Brexit – pressure on Public Sector cost reductions; trade	Increasing ageing population & long-term conditions	Remote monitoring/ telecare	New legislation to enable integrated care systems	Climate targets & standards, e.g. waste, travel, emissions	AQP contracts to independent sector de-stabilising 'whole-service' sustainability
NHS/Local Authority funding settlements	Longer term impact of period of austerity, inflation & exchange rates	Population as 'social capital'	Personalised medicine & genomics	Licence changes drive ICS performance	Impact on weather-derived health issues	Affordability and/or perceived additional value of private providers
Integration of NHS England & NHS Improvement	Growing cost of health & social care	More informed consumers	Artificial Intelligence in diagnostics	Pace of innovation & technology; litigious society	Antibiotic resistance	Non-Gloucestershire ICS 'alliances' lowering cost bases below local thresholds and population mass to retain accreditations
Local politician support for clinical strategy and alignment with re-election agenda	Economics as primary determinant of health (+deprivation, work, economy)	Lower availability of workforce in 'caring professions'	Innovation impact on length of stay & out of hospital care	Kark Review of Fit and Proper Persons Test (FPPT)	Global health (pandemics)	LTP shift of care to ICS partner Trusts and primary care
Commitment to collaboration & integration in ICS	NHS contracting/ funding changes	Increased environmental impact & awareness (e.g. sun damage; veganism)	Impacts training need	Revisions to FT Code of Governance	Smoke-free	
Unknown long-term impact of Brexit	Ability of supply chains to deliver	Increase in informal caring	Social media	Regulation of SubCos	Heritage sites constrain development	
		Health tourism	Remote/ mobile work	Data Protection	Corporate Social Responsibility	
			Cyber attacks	Stringent and costly accreditation regimes	Diet & environment impact on allergies	

Context & Challenges: Regional

South West

The Gloucestershire health economy, and our Trust, operates within the **South West Region** of the NHS, however our geographical location means we have close working relationships with parts of the Midlands and the Welsh Health Boards.

By 2025 the population of the South West region is estimated to rise by 5.6% above 2017 levels, largely in the over-65 year old group (+16.5%) with resulting demands on healthcare services of long-term conditions.

Pathology

The NHS is bringing together clinical expertise into hub and spoke '**Pathology Networks**' to deliver high quality diagnostics in a more efficient way. This is a response to the level of unwarranted variation in pay and non-pay costs of providing pathology services across the country, primarily linked to the adoption of best practice and innovative ways of working through advanced roles that can be difficult to replicate across every Trust but easier to implement in fewer, centralised hubs.

We are developing the 'South 3' network with Bristol, Bath acute and Weston Trusts; core services will still take place in our own hospital laboratories, with some samples being analysed quickly and expertly in advanced centres. We are working closely with our partner Trusts to design the best model for our regional Pathology Network that ensures the most efficient and effective service and turnaround times.

Academic Health Science

We work actively with the West of England **Academic Health Science Network (AHSN)**, driving the development and adoption of new innovations and enabling patients to play an increasing role in their own care. Funding for AHSNs has been extended for at least the first four years of this strategic period, and we will work in close partnership to support innovation and improve patient safety through evidence-based improvement and the involvement of our patients and the public.

Genomes

Our involvement with the **100,000 Genomes** project, and the planned expansion and mainstreaming of genomic medicine in the NHS over the next 5 and 10 year periods, aligns us with the current **West of England Genomic Medicine Centre** and the genomics laboratory in North Bristol Trust. Some of our senior doctors hold regional positions for the regional genomics medicine service and we have influenced both the original 100,000 Genomes Project and its mainstreaming successor work.

Clinical

Over the next five years we will continue to work closely with the **South West Clinical Senate** and the **South West Clinical Network** teams to inform our new clinical model, reduce unwarranted variation in health and well being services, encourage innovation in how services are provided now and in the future, and influence clinical advice and leadership to support decision making and strategic planning.

Context & Challenges: Local

One Gloucestershire

In 2016, NHS organisations and local councils came together to form 44 Sustainability and Transformation Partnerships (STPs) covering the whole of England, and set out their proposals to improve health and care for patients. Some of these STPs evolved over the following two years to form **Integrated Care Systems (ICS)** in which the system partners take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve. All STPs will become ICSs during the next few years.

The **One Gloucestershire ICS** was a wave two 'early adopter' area. Our ICS is characterised by its relative simplicity – one clinical commissioning group, one community care provider and one mental health service provider (these two organisations will become one Trust in the first year of this strategic period), one county council, one ambulance service provider, and 74 GP practices grouped into Primary Care Networks and Integrated Locality Partnerships.

Our Trust is the provider of acute healthcare services in the One Gloucestershire ICS. The majority of these services are provided from our two main hospital sites in Gloucester and Cheltenham, with further maternity services provided in Stroud. We also provide services within the county's seven community hospitals, and to a number of other commissioners outside the county.

The benefits of an ICS are a focus on improving the health and wellbeing of the population through reducing barriers between our organisations that could delay patient care, reducing administrative overheads, and ensuring we get the most value out of every 'Gloucestershire £'.

Naturally this involves a pace of change that we need to maintain in addition to our everyday operational priorities; as the ICS develops we will adapt our organisational form to ensure the system, patients, and partners benefit from the value a high performing acute Trust brings to a partnership.

A key challenge we face, as presented in the NHS Long Term Plan, is the drive to move more care out of acute hospital settings and into the community or patients' own homes where appropriate. Detailed planning and risk management between all members of the ICS will be critical to ensuring the long-term sustainability of our services, and we believe there are significant opportunities for our buildings, staff and resources.

This strategy has been developed with full consideration to the challenges these crucial changes will bring. Our most significant transformational work around new models of care and integrated pathways are being conducted in full partnership with the rest of the ICS.

Gloucestershire 2050

The public sector organisations in the county are collaborating on a wide scale 'conversation' that started in 2018 to explore ideas and shape the long-term future with all stakeholders, particularly younger people, to understand how we can plan for and tackle the priority issues arising from our changing demographic. Its key findings are important for Gloucestershire health services and our Trust and include:

- Limited job opportunities
- Net migration of younger people out of county
- Loss of skills
- Loss of investment to cities
- Limitations of infrastructure, transport and internet connectivity
- High cost of housing

Context & Challenges: Hospitals Trust

Market Analysis

Demand

Change in demand is determined by two primary factors – population and demographic change, and commissioning intentions (i.e. the services purchased by commissioners to address the healthcare priorities for the population). By 2025 the Gloucestershire population will increase by 5.9% compared to 2017; the vast majority of this increase is in the over-65 year old population (+19%), with associated demands on healthcare services of long-term conditions.

Overall we are a net 'importer' of patient referrals and patient choice. This is in part a consequence of our role as the main provider of specialist cancer services for Gloucestershire, South Worcestershire and Herefordshire. Pathways are relatively stable but we have recently secured a seat at the West Midlands Cancer Alliance so we are able to influence possible pathway changes – we already form part of the Somerset , Wiltshire, Avon & Gloucestershire (SWAG) Cancer Alliance.

Our provision of private patient services has reduced over the last ten years. This is a consequence of both a reduction in the fee paying market and the need in recent years to prioritise beds, previously ring-fenced for private patients, for NHS use. This was compounded by our recent financial challenges reducing available capital for investment.

Our competitors

Our positioning as the only major provider of NHS acute care in Gloucestershire means that we have very little competition for the non-elective services we offer.

In recent years a wider range of 'specialised services' have moved from local to national commissioning directly by NHS England and we have participated in providing these services where appropriate, mindful of not destabilising our existing core services.

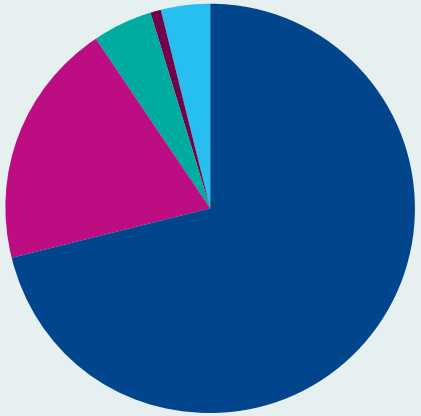
A small transfer of NHS choice activity to commercial providers, including elective orthopaedic activity, has continued as a way of managing demand and helping our efforts to meet some access targets.

The independent and third sector in Gloucestershire is providing increasing levels of NHS funded treatment, although the level of provision (as a proportion of commissioning spend) remains small.

We face some notable threats from commercial providers, as detailed on the next page.

Income and market share

The main income sources for our Trust are as follows (2018-19):



- 71.2% **NHS Gloucestershire**
- 19.3% **NHS England Specialised Commissioning**
- 4.7% **Other Commissioners** (e.g. Worcestershire, Herefordshire, Wiltshire)
- 0.9% **Welsh Health Boards**
- 3.8% **Other income** (e.g. research, private patients)

We continue to be the market leader for the provision of acute health services in Gloucestershire. 84.9% of Gloucestershire CCG's spend on acute care is with us. The projected trend over the next five years is that this will continue, with a marginal transfer of some activity and income to other providers; conversely we anticipate repatriating some activity from other areas and providers into the Trust. The market share trend is expected overall to remain relatively static.

Market Opportunities 2019-21

In response to national policy to enhance plurality of provision alongside capacity constraints in some services, we have lost market share to local independent sector providers – most notably in the areas of urology ambulatory care and aspects of elective orthopaedic provision. As an output of the national Getting It Right First Time (GIRFT) programme we are actively mobilising plans to repatriate this work with a view to increasing our market share in the first year of this strategy once backlogs and residual capacity constraints are addressed.

As we develop our consultant and service base in cardiology, there are new opportunities to repatriate patient flows from Birmingham and Bristol, most notably in the areas of interventional cardiology and devices. New consultant appointments and a business case to develop 24/7 primary percutaneous angioplasty will support this ambition. These developments are especially important for patients and families, many of whom travel considerable distance for this care currently.

Similarly an improvement in our interventional facilities and capacity present the opportunity to stop sending patients to tertiary centres (with 6 month waits) for electrophysiology studies and ablation. This development would also enable us to work towards establishing a seven days a week urgent pacemaker implant service, reducing length of stay and improving inpatient flow while reducing morbidity and mortality associated with temporary pacing wire use.

Our proximity to Wales presents opportunities to further expand our range of offered services to patients across the border.

We also have key opportunities in reinvigorating our private patient. Analysis shows that there is demand for these services that is either unmet, or met by services that we could either host or provide directly without compromising our core NHS services; indeed increasing our private capacity would lead to increased income to invest in all services. Likely clinical areas would initially be: fertility services, ophthalmology, maxillo-facial surgery, audiology, cancer treatment and pain management.

Market Threats 2019-21

We are facing a number of market threats, some of which have the potential to impact on the future sustainability of services.

We face the threat presented of some sub-specialty contracts being awarded to commercial providers, migrating lower-cost, income-generating work out of the Trust whilst we have retained the complex and high-cost/low-margin elements that are potentially unsustainable without the 'balancing' financial effect of the more routine procedures. This has already occurred in the field of cataract surgery.

We also face threats relating to haematology & oncology and cancer surgery, stemming from alliances that Herefordshire and Worcestershire Acute Trusts are forging with other providers in their STP area, and wider Midlands networks. These undermine flows from these areas to our Trust, where population mass is required to maintain accreditation and/or cancer unit status.

We are working closely with our commissioners in the rest of the ICS to plan for the long-term sustainability of services; and our proposed Gloucestershire Cancer Institute and close work with the regional cancer alliance will tackle the latter threat.

Progress Against Previous Strategy

Below is a summary of the key highlights and achievements from the previous strategic plan, which covered the period 2014 – 2019. We made significant progress, despite some challenging circumstances, and take confidence from the progress we made and success we delivered as we transition to our new strategic plan.

Our Patients

- CQC overall rating 'Good' February 2019
- A&E 4-hour wait standard – NHS Improvement target achieved; upper quartile of Trusts nationally,
- Cancer 2ww standard met for Q4 18/19 (93.6%); 90% as a whole (best performance since 2015/16)
- Cancer 62 day treatment recovery plan to deliver by Sept. 2019
- Diagnostics 6 week standard met
- Hospital standardised mortality ratio below 100 (99.1)
- FFT score of 93% recommending us to friends and family met in Outpatients and Maternity
- Reduced average monthly outpatient complaints to 22

Our Services

- New 'Centres of Excellence' clinical model developed
- New urgent care assessment units implemented
- RTT reporting recovery plan delivered on schedule
- Allocated £39.5m estates development funding
- Reconfiguration of Gastroenterology as part of winter planning
- Armed Services Covenant 'Gold' award; Veteran Aware
- Hundreds of staff trained to support making healthy choices

Our Staff

- Staff engagement score improved from 6.7 to 6.8
- Staff turnover rate below 11% (10.95%)
- More staff recommend us as a place to work (56%)
- New talent management system launched
- Innovative clinical and apprentice roles in place
- Quality Improvement academy trained hundreds of staff and implemented dozens of improvement projects
- 'One stop shop' for staff health and wellbeing launched May 2019

Our Organisation

- Exited financial regulatory action in November 2018
- Cost Improvement Programme delivered industry-leading results (6%) year on year; however delivery of financial recovery against trajectory not complete
- 78% of CIP delivery was recurring
- Favourable benchmarking on 'Model Hospital' tool
- Range of investment projects approved to drive further quality and financial improvement
- Integration of respiratory teams commenced; model for integrated leg ulcer (diabetes) agreed; new MSK model progressing (shortlisted for HSJ award)
- Recruited 1,678 patients (target 1,000) across over 100 clinical trials

Strengths, Weaknesses, Opportunities and Threats (SWOT)

To better understand the context in which we operate we used a simple Strengths, Weaknesses, Opportunities and Threats (SWOT) assessment with a range of groups as part of our engagement programme, and this is summarised below. We linked our strengths to our opportunities and our weaknesses to our threats and used this to inform our strategic objectives.

Strengths

Patient care is our priority – We provide high quality patient care and are recognised for that locally, nationally and internationally. Our good reputation is growing.

Culture, leadership and engagement – We have a renewed vigour, energy and vision. We are resilient, open to conversations, and we are responsive to risks and concerns.

Our staff – Are our greatest strength; we overwhelmingly have shared values and purpose, and go the extra mile whenever possible. Staff are proud of the services they give to patients and each other.

Improvement – Is evident in our track record of service delivery in response to real needs, notably emergency care performance, reduced mortality, and productivity and cost improvement.

Risk – Is managed well and used as a driver for improvement. We listen and respond to staff, patient and public concerns and make the right decisions at every opportunity, and learn from our mistakes.

Transformation – Is at the heart of our daily work – we seek ways to improve quality in all we do and we have a track record of delivering projects that improve patient care and our use of resources.

Working in partnership – With local, regional and national organisations, NHS or otherwise, is increasingly core to what we do, and we seek to influence best practice through our successes.

Training, education and research – Are things we have a strong reputation for, and we recognise the need to increase these as the foundation for continuously improving patient care.

Weaknesses

Staff management – Is as consistent as it should be; some staff are not treated as they deserve to be, and some poor performance is not tackled.

Workforce gaps – Exist in some services, creating pressures both in terms of frontline patient care, and support services to our clinicians.

Our IT systems and data – Are not yet providing improved insight on which to base better decision-making; we still rely too much on paper.

Patient 'flow' – Through some of our services can be inconsistent; too many patients who could be safely discharged stay with us longer than necessary.

Variation – In some clinical practice variation undermines consistent performance and patient experience, impacting morale and our improvements.

Inefficiency – Across our hospitals inefficiency still exists in some services, and we have some excessive waiting times leading to poor patient experience.

Communication – With staff and patients can be difficult in an organisation of our size, complexity and diversity. Despite best efforts we don't always get it right.

Staff ownership – Of, and involvement in, service change can be inconsistent, impacting on their morale, increasing risk to improvements, and risks impacting patient experience.

Financial deficit – Has created a lack of capital investment, and ageing buildings, equipment, IT, and medical and diagnostic equipment. We have huge costs but there is more to do.

SWOT (cont'd)

Opportunities

Recruitment and retention – Of the best staff by ensuring we create roles that people want to do that help solve our workforce gaps, and we keep investing in and developing all our staff.

More patients could choose our services – If we reduce waiting times and how long patients have to stay with us while improving their experience while in our care, and communicate clearly with them.

University Hospital – This status could enhance patient care and outcomes through the positive impact of research, education and training and enable us to deliver more specialist services.

'Integrated Care Provider' – Contributing constructively would enable us to reduce barriers and improve how patients move between us and other providers, and within our own services.

Expand our services – To new clinical specialties and/or locations by assessing and improving our productivity and performance, and accurately model what we can achieve to make realistic bids.

Private Patient – Private services could improve our income and good reputation, increasing the amount we have available to invest in our NHS services and improving our long-term financial stability.

Working in community locations – Can be reviewed to understand where services are not working efficiently, and where we could provide excellent services outside our two main hospitals.

Efficiency, productivity and financial health – Can all be improved by innovative use of the resources we already have, improved digital and IT systems (e.g. telecare).

Population health – Can be a crucial part of what we do by promoting healthy lifestyle and choices for patients and staff alike, and ensuring we prevent ill-health whenever possible.

Threats

Growth in demand – Could exceed capacity to provide services in a timely fashion, creating risks to care, staff morale and financial sustainability.

Recruitment and retention – In various staff groups including doctors, nurses and professional support services.

Loss of market share – To other Trusts or new private providers due to attractive reward packages and work patterns; some contracts move simple procedures to providers with shorter waiting times while we continue providing higher-cost complex procedures.

Adverse impacts of NHS structural changes – The drive towards out-of-hospital care could leave us with liabilities and risks. Pace of change to deliver projects could conflict with operational capacity and priorities.

Sustainability of clinical services (including screening programmes) – Due to lack of capital, increasing stringency & subsequent resource demands of accreditations (e.g. labs), pathology networks etc, it may be challenging to sustain the current portfolio of provision in its current format.

Financial issues out of our control – Could worsen sustainability, such as outdated tariffs, increased outsourcing costs, inability to access greater purchasing power through regional arrangements.

Lack of commissioning – Of some of the work we do due to historical reasons, combined some lack of locally agreed tariffs, means that some services have no income.

External regulations – These could change or be applied stringently.

Brexit – The implications are relatively unknown despite planning; adverse national economy likely to hit public funds; workforce pipeline may be further constrained; disruption to supply chains and innovation routes.

Politicisation of healthcare – Both national and local, diverts support for 'right' decisions.

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Gloucestershire Hospitals
NHS Foundation Trust

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

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

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

Key issues to note
- The Trust Risk Register enables the Board to have oversight, and be assured of the active management, of the key risks within the organisation which have the potential to affect patient safety, care quality, workforce, finance, business, reputation or statutory matters.
- Divisions are required on a monthly basis to submit reports indicating any changes to existing high risks and any new 12+ for safety and 15+ other domains to the Trust Leadership Team (TLT) for consideration of inclusion on the Trust Risk Register.
- New risks are required to be reviewed and reassessed by the appropriate Executive Director prior to submission to TLT to ensure that the risk does not change when considered in a corporate context.

Changes in the reporting period
The Trust Leadership Team (TLT) met on 3 July 2019 and agreed the following changes to the Trust Risk Register:

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

M2268Emer - The risk of patient deterioration (Safety) due to lack of capacity leading to ED overcrowding with patients in the corridor.

Executive Lead: Steve Hams.
Score: a consequence of 3 (Moderate) x likelihood of 4 (Likely) = 12 for Safety.

M2473Emer - The risk of poor quality patient experience during periods of overcrowding in the Emergency Department

Executive Lead: Steve Hams.

Score: a consequence of 3 (Moderate) x likelihood of 5 (Almost Certain) = 15 for Quality.

Controls are in place for both of the above risks – detail of controls and further actions/mitigations is shown in Appendix 1.

No risks on TRR have been upgraded in this period.

One risk has had the wording changed.
F2335 - 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 FY20 CIP programme - this risk will remain as is, with the change of the date (i.e. FY 19 change to FY20)

Removal of risks/ closure of risks on the Trust Risk Register (TRR)
The audit process for 20018/19 has now been completed. Therefore the following 2018/19 finance risks have been removed from the Trust Risk Register:

F7242 - Risk that the Trust does not achieve the required cost improvement resulting in failure to deliver the Financial Recovery Plan for FY19.
(NB a similar, 2019/20 risk – reference F2927 – was added to the Trust Risk Register in June).

F2722 - Risk that the Trust's expenditure exceeds the budgets set resulting in failure to deliver the Financial Recovery Plan for FY19
(NB a similar, 2019/20 risk – reference F2928 – is on the Finance Risk Register, but that risk does not currently reach the criteria for the TRR).

As requested by the Board in June, a review of controls and actions has been undertaken to ensure they were up to date; consequently, some minor changes have been made to some risk (adding new controls/mitigations; removing completed actions etc.) e.g. S2275 – Health and Wellbeing hub service now shown as a control as Hub established; service reconfiguration ('part of the Centres of Excellence Programme and subject to engagement and consultation on the future model') added as action/mitigation.

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		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)**
	27 June 2019 (finance risk changes)					3 July 2019	

Outcome of discussion when presented to previous Committees/TLT
Changes to finance risks were discussed and agreed at the Finance and Digital Committee. TLT recommended to the Board endorsing the above changes to the TRR.

Appendix 1 **Trust Risk Register** **July 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
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 assisting 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	Partially 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. Estates and Facilities Committee and Board oversight	1. 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	Estates and Facilities 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 5. Health and Wellbeing Hub offering greater emotional well being services	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. Service reconfiguration (part of the Centres of Excellence Programme and subject to engagement and consultation on the future model	Partially complete	Major (4)	Likely - Weekly (4)	16	Surgical	Workforce	Medical Director	Trust Leadership Team, People and OD Committee
F2335	The risk of agency spend in clinical and non-clinical areas exceeding planned levels due to ongoing high vacancy levels, with resulting impact of delivery of FY20 CIP programme	1. Challenge to agency requests via VCP 2. Agency Programme Board receiving detailed plans from nursing medical workforce and operations working groups 3. Finance agency report review on a 6 monthly basis 4. Turnaround Implementation Board 5. Quarterly Executive Reviews	1. Convert locum/agency posts to substantive 2. Promote higher utilisation of internal nurse and medical bank 3. Implementation of Health Roster for roster and Bank management 4. Implementation of Master Vendor Agreement for Nursing Agency - improving the control of medical agency spend and authorisation 5. Finalise job planning 6. Ongoing recruitment processes including international recruitment 7. Creation of new medical roles such as Associate specialists 8. Creation of a health and wellbeing hub aimed at reducing absence and reliance on costly temporary solutions	Partially complete	Major (4)	Likely - Weekly (4)	16	Corporate, Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Finance	Chief Nurse	Finance and Digital Committee, People and OD Committee

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

Ref	Inherent Risk	Controls in place	Action / Mitigation	How would you assess the status of the controls?	Consequence	Likelihood	Risk rating	Division	Highest Scoring Domain	Executive Lead Title	Title of Assurance / Monitoring Committee
C2628COO	The risk of regulatory intervention (including fines) and poor patient experience resulting from the non-delivery of appointments within 18 weeks within the NHS Constitutional standards.	The standard is not being met and reporting is planned for March 2019 (February data). This risk is aligned with the recovery of Trak. Controls in place from an operational perspective are: 1.The daily review of existing patient tracking list 2. Additional resource to support central and divisional validation of the patient tracking list. 3.Review of all patients at 45 weeks for action e.g. removal from list (DNA / Duplicates) or 1st OPA, investigations or TCI. 4. A delivery plan for the delivery to standard across specialities is in place 5. Additional non-recurrent funding (between cancer/ diagnostics and follow ups) to support the reduction in long waiting	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
M2473Emer	The risk of poor quality patient experience during periods of overcrowding in the Emergency Department	1. Identified corridor nurse at GRH for all shifts 2. ED escalation policy in place to ensure timely escalation internally 3. Cubicle kept empty to allow patients to have ECG / investigations (GRH) 4. Pre-emptive transfer policy 5. Patient safety checklist up to 12 hours 6. Monitoring Privacy & Dignity by Senior nurses 7. ED Matron now in post 8. NAAS programme in place	1. CQC action plan for ED 2. Development of and compliance with 90% recovery plan	Partially Complete	Moderate (3)	Almost certain - Daily (5)	15	Medical	Quality	Director of Quality / Chief Nurse	Divisional Board, Quality and Performance Committee
C2667NIC	The risk of poor patient experience and/or outcomes as a result of hospital acquired C.Diff infection.	1. Strengthened infection control team. 2. Deputy Director of Infection control in post 3. New cleaning regime introduced	1. Delivery of the detailed action plan, developed and reviewed by the Infection Control Committee. The plan focusses on reducing potential contamination, improving management of patients with C.Diff, staff education and awareness, buildings and the environment and antimicrobial stewardship	Partially complete	Major (4)	Possible - Monthly (3)	12	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Director of Quality and Chief Nurse	Infection Control Committee, Quality and Performance Committee

Appendix 1 **Trust Risk Register** **July 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
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)		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
M2268Emer	The risk of patient deterioration (Safety) due to lack of capacity leading to ED overcrowding with patients in the corridor	1. Registered General Nurse (RGN) and Health Care Assistant (HCA) now identified on every shift to have responsibility for patients in the ambulance assessment corridor 2. Where possible room 24 to be kept available to rotate patients 9 (or identified alternative where 24 occupied) (GRH) 3. 8am - 12midnight consultant cover 7/7 (GRH) 4. Safety checklist 5. Escalation to silver/gold on call for extra help should the department require to overflow into the third (radiology) corridor. 6. Silver QI project undertaken to attempt to improve quality of care delivered in corridor 7. 90% recovery plan May 2019. 8. ED Matron now in post 9. NAAS programme in place	1. Complete CQC action plan 2. Compliance with 90% recovery plan	Partially Complete	Moderate (3)	Likely - Weekly (4)	12	Medical	Safety	Medical Director	Divisional Board, 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 – July 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 26th June 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
Risk Register	Noted concern in relation to the deteriorating patient and associated risk. Consideration of a collective nursing workforce risk in the context of the adult inpatient safe staffing review. Noted concern in relation to emergency surgery and the current review by the Surgical Division to understand the risk. Which will go on to TLT in the first instance	Care of deteriorating patients feature through the agenda items and do not appear as a risk, is that because the risk does not score highly enough? Papers indicate urgency needed to improve, are we confident that progress is being made quickly enough? What is the status of the pending functionality of Datix as this can be a source of assurance?	Current risk status being reassessed following the planned deteriorating patient quality summit. Description of current work in place, therefore not waiting for output of the deteriorating patient quality summit.Continual audit of NEWS2 Sepsis summits x 2 held with subsequent plans having been developed.	Undertake review of risk assessment and if appropriate risk, include in Corporate Risk register in July Review proactive use of pending function Deteriorating Patient deep dive to include sepsis to be presented to August committee

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Serious Incident Report	No new never Events reported Three new Serious incidents, two x 72-hour reports included for information. 10 PHSO cases open.	If a parent does not wish an external Health Safety Investigation Branch (HSIB) review into their case, what powers do HSIB have? Is there an update on the 72 hour report concerning immediate actions regarding concerns on deteriorating patient, nursing documentation and agency staff? How do you know local induction happens as it should?	None Local induction for agency staff in place and has been tested several times. Also reviewing substantive staff as issue not confined to temporary workers. Key areas to focus on is nighttime.	Split out PHSO data into those upheld and not upheld as more useful indicator. External work by CCG linking into agencies/care homes and training on NEWS2 and the deteriorating patient. Work ongoing led by Director of Quality and Chief Nurse on clarity of professional standards in clinical areas
Seven Day Services standards assurance briefing	Nationally reported standards set out and self-assessment of compliance Two of four standards assessed as achieved. Plan for clinical audit in quarter three to provide evidence with submission externally due on 28th June 2019.	What is the confidence in the reliability of the data sets? Given the last audit was in April 2018 and the gaps described, is the plan for Q3 audit too far away? Paper is not set out describing all the steps being taken, with timeline to achieve all four standards.	No concerns re data set reliability have been highlighted. Some assurance given that improvements are taking place without the audit results, (not explicit in the paper)	Limited assurance Agreed Chief Executive action to oversee progress before submission date. Paper to return for July committee review

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Quality and Performance Report	**Quality Delivery Group** Amended format, focusing on outcomes. End of Life review based on National Audit and GHT results. Surprise as indicators in use locally not highlighting any issues. Histology plan in place but will 'get worse' before it gets better Three agenda items deferred due to time constraints **Cancer Delivery Group** Comprehensive report, standard process control (SPC) charts now included Appendix E showing new rules vs old rules performance. **Planned Care Delivery Group** Detailed updates on key priority areas **Emergency Care Delivery Group** Attendance noted as increased and admission rate going up year on year	Observations that end of life group struggling to convert individual champions into wider influence across the Trust. What reflections are there on current metrics measured and any gaps re National Audit results? What does that mean for our patients? Are there any risks in deferring agenda items? Scale of demand increase noted and questions of external/system actions 104+ waiters What is the assurance on clinical review of potential harm of any long waiters? Delays, can updates include progress on the four areas identified as priorities (effective use of TrakCare, clinical flow and planning, Booking responsibilities,	Amended report format welcomed by the committee. Review of end of life focus and influence as a result of audit results. NAAS will in future include some metrics on end of life. Significant detailed work on this, with senior weekly check and challenge meetings on individual patient level information. Division challenging the timing of delivery, wanting it to be brought forward. Agenda was prioritised based on risk areas, deferred items will be at beginning of next meeti Every patient is tracked and reviewed through harm review process and multi-disciplinary team meetings Detail contained within the report, will be more explicit for	Updated NAAS to be presented to committee as per forward planner Review of outstanding end of life service externally with 'outstanding' organisations to compare and learn. Chief Executive to raise on Integrated Care System Board agenda for sightedness include summary level harm reviews in future papers. Confirmation to be included that the MDT reviews the PTL. Front door streaming and piece of work to be undertaken and reported back Flu plan to be added to forward planner

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
		assessment of harm) 52 weeks wait, upper and lower GI now featuring, why? How does it feel to be a patient in this process? What is the level of communications and when? Limited detail on reasons for admissions and understanding the behaviours at the front end of care Noting the data regarding Australian Flu, what implications if any for us?	future reports. Strengthened links between the patient safety team and the planned care team to ensure agile response to safety concerns. GI identified, actions described in terms of additional locum capacity and additional planned lists to mitigate the numbers. Assurance that management team review on a daily basis Data validation continues to be undertaken to ensure robust reporting. Content with operational grip on key issues. Individual patients managed at General Manager and Specialty Director level with direct and personal communications	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Maternity	Briefing on the system wide maternity safety plan, within Better Births context. Including system dashboard and safety culture. Endorsed the Local Maternity System Safety Improvement Plan. NHS Resolution 10 safety actions paper not included in pack so not discussed, for review on behalf of the Board at the July Committee.	Why is the local ambition for a 10% reduction in stillbirth when the national ambition is 20%? Important to see system plan and our part in that, what Trust data will we see on our clinical performance and when? How do we know the areas of on staff learning is where it should be in relation to a positive safety culture? What are the key high impact actions for most improvement?	Some data contained in general QPR but not detailed Key area of staff/ culture considered through staff survey undertaken, feedback just received. Good response, includes benchmarking, survey results by team and no initial surprises.	Ambition to be reviewed and reported back into Committee (July) Desire to report on internal data, review and propose level of reporting and frequency for forward planner To consider inclusion in joint P and OD/Q and P meeting in August To come to July meeting as sign off Needed thereafter by Board
Patient Experience Report	Annual report outlining theory, tools available, approaches taken and examples of learning from feedback.	How do we get assurance that the activities being undertaken are the right activities to support positive patient experience/ improvement? What is the aspiration to reach parts of population with different and varied language needs?	Noted that patient experience would be detailed within the forthcoming Quality Strategy.	Noting the absence of patient experience strategy (to be included in the Quality Strategy). Assurance will be focused on four areas, priorities, data and measures, Living the Values and Quality Improvement

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Learning From Deaths Report	Regular report demonstrating data, reviews becoming more embedded, noting pace needs to continue	What links, if any are there to other sources of evidence for learning e.g. LeDeR reviews?	Links exist through incident reporting and the use of Datix. Clarity on themes from previous quarter of Structured Judgement Reviews and associated improvement plans.	More work will be undertaken to ensure the links are explicit between different aspects of mortality reviews.
Outpatient Transformation programme	Detailed outline of Programme approach and governance route through planned care delivery group	How does patient feedback influence the Programme? Are volunteers used for their knowledge daily contacts and contribution?	Patient feedback embedded throughout the Programme and at different levels. Joint Outpatient Board in place.	Involvement of volunteers will be considered. Regular reporting through Planned Care Delivery Group.

Board to note:

- Discussion on progress within Integrated Care System
- GHFTT link Executive Directors now aligned to the seven Integrated Locality Partnerships (which include the primary care networks)
- Agreed piece of work to review lessons learnt in system decison making using new stroke unit and service as example.

Alison Moon
Chair of Quality and Performance Committee

Gloucestershire Hospitals
NHS Foundation Trust

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

Report Title	
Quality and Performance Report	
Sponsor and Author(s)	
Authors:	Felicity Taylor Drewe, Director of Planned Care, Deputy Chief Operating Officer
Sponsor:	Rachael DeCaux, Chief Operating Officer Steve Hams, Executive Director of Quality and Chief Nurse

Executive Summary

Purpose

This report summarises the key highlights and exceptions in Trust performance for the May 2019 reporting period.

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

Quality Delivery Report

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

Performance

During May the Trust did not meet the national standards or Trust trajectories for; A&E 4 hour standard and the 62 day cancer standard and the referral to treatment (RTT) standard. There remains significant focus and effort from operational teams to support performance recovery.

In May 2019, the trust performance against the 4hr A&E standard was 87.99%, including system performance was 91.7%. A 90% recovery plan has been completed and is being monitored at the Unscheduled Care Strategic service review meeting.

In respect of RTT, we are reporting 80.62% for May 2019. Operational teams continue to monitor and manage the long waiting patients on the Referral to Treatment pathways. As reported previously to the Board we will continue to see 52 week breaches, teams are working hard to address the key specialties in this regard, further information is provided within the exception report.

Our performance against the cancer standard saw non- delivery in delivery for the 2 week standard in May at 86.5%, (un-validated) continued compliance is expected, subject to fluctuations in referral rates.

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

Cancer 62 day Referral to Treatment (GP referral) performance for April was 79.7% (un-validated). For May current un-validated performance is 70.3% with 163.5 treatments and 48 breaches.
As last month, we are addressing our longest waiting patients and reviewing the opportunities for how we can support a reduction in the 104 patient cohort.

Conclusions

Cancer delivery, with a particular focus on delivery against the 62 day trajectory and sustaining A&E performance is the priority for the operational teams to continue the positive performance improvement, this is delivered through transformational change to patient pathways now robust operating models are developed.

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

Improvements to the Quality and Performance Report continue with further changes and reviews in the first quarter of 19/20.

Recommendations
The Trust Board is requested to receive the Report as assurance that the Executive team and Divisions fully understand the current levels of poor performance and have action plans to improve this position.
Impact Upon Strategic Objectives
Current performance jeopardises delivery of the Trust's strategic objective to improve the quality of care for our patients.
Impact Upon Corporate Risks
Continued poor performance in delivery of the two national waiting time standards ensures the Trust remains under scrutiny by local commissioners and regulators.
Regulatory and/or Legal Implications
Equality & Patient Impact
Failure to meet national access standards impacts on the quality of care experienced by patients. There is no evidence this impacts differentially on particular groups of patients.

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

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

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

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report

Reporting period May 2019

to be presented at June 2019 Quality and Performance Committee

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Gloucestershire Hospitals NHS Foundation Trust

Executive Summary

Gloucestershire Hospitals NHS Foundation Trust

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 May was 87.99% against the STP trajectory at 85.37% against a backdrop of significant attendances. The STP met the delivery of 90% for the system in May.

The Trust has met the diagnostics standard for May 0.67%.

The Trust has not met the standard for 2 week wait cancer at 86.50% in May, this is as yet un-validated performance at the time of the report.

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

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 this will be presented next month.

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.

Performance Against STP Trajectories

Gloucestershire Hospitals NHS Foundation Trust

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.
Note that data is subject to change.

Indicator		May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Referral to treatment ongoing pathways over 52 weeks (number)	Trajectory												95	93
	Actual	92	98	113	125	105	103	105	97	89	97	95	93	91
ED: % total time in department – under 4 hours (types 1 & 3)	Trajectory												90.00%	90.00%
	Actual	94.20%	95.33%	93.65%	93.45%	92.47%	93.60%	93.98%	91.29%	89.02%	90.21%	91.00%	90.39%	91.70%
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%	85.32%	85.37%
	Actual	91.58%	93.33%	91.34%	90.26%	89.01%	90.54%	91.59%	87.55%	84.46%	86.08%	87.13%	86.01%	87.99%
Referral to treatment ongoing pathways under 18 weeks (%)	Trajectory												78.00%	78.00%
	Actual											79.75%	79.46%	80.62%
% 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%	0.98%	0.98%
	Actual	1.26%	0.52%	0.55%	1.27%	0.63%	0.03%	0.35%	0.20%	0.67%	0.21%	0.45%	0.54%	0.67%
Cancer – urgent referrals seen in under 2 weeks from GP	Trajectory	93.00%	93.00%	93.00%	93.10%	93.00%	93.10%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%
	Actual	86.30%	88.60%	90.40%	88.90%	82.80%	91.70%	90.40%	94.30%	92.00%	93.90%	95.20%	87.90%	86.50%
2 week wait breast symptomatic referrals	Trajectory	93.30%	93.40%	93.40%	93.30%	93.20%	93.40%	93.40%	93.10%	93.00%	93.50%	93.10%	93.10%	93.20%
	Actual	91.90%	95.10%	96.00%	97.80%	98.90%	99.20%	94.60%	97.70%	95.50%	97.00%	95.60%	96.90%	97.30%
Cancer – 31 day diagnosis to treatment (first treatments)	Trajectory	96.30%	96.10%	96.20%	96.30%	96.20%	96.20%	96.30%	96.20%	96.40%	96.20%	96.40%	96.10%	96.20%
	Actual	96.90%	97.10%	96.80%	96.90%	93.50%	93.30%	93.20%	94.20%	92.90%	91.60%	92.10%	92.00%	92.40%
Cancer – 31 day diagnosis to treatment (subsequent – drug)	Trajectory	100.00%	98.80%	98.10%	100.00%	98.40%	98.00%	98.10%	100.00%	100.00%	100.00%	98.40%	98.10%	98.30%
	Actual	100.00%	100.00%	100.00%	100.00%	98.80%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	98.00%
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	Trajectory	95.80%	94.60%	95.10%	94.60%	95.00%	94.30%	94.70%	94.50%	94.40%	94.20%	94.40%	94.90%	94.40%
	Actual	100.00%	100.00%	98.70%	100.00%	100.00%	98.60%	98.70%	98.60%	100.00%	98.90%	98.70%	96.40%	97.40%
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	Trajectory	95.00%	94.20%	95.90%	94.60%	95.30%	94.30%	95.00%	94.80%	94.30%	94.60%	94.20%	94.00%	95.50%
	Actual	96.60%	94.50%	96.00%	95.70%	94.30%	98.30%	96.80%	92.90%	93.20%	96.60%	96.60%	94.00%	92.50%
Cancer 62 day referral to treatment (screenings)	Trajectory	94.70%	90.50%	90.00%	91.20%	92.10%	92.90%	92.90%	90.90%	92.90%	92.90%	90.90%	90.30%	90.90%
	Actual	94.10%	100.00%	100.00%	100.00%	85.50%	93.50%	93.80%	100.00%	94.10%	96.40%	100.00%	100.00%	96.60%
Cancer 62 day referral to treatment (upgrades)	Trajectory	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Actual	100.00%	84.60%	53.30%	100.00%	75.00%	73.30%	58.80%	70.00%	71.40%	60.00%	77.30%	44.40%	57.10%
Cancer 62 day referral to treatment (urgent GP referral)	Trajectory	84.40%	85.30%	79.70%	77.10%	81.70%	82.00%	83.70%	82.80%	80.90%	82.60%	85.40%	81.80%	82.30%
	Actual	79.90%	66.90%	74.70%	76.30%	69.00%	69.40%	78.70%	74.90%	76.80%	66.20%	77.40%	79.70%	70.20%

Summary Scorecard

Gloucestershire Hospitals NHS Foundation Trust

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
% of adult inpatients who have received a VTE risk assessment
Number of never events reported
Number of trust apportioned Clostridium difficile cases per month
Number of trust apportioned MRSA bacteraemia
Safety thermometer – % of new harms

Effective
% C-section rate (planned and emergency)
Emergency re-admissions within 30 days following an elective or emergency spell
Hospital standardised mortality ratio (HSMR)
Hospital standardised mortality ratio (HSMR) – weekend

Caring
ED % positive
Maternity % positive
Number of breaches of mixed sex accommodation
Outpatients % positive

Responsive
% of ambulance handovers that are over 60 minutes
% waiting for diagnostics 6 week wait and over (15 key tests)
Cancer 62 day referral to treatment (screenings)
Cancer 62 day referral to treatment (upgrades)
Cancer 62 day referral to treatment (urgent GP referral)
Did not attend (DNA) rates
ED: % total time in department – under 4 hours (type 1)
ED: % total time in department – under 4 hours (types 1 & 3)
Referral to treatment ongoing pathways over 52 weeks (number)
Referral to treatment ongoing pathways under 18 weeks (%)

Well Led
% sickness rate
% total vacancy rate
% turnover
Cost Improvement Year to Date Variance
NHSI Financial Risk Rating
Overall % of nursing shifts filled with substantive staff
Trust total % mandatory training compliance
Trust total % overall appraisal completion
YTD Performance against Financial Recovery Plan

Demand and Activity

Gloucestershire Hospitals NHS Foundation Trust

The table below shows monthly activity for key areas. The columns to the right show the percentage change in activity from the previous year, by comparing the activity that occurred in the same month in the previous year, and in the same year to date periods.

Measure	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	% change from previous year Monthly (May)	% change from previous year YTD
GP referrals	14,183	14,033	13,418	13,332	12,842	15,690	14,814	11,965	14,521	13,202	14,044	13,094	13,415	-5.41%	-5.05%
OP attendances	13,619	13,642	13,983	12,721	12,318	14,284	14,707	11,084	14,083	12,474	13,525	12,663	13,025	-4.36%	-2.28%
Day cases	5,641	5,886	6,392	6,127	5,793	6,828	6,766	5,833	6,167	5,995	6,318	5,815	6,520	15.58%	13.76%
All electives	6,818	7,086	7,524	7,125	6,831	7,901	7,877	6,837	7,124	6,955	7,465	7,255	7,556	10.82%	13.83%
ED attendances	12,961	12,533	13,482	12,200	12,488	12,610	12,230	12,639	12,962	11,701	13,245	12,949	13,618	5.07%	8.0%
Non electives	4,838	4,559	4,823	4,602	4,668	4,878	5,088	5,081	5,132	3,085	4,900	4,696	4,861	0.48%	0.07%

Trust Scorecard – Safe (1)

OVERALL SCORE

Note that data in the Trust Scorecard section is subject to change.

	18/19	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	18/19 Q4	19/20	Standard	Threshold
Infection Control																		
Number of trust apportioned MRSA bacteraemia	6	0	0	1	1	2	0	0	0	0	0	1	0	1	1	1	0	
MRSA bacteraemia – infection rate per 100,000 bed days													0	3.5		1.7	TBC	
Number of trust apportioned Clostridium difficile cases per month	56	9	2	7	6	3	4	4	1	6	5	4	7	6	15	13	<=8	
Clostridium difficile – infection rate per 100,000 bed days													24.7	20.8		22.7	<30.2	
Number of MSSA bacteraemia cases	164	9	10	13	8	14	9	4	2	25	30	31	0	1	86	0	TBC	
MSSA – infection rate per 100,000 bed days												31	0	3.5		1.7	TBC	
Number of ecoli cases	295	15	24	23	28	32	25	4	3	39	41	44	5	4	124	5	N/A	
Number of pseudomona cases	59	1	3	8	3	3	3	1	0	11	12	12	1	0	35	1	N/A	
Number of klebsiella cases	135	6	1	9	7	10	7	3	2	25	28	31	1	3	84	1	N/A	
Number of bed days lost due to infection control outbreaks													40	66		40	<10	>30
Patient Safety Incidents																		
Number of patient safety alerts outstanding	5												5	1	5	5	0	
Number of falls per 1,000 bed days		7.6	8.3	6.9	6.3	7.5	7.3	6.8	7.2	6.8	7.1	6	6.6	6			TBC	
Number of falls resulting in harm (moderate/severe)	8	8	7	11	6	9	8	6	8	8	2	7	3	4			TBC	
Number of patient safety incidents – severe harm (major/death)	1	1	1	1	1	2	1	0	1	0	3	7	13	7			TBC	
Medication error resulting in severe harm												0	0	0			TBC	
Medication error resulting in moderate harm												1	1	3			TBC	
Medication error resulting in low harm												12	10	15			TBC	
Number of category 2 pressure ulcers acquired as in-patient		31	43	31	31								43	36			TBC	
Number of category 3 pressure ulcers acquired as in-patient		8	7	11	7								10	7			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	14			TBC	

Trust Scorecard – Safe (2)

OVERALL SCORE

	18/19	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	18/19 Q4	19/20	Standard	Threshold
RIDDOR																		
Number of RIDDOR		0	1	2	2	5	4	1	4	1	3	3	2	2			SPC	
Safety Thermometer																		
Safety thermometer – % of new harms		97.80%		98.40%	97.70%	98.60%	98.50%	97.90%	97.30%	97.30%	97.70%	97.20%	96.20%	97.20%			>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	0	0	0	0	0	0	0	0	0	0	1	1	0			Zero	
Number of serious incidents reported		10	5	0	4	4	2	1	1	3	0	3	2	3			Zero	
Serious incidents – 72 hour report completed within contract timescale		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%			>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	93.20%	96.60%	91.70%	94.80%	94.60%	93.80%	94.80%	95.40%	90.70%	96.60%	94.20%	94.80%	95.40%	88.60%	95.20%	93.40%	>97%	<=95%

Trust Scorecard – Effective (1)

OVERALL SCORE

	18/19	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	18/19 Q4	19/20	Standard	Threshold
Dementia Screening																		
% of patients who have been screened for dementia (within 72 hours)	1.90%	1.60%	1.60%	1.70%	3.50%	2.30%	1.80%	2.60%	3.30%	1.90%	0.80%	0.60%	0.40%	0.30%	1.20%	0.40%	>=90%	<70%
% of patients who have scored positively on dementia screening tool that then received a dementia diagnostic assessment (within 72 hours)	27.90%	16.70%	33.30%	11.10%	41.20%	18.20%	33.30%	22.20%	26.30%	40.00%	0.00%	33.30%	100%	50.00%	30.40%	100%	>=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)	2.80%	0.00%	0.00%	0.00%	12.50%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	>=90%	<70%
Maternity																		
% C-section rate (planned and emergency)	26.78%											29.71%	28.93%	30.20%	28.59%	29.57%	<=25%	>=27%
% emergency C-section rate	14.13%											16.11%	16.31%	16.73%	15.66%	16.52%	<=14%	
% of women that have an induced labour	29.19%											31.17%	29.13%	27.96%	30.68%	28.54%	<=20%	>25%
% stillbirths as percentage of all pregnancies > 24 weeks	0.26%											0.21%	0.39%	0.00%	0.21%	0.19%	<0.52%	
Mortality																		
Summary hospital mortality indicator (SHMI) – national data	102.6		103.3			102.6											Dr Foster	
Hospital standardised mortality ratio (HSMR)	95.2	95.2	96	96.4	98.1	99.8	100.8	99.1	97.7	97.2	95.2						Dr Foster	
Hospital standardised mortality ratio (HSMR) – weekend	97.2	97.3	97.1	97.9	96.6	98.4	101.7	101.4	99.3	101.3	97.2						Dr Foster	
Number of inpatient deaths												167	162	161		323	N/A	
Number of deaths of patients with a learning disability												2	4	1		5	N/A	
Readmissions																		
Emergency re-admissions within 30 days following an elective or emergency spell	6.90%	6.90%	7.20%	7.20%	7.20%	6.80%	7.10%	6.10%	7.10%	6.70%	6.90%	6.30%	7.30%		6.60%	7.30%	<8.25%	>8.75%
Research																		
Research accruals	1,621	136	406	149	147	121	199	96	84	71	81	91	115	119	267		TBC	

Trust Scorecard – Effective (2)

OVERALL SCORE

	18/19	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	18/19 Q4	19/20	Standard	Threshold
Stroke Care																		
Stroke care: percentage of patients receiving brain imaging within 1 hour	36.90%	50.0%	40.6%	37.8%	47.0%	41.5%	34.3%	26.6%	31.9%	37.1%	32.7%	22.4%	52.1%	55.3%	31.7%	53.70%	>=50%	<45%
Stroke care: percentage of patients spending 90%+ time on stroke unit	90.80%	95.1%	95.6%	94.1%	97.2%	93.4%	80.7%	87.7%	91.9%	88.7%	84.1%	87.7%	85.7%		86.9%	85.70%	>=80%	<70%
% of patients admitted directly to the stroke unit in 4 hours												51.70%	68.10%	62.70%		65.30%	>=80%	<72%
% patients receiving a swallow screen within 4 hours of arrival												70.70%	52.10%	59.20%		55.80%	>=90%	<80%
Trauma & Orthopaedics																		
% of fracture neck of femur patients treated within 36 hours	76.00%	79.40%	68.30%	74.20%	88.70%	85.50%	67.70%	70.10%	75.00%	83.90%	85.60%	77.80%	80.20%	81.80%	82.60%		>=90%	<80%
% fractured neck of femur patients meeting best practice criteria												77.78%	77.78%	81.82%	79.80%		>=65%	<55%

Trust Scorecard – Caring

OVERALL SCORE

	18/19	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	18/19 Q4	19/20	Standard	Threshold
Friends & Family Test																		
Inpatients % positive	91.20%	91.4%	91.7%	91.7%	90.7%	91.9%	92.2%	90.9%	91.50%	91.90%	89.20%	91.50%	89.10%	90.8%	90.90%	90.0%	>=96%	<93%
ED % positive	83.10%	83.2%	84.6%	83.6%	82.0%	85.9%	82.7%	82.7%	81.00%	82.70%	82.80%	82.70%	82.70%	81.9%	82.70%	82.3%	>=84%	<81%
Maternity % positive	96.70%	94.0%	95.6%	93.3%	94.7%	0.0%	100.0%	98.2%	100%	100%	93.50%	97.50%	96.60%	97.0%	97.00%	96.8%	>=97%	<94%
Outpatients % positive	92.60%	92.3%	92.3%	93.3%	91.9%	92.3%	93.0%	92.5%	92.90%	93.40%	92.50%	93.10%	92.80%	93.2%	93.00%	93.0%	>=94%	<91%
Total % positive	91.2%	91.2%	91.3%	91.6%	90.3%	91.6%	91.8%	91.2%	90.90%	91.90%	90.7%	91.4%	90.60%	91.1%	91.30%	90.8%	>=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	20	5	6	0	7	2	6	2	1	3	4	11	6	15	<=10	>=20

Trust Scorecard – Responsive (1)

OVERALL SCORE

	18/19	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	18/19 Q4	19/20	Standard	Threshold
Cancer																		
Cancer – urgent referrals seen in under 2 weeks from GP	90.00%	86.3%	88.6%	90.4%	88.9%	82.8%	91.7%	90.4%	94.3%	92.0%	93.9%	95.2%	87.90%	86.50%	93.8%	86.60%	>=93%	<90%
2 week wait breast symptomatic referrals	95.80%	91.9%	95.1%	96.0%	97.8%	98.9%	99.2%	94.6%	97.7%	95.5%	97.0%	95.6%	96.90%	97.30%	96.0%	96.80%	>=93%	<90%
Cancer – 31 day diagnosis to treatment (first treatments)	94.60%	96.9%	97.1%	96.8%	96.9%	93.5%	93.3%	93.2%	94.2%	92.9%	91.6%	92.1%	92.00%	92.40%	92.2%	93.30%	>=96%	<94%
Cancer – 31 day diagnosis to treatment (subsequent – drug)	99.90%	100.0%	100.0%	100.0%	100.0%	98.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.00%	100.0%	100.0%	>=98%	<96%
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	95.30%	96.6%	94.5%	96.0%	95.7%	94.3%	98.3%	96.8%	92.9%	93.2%	96.6%	96.6%	94.00%	92.50%	95.5%	95.50%	>=94%	<92%
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	99.30%	100.0%	100.0%	98.7%	100.0%	100.0%	98.6%	98.7%	98.6%	100.0%	98.9%	98.7%	96.40%	97.40%	99.2%	95.30%	>=94%	<92%
Cancer 62 day referral to treatment (urgent GP referral)	74.80%	79.9%	66.9%	74.7%	76.3%	69.0%	69.4%	78.7%	74.9%	76.8%	66.2%	77.4%	79.70%	70.20%	73.7%	78.50%	>=85%	<80%
Cancer 62 day referral to treatment (screenings)	96.50%	94.1%	100.0%	100.0%	100.0%	85.5%	93.5%	93.8%	100.0%	94.1%	96.4%	100.0%	100.0%	96.60%	96.9%	100.0%	>=90%	<85%
Cancer 62 day referral to treatment (upgrades)	68.90%	100.0%	84.6%	53.3%	100.0%	75.0%	73.3%	58.8%	70.0%	71.4%	60.0%	77.3%	44.40%	57.10%	71.7%	30.00%	>=90%	
Number of patients waiting over 104 days with a TCI date	141	12	6	8	22	26	7	13	8	8	8	14	20	15	30	20	Zero	
Number of patients waiting over 104 days without a TCI date	347	18	22	28	24	30	39	37	27	42	37	25	19	30	104	19	TBC	
Diagnostics																		
% waiting for diagnostics 6 week wait and over (15 key tests)	0.45%	1.26%	0.52%	0.55%	1.27%	0.63%	0.03%	0.35%	0.20%	0.67%	0.21%	0.45%	0.54%	0.67%	0.45%	0.67%	<=1%	>2%
The number of planned / surveillance endoscopy patients waiting at month end	726	223	260	311	407	576	630	680	686	639	600	726	835	977	726	977	TBC	
Discharge																		
Number of patients delayed at the end of each month	43	27	36	47	44	41	44	40	34	29	24	43	45	39	43	39	TBC	
Patient discharge summaries sent to GP within 24 hours	50.50%	50.10%	51.60%	52.60%	49.60%	51.80%	51.50%	49.10%	47.10%	51.90%	49.50%	50.90%	56.60%		50.80%	56.60%	>=88%	<75%

Trust Scorecard – Responsive (2)

OVERALL SCORE

	18/19	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	18/19 Q4	19/20	Standard	Threshold
Emergency Department																		
ED: % total time in department – under 4 hours (type 1)	89.60%	91.58%	93.33%	91.34%	90.26%	89.01%	90.54%	91.59%	87.55%	84.46%	86.08%	87.13%	86.01%	87.99%	85.89%	86.01%	>=95%	<90%
ED: % total time in department – under 4 hours (types 1 & 3)	92.78%	94.20%	95.33%	93.65%	93.45%	92.47%	93.60%	93.98%	91.29%	89.02%	90.21%	91.00%	90.39%	91.70%	90.09%	90.39%	>=95%	<90%
Count of handover delays 60+ minutes													0.00%	0.00%			Zero	
ED: % total time in department – under 4 hours CGH	96.40%	98.10%	96.30%	96.90%	96.00%	96.40%	96.90%	96.94%	95.47%	93.70%	95.50%	96.10%	94.66%	96.04%	95.10%	94.66%	>=95%	<90%
ED: % total time in department – under 4 hours GRH	86.20%	88.10%	91.80%	88.40%	87.40%	85.20%	87.30%	89.06%	83.82%	80.10%	81.60%	82.80%	81.89%	84.16%	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	Zero	
ED: % of time to initial assessment – under 15 minutes	87.4%	90.3%	90.8%	88.6%	90.7%	87.3%	88.8%	89.6%	85.4%	85.20%	83.6%	78.4%	75.80%	78.30%	82.3%	77.10%	>=95%	<92%
ED: % of time to start of treatment – under 60 minutes	33.5%	33.6%	34.1%	31.4%	34.3%	29.0%	36.7%	34.5%	32.1%	34.90%	32.4%	32.6%	32.00%	35.90%	33.3%	34.00%	>=90%	<87%
% of ambulance handovers that are over 30 minutes												7.90%	1.66%	1.28%		1.66%	TBC	
% of ambulance handovers that are over 60 minutes												0.10%	0.03%	0.00%		0.03%	<=1%	>2%
Operational Efficiency																		
Number of patients stable for discharge	73	66	71	71	75	80	75	76	69	74	72	77	86	77	74	82	TBC	
% of bed days lost due to delays													4.74%	3.78%		3.78%	<=3.5%	>4%
Number of stranded patients with a length of stay of greater than 7 days	384	395	369	373	382	376	374	382	374	399	412	397	389	391	402	390	TBC	
Average length of stay (spell)	5.05	4.92	4.88	4.78	5.11	5	5.05	5.14	4.83	5.14	5.35	4.98	5.06	5.35	5.15	5.21	TBC	
Length of stay for general and acute non-elective (occupied bed days) spells	5.66	5.55	5.59	5.38	5.62	5.58	5.72	5.77	5.29	5.7	6.07	5.67	5.56	5.99	5.8	5.78	TBC	
Length of stay for general and acute elective spells (occupied bed days)	2.71	2.78	2.52	2.61	3	2.75	2.47	2.84	2.89	2.6	2.67	2.56	2.78	2.68	2.61	2.73	<=3.4	>4.5
% day cases of all electives												84.60%	80.00%			80.00%	>80%	<70%
Intra-session theatre utilisation rate													87.80%	88.49%			>85%	<70%
Outpatient																		
Outpatient new to follow up ratio's												1.93	1.91	1.92		1.92	TBC	
Did not attend (DNA) rates												6.40%	6.80%	6.90%		6.90%	<=7.6%	>10%

Trust Scorecard – Responsive (3)

OVERALL SCORE

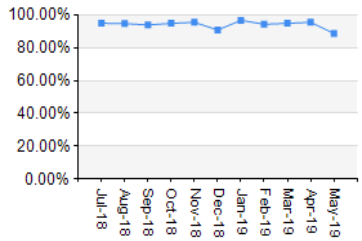
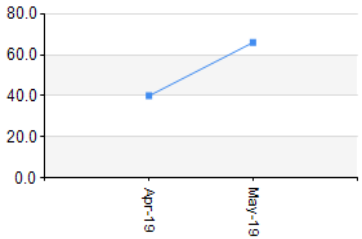
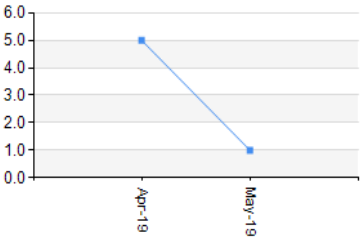
	18/19	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	18/19 Q4	19/20	Standard Threshold
RTT																	
Referral to treatment ongoing pathways under 18 weeks (%)	79.75%											79.75%	79.46%	80.63%	79.75%	80.63%	>=92%
Referral to treatment ongoing pathways 35+ Weeks (number)	2,352											2,352	2,163	2,149	2,352	2,149	TBC
Referral to treatment ongoing pathways 40+ Weeks (number)	1,860											1,860	1,699	1,748	1,860	1,748	TBC
Referral to treatment ongoing pathways over 52 weeks (number)	95	92	98	113	125	105	103	105	97	89	97	95	93	91	95	91	Zero
SUS																	
Percentage of records submitted nationally with valid GP code	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%	100%	>=99%
Percentage of records submitted nationally with valid NHS number	99.80%	99.8%	99.8%	99.8%	99.8%	99.8%	99.80%	99.80%	99.80%	99.80%	99.80%	99.80%	99.80%		99.80%	99.80%	>=99%

Trust Scorecard – Well Led

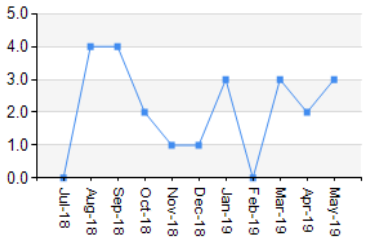
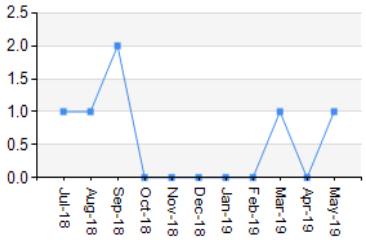
OVERALL SCORE

	18/19	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	18/19 Q4	19/20	Standard	Threshold
Appraisal and Mandatory Training																		
Trust total % overall appraisal completion	79.00%		74.0%	74.0%	75.00%	79.0%	80.00%	79.00%	79.00%	79.0%	79.0%	81.00%	80.00%	81.00%	81.0%	81.00%	>=90%	<70%
Trust total % mandatory training compliance	89%		87%	87%	88%	90%	91%	91%	91%	89%	89%	91%	91%	91%	91%	91%	>=90%	<70%
Finance																		
NHSI Financial Risk Rating		4	4	4	4	4	4	4	4	3	4	4	3	3			TBC	
YTD Performance against Financial Recovery Plan		.07	.09	0.18	.2	.2	.2	.4	.04	-3	-6.6	-14.1	0.1	0.3			TBC	
Total PayBill Spend		28.5	28.05	28.5	30.5	27.5	29.5	29.03	29.7	29.4	29.9	33.3	31.8	30.8			TBC	
Agency – Performance Against NHSI Set Agency Ceiling		2	2	2	2	3	3	3	3	3	3	3	3	3			TBC	
Cost Improvement Year to Date Variance		121	1,116	2,365	2,342	2,975	2,994	2,013	1,593	0	-1,784	-3,378	0	0.8			TBC	
Capital service		4	4	4	4	4	4	4	4	4	4	4	4	4			TBC	
Liquidity		4	4	4	4	4	4	4	4	4	4	4	4	4			TBC	
Safe Nurse Staffing																		
Overall % of nursing shifts filled with substantive staff													96.55%	96.40%		96.40%	>=75%	<70%
% registered nurse day													97.90%	97.90%		97.90%	>=90%	<80%
% unregistered care staff day													97.00%	99.20%		98.10%	>=90%	<80%
% registered nurse night													94.10%	93.50%		93.80%	>=90%	<80%
% unregistered care staff night													100.3%	99.40%		99.90%	>=90%	<80%
Care hours per patient day RN												6.2	4.61	4.6		4.6	TBC	
Care hours per patient day HCA												3.2	2.8	2.9		2.8	TBC	
Care hours per patient day total	7	7	8	7	7	7	7	7	7	7	7	8	7	8	7	7	TBC	
Vacancy and WTE																		
% total vacancy rate													11.46%	11.50%			<=11.5%	>13%
% vacancy rate for doctors													8.07%	8.00%			<=5%	>5.5%
% vacancy rate for registered nurses													12.09%	12.00%			<=5%	>5.5%
Staff in post FTE													6181.16	6183.48			TBC	
Vacancy FTE													792.72	792			TBC	
Starters FTE													65.5	65			TBC	
Leavers FTE													55.14	55			TBC	
Workforce Expenditure and Efficiency																		
% turnover	11.8%	11.8%	12.3%	12.3%	12.0%	12.1%	11.9%	11.6%	11.7%	11.7%	11.9%	12.2%	11.8%	11.80%			<=11%	>15%
% turnover rate for nursing	10.99%												10.93%	10.93%			<=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%	3.90%				<=3.5%	>4%

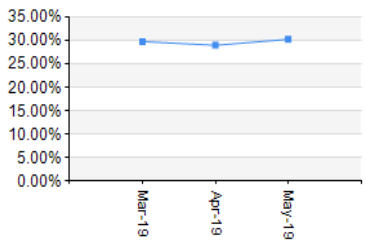
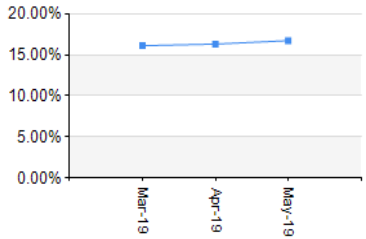
Exception Reports – Safe (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of adult inpatients who have received a VTE risk assessment **Standard: R<=95% A96% G>97%**		Performance through local audit collection remains around 94-95%	Director of Safety
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 May. As a mean to control the outbreak bays a ward and bays 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
Number of patient safety alerts outstanding **Standard: 0**		There is one outstanding PSA in Orthoapedics due to difficulty in accessing records, the notes are being checked for the wrong type of surgical plate being used for a procedure. The alert will be closed by the 30th June 2019	Director of Safety

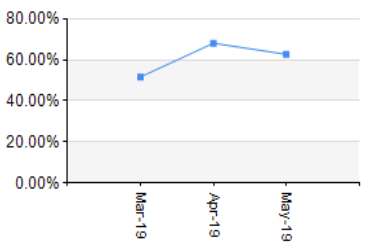
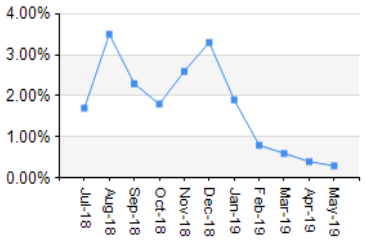
Exception Reports – Safe (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of serious incidents reported **Standard: 0**		SIs are monitored at effectively throughout the system. The numbers will vary with a normal range of 0-10 per month, clusters of incidents would be reviewed together.	Director of Safety
Number of trust apportioned MRSA bacteraemia **Standard: 0**		There was one trust apportioned MRSA bacteraemia case in May. This has been investigated through the post infection review (PIR) process and discussed at a multi-disciplinary PIR meeting. Findings identified the peripheral venous catheter (PVC) as a possible source of infection. In particular, ongoing care and monitoring of the PVC was not always completed and the patient experienced several failed attempts at cannulation. A local ward based action plan has been formulated to improve invasive device care management and provide assurance of improvements, which is being supported by the Infection Prevention and Control Team. On a wider trust level the peripheral venous cannulation documentation has been updated. The documentation now includes vessel health and preservation assessment to support placement of clinically appropriate venous access based on patient need and vein assessment and twice daily device monitoring/ evaluation. The new form is presently being piloted across 3 wards and is expected to be launched in July 2019 with a trust wide educational update supported by clinical skills and IPCT.	Associate Chief Nurse and Deputy Director of Infection Prevention and Control

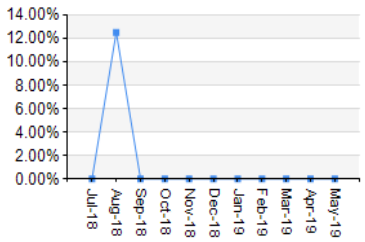
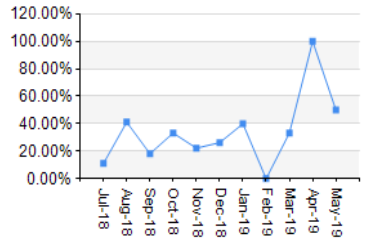
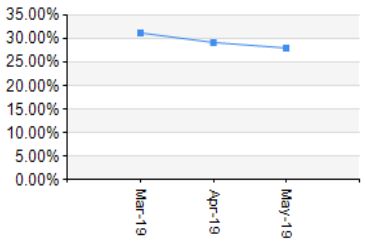
Exception Reports – Effective (1)

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. An audit is being undertaken by one of the Registrars to ascertain the main reasons for both emergency and elective caesareans.	Divisional Chief Nurse and Director of Midwifery
% emergency C-section rate **Standard: R>14% G<=14%**		National and Regional benchmarking to be undertaken. An audit is being undertaken by one of the Registrars to ascertain the main reasons for both emergency and elective caesareans.	Divisional Chief Nurse and Director of Midwifery

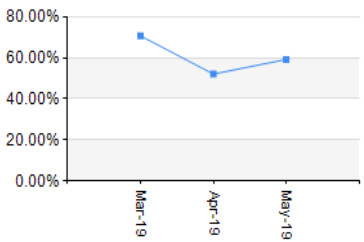
Exception Reports – Effective (2)

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%**		63.6% of patients were admitted to the Stroke Unit within 4 hours in May 2019. By comparison, 67.5% of patients in April 2019 were admitted within 4 hours. This is a performance deterioration of 3.9% and represents 25 patents out of a total 46 admitted to the Stroke Unit in May failing the standard. Analysis of the breaches is as per below: 15/25 (60%) of breaches were attributable to medical patients bed blocking on the Stroke Unit leading to patients being held in AMU for a number of hours. 7/25 (28%) of breaches were due to patients not having a clear diagnosis of a stroke, leading to the patient remaining in their existing inpatient bed for a proportion of time whilst further tests / observations were required. 1/25 breaches did not have a clear breach reason specified 2/25 breaches were due to delayed assessment by the Stroke team which had a knock on impact to the rest of the pathway.	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%**		EPR is the long term solution remains unresolved. Paper audits have been completed.	Deputy Chief Nurse

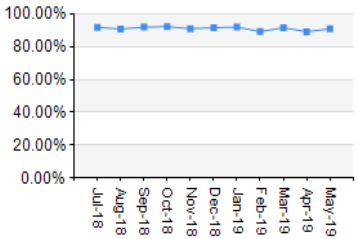
Exception Reports – Effective (3)

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)		EPR is the long term solution remains unresolved. Paper audits have been completed.	Deputy Chief Nurse
% of patients who have scored positively on dementia screening tool that then received a dementia diagnostic assessment (within 72 hours) Standard: R<70% A70-89% G>=90%		EPR solution is long term plan. Paper audits of pathway have been completed in acute care areas.	Deputy Chief Nurse
% of women that have an induced labour Standard: R>25% A21-25% G<=20%		The induction of labour increase should be addressed by new guidelines; which are currently in the process of being developed, specifically around reduced foetal movement. When comparing IOL with other Trusts within the South West, our figures are comparable and no worse than others within the Region.	Divisional Chief Nurse and Director of Midwifery

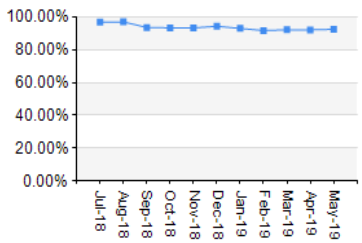
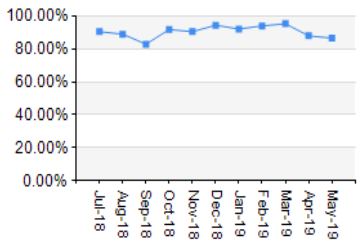
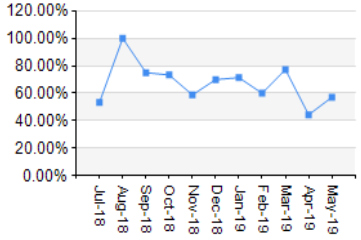
Exception Reports – Effective (4)

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%**		In May 2019 there was performance improvement against the April position (70.6% May versus 62.5% in April). The service delivered an underperformance of 5% however against the national standard. The analysis of the 23 breaches is below: 10/42 patients breached swallow screen owing to delays in getting admitted to the Stroke Unit due to medical patients on the ward. 5/42 patients were delayed in receiving their swallow screen on the Stroke Unit but did arrive in time 5/42 patients were too unwell and therefore did not receive a swallow screen 3/42 patients were either a difficult diagnosis and were already an inpatient on another ward or a transfer from CGH inpatient ward.	Director of Unscheduled Care and Deputy Chief Operating Officer

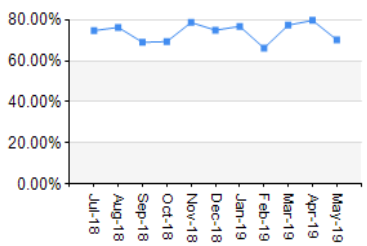
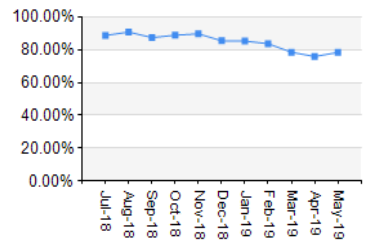
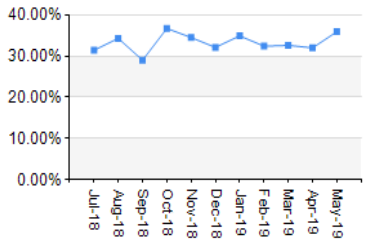
Exception Reports – Caring

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Inpatients % positive **Standard: R<93% A93-95% G>=96%**		The Trust target is 93%. This has not been met since it was introduced in 2016. The score for this time period is 90.8%. Picker are running a workshop on 11 July, looking at our National Inpatient survey scores, to identify areas for improvement to be led by teams across the Trust. This is being attended by all divisions. We are piloting a 'placemat' for patients at 3 wards in Cheltenham, that looks at improving the amount of feedback we get from patients, and raising awareness of the ways they can provide feedback to the organisation. If successful, this pilot will be rolled out to wards across the organisation, to encourage more feedback from our patients, and hopefully improve patient experience by encouraging more dialogue.	Deputy Director of Quality

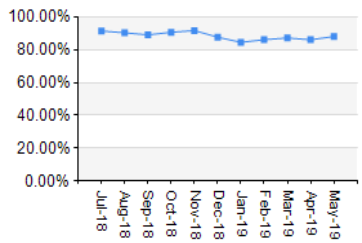
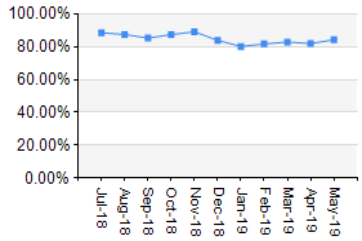
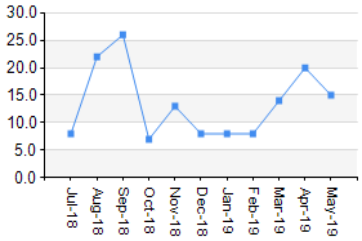
Exception Reports – Responsive (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Cancer – 31 day diagnosis to treatment (first treatments) **Standard: R<94% A94-95% G>=96%**		Performance - 92.6% 269 treatments 20 breaches (17 of which were Urology) National performance - 96.3%	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%**		Performance - 86.5% 2171 Date First Seens 293 breaches National performance 89.9% Lower GI 163 breaches (56.4%)- Specific 2ww demand and capacity work has highlighted that demand for endoscopy is outstripping capacity currently. Task and finish group established for endoscopy and additional GLANSO lists agreed. Skin 88 (83.1%) - performance has now stabilised for June	Director of Planned Care and Deputy Chief Operating Officer
Cancer 62 day referral to treatment (upgrades) **Standard: >=90%**		Performance - 57.1% National performance - 85% 3.5 treatments 1.5 breaches	Director of Planned Care and Deputy Chief Operating Officer

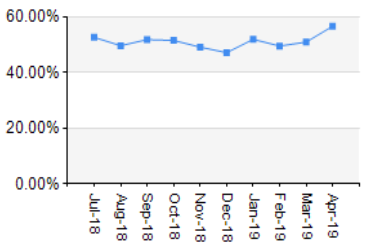
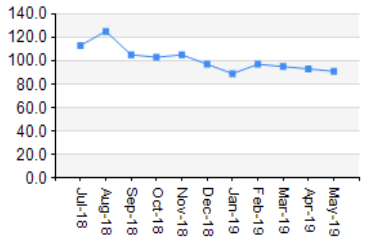
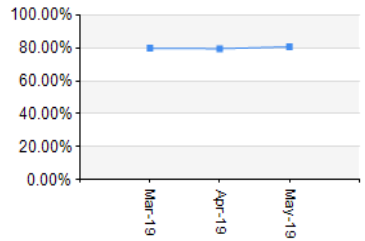
Exception Reports – Responsive (2)

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 - 70.3% 163.5 tx 48 breaches National performance - 79.4% Uro 18 (42.9%) LGI 6.5 (72.3%) Lung 4.5 (69.7%) Upper GI 4 (65.2%) Gynae 4 (69.2%)	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%**		An improvement from April. Locally the aim is to triage within 15 mins, reporting next month will reflect national standards.	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%**		Slightly improved performance from April. Next month reporting will share time at median and 95th centile under 60 mins.	Director of Unscheduled Care and Deputy Chief Operating Officer

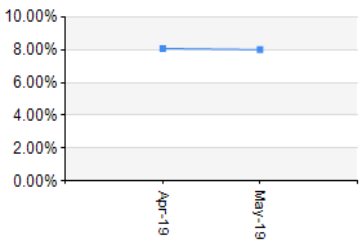
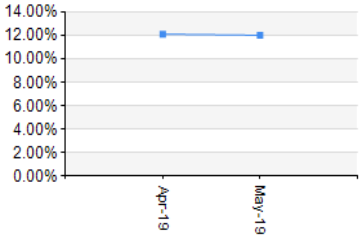
Exception Reports – Responsive (3)

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%**		System level performance for May was 91.7%. Trust performance was 87.99%. A full exception report detailing both performance and delivery actions is included.	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%**		See exception report.	Director of Unscheduled Care and Deputy Chief Operating Officer
Number of patients waiting over 104 days with a TCI date **Standard: 0**		Row Labels Count of MRN Urological (excl. testicular) 25 Lower gastrointestinal 2 Breast 1 Head & neck 1 Grand Total 29	Director of Planned Care and Deputy Chief Operating Officer

Exception Reports – Responsive (4)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Patient discharge summaries sent to GP within 24 hours **Standard: R<75% A75-87% G>=88%**		Percentage sent within 24 hours remains static despite a number of improvement projects, education and training and performance reporting. Different approaches being worked up at present for implementation in August 2019.	Medical Director
Referral to treatment ongoing pathways over 52 weeks (number) **Standard: 0**		Trajectory met for May. Recovery trajectory in place. Speciality level detail provided in exception report. Key specialties are Upper GI (30); LGI (28); Gynaecology (10); General Surgery (10) and ENT (7). Whilst there are some residual data quality issues these are reducing. May saw the first month in a decline, albeit slight to the levels of 52 week waiting patients. This is the key priority for delivery this year.	Deputy Chief Operating Officer
Referral to treatment ongoing pathways under 18 weeks (%) **Standard: >=92%**		RTT performance is in line with the agreed NHS I and Trust trajectory. This is the 3rd month of reporting since a period of 23 months. The performance is stable as is the waiting list position. A series of technical fixes will be applied as part of the next Trak upgrade which will support a further reduction in Data Quality errors. This is alongside a training plan to support the closure of errors (either to remove or to stop them occurring).	Deputy Chief Operating Officer

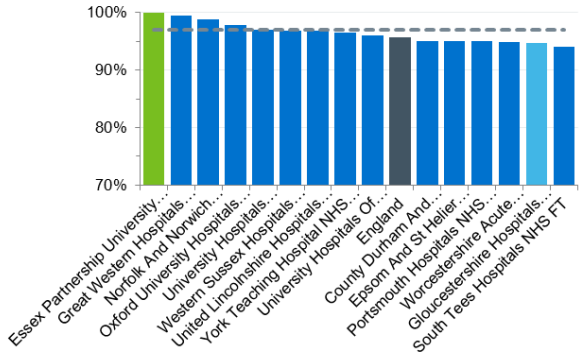
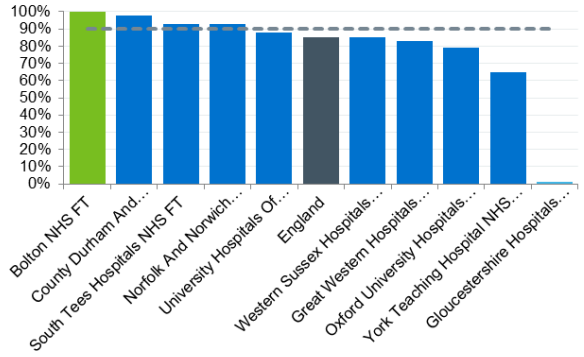
Exception Reports – Well Led

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% vacancy rate for doctors **Standard: R>5.5% A5.1-5.5% G<=5%**		• Significant gaps continue to exist within the Doctors in Training rota (c40 fte). In managing this pressure we continue use agency locums where appropriate and other support roles such as: Physicians Associates and Advanced Clinical Practitioners. • ACP Business case to be reviewed by Chief Nurse and Medical Director June 2019. • 5 year Workforce plans under development during summer 2019, to include alternative role solutions to support ongoing pressure whilst scrutinising Medical establishment levels. • Significant Consultant vacancy pressures exist within Care of the Elderly and Acute medicine, active recruitment campaigns continue with support from external agencies. • The People and OD Delivery Group have commissioned a scoping exercise of our current medical offer and incentives; to ensure we remain competitive and attractive to candidates.	Director of Human Resources and Operational Development
% vacancy rate for registered nurses **Standard: R>5.5% A5.1-5.5% G<=5%**		• Overseas campaigns continue with a pipeline of Australian Nurses currently in process and further skype recruitment in the Philippines planned. • Additional pathways (from HCA to RGN) are being developed and promoted • Turnover remains a significant concern, the staff and patient experience group oversea a number of key 'task and finish' workstreams relating to retention, including exit interview improvements • Vacancy levels are supported by increased bank and agency usage. • There is a daily, dynamic risk assessment of safe staffing numbers.	Director of Human Resources and Operational Development

Benchmarking (1)

Gloucestershire Hospitals NHS Foundation Trust

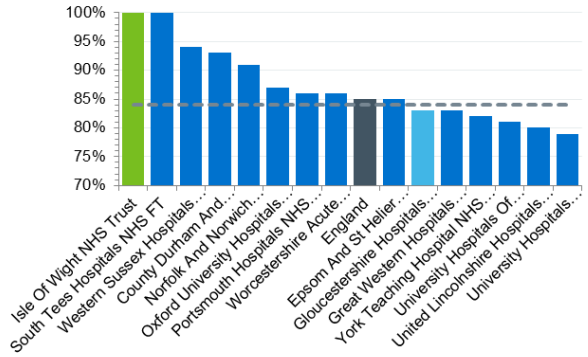
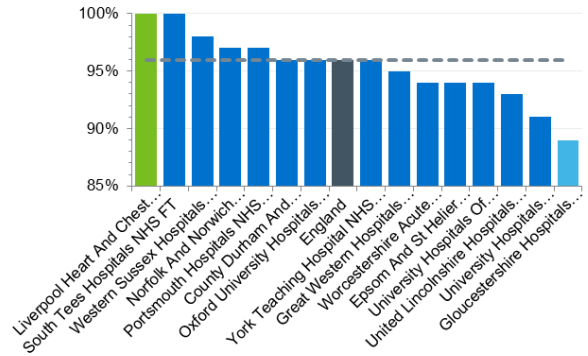
Standard | England | Other providers
GHT | Best in Class

Metric	Period	Peer Group	Rank	Quartile
VTE	Mar-19		119/149	4th
Dementia	Mar-19		85/85	4th

Benchmarking (2)

Gloucestershire Hospitals NHS Foundation Trust

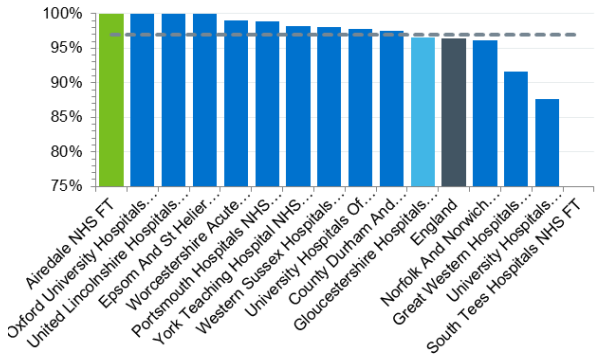
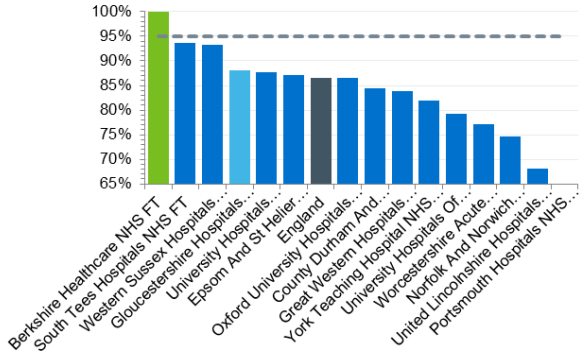
Standard | England | Other providers
GHT | Best in Class

Metric	Period	Peer Group	Rank	Quartile
FFT - ED	Apr-19		86/132	3rd
FFT - Inpatient	Apr-19		139/145	4th

Benchmarking (3)

Gloucestershire Hospitals NHS Foundation Trust

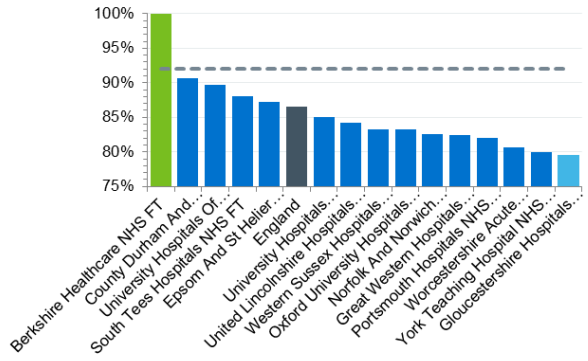
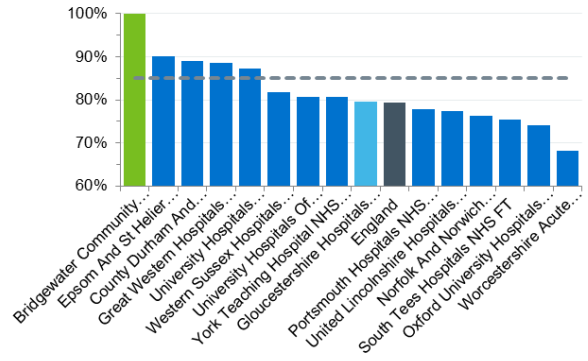
Standard | England | Other providers
GHT | Best in Class

Metric	Period	Peer Group	Rank	Quartile
FFT - Maternity	Apr-19		83/119	3rd
ED 4 Hour (Type 1 & Type 3)	May-19		63/142	2nd

Benchmarking (4)

Gloucestershire Hospitals NHS Foundation Trust

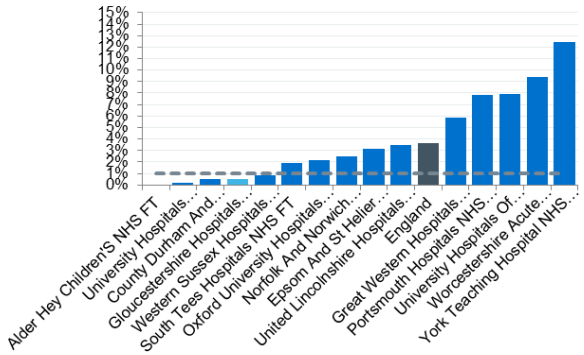
Standard | England | Other providers
GHT | Best in Class

Metric	Period	Peer Group	Rank	Quartile
RTT	Apr-19		163/179	4th
Cancer 62 Days GP Referrals	Apr-19		90/143	3rd

Benchmarking (5)

Gloucestershire Hospitals NHS Foundation Trust

Standard
GHT
England
Best in Class
Other providers

Metric	Period	Peer Group	Rank	Quartile
Diagnostics	Apr-19		50/172	2nd

Gloucestershire Hospitals
NHS Foundation Trust

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

Report Title
Learning from Deaths Quarterly Report
Sponsor and Author(s)
Author: Andrew Seaton, Quality Improvement & Safety Director Sponsor: Prof Mark Pietroni, Director for Safety & Medical Director
Executive Summary

Purpose
To comply with National Guidance on Learning from Deaths – a quarterly update should be presented to the open session of the Board.

Key issues to note

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

Conclusions

- All deaths are reviewed in the Trust through the Medical Examiner, structured judgement reviews drives local learning and feedback.

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

Recommendations
Main Board is asked to note the Learning from Deaths Quarterly Report.
Impact Upon Strategic Objectives
This work links directly to our Trust objectives for our patients to be safe in our care and to be treated with care and compassion
Impact Upon Corporate Risks
None
Regulatory and/or Legal Implications

National requirement to report to Trust Board.
Equality & Patient Impact
None
Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	

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

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

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

TRUST BOARD – JULY 2019

LEARNING FROM DEATHS QUARTERLY REPORT

1. Aim

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

1.2 The period covered is that to the end of Q4 2018/19.

2. Executive Summary

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

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

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

2.4 An analysis of these comments is included within this paper (Appendix VI). The feedback is overwhelmingly positive and is routinely shared with the relevant ward area.

2.5 The main learning from structure reviews is through the feedback and discussion in local clinical meetings at Specialty level. Some themes continue to be identified which are in common with known areas of quality in particular the complex management of the deteriorating patient and end of life care particularly in the first stages of admission.

3. Mortality Review Process

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

3.2 The SJR approach continues to embed within all divisions. This allows the clinical team to focus increasingly on the quality of these reviews and feedback to teams.

4. Family Involvement

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

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

4.3 We recognise that negative feedback is limited in comparison to huge quality of positive comments. Quick feedback to staff on performance is an excellent method to improve care or cement good practice at a local level.

5. Learning from Deaths

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

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

5.3 The main learning from structure reviews is through the feedback and discussion in local clinical meetings at Specialty level. Some common themes continue to be identified which are in common with known areas of quality in particular the complex management of the deteriorating patient and end of life planning particularly in the first stages of admission. These reflect two current improvement programmes.

1. The Quality summit on Deteriorating patient.
2. The introduction of the RESPECT pathway

6. Learning with Partners

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

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

7. Mortality Dashboard (Appendices)

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

a) The total number of deaths in the quarter

b) The most recent mortality indicators

c) The number of deaths having a high level review

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

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

f) Themes and issues identified

g) Any changes that have resulted.

8. Conclusions

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

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

8.2 There is good progress on capturing local learning from problems in care and ensuring these are being reflected on within specialties.

9. Recommendations

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

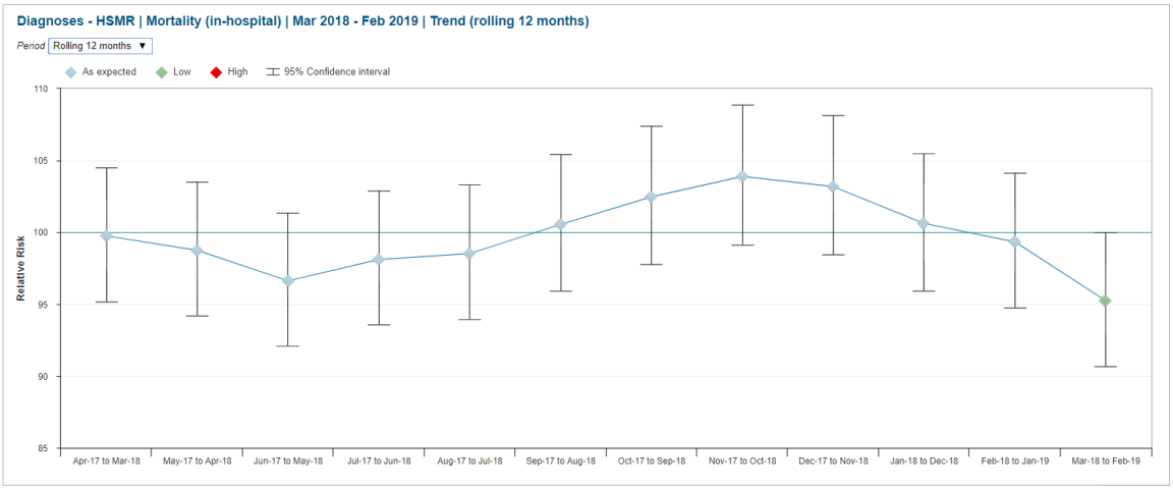
Prof Mark Pietroni, Director for Safety & Medical Director
July 2019

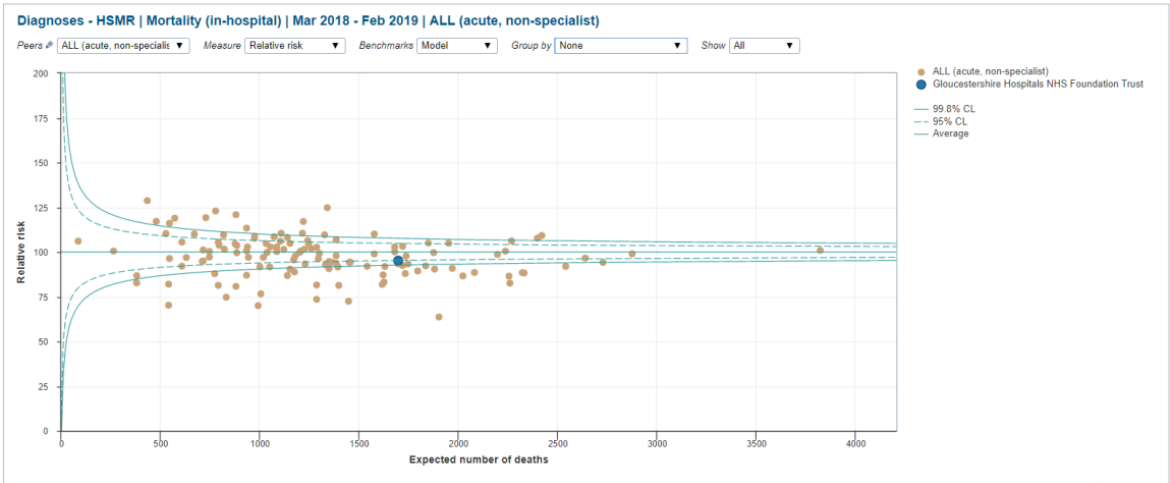
APPENDIX I – HSMR DETAILS

Deaths by Quarter with Medical Examiners Review (Insight Data)		
	Deaths	ME Review
Q4 17/18	651	651
Q1 18/19	460	460
Q2 18/19	463	463
Q3 18/19	475	475
Q4 18/19	544	544

HSMR Graph

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





APPENDIX II – OVERVIEW (Data from Datix)

Learning from Deaths – Summary Data

Quarter 4 (January, February, March 2019)

Division	Deaths (Datix)	SJRs completed (or national)	Rating of poor or very poor care	DoC or SI reviews of deaths (date confirmed)	Rating of excellent care
Surgery	139	16	1	1	4
Medicine	373	78	3	1	27
D&S	40	8	0	0	1
W&C	3	0	0	0	0
Total	**555**	**102**	**4**	**2**	**32**

Deaths reviewed by other processes *Type*	*Q2*	*Q3*	*Q4*
LeDeR	3	5	7
Paediatrics Mortality Review	0	1	1
Coroner Inquests & Trust Investigation	4	1	1
Serious Incident Deaths	1	1	2

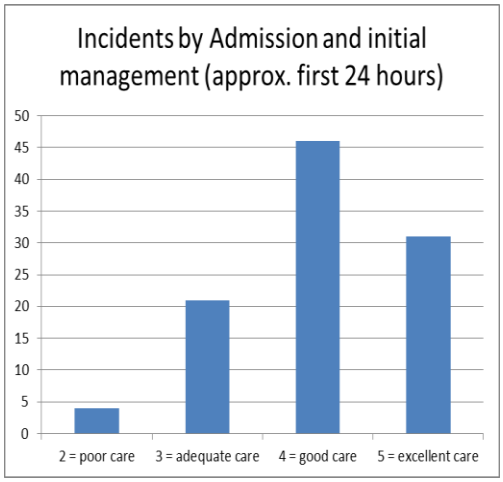
Categories of Care which Trigged a Structured Judgement Review

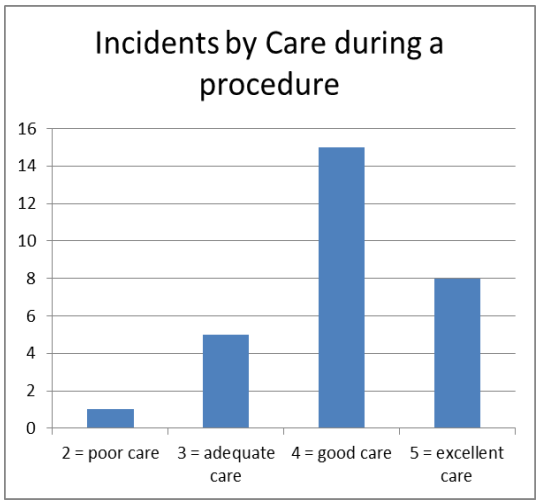
TRIGGER	No.	%
Concern raised by family	12	20%
Concern raised by healthcare staff	8	13%
Deaths following readmission (within 72hrs)	15	25%
Deaths following elective admission	5	8%
Deaths taking place during or shortly after a procedure	4	6%
Patients with a Learning Disability	4	6%
Safeguarding concerns	1	2%
Systemic Anti-Cancer Treatment (SACT) in last 30 day - (Specialty Trigger)	5	8%
DCC Specialty Trigger	5	8%
Other Trigger	2	3%

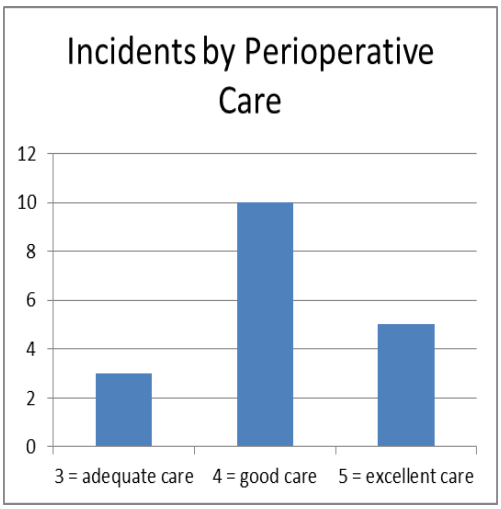
Location at Time of Death

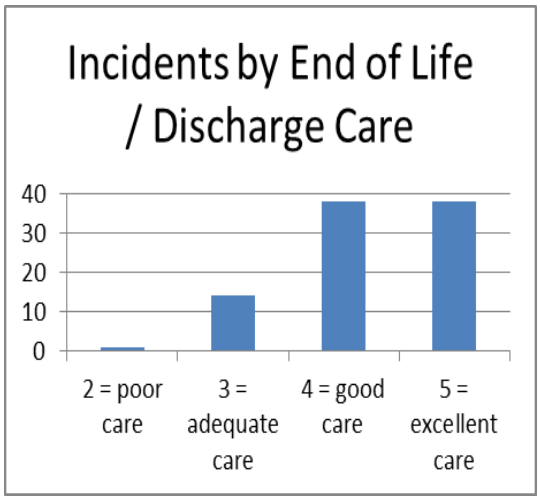
LOCATION	No.
Emergency Department	42
ACUA / AMU	41
8b Respiratory	39
Critical Care GRH	31
Ryeworth Ward	31
Woodmancote COTE	31
Avening Respiratory	29
4a COTE	28
4b COTE	28
Lilleybrook Oncology	20
7a Renal	19
Rendcomb Oncology	19
7b Renal	18
Guiting Vascular	16
3a Trauma	15
6b stroke	15
9b Acute Medicine	14
Critical Care CGH	14
5a / SAU	13
2a Trauma	11
Prescott Ward (Urology & Breast)	11
3b Trauma	9
Gallery Ward (MSFD), GRH	7
Knightsbridge Respiratory	7
Snowshill Ward (Gastro)	7
5b Upper & Lower GI	6
Bibury Ward (Lower GI & Gen Surgery)	6
8a Neuro	5
Cardiology Ward, GRH	5
2b Head and Neck	4
6a Stroke	4
ACUC	3
9a Gynae	2
Cardiac Cardiology, CGH	2
Anaesthetic Rooms	1
Recovery	1
T & O Theatres	1

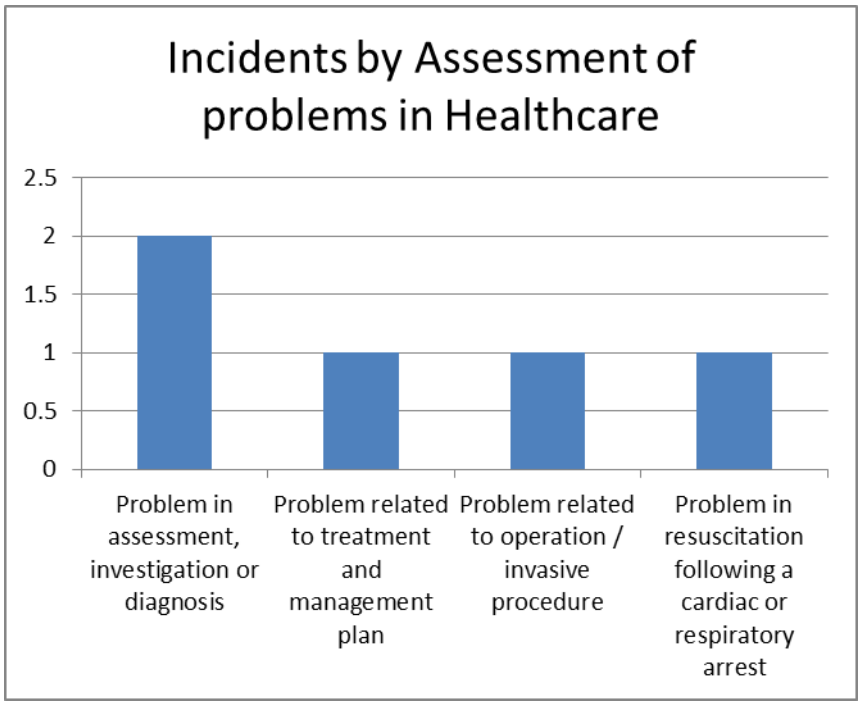
Ratings by Stage of Care










Incidents by Assessment of problems in Healthcare
2.5
2
1.5
1
0.5
0
Problem in assessment, investigation or diagnosis
Problem related to treatment and management plan
Problem related to operation / invasive procedure
Problem in resuscitation following a cardiac or respiratory arrest

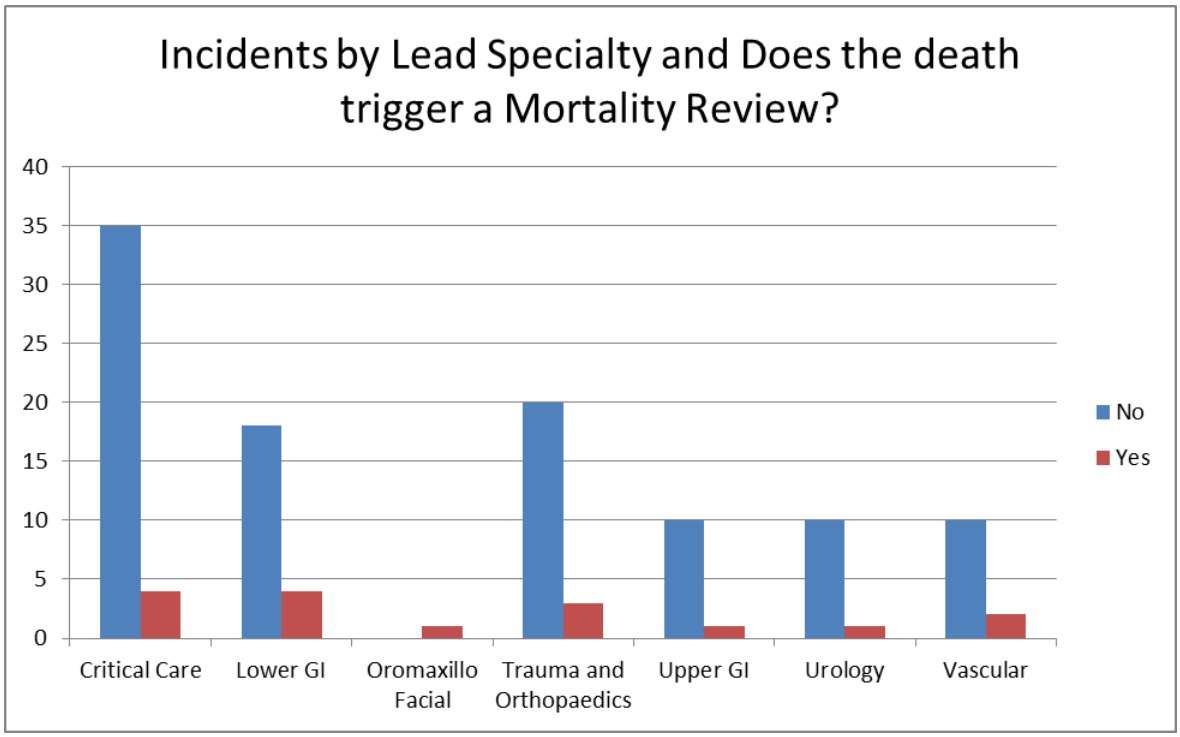
APPENDIX III – DIVISIONAL DETAIL
Learning from Deaths
Quarter 4 (January, February, March 2019)

Surgical Division

Total number of deaths = 139
Number of completed SJRs = 16
Number of SJRs indicating sub-optimal care = 1
Number of SJRs indicating excellent care = 4

Number of deaths by lead Speciality

Lead specialty at death	Specialty at death	Q3 total	Jan	Feb	Mar	Q4 total
Surgical	Colorectal surgery	10	5	11	6	**22**
	Critical care medicine	24	12	8	19	**39**
	ENT	1	0	0	0	**0**
	Trauma and Orthopaedics	15	11	8	4	**23**
	Upper gastrointestinal surgery	18	4	1	6	**11**
	Urology	4	7	3	1	**11**
	Vascular surgery	7	6	4	2	**12**
	Division total	79				



Number of SJRs by Speciality

Speciality	*No. of SJRs conducted*	*No. of SJRs indicating sub-optimal care*	*No. of SJRs indicating excellent care*
Critical Care	5	1	3
Lower GI	2	0	0
T&O	2	0	0
Upper GI	1	0	1
Vascular	3	0	0
OMF	1	0	0
Urology	2	0	0

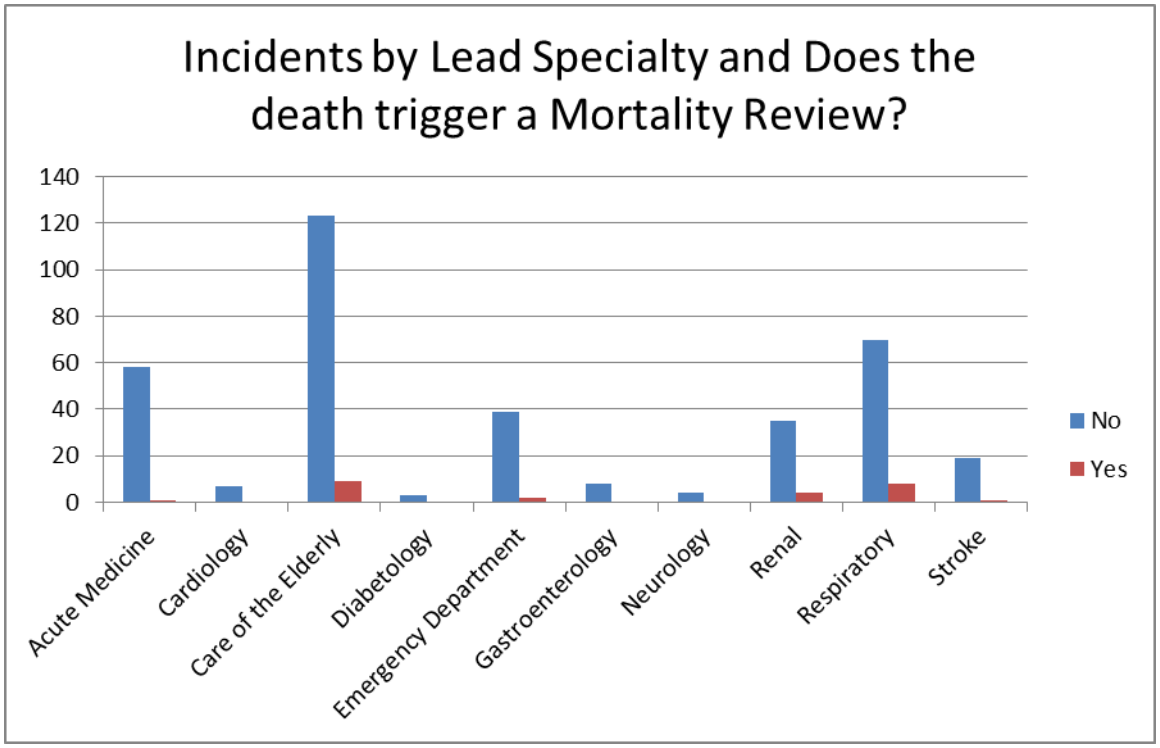
TOTAL = 16

Medical Division

Total number of deaths = 373
Number of completed SJRs = 78
Number of SJRs indicating sub-optimal care = 3
Number of SJRs indicating excellent care = 27

Number of deaths by Speciality

division at death	Specialty at death	Q3	Jan	Feb	Mar	Q4 total
Medical	Accident and Emergency	33	21	11	9	**41**
	Cardiology	20	4	0	3	**7**
	Diabetic medicine	1	1	2	0	**3**
	Emergency Medicine	50	26	18	16	**60**
	Stroke	28	10	4	6	**20**
	Gastroenterology	24	1	4	3	**8**
	Care of the elderly	105	44	43	45	**132**
	Renal	20	17	9	13	**39**
	Neurology	15	1	1	2	**4**
	Respiratory medicine	71	37	12	29	**78**
	Division total	367	**162**	**104**	**126**	**392**



Number of SJRs by Speciality

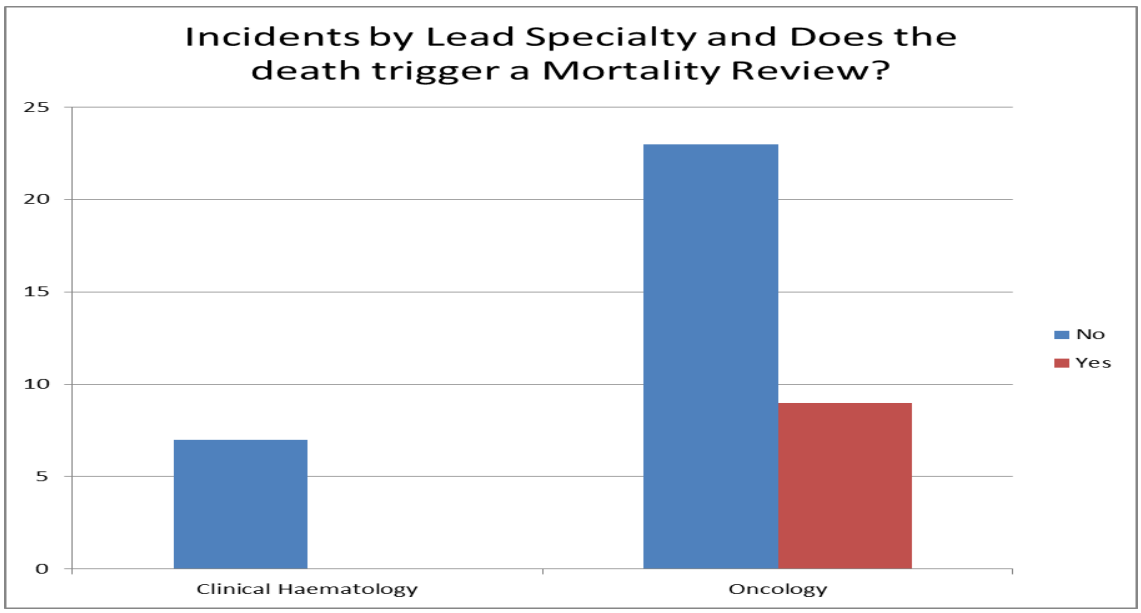
Speciality	*No. of SJRs conducted*	*No. of SJRs indicating sub-optimal care*	*No. of SJRs indicating excellent care*
Acute Medicine	**3**	**1**	**0**
Care of the Elderly	**6**	**1**	**0**
Emergency	**49**	**1**	**25**
Respiratory	**5**	**0**	**0**
Stroke	**7**	**0**	**2**
Renal	**1**	**0**	**0**
Cardiology	**2**	**0**	**0**
Gastroenterology	**3**	**0**	**0**
Neurology	**2**	**0**	**0**

TOTAL = 78

D&S Division

Total number of deaths = 40
Total number of completed SJRs = 8
Number of SJRs indicating sub-optimal care = 0
Number of SJRs indicating excellent care = 0

Division at death	Specialty at death	Q3 total	Oct	Nov	Dec	Q4 total
Diagnostic & Specialist	Clinical haematology	7	4	1	2	**7**
	Medical oncology	25	12	9	11	**32**
	Division total	**32**	**16**	**10**	**13**	**39**



Number of SJRs by Speciality

Speciality	*No. of SJRs conducted*	*No. of SJRs indicating sub-optimal care*	*No. of SJRs indicating excellent care*
Oncology	8	0	1
Clinical Haematology	0	0	0

TOTAL = 8

Learning from Deaths

Quarter 4 (January, March, April 2019)

W&C Division

Total number of deaths = 3
Total number of completed SJRs = 0
Number of SJRs indicating sub-optimal care =0
Number of SJRs indicating excellent care = 0

Division at death	Specialty at death	Q3 total	Jan	Feb	Mar	Q4 total
Women & Children	Gynaecological oncology	**0**	0	0	0	**0**
	Gynaecology	**0**	1	1	0	**2**
	Neonatology	**0**	0	0	0	**0**
	Obstetrics	**0**	0	0	0	**0**
	Paediatrics	**1**	0	0	0	**0**
	Well babies	**0**	0	0	0	**0**
	Division total	**1**	**0**	**0**	**0**	**2**

APPENDIX IV – Feedback Report from Bereaved Families

1.0 Background

For many years relatives of deceased patients have openly discussed their experiences of care provided by GHFT during the final admission/end of life at the time of collecting the medical certificate of cause of death (MCCD). The feedback was often passed to ward staff by the Bereavement Officers via telephone or email or to the ward clerk or manager, for relaying to the team. This was deemed an unreliable method and did not encourage wider learning or recognition of excellence. With the development of the Datix mortality system all feedback from relatives is now entered on the system for completeness e.g it sits with the individual deceased patient details/cause of death given, people involved and any SJR recordings. The benefits of using Datix are that the comments can be linked to incident reports and complaints pertaining to the deceased and comments are visible to senior ward and departmental staff and can be included in reporting structures.

2.0 Methodology

All families are asked in person/real time 'is there anything about the care your ..... received in the hospital you would like to feedback to us?' This ensures that the question is not leading and is simple to understand and respond to. The benefits of this approach include:

1) it is asked in real time when the experiences of care are fresh in the relatives' minds.
2) The Bereavement/Medical Examiner (ME) service and its staff are independent of the care and normally gain the trust of the relatives during the time they are involved with them after the death.
3) Raising concerns with safety and transparency are the key to the remit of the Medical Examiner role.

Bereavement/ME service staff always check with the family if they are happy for their feedback to be passed on. In any rare instances, where this is not permitted, the request is noted and respected at the time of discussion.

The limitations of this method are that:

1) it does not necessarily reflect the full experience of the deceased person.
2) relatives may have differing perspectives so the review is limited to the person collecting the MCCD and
3) relatives with further time to dwell on experiences can change their minds.

The data included in this initial report dates from June to November 2018 but is not complete for this date range and currently excludes neutral comments i.e. the relative neither has negative or positive comments to make.

The results have been filtered by area linked to the feedback and have been divided into positive negative and mixed comments. The comments have then been analysed for key words and themes. The full comments without PID are included in the appendix.

3.0 Results

555 deaths were recorded between 01/01/2019 and 31/03/2019. 226 (41%) of these recorded feedback from families. Feedback was 79% positive, 6% negative and 15% mixed. The table below illustrates the location for feedback and the nature of the feedback.

Location for feedback	Positive	Negative	Mixed
2a Trauma	1(100%)	0	0
2b Head and Neck	2(67%)	0	1(33%)
3a Trauma	1(100%)	0	0
3b Trauma	2(100%)	0	0
4a COTE	8(89%)	1(11%)	0
4b COTE	7(87.5%)	0	
1(12.5%)			
5a / SAU	5(100%)	0	0
5b Upper & Lower GI	2(100%)	0	0
6a Stroke	1(50%)	1(50%)	0
6b stroke	6(75%)	1(12.5%)	
1(12.5%)			
7a Renal	4(80%)	1(20%)	0
7b Renal	4(80%)	0	1(20%)
8a Neuro	2(67%)	1(33%)	0
8b Respiratory	8(89%)	1(11%)	0
9a Gynae	1(100%)	0	0
9b Acute Medicine	4(66%)	1(17%)	1(17%)
ACUA / AMU	3(43%)	3(43%)	1(14%)
ACUC	3(50%)	1(17%)	2(33%)
Avening Respiratory	13(76%)	1(6%)	3(18%)
Cardiac Cardiology, CGH	1(100%)	0	0
Cardiology Ward, GRH	2(100%)	0	0
Critical Care CGH	10(100%)	0	0
Critical Care GRH	5(100%)	0	0
Emergency Department	4(80%)	0	1(20%)
Gallery Ward (MSFD), GRH	1(100%)	0	0
Guiting Vascular	8(100%)	0	0
Gynae / General Theatres	1(100%)	0	0
Knightsbridge Respiratory	4(80%)	0	1(20%)
Lilleybrook Oncology	13(87%)	1(7.5%)	1(7.5%)
Rendcomb Oncology	11(73%)	0	4(27%)
Ryeworth Ward	17(85%)	1(5%)	2(10%)
Woodmancote COTE	12(75%)	1(6%)	3(19%)
Bibury Ward (Lower GI & Gen Surgery)	3(60%)	1(20%)	1(20%)
Prescott Ward (Urology & Breast)	3(100%)	0	0
Snowshill Ward (Gastro)	4(100%)	0	0

2.1 Positive comments

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

Wonderful (50 times)
lovely (15 times)
excellent (21 times)
kind (15 times)
good (22 times)
amazing (16 times)
caring (10 times)
faultless (8 times)
Fantastic (17 times)
Brilliant (16 times)
Compassionate (11 times)
Great (7 times)
Superb (6 times)
Outstanding (5 times)

Communication was mentioned 14 times expressing how grateful they were that clear and honest explanations were given, that they were kept fully informed and up to date. One comment described how the staff took time to explain to the son what happens during the last moments and what to expect.
7 comments mentioned the consideration for the families, that they felt well looked after and supported. Specific comments related to the open visiting hours, being able to stay at the bedside, having a side room prior to death, being provided with a hospitality room and being called after the death to check how the family were. There were mentions also of staff being attentive to the small details and offering food and drink.
1 comment mentions the importance of seeing their relative clean with hair brushed.

Most comments refer to staff or teams in general however 37 comments specifically refer to the nursing staff, 30 to doctors, 6 to the palliative care team and 9 to the bereavement team. Mentions were all made of ambulance staff, organ donation team, mortuary and cleaners. 51 staff were specifically named by the relatives for the care they provided.

2.2. Negative comments

3 comments referred to concerns over previous discharges from hospital
12 comments referred to poor communication. 2 referred to the relatives not being told that patients had deteriorated/ passed away. 1 referred to constantly having to chase results, 3 referred to poor bedside manner of doctors
3 comments refer to the length of time to issue the MCCD
3 comments refer to being distressed by the resuscitation discussion in front of the patient
2 comments refer to inadequate pain relief
2 comments refer to disappointment re not having a side room available
2 comments refer to poor experience in Emergency Dept waiting on trollies in the corridor

Specific comments included:
Concern re lack of signage for relative with swallowing difficulties
Blood test not being acted upon
Dirty false teeth
No one to one care for sectioned patient

Falls in hospital
Agency staff asleep on duty
Unnecessary interruptions during last few hrs (suggested sign on door to make staff aware)
Patient not turned
Medications left on bedside table not administered
Not provided with bereavement booklet
Ward dirty and smelly
Lack of wash and oral hygiene
Requests not carried out
No chairs to sit on
No staff around to support

3.0 Conclusion

79% of comments were positive with 15 areas having 100% positive comments. Wards are asked to review their comments and provide feedback to staff especially where they have been specifically named.

Gloucestershire Hospitals
NHS Foundation Trust

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

Report Title
Board report on Gloucestershire Hospital NHS Foundation Trust progress against the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme (Year 2).
Sponsor and Author(s)
Sponsor; Steve Hams, Executive Director of Quality and Chief Nurse Author; Judith Hernandez, Director of Operations, Division of Women and Children's Services
Executive Summary

Purpose

The maternity element of trust CNST contributions for 2018/19 was increased by 10% to create a maternity incentive fund. Maternity services that could demonstrate progress against 10 actions would eligible for a share of that incentive fund. In some circumstances this means that the Trust could be returned both the incentive scheme component of its contribution and a share of the balance of any undistributed funds. The Trust was successful last year in achieving these 10 standards and was awarded the full incentive fund value and a share of the balance of undistributed funds.

The scheme has been run for a second year and the Trust has worked towards achieving compliance with the 10 standards, which have been considerably expanded. The financial value of meeting the required standards equates to a premium reduction of approximately £757,800 plus any balance of undistributed funds.

The Maternity incentive scheme requires trusts to self-certify (with Board sign-off) their progress against the 10 actions and discuss this with their commissioners before submitting this report and evidence to NHS Resolution by 12 noon on Thursday 15 August 2019.

Evidence for compliance with the standards is not required to be submitted with this self-assessment, but the project plan forms part of this paper for Board assurance, and all evidence will be held in the Division for inspection as required, in line with last year's evidence.

Key issues to note

The Division is fully compliant with all ten elements of the required standards. Details of which are in this board report.

Conclusions

In order to meet the submission deadline and meet the required sign off governance process, the Trust Board is asked to review and agree the proposed self-certification.

Implications and Future Action Required

Ongoing evidence collection and assurance through Women and Children's Divisional Board of compliance against all ten standards will continue as part of Divisional business.

Recommendations
Approve self certification of compliance against 10 specific actions related to safety in maternity services

Impact Upon Strategic Objectives
Supports Organisational strategic objectives
Impact Upon Corporate Risks
No impact on Corporate risks
Regulatory and/or Legal Implications
None
Equality & Patient Impact
Provides continued assurance for delivery of safe care to all women within maternity services

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

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

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

Board report on Gloucestershire Hospital NHS Foundation Trust progress against the Clinical Negligence Scheme for Trusts (CNST) incentive scheme maternity safety actions

Date: 04 July 2019

SECTION A: Evidence of Trust's progress against 10 safety actions:

Please note that trusts with multiple sites will need to provide evidence of each individual site's performance against the required standard.

Safety action – please see the guidance for the detail required for each action	Evidence of Trust's progress	Action met? (Y/N)
1). Are you using the National Perinatal Mortality Review Tool (NPMRT) to review perinatal deaths?	Yes. The Trust uses the MBBRACE tool. This was released to GHNHSFT in February 2018. All perinatal deaths within the NPMRT criteria are being entered onto the tool to facilitate the mortality review of all cases. The Medical Director provides a quarterly report to the Trust Board that includes details of the deaths reviewed and the consequent action plans. All deaths of babies suitable for review using the Perinatal Mortality Review Tool (PMRT) are reviewed at the mortality and morbidity meeting within three months of each death. The bereavement midwife informs all parents that a review will take place and	**Y**

	informed that their perspective and concerns will be sought.	
2). Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes. We are submitting all 10 tables with a pass level of greater than 90% (10% greater than the required level).	**Y**
3). Can you demonstrate that you have transitional care facilities that are in place and operational to support the implementation of the ATAIN Programme?	Yes. Neonatal and maternity services provide transitional care in both the Neonatal Unit and on the postnatal ward. A transitional care tariff for these patients is charged and received in line with national HRG guidance for transitional care, and this is reflected through data available on BadgerNet . Pathways of care for admission into and out of transitional care have been jointly approved by maternity and neonatal teams. A data recording process is established and being used. An action plan is in place and updated regularly. The Trust remains below the 5% target.	**Y**
4). Can you demonstrate an effective system of medical workforce planning?	Yes. The required evidence which includes the need for a formal record of the proportion of obstetrics and gynaecology trainees in the trust who disagreed/strongly disagreed with the 2018 General Medical Council National Training Survey question *"In my current post, educational/training opportunities are rarely lost due to gaps in the rota"* has been met. An action plan to address the outcomes is in place. Yes: We are fully compliant with this required standard as we have been	**Y**

	shown to have met all the Anaesthesia Clinical Services Accreditation standards and therefore no action plan is required.	
5). Can you demonstrate an effective system of midwifery workforce planning?	Yes. Birthrate Plus is the only recognised maternity specific workforce planning tool which has been endorsed by NICE (2016), The Kings Fund (2012) and the Royal Colleges (2007). The recommended midwife to birth ratio is discussed in detail in the NICE 2015 document (NICE report on safer staffing in childbirth) – although no specific ratio is detailed in this. The evidence to support this submission includes the details of a completed table top exercise with Birthrate Plus to ensure that the Trust has the correct midwifery staffing levels.	**Y**
6). Can you demonstrate compliance with all 4 elements of the Saving Babies' Lives (SBL) care bundle?	Element 1: Reducing smoking in pregnancy – • Smoking status of pregnant women recorded at booking • Carbon Monoxide monitoring is offered to every woman at the time of booking and to every women who smokes at every midwife / antenatal appointment thereafter. • If CO reading is high a referral to stop smoking service is made with the consent of the woman. Element 2: Risk assessment and surveillance for fetal growth restriction	**Y**

	• The RCOG Risk assessment tool is used to aid decision making on classification of risk and corresponding surveillance of all pregnancies • With this tool - women identified of being at high risk of fetal growth restriction have serial ultrasound assessments of fetal biometry undertaken during their pregnancy. Measurements of HC/AC and FL (head and abdominal circumference and femur length) are plotted on the CRIS generated reporting program. • Low risk women have fetal growth assessed using antenatal symphysis fundal height charts using a tape measure with the height in cms plotted on chart in their hand held records. Women who plot small for gestation or those with measurements that demonstrate measurements crossing growth centiles are referred for ultrasound assessment of feta growth and wellbeing. • Audit is undertaken and SGA rate recorded on dashboard as <2500g at term (37-42 weeks); however an action plan is in place to test whether Trak can support the plotting of SGA rate recorded as BW<10th centile rather than <2500g • An action plan is in place to ensure that twice-yearly audit is established to monitor SGA detection rates – recommendation is for the analysis of 10 cases with action plans being developed for any barriers to detection Element 3: Raising awareness of reduced fetal monitoring: • Information and advice leaflet on reduced fetal movement provided to	**Y**

	all pregnant women at time of booking. Sticker regarding the ACT campaign (Active, Change, Tell someone on the front of handheld notes. • Fetal movements are discussed at every antenatal contact • Clear pathway for all pregnant women reporting reduced fetal movements are in place (referral to mat triage / urgent assessment within our maternity day assessment units). Element 4: Effective fetal monitoring during labour: • All staff who care for women in labour undertake annual training on CTG interpretation and use of auscultation. Training undertaken on PROMPT multidisciplinary training and midwives mandatory training. New fetal monitoring guideline launched April 2018 with new CTG interpretation stickers. New CTG training package launched in April 2018 with baseline competency assessment undertaken. Future annual competency assessments to be undertaken. CTG masterclass delivered March 2018. • Fresh eyes system and interpretation stickers in place for review of CTG interpretation and escalation process in place Following the successful achievement of the CNST safety standards last year we invested some of the savings in purchasing the “Viewpoint” system which will allow all babies to have their fetal weight plotted.	**Y** **Y**

7). Can you demonstrate that you have a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership Forum, and that you regularly act on feedback?	Yes. Maternity Services has a number of effective tools for ensuring patient feedback and can demonstrate through evidence that feedback is acted on. A successful bid was submitted in April 2018 to the South West Network to develop the Maternity Voices Partnership, Gloucestershire MVP was awarded a grant of £10,000. The aim of the MVP is to embed service user co-production in all aspects of Maternity Services. Gloucestershire CCG Communications Team have engaged with women and staff by designing logo options for our MVP. The logo is now in place. The CCG team have worked closely with a Midwife to develop the content and layout of the new MVP Website. The website is now in a draft form and is due to be launched soon. Listening Clinics are in place throughout the county by the Better Births Team to engage with women who have recently given birth to find out their views on current maternity services and what they would value in a Community Hub. Links have been made with the National Maternity Voices Partnership and work has been carried out on the development of role descriptions and a training programme for MVP Chair and its members. The Gloucestershire's MVP Chair and full MVP have been recruited and are now in place. The MVP have embarked on training and a plan for the year ahead has been collated. The outcome of the engagement work ensures that maternity services are truly wrapped around the needs of women, their families and local communities in Gloucestershire. The service uses The NHS Friends and Family Test (FFT) which was created	**Y**

	to help service providers and commissioners understand whether their patients are happy with the service provided. Feedback is reviewed and acted on regularly, and there are many examples available for review in the evidence. The national maternity survey also provides a mechanism for patient feedback for which the service performs extremely well, and again there are good examples of how feedback has been acted on as an outcome from this review.	
8). Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	Full compliance on this point is declared as all staff groups have individually reached or exceeded the 90% target. A training assurance report is available as evidence.	**Y**
9). Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?	Meetings have taken place bi-monthly with the Chief Nurse. Agenda, and minutes of the meeting are available as evidence The Trust now has three maternity safety champions in post.	**Y**
10). Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early	All qualifying cases are notified to the legal department on the same day as the case is identified. The legal department register the case on the Early notification portal. Legal department then complete the process of providing	**Y**

Notification scheme?	patient records to NHSR. A report from the Trust's legal team will be available for all cases that have been reported for the 2018/19 period.	

SECTION B: Further action required:

If the Trust is unable to demonstrate the required progress against any of the 10 actions, please use this section to set out a detailed plan for how the Trust intends to achieve the required progress and over what time period. Where possible, please also include an estimate of the additional costs of delivering this.

The National Maternity Safety Champions and Steering group will review these details and NHS Resolution, at its absolute discretion, will agree whether any reimbursement of CNST contributions is to be made to the Trust. Any such payments would be at a much lower level than for those trusts able to demonstrate the required progress against the 10 actions and the 10% of the maternity contribution used to create the fund. If made, any such reimbursement must be used by the Trust for making progress against one or more of the 10 actions.

SECTION C: Sign-off

……..

For and on behalf of the Board of [INSERT TRUST NAME] confirming that:

- **The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets the required standards and that the self-certification is accurate.**
- **The content of this report has been shared with the commissioner(s) of the Trust's maternity services**
- **If applicable, the Board agrees that any reimbursement of CNST funds will be used to deliver the action(s) referred to in Section B**

Position: …….

Date: …….

We expect trust Boards to self-certify the Trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering group escalate to the appropriate arm's length body/NHS System leader.

……..

SECTION D: Appendices

Please list and attach copies of all relevant evidential appendices:

REPORT TO TRUST BOARD – JULY 2019

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

This report describes the business conducted at the Finance & Digital Committee held 27th June 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 2 cumulative position – actual deficit of £5.5 million, £0.3 million favourable v. budget. Activity predominantly on plan, variances reviewed in detail with pay underspend (£0.7 millon) largely offsetting non-pay overspend (£0.9 million). Cash position appropriate	When in the year does the deficit reverse? Does the Trakcare asset impairment introduce a difference in comparison to plan? Is the spike in pay costs that arose in March '19 likely to recur and adversely impact comparison to budget in 19/20?	Detailed year's budget by month has been prepared – detailed presentation to committee delayed following exceptional demands of year end audit. Will be presented in July meeting. Revises depreciation charge v.plan Overall budget considered correct – Finance team looking at phasing to ensure it reflects expected patterns	

Capital Programme Update	Year's programme initially set at £26 million. £18 million secured funding. Detailed plan contents and associated prioritisation process described	Will accounting rule changes create issues beyond financial technicalities? Is capital availability sufficient? Is the long term capital strategy on track?	No Funding under constant review and commitments managed accordingly Yes – reports to Committee and Board scheduled for July and September respectively with further follow up steps planned	
Cost Improvement Programme	Year to date actual of £2.3 million delivered against £1.5 million plan. Identified programmes for the year currently total £12.2 million versus the £22.4 million plan – weekly deep dives continue and mitigating actions to address the potential shortfall are under review.	Is there a tracker that shows programmes in the pipeline? Can these be shared with the Committee? Are there programmes that are truly transformational? Do the vacancy factor savings have any loss of income implications?	Yes – will be shared at July Committee Yes – programmes in place involving outpatient transformation, theatre usage and length of stay No as we are in a block contract situation.	Greater clarity in reporting would be appropriate
Clinical Productivity Update	Job Plan review rate of 96% achieved with 82% signed off. Specialties with less than 50% sign off to provide exception reports. Detailed data analysis of SPA allocations has commenced	What is the opportunity for cash releasing savings from productivity gains?		Keep under review pending learning from SPA data review

Risk Register (Finance)	Report reviewed and updates from move in to new financial year noted			
Division Finance Manager Presentation	Presentation by 2 division financial managers describing how they undertake their role in working with division management. Particular emphasis on how budgets are established and signed off.	What system is used in the budget setting, sign off and reporting process?	There is not a comprehensive budget setting system deployed in the trust currently – work is spreadsheet based.	New ledger system and associated budgeting modules business case to be developed by the end of October

Future digital Review Programme	Proposal to revise the Committee's approach to topic review to provide scrutiny and assurance while avoiding unnecessary duplication. The following items to be on the agenda monthly: - Digital Care Board - IR Risk Register - EPR Progress - IM & T Programme Board Summary - Trak Optimisation Board Summary Following items to be on a rolling, staggered 6 month review cycle: - IT Service provision - Back Office issues - Information and Coding - Information Governance and Cyber Security - ICS - Application Support and Clinical Systems	Where is review of the overall Digital Strategy in this programme?		To be added as an element of the 6 month rolling programme - next review in September.

Digital Cate Board Report	Update on all key projects. Infoflex upgrade has gone live – no issues. Focus in Trakcare update scheduled for Jujly 2nd. Some operational issues identified which will require a go/no go decision.	What is the process for the go/no go decision?	Decision criteria identified and timetable in place for decision to be made and Board advised if appropriate	
Risk Register (Digital)	All Risks updated with no extreme rated risks	Why is Trakcare T2018 upgrade not on the register	An emerging issue	

Rob Graves
Chair of Finance and Digital Committee
6th July 2019

Gloucestershire Hospitals
NHS Foundation Trust

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

Report Title
Financial Performance Report – Month 2 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 31st May 2019.

Key issues to note

- At Month 2 the Trust reported a cumulative deficit of £5.5m (£0.3m favourable to plan).
- Commissioner income is on plan.
- Private and paying patients' income is £0.2m favourable to plan.
- Other NHS patient related income is on plan.
- Other operating income (including Hosted Services) is favourable by £0.2m.
- Pay expenditure is showing a favourable variance of £0.7m.
- Non-pay expenditure is showing an adverse variance of £0.9m.

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

Outcome of discussion when presented to previous Committees/TLT

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

Gloucestershire Hospitals NHS
NHS Foundation Trust

Report to the Trust Board

Financial Performance Report
Month Ended 31st May 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 2.

The financial position as at the end of May 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 May the Group's consolidated position shows a year to date deficit of £5.5m. This is £0.3m favourable against plan. The position includes an impairment of £4.9m for the writing down of TrakCare expenditure incurred in previous financial years which has no impact on the control total position. 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 02 Cumulative Financial Position	Budget £000s	Actuals £000s	Variance £000s	Budget £000s	Actuals £000s	Variance £000s	Budget £000s	Actuals £000s	Variance £000s
SLA & Commissioning Income	78,770	78,793	24	0	0	0	78,770	78,793	24
PP, Overseas and RTA Income	800	962	162	0	0	0	800	962	162
Other Income from Patient Activities	76	61	(15)	0	0	0	76	61	(15)
Operating Income	12,175	12,276	101	7,667	7,678	11	12,824	13,028	204
Total Income	**91,821**	**92,092**	**272**	**7,667**	**7,678**	**11**	**92,470**	**92,844**	**374**
Pay	60,222	59,293	929	3,085	3,325	(240)	63,251	62,569	682
Non-Pay	33,597	34,474	(877)	4,179	4,105	73	30,814	31,702	(888)
Total Expenditure	**93,819**	**93,767**	**52**	**7,263**	**7,430**	**(167)**	**94,065**	**94,271**	**(206)**
EBITDA	**(1,999)**	**(1,675)**	**324**	**403**	**247**	**(156)**	**(1,596)**	**(1,428)**	**168**
EBITDA %age	**(2.2%)**	**(1.8%)**	**0.4%**	**5.3%**	**3.2%**	**(2.0%)**	**(1.7%)**	**(1.5%)**	**0.2%**
Non-Operating Costs	3,851	8,787	(4,937)	403	247	156	4,254	9,035	(4,781)
Surplus/(Deficit) with Impairments	**(5,850)**	**(10,462)**	**(4,613)**	**0**	**0**	**0**	**(5,850)**	**(10,462)**	**(4,613)**
Less Fixed Asset Impairments	0	4,918	4,918	0	0	0	0	4,918	4,918
Surplus/(Deficit) excluding Impairments	**(5,850)**	**(5,545)**	**305**	**0**	**0**	**0**	**(5,850)**	**(5,545)**	**305**
Excluding Donated Assets	74	73	(1)	0	0	0	74	73	(1)
Control Total Surplus/(Deficit)	**(5,776)**	**(5,472)**	**304**	**0**	**0**	**0**	**(5,776)**	**(5,472)**	**304**

* Group Position excludes £7.1m 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 May the Group's consolidated position shows a cumulative deficit of £5.5m on a control total basis, which is favourable against plan by £0.3m.

Month 02 Financial Position	Annual Budget £000s	M02 Budget £000s	M02 Actuals £000s	M02 Variance £000s	M02 Cumulative Budget £000s	M02 Cumulative Actuals £000s	M02 Cumulative Variance £000s
SLA & Commissioning Income	482,404	40,372	40,313	(59)	78,770	78,793	24
PP, Overseas and RTA Income	4,802	400	486	86	800	962	162
Other Income from Patient Activities	456	38	34	(4)	76	61	(15)
Operating Income	84,330	6,418	6,837	419	12,824	13,028	204
Total Income	**571,992**	**47,229**	**47,670**	**441**	**92,470**	**92,844**	**374**
Pay	365,118	31,003	30,812	191	63,251	62,569	682
Non-Pay	182,289	15,528	16,073	(544)	30,814	31,702	(888)
Total Expenditure	**547,407**	**46,532**	**46,885**	**(353)**	**94,065**	**94,271**	**(206)**
EBITDA	**24,584**	**697**	**785**	**88**	**(1,596)**	**(1,428)**	**168**
EBITDA %age	**4.3%**	**1.5%**	**1.6%**	**0.2%**	**(1.7%)**	**(1.5%)**	**0.2%**
Non-Operating Costs	25,526	2,110	6,910	(4,800)	4,254	9,035	(4,781)
Surplus/(Deficit) with Impairments	**(942)**	**(1,413)**	**(6,125)**	**(4,712)**	**(5,850)**	**(10,462)**	**(4,613)**
Less Fixed Asset Impairments	0	0	4,918	4,918	0	4,918	4,918
Surplus/(Deficit) excluding Impairments	**(942)**	**(1,413)**	**(1,207)**	**206**	**(5,850)**	**(5,545)**	**305**
Excluding Donated Assets	(558)	37	37	(0)	74	73	(1)
Control Total Surplus/(Deficit)	**(1,500)**	**(1,376)**	**(1,170)**	**206**	**(5,776)**	**(5,472)**	**304**

Detailed Income & Expenditure

Gloucestershire Hospitals NHS
NHS Foundation Trust

Month 02 Financial Position	M02 Budget £000s	M02 Actuals £000s	M02 Variance £000s	M02 Cumulative Budget £000s	M02 Cumulative Actuals £000s	M02 Cumulative Variance £000s
SLA & Commissioning Income	40,372	40,313	(59)	78,770	78,793	24
PP, Overseas and RTA Income	400	486	86	800	962	162
Other Income from Patient Activities	38	34	(4)	76	61	(15)
Operating Income	6,418	6,837	419	12,824	13,028	204
Total Income	**47,229**	**47,670**	**441**	**92,470**	**92,844**	**374**
Pay						
Substantive	28,952	28,243	709	59,220	57,302	1,919
Bank	983	1,148	(166)	1,958	2,495	(537)
Agency	1,069	1,421	(352)	2,072	2,772	(700)
Total Pay	**31,003**	**30,812**	**191**	**63,251**	**62,569**	**682**
Non Pay						
Drugs	5,607	6,181	(574)	10,996	11,751	(754)
Clinical Supplies	3,264	3,026	239	6,531	6,568	(37)
Other Non-Pay	6,657	6,866	(209)	13,287	13,384	(97)
Total Non Pay	**15,528**	**16,073**	**(544)**	**30,814**	**31,702**	**(888)**
Total Expenditure	**46,532**	**46,885**	**(353)**	**94,065**	**94,271**	**(206)**
EBITDA	**697**	**785**	**88**	**(1,596)**	**(1,428)**	**168**
EBITDA %age	**1.5%**	**1.6%**	**0.2%**	**(1.7%)**	**(1.5%)**	**0.2%**
Non-Operating Costs	2,110	6,910	(4,800)	4,254	9,035	(4,781)
Surplus/(Deficit)	**(1,413)**	**(6,125)**	**(4,712)**	**(5,850)**	**(10,462)**	**(4,613)**
Fixed Asset Impairments	0	4,918	4,918	0	4,918	4,918
Surplus/(Deficit) after Impairments	**(1,413)**	**(1,207)**	**206**	**(5,850)**	**(5,545)**	**305**
Excluding Donated Assets	37	37	(0)	74	73	(1)
Surplus/(Deficit)	**(1,376)**	**(1,170)**	**206**	**(5,776)**	**(5,472)**	**304**

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

PP / Overseas / RTA Income – is reporting a year to date over performance of £0.2m, reflecting private Oncology patients in D&S.

Pay – expenditure is showing an underspend of £0.7m year to date reflecting an underspend on substantive budgets (£1.9m), offset by overspends on bank (£0.5m) and agency budgets (£0.7m).

Non-Pay – expenditure is showing a year to date £0.9m overspend, reflecting overspends on drugs and clinical supplies which are offset within income (£0.7m). 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 2 the trust has delivered £2.3m of CIP against the Year to date NHS Improvement target of £1.5m, an over performance of £0.8m. Within the month, the Trust has delivered £1.2m of CIP against an in-month NHSI target of £0.8m, a positive variance of £0.5m, which is due to vacancy factor (i.e. underspend against pay budgets).

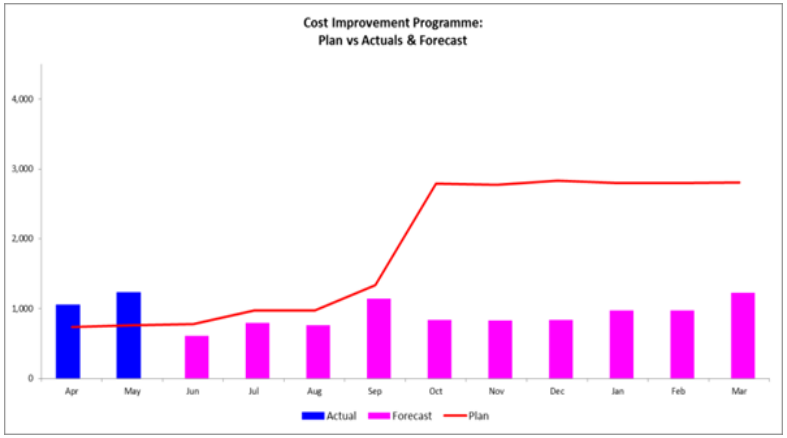
2. To date £12.2m of cost improvement schemes have been identified against a target of £22.4m.
£2m of this is Operational Growth margin. £2.5m relating to a review of Business Rates which is very high risk has been profiled into month 12 in the Trust's CIP plan submission (for NHSI) but has not been assumed within the internal CIP plan.

3. Work continues with the Divisions to progress planning and mobilisation for the 19/20 Cost Improvement Programme and additional in-year measures are being progressed. Stock take against the NHSI grip and control measures to identify top high value opportunities per Division including Corporate. Additional theatres opportunities as identified using national benchmarking. Outpatients transformation programme uncovering opportunities through better efficiency.

The table below highlights year to date actuals versus the cost improvement plan.

		Year To Date		
Trust Total	Annual Plan £000s	Plan £000s	Actual £000s	Variance £000s
Local Divisional Schemes	2,472	81	101	19
Trustwide - Income Improvement	2,000	333	333	0
Agency	900	147	0	(147)
Theatre	300	39	0	(39)
Medicines Optimisation	228	38	56	19
Procurement	1,850	161	127	(35)
Vacancy Factor	1,653	235	1,321	1,085
Trustwide	0	0	0	0
FYE	2,759	460	345	(115)
Phasing	0	0	0	0
Unidentified	10,196	0	0	0
Total	22,357	1,495	2,283	788

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 M2 £000	B/S movements from 31st March 2019 £000
Non-Current Assests			
Intangible Assets	10,412	5,364	(5,048)
Property, Plant and Equipment	231,216	230,013	(1,203)
Trade and Other Receivables	5,185	4,647	(538)
Total Non-Current Assets	**246,813**	**240,024**	**(6,789)**
Current Assets			
Inventories	7,572	7,656	84
Trade and Other Receivables	25,419	25,882	463
Cash and Cash Equivalents	7,317	9,065	1,748
Total Current Assets	**40,308**	**42,603**	**2,295**
Current Liabilities			
Trade and Other Payables	(54,316)	(55,592)	(1,276)
Other Liabilities	(5,837)	(4,782)	1,055
Borrowings	(12,527)	(12,527)	0
Provisions	(160)	(160)	0
Total Current Liabilities	**(72,840)**	**(73,061)**	**(221)**
Net Current Assets	**(32,532)**	**(30,458)**	**2,074**
Non-Current Liabilities			
Other Liabilities	(6,860)	(6,797)	63
Borrowings	(135,294)	(141,104)	(5,810)
Provisions	(1,434)	(1,434)	0
Total Non-Current Liabilities	**(143,588)**	**(149,335)**	**(5,747)**
Total Assets Employed	**70,693**	**60,231**	**(10,462)**
Financed by Taxpayers Equity			
Public Dividend Capital	172,676	172,676	0
Reserves	23,915	23,915	0
Retained Earnings	(125,898)	(136,360)	(10,462)
Total Taxpayers' Equity	**70,693**	**60,231**	**(10,462)**

The table shows the M02 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 2 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.
- Cash has increased by £1.7m since the year-end, reflecting the deficit income and expenditure position, offset by borrowing, the movement in working balances and the timing of capital expenditure.

Non-Current Liabilities

- Borrowings have increased by £5.8m, reflecting working capital loan support.

Retained Earnings

- The retained earnings reduction of £10.5m 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 May	
	Number	£'000	Number	£'000
Total Bills Paid Within period	17,741	41,838	7,652	17,744
Total Bill paid within Target	15,025	35,343	6,435	15,463
Percentage of Bills paid within target	85%	84%	84%	87%

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

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

Liabilities – Borrowings

Analysis of Borrowing	As at 31st May 2019 £000
<12 months	
Loans from ITFF	2,988
Distress Funding	7,373
Obligations under finance leases	1,598
Obligations under PFI contracts	568
Balance Outstanding	**12,527**
>12 months	
Loans from ITFF	22,593
Capital Loan	3,018
Distress Funding	93,039
Obligations under finance leases	17,869
Obligations under PFI contracts	4,585
Balance Outstanding	**141,104**
Total Balance Outstanding	**153,631**

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 £5.8m of additional in-year borrowing from the DoH.

Cashflow : May

Gloucestershire Hospitals NHS
NHS Foundation Trust

Cashflow Analysis	Apr-19 £000s	May-19 £000s
Surplus (Deficit) from Operations	**(3,464)**	**(5,470)**
Adjust for non-cash items:		
Depreciation	1,229	1,229
Other operating non-cash	0	4,918
Operating Cash flows before working capital	**(2,235)**	**677**
Working capital movements:		
(Inc.)/dec. in inventories	113	0
(Inc.)/dec. in trade and other receivables	1,444	2,310
Inc./(dec.) in current provisions	0	0
Inc./(dec.) in trade and other payables	(2,349)	916
Inc./(dec.) in other financial liabilities	0	(1,055)
Net cash in/(out) from working capital	**(792)**	**2,171**
Capital investment:		
Capital expenditure	(1,129)	(1,129)
Capital receipts	0	0
Net cash in/(out) from investment	**(1,129)**	**(1,129)**
Funding and debt:		
PDC Received	0	0
Interest Received	3	3
Interest Paid	(124)	(294)
DH loans - received	2,442	3,368
DH loans - repaid	0	0
Finance lease capital	(488)	(488)
Interest element of Finance Leases	(12)	(12)
PFI capital element	(68)	(68)
Interest element of PFI	(38)	(38)
PDC Dividend paid		
Net cash in/(out) from financing	**1,715**	**2,471**
Net cash in/(out)	**(2,441)**	**4,190**
Cash at Bank - Opening	**7,317**	**4,876**
Closing	**4,876**	**9,065**

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

Cashflow Key movements:

The Cash Position – reflects the Group position. The Trust has drawn down loan support of £5.8m 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 31st May 2019

Capital Summary	Internal YTD Plan	YTD Spend	YTD Var	19/20 Full Year Plan	FOT 19/20 Spend	Forecast Variance
	£k	£k	£k	£k	£k	£k
Health & Safety Projects	346	213	(133)	2,605	2,617	12
Environmental Works	46	0	(46)	350	350	0
Non Health & Safety Projects	158	178	20	975	986	11
Committed Schemes	62	80	19	460	472	12
Service Reconfiguration	1	0	(1)	9	9	0
Major Equipment Replacement	3	0	(3)	1,020	1,020	0
IM&T	1,440	392	(1,048)	9,883	9,883	0
MEF	332	0	(332)	2,490	2,490	0
Other Schemes	728	241	(488)	6,908	6,873	(35)
Contingency/Leases Capitalisation	105	0	(105)	1,300	1,300	0
Overspend/(Underspend)	**3,221**	**1,104**	**(2,117)**	**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. Additionally £1m of expenditure was expected in May for the EPR project but is now anticipated in June.

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 which is forecast to complete by August 2019.
- The Apollo Theatre refurbishment is progressing well and 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 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 year to date an actual income and expenditure deficit on a control total basis of £5.5m at May 2019. This is £0.3m favourable against plan.

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

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

Date: **July 2019**

REPORT TO TRUST BOARD – JULY 2019

From the People & Organisation Development Committee Chair – Balvinder Kaur Heran, Non-Executive Director

This report describes the business conducted at the People and Organisational Development Committee on 17 June 2019 indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Risk Register	• Health and Safety Executive improvement notices closed for SHARPS. • Closed DBS rechecking risk and closed pension risk. • New Health and Safety risk added regarding a fall from wheelchair incident. • Sustainable Workforce risk ongoing with Advanced Clinical Practitioner business case outstanding.	• How do we ensure Disclosure and Barring Service (DBS) issues are managed? • Will the business case (Advanced Clinical Practitioner) be delivered this month?	• HR policy and process describes actions to take where DBS issues or other conduct matters arise. • Meeting planned for it to be presented, but Advanced Clinical Practitioners still being recruited.	
Freedom to speak up	• Good to see how the strategy has developed and is being delivered.	• Why are survey respondent numbers low? How else may we engage staff and those less inclined to come forward	• The Trust has taken a different approach to engagement recently. Divisions do review any survey detail and the Staff and Patient Experience	• The future Engagement strategy should reflect communication and engagement

		• Could future reports provide a view of organisational learning, not just individual impact	Improvement Group.	channel
Retention Deep dive	• Overview of initiatives provided and how well these benchmark across the NHS reviewed. • Silver QI project on exit interview processes is underway.	• People and OD team to ensure benchmarks are not used to agree we are doing well to then fail to make further improvements. • What will stop the committee talking about the same item i.e. exit process not resulting in accurate data and information? • Single most important issue must be improving exit interview data. We know reasons for leaving from other sources but have little recorded detail from line managers or individuals.	• The programme of work outlined indicates an ambition to be outstanding. • Silver QI project should improve data collection • Operational dashboard will be developed out of the new strategy. This will push down ownership to divisions.	• Visibility on divisional action and ownership for retention to be provided under new performance regime.
Update on Violence and	• Update on Violence and Aggression governance	• Does the organogram provide assurance on		• Further assurance is

Aggression governance	provided with nursing directorate responsible for delivery.	Violence and Aggression and its link to committee's?		required on how the Violence and Aggression group reports into the committees by improving the organogram provided.
HSE Update and Health and Safety Objectives	• 2 year plan • Looking to embed cultural change to health and safety management. • The objectives are the areas of focus but won't resolve all the gaps in our provision. • Committee assured the Health and Safety function is looking to improve data and be multi-disciplined in its approach. • Health and Safety Executive sharps improvement notice discharged. • Fall from wheelchair incident discussed • Health and Safety risks	• Which issues keep the Health and Safety lead awake at night • Are there enough resources in Health and Safety	1. Days lost to stress 2. Manual handling (Bariatric patients) 3. Central risk assessment record/repository • A review is underway to consider Health and Safety resources.	• Health and Safety expert resources are limited across the trust. The Committee would want further assurance on the review of resources and an update of outcome • Are GMS sighted and assured on PFI management

	discussed			given link to fall from wheelchair incident discussed.
People and OD Strategy	• Clear document • Where we are and want to go provides an early picture and link through the document. • Good strategy. • Powerful document	• Is Digital ambition in it for Trust or People and Organisational Development teams? • Can we be clearer that we want to eliminate unlawful discrimination and should equality, diversity, inclusion and human rights be a pillar or arranged in another way	• Main digital matters are for People and OD to enhance internal service or staff 'HR' issues • Ambition of the strategy it to ensure equality is not an 'initiative' but a golden thread throughout the Trust.	• Digital strategy to answer wider Trust issues and the impact of technology on People e.g.: Artificial Intelligence.
Equality report 18/19	• Report provided and assurance taken on equality objectives and equality agenda			
WRES WDES	• No Workforce, Race, Equality Standard report available due to national data not being published • Workforce, Disability, Equality Standard data shared indicating some disabled staff have a different (negative) experience to	• Does everyone declare status of disability and other characteristics? • Useful info – but what is the purpose and do staff understand the value of the Workforce, Disability,	• Not everyone does declare their status which is why a key action is to improve self declaration. • Need to be clearer on why the information is important and answer the 'what's in it for me' especially if we want	.

	counterparts; and candidates on some national indicators.	Equality Standard	to get more data/self-reporting.	
Performance Dashboard	• Health Care Assistant Turnover still a concern and Trauma and Orthopaedic sickness absence is an ongoing issue. • Trajectories on Health Care Assistant and nurse recruitment provided	• Is there divisional responsibility for data and improvements? • Divisional impact on improving retention would have a huge benefit on dashboard and retention statistics.	• The new strategy allows the People and Organisational Development function to challenge ownership at a divisional level via Executive review process.	• Divisional reporting and exception reporting to commence with the new People and OD performance dashboard.
Temporary Staffing 18/19 review	• Full year review provided with overview on - Managing demand - Service innovations - Agency reductions - Bank innovations - Rostering and online booking - Presentation at NHSI collaborative meeting on Trust e-rostering roll out for national audiences	• Can we continue to make improvements?	• Excellent assurance and progress made and commitment to continue to drive enhancements.	
Update on wellbeing launch	Data shared (3weeks) 100 – 120 hits on website every day 76 enquiries Most over the phone (80%) Nature: Mental health 50% + 25% physical, 4% reasonable adjustment, 3% finance,	• Is there a return on investment for the business case?	• Assured that Return on Investment is linked to faster multi-skeletal pathway access and faster return to work thereby limiting cost of cover for front line roles.	

	remaining about assorted workplace issues			

Board note/matter for escalation

- **GMS to check assurance process for PFI management post fall from wheelchair incident**

Balvinder Heran
Chair of People and OD Committee, 17 June 2019

Gloucestershire Hospitals
NHS Foundation Trust

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

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

Purpose

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

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

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

Key issues to note

- **Numbers of staff in post has decreased by 18.45 fte.** Additional Clinical Services (-3.50fte) and Nursing and Midwifery (-7.09fte) show the most movement.
- April saw a greater proportion of starters compared to leavers, which matches the general trend over the past 6 months of more starters than leavers (excluding March).
- **Vacancy factors have risen slightly**, however it is important to note that some establishments also changed in April 2019, therefore this is not necessarily an indication of significant changes to recruitment or retention. The report shows more detail across key pressure areas: Registered Nurses and Non Registered Nursing staff (HCA's) and Allied Health Professionals.
- **Overall Turnover is at 11.80%, against an 11% target**
- The report also shows how our Trust benchmarks against other large Trusts (and their CQC rating) and places us in a favourable position when we compare Nursing and Midwifery turnover.
- Supply and retention pressures mean that **Nurse and HCA Turnover remains a concern** – **Trajectory's for Nurse and HCA recruitment** are shown within the report. A new Starter and Leaver target line has been added to show the planned 50% reduction to turnover and the recruitment pressure this alleviates once achieved.
- Key actions over April and May 2019 to further boost recruitment to Nursing and HCA posts included:
  - The preparation of new promotional video and marketing material (currently with our editors) to enhance our promotional material and web/ social media offer. This included involvement of a number of clinical staff working in shortage areas.
  - Continued career fair schedule, plus collaboration with ICS partners at June fair.
  - Launch of on-boarding/ new starter surveys
  - Confirmed start and preparation for the arrival of 15 pre- PIN Philippine Nurses (Aug

2019)
    - Establishing PIN qualification for 8 Philippine Nurses within our workforce in band 3 pre-pin positions.
    - Launch of cohort 2 of the Chief Nurse Junior Fellows
    - Agreement to recruit to an interim Nurse Recruitment and Retention Lead post (secondment advertised internally June 2019
    - Review of Occupational Sick Pay arrangements as part of the HCA retention plan (c50% of our HCA's opted to amend their T&C's)
- The report contains a breakdown of our approach to key recruitment challenges and hard to fill posts as identified through our recent workforce planning round. This will be revisited in the August People and OD Committee as we report on progress made and start to pull out key themes from the development work underpinning the creation of our 5 year workforce plans for launch in autumn 2019. Alongside the hard to fill posts, the report shows the detail of the two risks on the Trust Risk Register, impacted on by a failure to recruit.
- Annual **sickness absence rate 3.85%**. The Trust sickness rates remains lower than the national average for Large Acute Trusts - 4.34% Sep 18 (GHFT were 3.75% from same report) and shows how long term (over 28 days) sickness accounts for just under half of absence taken (48%).
- Triangulation of the areas of most concern, relating to sickness absence and turnover, highlighted T&O as an area of concern as highlighted at the last P&OD Committee. This has been further investigated and a number of ER cases and a patient complaint from this area were reviewed, with the involvement of the Divisional Chief Nurse and HR Business Partner. Additional HR Support has been put in place for the leadership team to ensure that the response to these issues is appropriate and in line with policy, whilst addressing development needs. We expect this to show on the reported stats for some time (rolling figure), however remain confident that measures are in place to improve attendance and retention in these areas. Further scrutiny of these actions and their effectiveness takes place via. the Executive review process.
- Appraisal summary report: 81% against a 90% target.
- Mandatory Training: 91%, so the 90% target has been achieved.

<u>Next Steps</u>

- Separate retention focus report presented to People and OD Committee June 2019.

- Through the Staff and Patient Experience Group continue to build the 'super dashboard' from which to triangulate a wide range of sources of data, including but not limited to: patient experience information, NAAS, freedom to speak up and ER case information.

Recommendations

The Committee is asked to note the trends illustrated in the Workforce Dashboard and measures detailed within to improve performance.

Impact Upon Strategic Objectives

Directly impacts on Trust Strategic Objectives, in particular: staff engagement, sickness absence, turnover and health and wellbeing.

Impact Upon Corporate Risks

Workforce stability is a critical part of our plans to mitigate the risk associated with the limited supply of key occupational groups such as Nurses, AHPs and Medical staff.

Regulatory and/or Legal Implications

n/a

Equality & Patient Impact

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

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

Gloucestershire Hospitals NHS
NHS Foundation Trust

Workforce Information Dashboard

People and OD Committee, June 2019

Alison Koeltgen, Deputy Director of People & OD

Gloucestershire Hospitals NHS
NHS Foundation Trust

Introduction and Overview

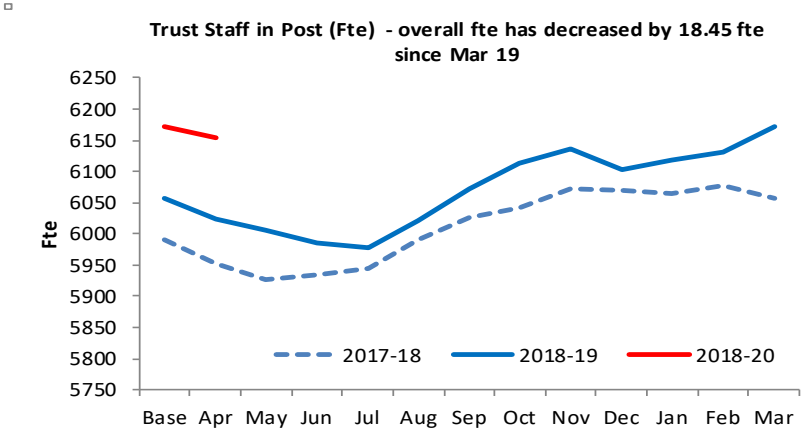
- The purpose of this presentation is to provide an overview to the People and OD Committee of the key performance indicators which link to our strategic priorities:

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

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

Performance summary:

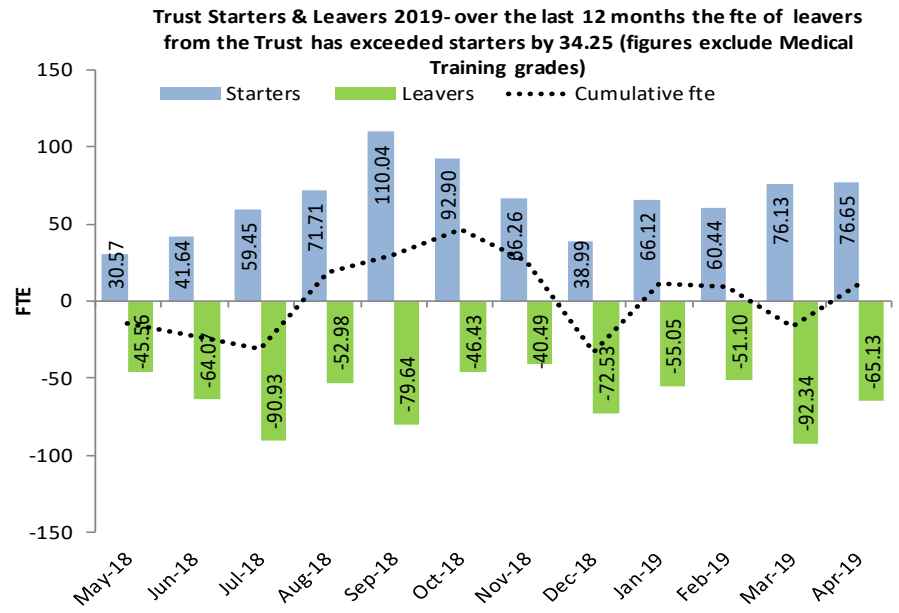
	VACANCY RATE	SICKNESS (Jan)	TURNOVER	APPRAISALS	MANDATORY TRAINING
Performance (in month)	9.41%	3.53%	n/a – rolling annual figure	81%	91%
Rolling Annual performance	n/a	3.85%	11.8%	n/a	n/a
Target	Not identified	3.50%	11%	90%	90%
Movement since last report	↑ 0.9	↓0.31	↓0.03	↑2%	↑1%

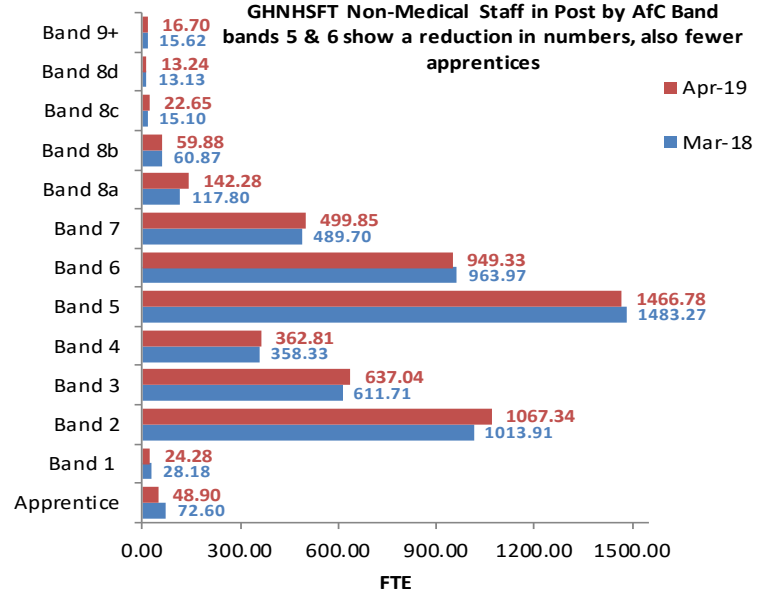


GHNHSFT Staff in post - change over financial year

FTE in Post	Mar-19	Apr-19	Increase/ decrease
Add Prof Scientific and Technic	237.02	235.07	-1.95
Additional Clinical Services	1,125.38	1,121.88	-3.50
Administrative and Clerical	1,371.22	1,370.00	-1.22
Allied Health Professionals	346.52	344.73	-1.79
Estates and Ancillary	29.7	29.35	-0.35
Healthcare Scientists	224.31	225.52	1.21
Medical and Dental	841.25	837.49	-3.76
Nursing and Midwifery Registered	1,996.14	1,989.05	-7.09
Total	**6171.54**	**6153.09**	-18.45

All figures in this report exclude Hosted GP Trainees & GMS Staff and are expressed as FTE (full time equivalent)





Key Issues:

- Numbers of staff in post decreased by 18.45 since March 2019. Additional Clinical Services (-3.50) and Nursing and Midwifery (-7.09) show the most movement.
- Bands 5, 6 and Apprentices, show a slight reduction in numbers. Whereas we can see growth across the majority of other bands. More significantly within bands 2 and 8a.
- April saw a greater proportion of starters compared to leavers, which matches the general trend over the past 6 months of more starters than leavers (excluding March).

Retention

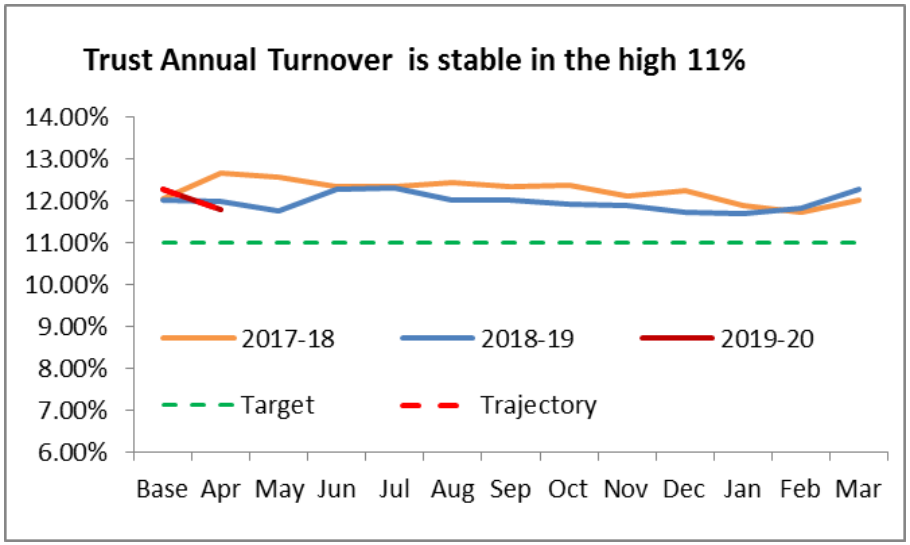
Gloucestershire Hospitals NHS
NHS Foundation Trust

Current Performance 12 months to 30th April 2019	Actual % TO	KPI % TO	Movement since last Month		Previous Month
Trust Total	11.80%	11.00%	↘	decrease	12.27%
Corporate	12.05%	11.00%	↘	decrease	13.54%
Diagnostics & Specialty	11.44%	11.00%	↘	decrease	11.70%
Medicine	13.52%	11.00%	↘	decrease	14.14%
Surgery	12.43%	11.00%	→	stable	12.34%
Womens & Children	7.87%	11.00%	↘	decrease	8.30%
Add Prof Scientific and Technic	10.16%	11.00%	→	stable	10.29%
Additional Clinical Services	15.79%	11.00%	↘	decrease	16.27%
Administrative and Clerical	11.78%	11.00%	↘	decrease	13.00%
Allied Health Professionals	15.69%	11.00%	↘	decrease	16.50%
Estates and Ancillary	3.68%	11.00%	→	stable	3.67%
Healthcare Scientists	10.88%	11.00%	↘	decrease	11.22%
Medical and Dental	4.39%	11.00%	↗	increase	4.03%
Nursing and Midwifery Registered	10.99%	11.00%	↘	decrease	11.15%
Staff Nurses	13.88%	11.00%	→	stable	13.90%

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

Benchmarking: NHS iView uses a different methodology for calculating Turnover, However it can be used for comparison between Trusts/ Groups of Trusts

NHS iView 12 months to January 2019				Staff Nurse	CQC RATING
GHNHSFT	11.10%	Nursing & Midwife	10.32%	17.36%	Good
All Large Acute	14.03%	Nursing & Midwife	14.75%	21.84%	
North Bristol	13.23%	Nursing & Midwife	15.55%	19.55%	R.I (March 2018)
Worcester Acute	11.60%	Nursing & Midwife	11.57%	17.68%	Inadequate (June 2018)
Sandwell	14.97%	Nursing & Midwife	11.93%	22.86%	R.I (April 2019)
Frimley Health	13.80%	Nursing & Midwife	14.54%	24.27%	Good (March 19)
Western Sussex	12.28%	Nursing & Midwife	10.61%	15.86%	Outstanding (April 2016)



Key Issues:

- Turnover is measured using the total leavers(fte) as a percentage of the average fte for the reporting period.
- Turnover is now reported as fte based - in line with QPR reporting
- When benchmarked against similar sized Trusts, our Trust shows a lower rate of overall Turnover and places us in a favourable position when we compare Nursing and Midwifery turnover.
- Nurse Turnover and HCA Turnover (Additional Clinical Services) remains a concern – especially within the Medical Division (16.07% Staff Nurse Turnover)
- AHP Turnover remains high and impacts on the continued vacancy pressure particularly within areas such as radiography.

- The newly published interim NHS people plan (launched 5.6.19) specifies a commitment to grow the number of substantive nurses employed by the NHS by 40,000 , by 2024. The strategy to achieve this outlined within the interim people plan, mirrors a number of the key strategic aims developed as part of our People and OD strategy, with key themes extracted from the NHS long term plan.

Vacancy levels – April 2019

Gloucestershire Hospitals NHS
NHS Foundation Trust

Staff Group	Recurrent Funded wte	Contracted	Vacancies	VR%
Add Prof Sci Tech	261.01	301.66	- 40.65	-15.57%
Additional Clinical Services	1,280.40	1,122.46	157.94	12.34%
Administration & Clerical	1,355.30	1,215.65	139.65	10.30%
Allied Health Professionals	373.31	341.98	31.33	8.39%
Estates & Ancillary	29.39	28.78	0.61	2.08%
Healthcare Scientist	154.31	145.81	8.50	5.51%
Medical & Dental	853.30	790.85	62.45	7.32%
Nursing & Midwifery	2,215.71	1,961.65	254.06	11.47%
Grand Total	**6,522.73**	**5,908.84**	**613.89**	**9.41%**

Reg Nursing & Midwifery	Recurrent Funded wte	Contracted		
Corporate Division	95.78	78.84	16.94	17.69%
Diagnostics & Specialty Division	167.51	171.63	- 4.12	-2.46%
Medicine Division	690.29	604.66	85.63	12.40%
Surgery Division	839.39	704.99	134.40	16.01%
Womens & Children Division	422.74	401.53	21.21	5.02%
Grand Total	**2,215.71**	**1,961.65**	**254.06**	**11.47%**

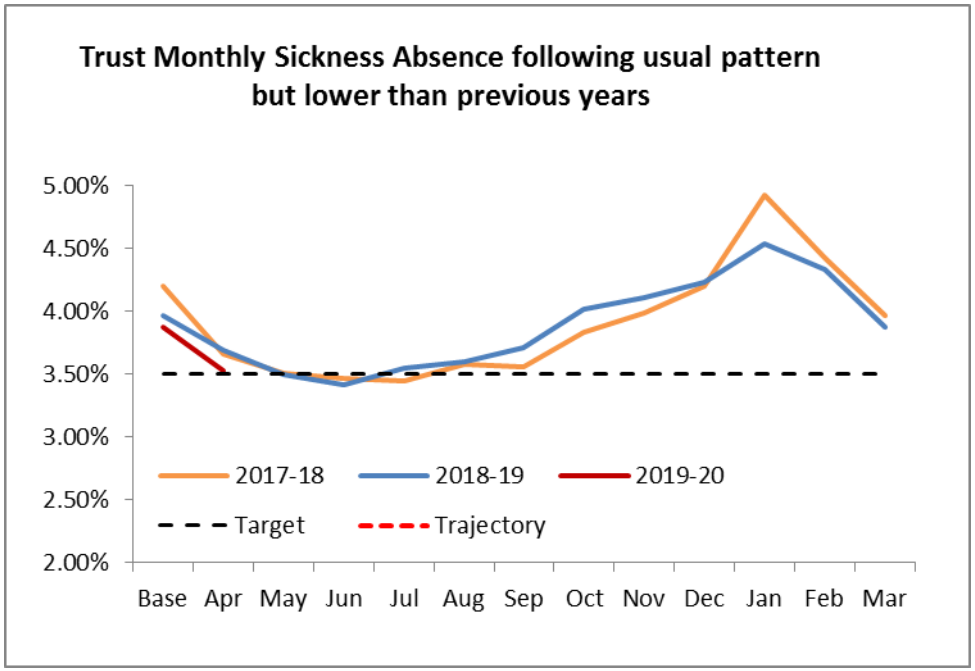
Non Registered Nursing	Recurrent Funded wte	Contracted		
Corporate Division	25.60	16.00	9.60	37.50%
Diagnostics & Specialty Division	73.96	74.54	- 0.58	-0.78%
Medicine Division	350.92	278.38	72.54	20.67%
Surgery Division	319.86	277.26	42.60	13.32%
Womens & Children Division	103.88	89.93	13.95	13.43%
Grand Total	**874.22**	**736.11**	**138.11**	**15.80%**

Highlights:

- key factors which should be considered when interpreting this high level data:
  - Data is, at this point in time, presented at a very high-level - therefore will not always highlight departmental level variance associated with bandings and / or local capacity and demand issues. For example, AHP's appear to be working over establishment – however we are aware of the shortage in radiography.
  - The figures presented show a more in depth look into Non Reg Nursing (HCA) and Nursing pressures, particularly highlighting pressures within Medicine (Non-reg) and Surgery (Reg).

Sickness Absence

Description	Current Performance			Maternity	Total	Sickness Absence by month						Movement
Sickness Absence is measured as percentage of available Full Time Equivalents (FTEs) absent against available FTE. The Trust target Is 3.5% w ith the red threshold 0.5% above this figure.	12 months to Apr 19 (Annual)	**Sickness**	**KPI**	Absence	Absence	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Jan to Feb
		% Abs	**% Abs**									
	Trust Total	3.85%	3.50%	2.77%	6.62%	4.11%	4.23%	4.54%	4.33%	3.87%	3.53%	decrease
	Corporate	3.87%	3.50%	1.64%	5.51%	4.17%	4.26%	4.22%	3.28%	2.83%	2.93%	increase
	Diagnostics & Specialty	3.90%	3.50%	2.18%	6.08%	4.37%	4.70%	4.95%	4.98%	4.33%	3.64%	decrease
	Medicine	3.59%	3.50%	3.03%	6.62%	3.39%	3.59%	4.25%	4.72%	4.25%	3.94%	decrease
	Surgery	3.96%	3.50%	2.95%	6.91%	4.38%	4.23%	4.42%	3.89%	3.84%	3.33%	decrease
	Womens & Children	3.99%	3.50%	4.37%	8.36%	4.24%	4.41%	4.89%	4.63%	3.60%	3.73%	increase
	Add Prof Scientific and Technic	3.14%	3.50%	2.85%	5.99%	2.89%	3.45%	2.37%	3.00%	2.79%	2.14%	decrease
	Additional Clinical Services	5.13%	3.50%	2.93%	8.06%	5.50%	5.65%	6.28%	6.26%	5.50%	5.31%	decrease
	Administrative and Clerical	3.89%	3.50%	1.40%	5.29%	4.17%	4.38%	4.64%	3.77%	3.59%	3.32%	decrease
	Allied Health Professionals	2.97%	3.50%	3.12%	6.09%	3.38%	3.87%	3.83%	4.23%	3.41%	2.24%	decrease
	Estates and Ancillary	7.17%	3.50%	0.00%	7.17%	9.35%	4.56%	4.44%	5.38%	6.13%	3.05%	decrease
	Healthcare Scientists	2.71%	3.50%	1.87%	4.58%	3.13%	2.81%	3.09%	2.59%	2.83%	2.53%	decrease
	Medical and Dental	1.66%	3.50%	2.69%	4.35%	1.63%	1.54%	1.99%	2.35%	1.79%	1.68%	decrease
	Nursing and Midw ifery Registered	4.36%	3.50%	3.68%	8.04%	4.65%	4.62%	4.89%	4.81%	4.33%	3.95%	decrease



Highlights:

- Annual sickness absence of 3.85% remains lower than the national average for Large Acute Trusts - 4.34% Sep 18 (GHFT 3.75% from same report)
- Long term (over 28 days) sickness accounts for just under half of absence taken (48%). In episodes LT accounts for 4.2%
- The estimated cost of annual sickness absence (lost hours, not replacement) is £7,180,801
- MSK and Mental Health remain the top reasons for absence.
- The Trust Health and Wellbeing Hub successfully launched in May 2019 and now provides increased support to staff , helping them to access services related to Mental, Physical and Financial health. This includes the addition of an Employee Assistance Programme, offering 24/7 telephone support.

Triangulation (Sickness and Turnover) & Intervention

Gloucestershire Hospitals NHS
NHS Foundation Trust

	%SA	Heads	Movement since	Short Term	Long Term
Ambulatory Emergency Care 76893	12.50%	26	*new*	4.61%	7.89%
GRH Head & Neck Theatre - Pay Only 7	11.99%	46	↘	3.35%	8.64%
Phlebotomy Services Trustwide 21441	10.79%	60	↗	2.40%	8.39%
Maternity Triage 26222	10.48%	30	*new*	1.69%	8.79%
Day Surgery Ward 72022	9.79%	41	↘	3.14%	6.65%
Ward 2a T&O Trauma & Spinal Unit 701	9.68%	55	stable	2.77%	6.90%
PALS 13322	9.53%	21	*new*	3.31%	6.22%
Trauma Ortho Fracture Clinic 43941	9.31%	32	↗	3.37%	5.94%
Pre-Analytical Area - Trustwide 22022	8.80%	49	↗	1.98%	6.82%
Ward Integrated Discharge 13693	8.60%	32	↗	4.89%	3.71%
Orthopaedic OPD 77022	8.48%	29	↗	2.55%	5.93%
Womens Health Admin 79222	8.32%	33	stable	1.73%	6.59%

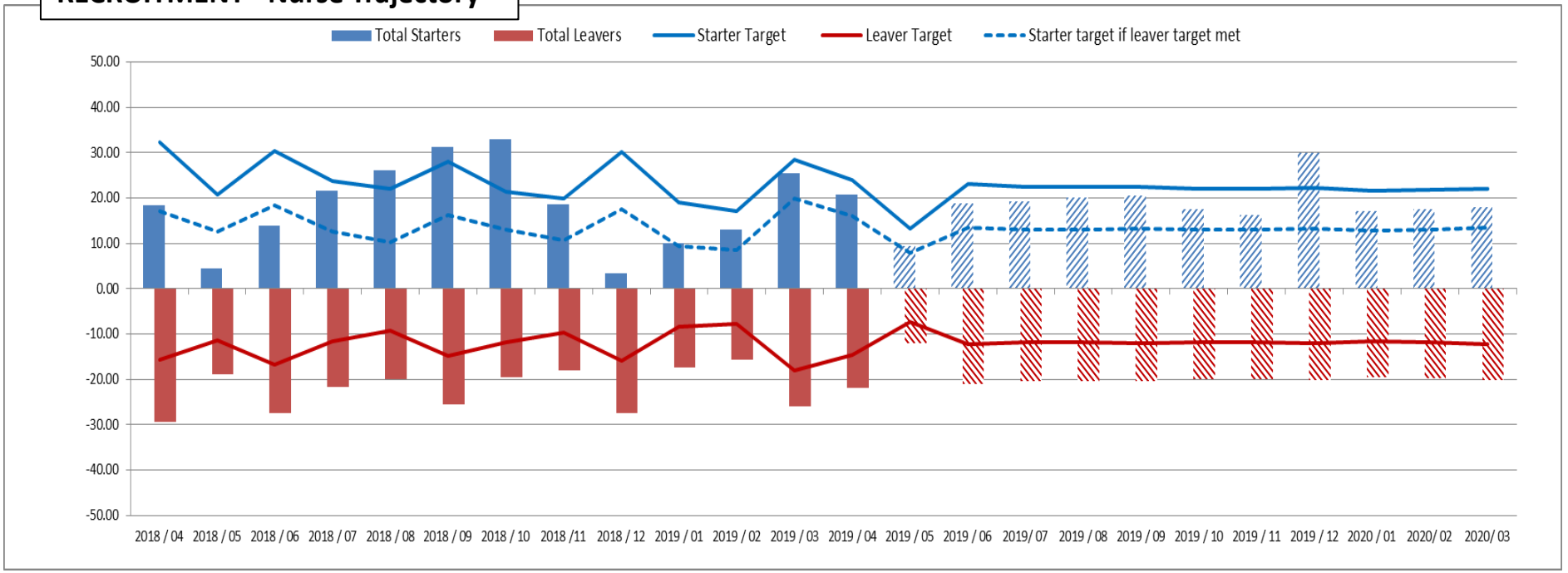
These are the areas (with 20 or more staff) with the highest turnover rates in the Trust

May 18 to Apr 19	% Turnover		Average FTE	Leavers	Movement
Alstone Ward - Orthopaedic 35341	50.86%		20.77	10.56	↗
Woodmancote CGH GOAM 73441	33.76%	33.76%	31.39	10.60	↗
Ward 3b T&O Trauma 74422	30.25%		32.35	9.79	↗
Ward 2a T&O Trauma & Spinal Unit 70122	29.62%		30.38	9.00	↘
Ward 6a Stroke 34822	28.99%	28.99%	27.60	8.00	↘
Audiology - GRH 23522	27.75%	27.75%	25.23	7.00	→
Prescott Ward 34541	27.63%	27.63%	33.92	9.37	↗
Avening Ward (Resp) 34141	27.51%	27.51%	27.43	7.55	↗
Ward 2b ENT Spec Surgery 73122	24.92%	24.92%	21.24	5.29	→
Ward 9b Acute (Unsched Care) 41522	24.78%		30.94	7.67	↗
Shared Serv-Procurement 85098	24.19%		20.67	5.00	→
Oncology Admin 12841	22.29%		42.63	9.50	↗
Cardiology Ward GRH 74222	20.86%		35.60	7.43	↗

Key Points to Note:

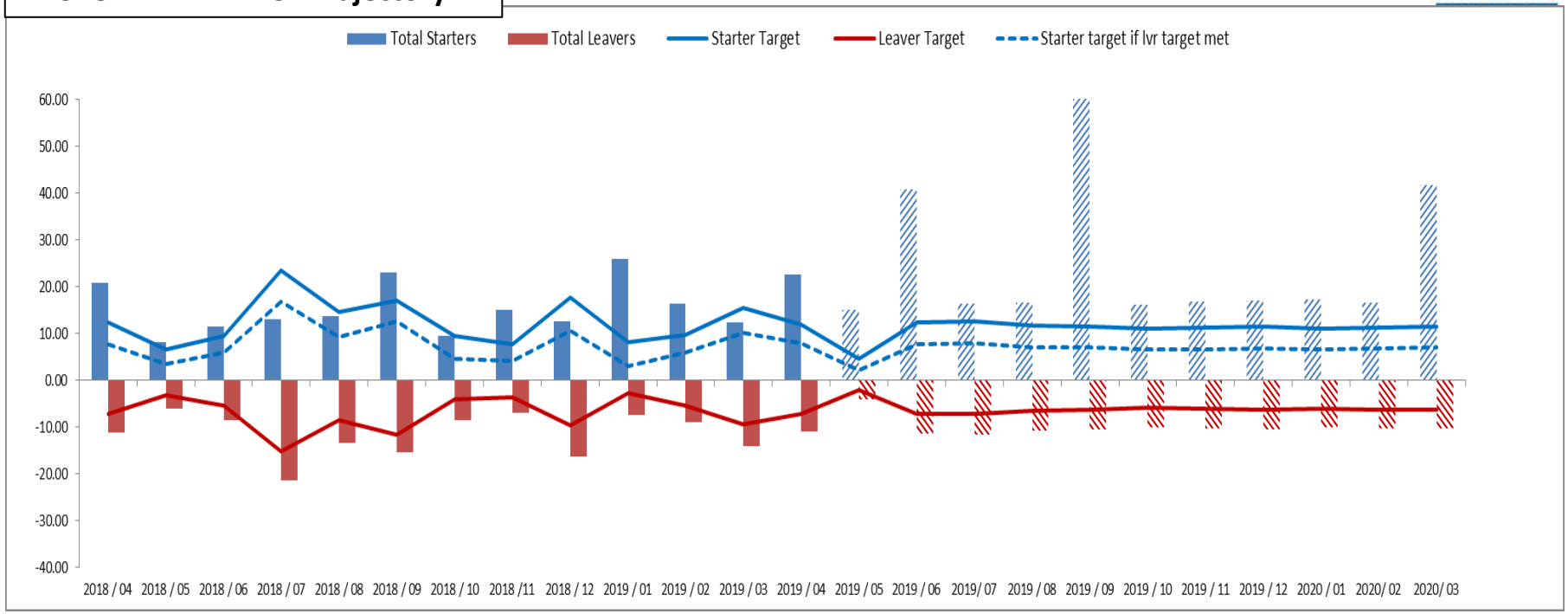
- The above tables show the top areas of concerns for sickness absence and turnover.
- Through the Staff and Patient Experience Group we have begun to develop a 'super dashboard' from which to triangulate a wide range of sources of data, including but not limited to: patient experience information, NAAS, freedom to speak up and ER case information.
- The triangulation of the two metrics above highlighted T&O as an area of concern discussed at the last POD Committee. This has been further investigated and a number of ER cases and a patient complaint from this area were reviewed, with the involvement of the Divisional Chief Nurse and HR Business Partner. Additional HR Support has been put in place for the leadership team to ensure that the response to these issues is appropriate and inline with policy, whilst addressing development needs. We expect this to show on the reported stats for some time (rolling figure), however remain confident that measures are in place to improve attendance and retention in these areas.
- Further scrutiny of these actions and their effectiveness takes place via. the Executive review process.
- The Executive review process has also focussed on retention within the medical division , which has contributed to the decision to launch a secondment opportunity for a Nurse Recruitment and Retention lead – to support continued focus in this area.

RECRUITMENT - Nurse Trajectory



- The trajectory graph for starters/ leavers shows confirmed starts as external FTE, this does not include internal moves and just indicates the pipeline we have coming through.
- April: 20.67 fte starters , however we lost 21.80 fte (6.75 of these leavers were retirements) , against a recruiting vacancy rate of 199.77 fte (the establishment also increased by c20 fte, worsening the vacancy position).
- Figures include ODPs and Nurses awaiting PIN
- Figures continue to reflect the pressure in balancing recruitment activity against turnover and sustained pressure in maintaining establishment levels.
- A new Starter and Leaver target line has been added to show the planned 50% reduction to turnover and the recruitment pressure this alleviates once achieved.
- Key actions over April and May 2019 to further boost recruitment to Nursing posts:
    - The preparation of new promotional video and marketing material (currently with our editors) to enhance our promotional material and web/ social media offer. This included involvement of a number of clinical staff working in shortage areas.
    - Continued career fair schedule , plus collaboration with ICS partners at June fair.
    - Launch of on-boarding/ new starter surveys
    - Confirmed start and preparation for the arrival of 15 pre- PIN Philippine Nurses (Aug 2019)
    - Establishing PIN qualification for 8 Philippine Nurses within our workforce in band 3 pre-pin positions.
    - Launch of cohort 2 of the Chief Nurse Junior Fellows
    - Agreement to recruit to an interim Nurse Recruitment and Retention Lead post (secondment advertised internally June 2019)

RECRUITMENT – HCA Trajectory



- The trajectory graph for starters/ leavers shows **actual confirmed starts** as external FTE, this does not include internal moves and just indicates the pipeline we have coming through. Bank HCA's are excluded from this graph**,** however represent significant recruitment activity.
- March 2019: 22.73 fte starters, however we lost 10.91 fte (almost 50% of these leavers were retirements) , against a vacancy rate of 180.58 fte. (the establishment also increased by c20 fte, worsening the vacancy position).
- The trajectory continues to reflect the pressure in balancing recruitment activity against turnover.
- In addition to the ongoing regular cycle of HCA recruitment, 3 additional recruitment events have been scheduled for June 2019 with the aim of significantly reducing the vacancy gap.
- As with the Registered Nurse trajectory a new Starter and Leaver target line has been added to show the planned 50% reduction to turnover and the recruitment pressure this alleviates once achieved.
- Key actions over April and May 2019 to further boost recruitment and retention of HCA's:
    - Development of named pathways for HCA entry, ready to be promoted and advertised to new and potential recruits.
    - Inclusion of HCA pathways (such as Trainee Nurse and apprenticeship routes) within the new promotional video material
    - On-boarding focus group with our new on-boarding co-ordinator, gathering informal intelligence about candidate experience
    - Review of recruitment testing, questions and candidate experience of recruitment events
    - Launch of the New starter survey
    - Review of Occupational Sick Pay arrangements as part of the HCA retention plan (c50% of our HCA's opted to amend their T&C's)

RECRUITMENT - Hard to Fill Posts & Approach (From April 2019 PODC, Full update due August 2019)

Long Term Vacancy (over 6 months)	WTE	Impact on service delivery	New Initiatives in place (Progress to be reported end of Q1)
RGN (Band 5)	9.22%	Increased pressure on existing workforce, impact on staff experience and retention.	Multiple recruitment and retention initiatives in place. Increased bank and agency usage. Daily, dynamic risk assessment of safe staffing numbers (Exec level)
Doctors in Training	42	(inc 16 Deanery gaps) Rota pressure, decreased cover.	Physicians Associates in place: further recruitment planned spring/ summer 2019. Development of ACP Business Case. Associate Specialist role: Scoping introduction of Trust contract which may support consultant gaps in the future.
Consultant Posts	10	Current Gaps: Care of the Elderly (2), Gastro, Acute (4), Diabetes, Oncology , Microbiology	Several active recruitment campaigns, including social media. Increase locum covered in place + additional hours
Radiographers	13	Reduced support to community services. Impact on staff morale and sickness.	Pay incentive for overtime agreed January 2019 . Developing 'Grow your own' initiatives including: Assistant Practitioners (Band 4), 2 year training programme to convert to Band 6. Overseas Recruitment Campaigns.
Cytology	3	Increased overtime	National changes to programme mean we do not intend to fill.
Band 7 Cardiac Physiologists	5	Mitigated by additional hours and agency cover	Apprenticeship proposal under development to support 'grow our own' model from band 5 – 7 (as tried and tested in Audiology)
Trust Surgeon/ Clinical Fellow (vascular) + Vascular Scientists	2 (CF) 2 (Sc)	Partial agency cover in place. Existing team providing cover.	Review of skill mix and alternative professional roles to commence post April 2019.
Audiologists	2	Impact reduced since introduction of apprenticeship pathway and skill mix review	Continue to actively target graduates with refreshed advertising campaign during 2019.
GMS – Elec/ Mech Technical	4	Impact mitigated via contractor cover	Development of alternative pay framework to enable industry benchmarked reward package. RRP in place for TUPE transferred staff.
GMS - Chef	1	Internal cover & agency support	Development of alternative pay framework to enable industry benchmarked reward package.

RECRUITMENT - Hard to Fill Posts & Triangulation Trust Risk Register (From April 2019 PODC, Full update due August 2019)

Gloucestershire Hospitals NHS
NHS Foundation Trust

S2275	The risk of workforce issues with staff well-being arising from an on-going lack of staff able to deliver the emergency general surgery rota due to reducing staffing numbers and vacancies.	1. Guardian of Safe Working Hours. 2. Junior doctors support 3. Staff support services available to staff 4. Mental health first aid services available to trainees in ED	1. Agency/locum cover for on call rota 2. Nursing staff clerking patients 3. Prioritisation of workload 4. Existing junior doctors covering gaps where possible 5. Consultants acting down 6. Ongoing recruitment for substantive and locum surgeons for rota including international opportunities 8. Health and well being hub will offer greater emotional well being services	Partially complete	Major (4)	Likely - Weekly (4)	16	Surgical	Workforce	Medical Director	Trust Leadership Team, People and OD Committee
F2335	The risk of agency spend in clinical and non-clinical areas exceeding planned levels due to ongoing high vacancy levels, with resulting impact of delivery of FY19 CIP programme	1. Challenge to agency requests via VCP 2. Agency Programme Board receiving detailed plans from nursing medical workforce and operations working groups 3. Finance agency report review on a 6 monthly basis 4. Turnaround Implementation Board 5. Quarterly Executive Reviews	1. Convert locum/agency posts to substantive 2. Promote higher utilisation of internal nurse and medical bank 3. Implementation of Health Roster for roster and Bank management 4. Implementation of Master Vendor Agreement for Nursing Agency - improving the control of medical agency spend and authorisation 5. Finalise job planning 6. Ongoing recruitment processes including international recruitment 7. Creation of new medical roles such as Associate specialists 8. Creation of a health and wellbeing hub aimed at reducing absence and reliance on costly temporary solutions	Partially complete	Major (4)	Likely - Weekly (4)	16	Corporate, Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Finance	Chief Nurse	Finance and Digital Committee, People and OD Committee

Appraisal & Mandatory Training

Gloucestershire Hospitals NHS
NHS Foundation Trust

Workforce Committee GHT April — 2. Education, learning and development

Appraisals	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	May-19	Movement	Apr to May
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%		
Corporate			72%	72%	74%	78%	84%	86%		84%	82%	82%	79%	79%	→	stable
Diagnostics			74%	74%	74%	81%	84%	81%		80%	79%	82%	82%	83%	↗	increase
Medicine			71%	72%	73%	75%	75%	76%		75%	76%	78%	77%	79%	↗	increase
Surgery			78%	76%	76%	79%	78%	76%		78%	78%	80%	80%	81%	↗	increase
Women & Children			76%	76%	78%	79%	79%	79%		80%	80%	82%	81%	82%	↗	increase
Trust			74%	74%	75%	79%	80%	79%		79%	79%	81%	80%	81%	↗	increase

Mandatory Training	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	Movement	Mar to Apr
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%		
Corporate excl Bank			88%	88%	89%	90%	91%	91%		88%	91%	91%	91%	→	stable
Diagnostics			90%	90%	91%	93%	93%	94%		94%	93%	93%	94%	↗	increase
Medicine			85%	85%	86%	88%	89%	89%		89%	88%	88%	88%	→	stable
Surgery			87%	87%	88%	90%	90%	91%		90%	90%	90%	91%	↗	increase
Women & Children			84%	85%	89%	91%	91%	91%		90%	89%	89%	89%	→	stable
Trust			87%	87%	88%	90%	91%	91%		89%	90%	90%	91%	↗	increase

Blank columns mean there was no data created this month

- Appraisals remain relatively stable at around the 80% mark, with a slight increase overall and in most divisions of 1%.
- Reminders are sent regularly and staff have been reminded at an individual level when their appraisal and associated pay step is due.
- Mandatory training rose to 91% overall in April, May data will be available mid-June

Training Compliance Report 30th April 2019

Gloucestershire Hospitals NHS
NHS Foundation Trust

Summary Breakdown of Compliance Rate by Training Competency and Staff Group

Training Competency / Staff Group	Trust Compliance	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical Staff - Consultants	Medical Staff - SAS	Medical Staff - Training Grades	Nursing and Midwifery Registered
318|LOCAL|Blood Transfusion|	86%	92%	85%	n/a	100%	n/a	73%	88%	70%	53%	89%
318|LOCAL|Code of Confidentiality|	91%	92%	87%	93%	96%	94%	92%	88%	82%	80%	92%
318|LOCAL|Conflict Resolution|	85%	88%	82%	84%	93%	81%	82%	95%	87%	90%	85%
318|LOCAL|Deprivation of Liberty Safeguards Level 1|	90%	95%	85%	n/a	97%	n/a	91%	90%	81%	90%	91%
318|LOCAL|Equality Diversity and Human Rights|	98%	98%	95%	99%	100%	99%	100%	99%	93%	95%	99%
318|LOCAL|Fire Safety|	84%	85%	81%	88%	88%	84%	83%	87%	73%	70%	84%
318|LOCAL|Health Safety and Welfare|	94%	95%	89%	96%	99%	99%	96%	96%	85%	90%	94%
318|LOCAL|Infection Prevention and Control|	88%	91%	83%	91%	94%	91%	91%	88%	80%	68%	90%
318|LOCAL|Information Governance and Data Security|	87%	90%	84%	92%	93%	94%	92%	89%	80%	66%	88%
318|LOCAL|Medicines Management|	81%	86%	74%	n/a		n/a	100%	n/a	n/a	n/a	84%
318|LOCAL|Mental Capacity Act Level 1|	90%	95%	85%	n/a	97%	n/a	91%	90%	81%	90%	91%
318|LOCAL|Moving and Handling Level 1|	85%	90%	81%	89%	91%	87%	88%	82%	74%	66%	86%
318|LOCAL|Moving and Handling Level 2 (2yr)|	84%	87%	79%	56%	94%	100%	91%	82%	74%	89%	85%
318|LOCAL|Prescribing|	64%	70%	n/a	n/a	n/a	n/a	n/a	85%	66%	43%	n/a
318|LOCAL|Resuscitation Level 2 Adult Basic Life Support (2yr)|	88%	90%	84%	67%	93%	80%	89%	88%	80%	68%	91%
318|LOCAL|Safeguarding Adults Level 2|	90%	96%	87%	n/a	97%	n/a	85%	89%	85%	89%	91%
318|LOCAL|Safeguarding Children Level 2|	88%	92%	83%	88%	93%	n/a	90%	91%	78%	91%	89%
NHS|CSTF|Preventing Radicalisation - Levels 1 & 2 (Basic Prevent Awareness) - 3 Years|	93%	95%	88%	96%	99%	97%	96%	97%	89%	91%	93%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	93%	95%	88%	96%	99%	97%	96%	98%	89%	91%	94%
NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - 3 Years|	93%	95%	88%	96%	99%	97%	96%	97%	89%	91%	93%

n/a : Staff group is not required to complete the training competency

Information Governance: At 87%, GHT is failing to meet the National target of 95%. An improvement plan is in place working with the IG Lead

A slight drop in Children's Safeguarding Level 2 due to the 3 year cycle coming to an end from when the programme was introduced – some staff have yet to update.

93% is a success story in these 3 topics as all staff have completed this since January 2018.

Manual Handling for A&C staff is low and will need further investigation. The Manual Handling Team will move into the Education and Development Service from 1st June and be part of a review of all MH training

Medical Trainees remains a challenge but recent meetings led to an agreement for future action and these changes will be introduced during 2019

Gloucestershire Hospitals
NHS Foundation Trust

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

Report Title
People and OD strategy 2019 - 2024
Sponsor and Author(s)
Author and Sponsor: Emma Wood, Director of People & OD/Deputy CEO
Executive Summary

Purpose
To share the finalised People and OD strategy 2019 – 2014

Key issues to note

- The People and OD strategy has been prepared in consultation with stakeholders through a number of forums inclusive of J2O divisional feedback, staff survey results, strategic objective engagement via TLT, forums and the on line survey.
- The strategy also takes into account internal and external sources of information and data and the foundations of the other enabling strategies.
- The strategy has been built around the new strategic objectives approved by the Board in May 2019.
- A summary of sources is available in Annex 1.
- The People and OD strategy has been reviewed by the People and OD team, the People and OD Group, the Trust Leadership Team, the People and OD committee three times in draft forms and the main Board as part of the overall strategy.
- The strategy provides an overview of the key strands of work to complete and the measures and outcomes which will determine success.
- The outcomes have been divided into strategic and operational measures which will be measured via the assurance processes of the People and OD Committee and Executive reviews respectively.
- Detailed action plans will be developed post approval to facilitate delivery of the milestones.

Conclusions
The People and OD strategy provides an overview of the key overarching themes and activities to undertake in the next 5 years to realise the Trust objectives.

Implications and Future Action Required

- The strategy will be further developed into action plans for each People and OD team.
- The assurance framework for Executive reviews and the Board Assurance Framework will be finalised after the Board ratify the strategy.

Recommendations
The Board agree the strategy as recommended by the People and OD Committee.
Impact Upon Strategic Objectives

The People and OD strategy will deliver upon the new Trust strategic objectives.

- We have a compassionate, skilful and sustainable workforce, organised around the patient that describes us as an outstanding employer who attracts, develops and retains the very best people.
- Quality improvement is at the heart of everything we do; our staff feel empowered and equipped to do the very best for their patients and each other.
- Patients, the public and staff tell us that they feel involved in the planning , design and

evaluation of our services.

- We are research active, providing innovative and ground breaking treatments; staff from all disciplines contribute to tomorrows evidence base, enabling us to be one of the best University Hospitals in the UK.

Impact Upon Corporate Risks

The strategy and actions will assist to mitigate the key principle risks of:

1. Risk that we fail to attract, recruit and retain candidates from diverse communities resulting in the Trust workforce not being representative of the communities we serve.

2. Risk of failure to support distributed leadership through leadership behaviours and governance arrangements at Board and Divisional level. This would adversely affect embedding quality improvement close to the patient and at the heart of what we do.

People and OD Risk Register Entries

1. The risk of continued poor levels of staff engagement is that our staff experience will impact negatively on retention, recruitment and patient experience. C2803P&OD

2. The risk of being unable to match recruitment needs with suitably qualified clinical staff (including: AHP's, Nursing and Medical), impacting on the delivery of the Trusts strategic objectives. C1437P&OD

Regulatory and/or Legal Implications

The strategy includes compliance with the Public Sector Equality Duty and associated legal reporting requirements.
The strategy strengthens compliance with Health and Safety legislation.

Equality & Patient Impact

The strategy will assist in the delivery of our vision to provide Best care for everyone and will support the strategic ambitions held for colleagues and patients as outlined in the Trust strategy.

Resource Implications

Finance	X	Information Management & Technology	X
Human Resources	X	Buildings	

Action/Decision Required

For Decision		For Assurance		For Approval	X	For Information	

Date the paper was presented to previous Committees

Quality & Performance Committee	Finance Committee	Audit Committee	Remuneration Committee	Trust Leadership Team	Other (specify)
				TLT 5 June 2019	P&OD Committee October 2018, April 2019, June 2019. P&OD Delivery Group 4 June 2019

Outcome of discussion when presented to previous Committees

- The People & OD Committee have supported the development of the strategy, the key objectives and themes for delivery.
- TLT recommend the adoption of the strategy to the People and OD committee.
- The People & OD Delivery Group supported the strategy for TLT approval.

NHS
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People and Organisational Development Strategy

Caring for those who care

Foreword

People are at the heart of the services we provide and we recognise that we need motivated, skilled and engaged colleagues to achieve our vision of Best Care for Everyone.

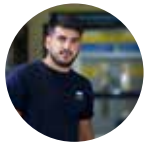
It is our desire to excel and treat colleagues and patients with fairness, respect, equality and dignity that drives the priorities within this People and Organisational Development Strategy for 2019 – 2024.

Putting colleagues at the heart of our delivery is why the People and Organisational Development directorate has entitled our people strategy 'Caring for those who care.' We want our services to enrich colleagues and illustrate the value we place on the care they take in their daily work, whether clinical, non-clinical, on a ward or in an office. If we can deliver upon the priorities in this strategy and treat colleagues as we commit to treating our patients – demonstrating our core values of Caring, Excelling and Listening; we will be able to improve the health, wellbeing and experience of the communities we serve.

We equally want our Equality, Diversity, inclusion and Human Rights agenda to be embedded as 'business as usual.' Treating collagues fairly to eliminate unfair discrimination and bias is a core feature of living our values and these expectations are threaded throughout our ambitions and enabling pillars.

By keeping these values at the centre of our programmes of work and priorities we know we can excel as a Trust and positively contribute to our 'Journey to Outstanding.'

Emma Wood
Director of People and Organisational Development and Deputy CEO



Caring for those who care

Our People and Organisational Development strategy has developed as a result of colleague, patient and partner engagement.

Together we have been defining the type of organisation we want to work in.

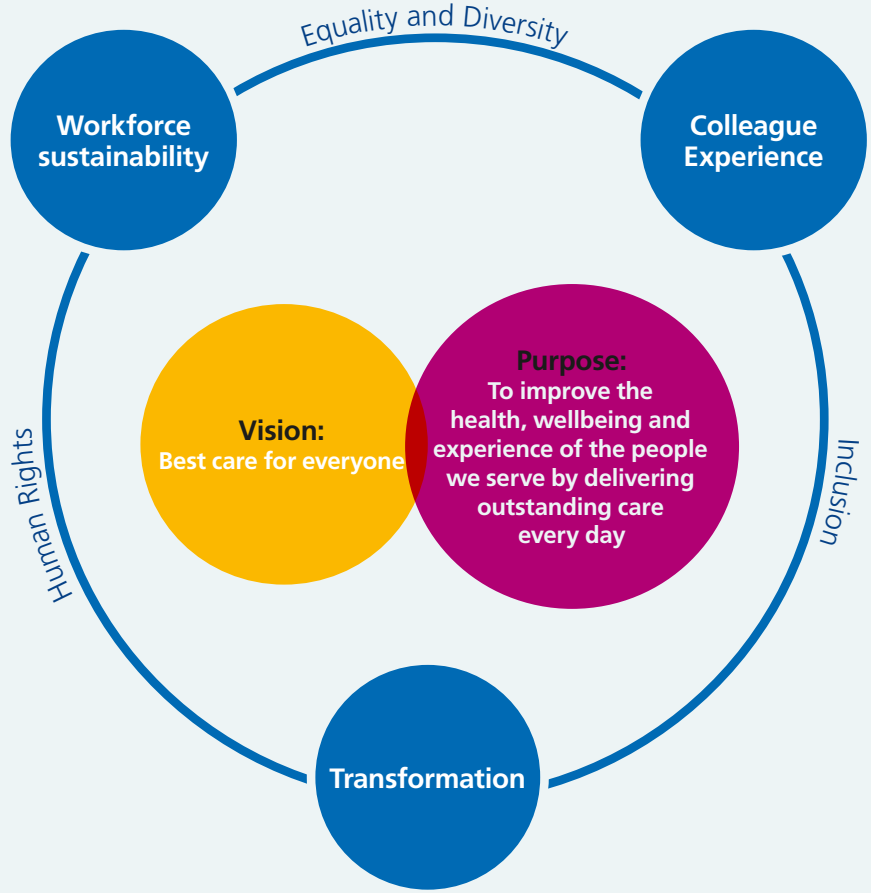
Throughout these conversations it is clear that colleagues want us to be ambitious, live by our values of caring, listening and excelling and be the very best versions of ourselves.

Our Journey to Outstanding ambitions have captured our imaginations to strive for improved services for our patients and our community and to focus on our commitments to colleagues, ensuring we grow and develop together to ensure best care for everyone.

We know from listening to you that if we focus on delivering upon two outcomes defined in our overall Trust Strategy, we will make a difference for one another and our patients:

- **We have a compassionate, skilful and sustainable workforce, organised around the patient, that describes us as an outstanding employer who attracts, develops and retains the very best people**
- **Quality improvement is at the heart of what we do; our staff feel empowered and equipped to do the very best for our patients and one another**

Enabling pillars to deliver the strategy



Workforce sustainability
A caring, compassionate and skilled workforce. A Trust able to attract, retain and develop the best people.

Equality, Diversity, Inclusion and Human Rights
Colleagues will recognise we act with fairness, respect, equality, dignity and encourage autonomy. Colleagues will recognise that this is central to our values and behaviours.

Colleague experience
Colleagues recognise the Trust as outstanding, they feel empowered and are confident that the Trust is driven by its values and ambition to excel in patient care.

Transformation
Colleagues are organised around the patient, equipped and inspired to deliver best care for everyone.

Where we are

We have a stable workforce and benchmark well with our peers, but we have some gaps in our medical and clinical rotas which we have not resolved

We have not consistently placed staff safety at the centre of our people practice

We do not always engage well with colleagues through operational service changes

We still have many colleagues who feel bullied, harassed and that their personal characteristics are an impediment to being treated fairly

We do not fill vacancies quickly enough and at times cannot attract the right people in the competitive market

We have a consistent absence rate which benchmarks well, but colleagues do not feel we provide enough support for their health and wellbeing

Where we want to get to

We will have the right staff in the right place with the right skills to meet the needs of our patients. We will have created new roles and developed colleagues to bridge workforce gaps

We will have a visible staff safety culture alongside a growing improvement academy

Colleagues will tell us they feel supported, developed and there are enough people employed to deliver care around the patient

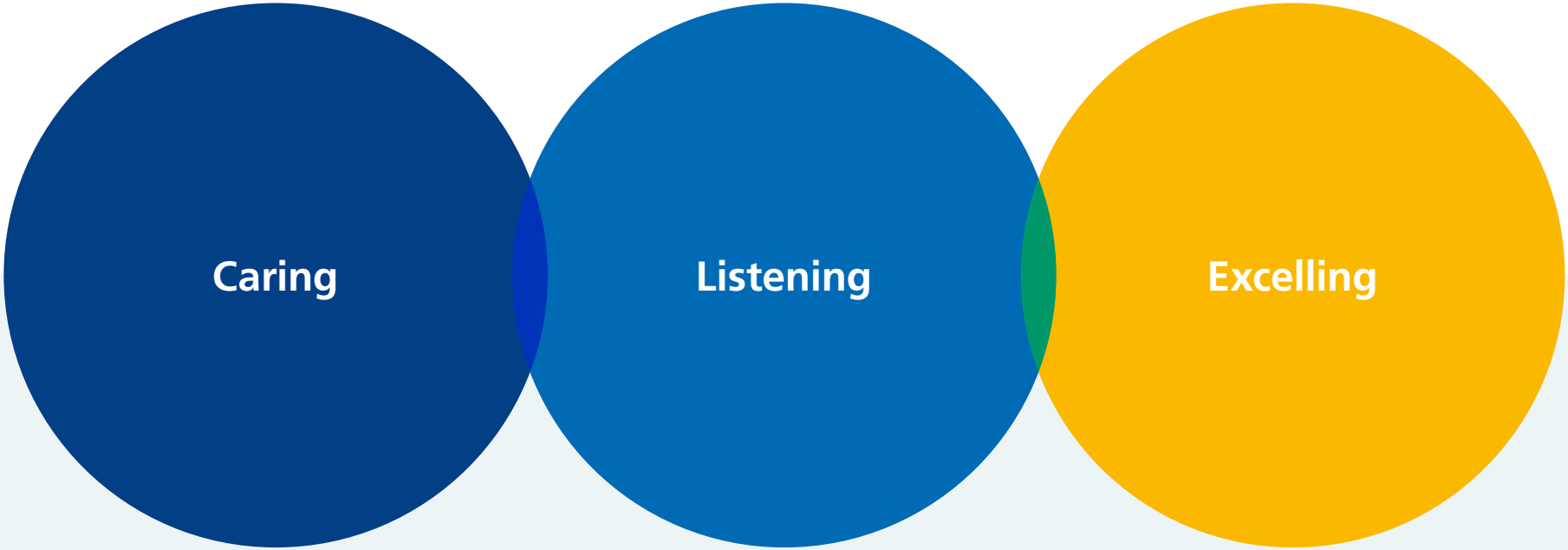
We will have new staff support and advice services to improve personal health and well-being

Regardless of colleagues' protected characteristics, everyone will feel valued and respected and this will be evident through staff survey responses, our progress in the Workforce Race Equality and Workforce Disability Equality Standards and Gender Pay Gap

Colleagues will be engaged and excited to work in new patient care pathways within the Trust and beyond; being confident that both the patients and their needs have been met

We will be an employer of choice and recognised as such by being the best in our peer group for attraction, retention and stability indices. We will be among the best University Hospitals in the UK

Values



We care for our patients and colleagues by showing respect and compassion.

Our ambition is to continue to develop how we recruit and retain colleagues who recognise the importance of caring, understanding the needs of others and responding to these with kindness, dignity and professionalism.

We listen actively to better meet the needs of our patients and colleagues.

We value the diversity of our colleagues and aspire to be inclusive and recognise everyone's contributions. We believe we can do this by acknowledging one another, actively listening and responding appropriately and clearly.

We are a learning organisation and we strive to excel. We encourage a culture of improvement in the Trust and we expect our colleagues to be and do the very best they can.

Our Journey to Outstanding will enable us to excel in our patient care and colleague services to fulfil our purpose to improve the health, wellbeing and experience of the people we serve.

Equality, Diversity, Inclusion and Human Rights

Equality, Diversity, Inclusion and Human Rights are vital components of good quality care.

As a Trust we believe in the principles of Human Rights; Fairness, Respect, Equality, Dignity and Autonomy.

When colleagues feel included they provide excellent care and services, they help us to improve by speaking out and place their service users at the heart of everything they do.

We are committed to a culture of fairness, equity and inclusion and as part of our commitment to ensure everyone feels safe we publish an annual equality, diversity and inclusion action plan.

This addresses issues raised by colleagues in our staff survey, pulse surveys, through Freedom to Speak Up channels, Workplace Race Equality Standard, Workplace Disability Equality Standard and Gender Pay Gap reporting. Our ambition is to celebrate difference and ensure that everyone feels they are treated fairly, regardless of their personal circumstances or protected characteristics.

Equality, Diversity, Inclusion and Human Rights must become business as usual and be embedded. As a Trust we publish objectives to seek to improve experience gaps but our ambition is to behave respectfully and ensure Equality is at the heart of everything we do and becomes second nature.

Significantly strengthen the support provided to staff with disabilities and support/education offered to line managers who work with disabled colleagues.

Improve the support and reporting mechanisms for colleagues when they experience or witness bullying, abuse, harassment or violence. Eliminate unfair discrimination.

Each year we will refresh our equality of opportunity, diversity and inclusion action plan to ensure changing priorities are captured.

Key metrics

National reports will show that the experience gap between colleagues with single or multiple protected characteristics have been eliminated. Staff survey reports will show that colleagues are treated fairly, unfair discrimination discrimination is eliminated and BAME staff are not disproportionately subject to disciplinary or grievance processes.

These objectives relate to our 2019 - 2024 Equality Duty Standard commitments

Enabling Pillars to deliver our Strategy: Workforce sustainability

Our ambition is to continue to develop our skilled, compassionate and caring workforce to meet the needs of our patients, colleagues and partners.

Enabling Pillar: Workforce sustainability

We need to ensure that in our ambitions to place patients at the heart we are mindful of future needs, demands and service changes.

As such we must make sure our workforce is future-proofed and the Trust focuses on attraction, development and retention of current (and future) staff.

This means we need to work on some key initiatives around Recruitment, Retention, Role development, Career pathways, Learning and Development, Continuous Professional Development, Coaching and Workforce planning (succession planning).

The initiatives listed below are key to deliver upon Trust objectives. Over a period of one to five years, milestones have been suggested. These are not an exhaustive list and as the strategy is delivered, some may be amended or added to accordingly.

Key initiatives	Year 1–2 milestones	Years 3–4 milestones	Year 5
Embed a strong unique employer brand to attract the best talent and embed value based recruitment	Ensure recruitment services are maximised to ensure time to hire is in the top quartile	Increase applications for medical grade roles by 10% in hard to fill areas	Be regarded by our peers as the best hospital to work for in the South West
	Innovate to recruit for behaviours and competencies not just skill. Integrate Human Rights principles in recruitment, appraisal and development	Develop innovative ways to attract staff and assess them	
	Improved supply routes to the Trust for key roles and build more bank networks Improved attraction and pipeline of nurses – establish a pipeline that looks to improve supply by 5–10% annually Ensure colleagues are recruited for their values and managers developed to role model the right behaviours	Close the gap to ensure the proportion of BAME colleagues employed in Leadership roles is consistent with local demographic data and BAME workforce percentages	
	Identify, publish and commence delivery of targets for BAME representation across Junior, Middle and Senior level Leadership roles		

Enabling Pillar: Workforce sustainability

Key initiatives	Year 1–2 milestones	Years 3–4 milestones	Year 5
Recognise the talent of colleagues and retain	Improve nurse retention by 1% Reduce vacancy factor for nurses 0.75-1% per annum	Improve nurse retention by 1% Reduce vacancy factor for nurses 0.75-1% per annum	Improve nurse retention by at least 2% in line with NHS Long Term Plan and a Vacancy Factor of 5%
	Reduce overall trust turnover to benchmark with peers in the top quartile		Reduce overall trust turnover to be the best in top quartile
	Reduce turnover in Health Care Assistants and Admin and Clerical roles by at least 1% per annum to ensure parity with other Trusts		Reduce turnover in Health Care Assistant roles by at least 5% and admin and clerical by 3%
	Improve retention measured by stability index by 1% each year Embed and improve the visibility of our talent pools and Accelerated Development pool		Improve retention measured by stability index. Aim to be in top quartile of good and outstanding large University Status Trusts
Develop new roles and career pathways	Delivery of grow your own / succession planning schemes		
	Grow Nursing Associates (50 per annum) and Chief Nurse Fellows (5–15 per annum)	Have at least 2 Nursing Associates on each ward by 2023	Trust will have developed at least 25 colleagues through the Chief Nurse Fellowship route
	Develop ‘step on’ Nurse degree pathways to BSc	Expand the number of Nursing Associates stepping onto the BSc Nursing Degree pathway	

Enabling Pillar: Workforce sustainability

Key initiatives	Year 1–2 milestones	Years 3–4 milestones	Year 5
Develop new roles and career pathways (cont)	Co-design MSc modules with Higher Education Institutes for Advanced Clinical Practitioner (ACP) roles and align supply with the workforce plan	Have a ready supply of professional colleagues educated to a Masters level in Advancing Clinical Practice	
	ACP role development and delivery into roles in stroke, ICU, frailty and acute response team	Have a developed and embedded ACP role and plan for 5 years	See the consistent use of advanced clinicians in roles more traditionally filled by medics
	Implement Associate Specialist roles in Acute medicine	Implement Associate Specialist role in Audiology, Pathology, theatre/Operating Department Practitioners and radiography	
	Develop and deliver an Assistant General Manager to General Manager to Director of Operations career pathway	Reduce the vacancy position in radiography and have a sustainable succession pathway	
	Commence radiography in-house training programmes	At least 5% of staff will be in the Accelerated Development pool and there will be a fair representation of diversity and protected characteristics	
	Embed talent development processes		
	Co-design Assistant Practitioner opportunities and Health Care Scientists with Integrated Care System (ICS) partners	Increase the number of higher level apprenticeships to meet Assistant Practitioner and Healthcare Scientist vacancy levels	Increase the number of staff accessing these pathways for career development opportunities

Enabling Pillar: Workforce sustainability

Key initiatives	Year 1–2 milestones	Years 3–4 milestones	Year 5
Understand supply changes and demands and analyse current and future needs	Develop a 5 year workforce plan which establishes gaps, future gaps and provides plans to resolve these within divisions	Reduce agency spend to meet NHSI control total	Efficient use of resources rated as outstanding by NHS Improvement (NHSI)
Develop and implement new workforce models within the Trust and with partners	Improve attraction and pipeline for hard to fill roles – Doctors in training, consultant posts in Care of the Elderly (COTE), Acute, Radiographers, Cardiac Physiologists, Paediatric Nurses	Have a confident social media and on line presence as a prospective employer	
	Consider alternative methods for attraction and develop sources of supply		
	Grow Apprenticeships by at least 10% and add 5 new standards per annum to our offer	Achieve national target for apprentices by 2021	
	Spend/transfer levy available to ensure none is unused	Maximise Levy spend for internal use Become an end point assessor organisation	
	Develop the Apprenticeship hub model with Health Education England.	Achieve an Integrated Care System Apprenticeship hub	Achieve provider status for standards such as Business and Admin, Health and Social care and Assistant Practitioner

Enabling Pillar: Workforce sustainability

Key initiatives	Year 1–2 milestones	Years 3–4 milestones	Year 5
Integrated Care System (ICS) education and work force collaboration	Deliver an education 'plan on a page' for year one. Deliver upon programmes of work together with Health Education England (Nursing Associates, leadership skills and tool kits, OD skills, Advanced Clinical Practitioners)	Deliver upon ICS priorities of shared procurement for education and development programmes and commissions	Deliver the 5 year ICS Local Workforce and Advisory Board plans for workforce development and sustainability
	Deliver upon an Integrated Care System (ICS) workforce plan and commence solution building to work in partnership rather than competition	Deliver workforce models and career development together ensuring partners develop skills required across organisational boundaries. e.g. ICS need for GPs to recruit roles traditionally found in other providers	
	Implement the ICS Pilot High Potential Scheme to encourage colleagues with aspirations to become Directors		
	Take action to encourage BAME colleagues to participate in organisation and ICS-wide Leadership Development Programmes		

Enabling Pillar: Workforce sustainability

Key initiatives	Year 1–2 milestones	Years 3–4 milestones	Year 5
Placement capacity and student experience	Increase adult nursing placements by 10%	Increase placement capacity by a further 15%	Continue to work with Higher Education Institutes to maximise numbers of locally trained health care professionals
	Improve student experience of placements by 10%	Implement recommendations from the National RePAIR project to improve the experience of students on placement	
	Bid for Health Education England funds to improve student experience		
	Improve collaboration with Higher Education Institutes to ensure local educational provision meets the Trust and Integrated Care System (ICS) 5 year workforce plan		
	Participate in the national RePAIR project relating to the retention of our older professional workforce, particularly in creation of alternative roles towards the end of careers and post-retirement	Implement recommendations from RePAIR relating to the more experienced workforce	

Enabling Pillar: Workforce sustainability

Key metrics

- Vacancy factor 5%
- Nurse retention improved by 2%
- Overall turnover is best in class
- Increased applications for hard to fill roles
- Established succession plans
- Role creation and innovation
- Career paths
- Increased number of staff accessing career opportunities
- Reduced agency spend

Outcomes for colleagues

"It feels like there are fewer vacancies"

"I know colleagues around me have the right skills and values to care for patients"

"I see more opportunities in the Trust than out"

"I know where my career is heading"

"I am proud to work at Gloucestershire Hospitals NHS Foundation Trust"

Outcomes for patients

"I know staff are caring and will do their very best for me"

"I can see services are run efficiently"

"I see kindness"

"I have confidence in the skills of those who care for me"

"I know the hospital cares for its staff and develops them well"

"I see staff are confident and proud of their hospital"

Enabling Pillar: Colleague experience

Our ambition is to continue to develop our skilled, compassionate and caring workforce to meet the needs of our patients, colleagues and partners.

Enabling Pillar: Colleague experience

Our ambition is that colleagues will recognise the Trust as an outstanding employer, one which lives our values and enables staff to deliver upon the ambition 'best care for everyone'.

In order to be the very best employer we can, we will work together to ensure colleagues have a positive experience of our Trust and feel engaged, listened to, respected and valued. In order to deliver an outstanding employment experience the People and Organisational Development strategy seeks to collaborate with colleagues to better understand how to engage and facilitate personal autonomy.

To achieve this we need to improve our health, safety and wellbeing services, improve engagement offers, embed our values, behaviours and freedom to speak up mechanisms, improve management and leadership, our learning and development offers, achieve improved inclusion and work to eliminate violence, aggression, bullying and harassment.

The initiatives listed below are key to deliver upon Trust objectives. Over a period of one to five years, milestones have been suggested. These are not an exhaustive list and as the strategy is delivered, some may be amended or added to accordingly.

Key initiatives	Year 1–2 milestones	Years 3–4 milestones	Year 5
Develop a culture where our values are well embedded in all our practices and policy	Ensure recruitment services are maximised to ensure time to hire is in the top quartile of peers	Improve experience indicators as measured by staff survey to be the best of Acute Trusts	To be recognised nationally as an employer of choice via national awards
	Tailor pulse surveys to determine colleague experience		
	Agree new models of communication and listening into action methodologies		
	Improve experience indicators as measured by staff survey to be in top quartile of Acute Trusts		
	Embed our values and define the associated behaviours. Launch 'Civility Saves Lives' and integrate with defined organisational behaviours and Human Factors training.		

Enabling Pillar: Colleague experience

Key initiatives	Year 1–2 milestones	Years 3–4 milestones	Year 5
Secure equity for all	Workplace Disability Equality Standard first report published	Closure of Workplace Race Equality Standard and Workplace Disability Equality Standard experience gaps	Annual reports indicate no experiential discrepancies between staff groups
	Improve reported experience gaps as measured by the Workplace Race Equality Standard	Closure of gaps in Gender Pay reporting	
	Reduce divisional reports of inequitable treatment relating to protected characteristics		
	Embed the Diversity Network further		
	Colleagues recognise that they can have a say in matters relating to them and influence change		
Remove violence and aggression, bullying and harassment from colleagues' working lives	Improved reporting of bullying and harassment resolution and ensure faster resolution of cases	Reduce year-on-year grievances relating to bullying and harassment	Colleagues have confidence that the Trust has a zero tolerance approach to violence, aggression, bullying and harassment
	Improve in staff survey results relating to violence and aggression, bullying and harassment to meet top quartile of Acute Trusts	Improve staff survey results relating to violence and aggression, bullying and harassment to be among the best of Acute Trusts	

Enabling Pillar: Colleague experience

Key initiatives	Year 1–2 milestones	Years 3–4 milestones	Year 5
Promote health, safety and wellbeing	Deliver and embed the staff support and advice hub. Embed processes for reasonable workplace adjustments and requests	Expand the staff support and advice hub to more proactive campaigning and ICS inclusion	Be recognised nationally for health, safety and wellbeing services
	Reduce colleague absence specifically for musculoskeletal and mental health illnesses	Closure of gaps in Gender Pay Report	
	Absence rates to match model hospital best peers	Be recognised as having improved and safe systems of work for colleagues	
	Reduce safety incidents involving colleagues in key areas: sharps, manual handling and incident rates per 100 staff in line with peer Trusts	Achieve full compliance with the Workplace Wellbeing Charter	
		Improve staff survey results to show disabled staff report the same experience as their non-disabled colleagues	
Embed new leadership and management practice	Deliver new education and development standards for managers and leaders	Ensure no people manager is in post without the prerequisite training and development	Ensure all people managers are professionally qualified in people management skills
	Improve on-boarding for management colleagues	Improve and embed a coaching and mentoring offer for managers and staff	The Trust has a coaching and mentoring culture
	Improve the ratings in the following NHS Staff Survey Themes: Immediate Manager, Quality of Appraisals and Staff Engagement		
	In collaboration with Integrated Care System (ICS) partners, develop new standards for Managers and Leaders. Design and deliver associated development opportunities to embed these and extend BAME representation		

Enabling Pillar: Colleague experience

Key metrics

- Improved staff survey results across staff experience themes to meet best in class peers
- Reduced safety incident and RIDDOR reportable accidents demonstrating a safety culture
- Zero tolerance to violence and aggression bullying and harassment
- Improvements in Workplace Race Equality Standard and Workplace Disability Equality Standard to show closure of gaps in experience for BAME and disabled staff
- Delivery of the Health and wellbeing business case benefits

What colleagues would say

"I know I work in an organisation that is open and transparent"

"I know the Trust cares about me and my health and wellbeing"

"I am proud of working here"

"I feel safe at work"

"My manager wants the best for me and encourages me to be my best"

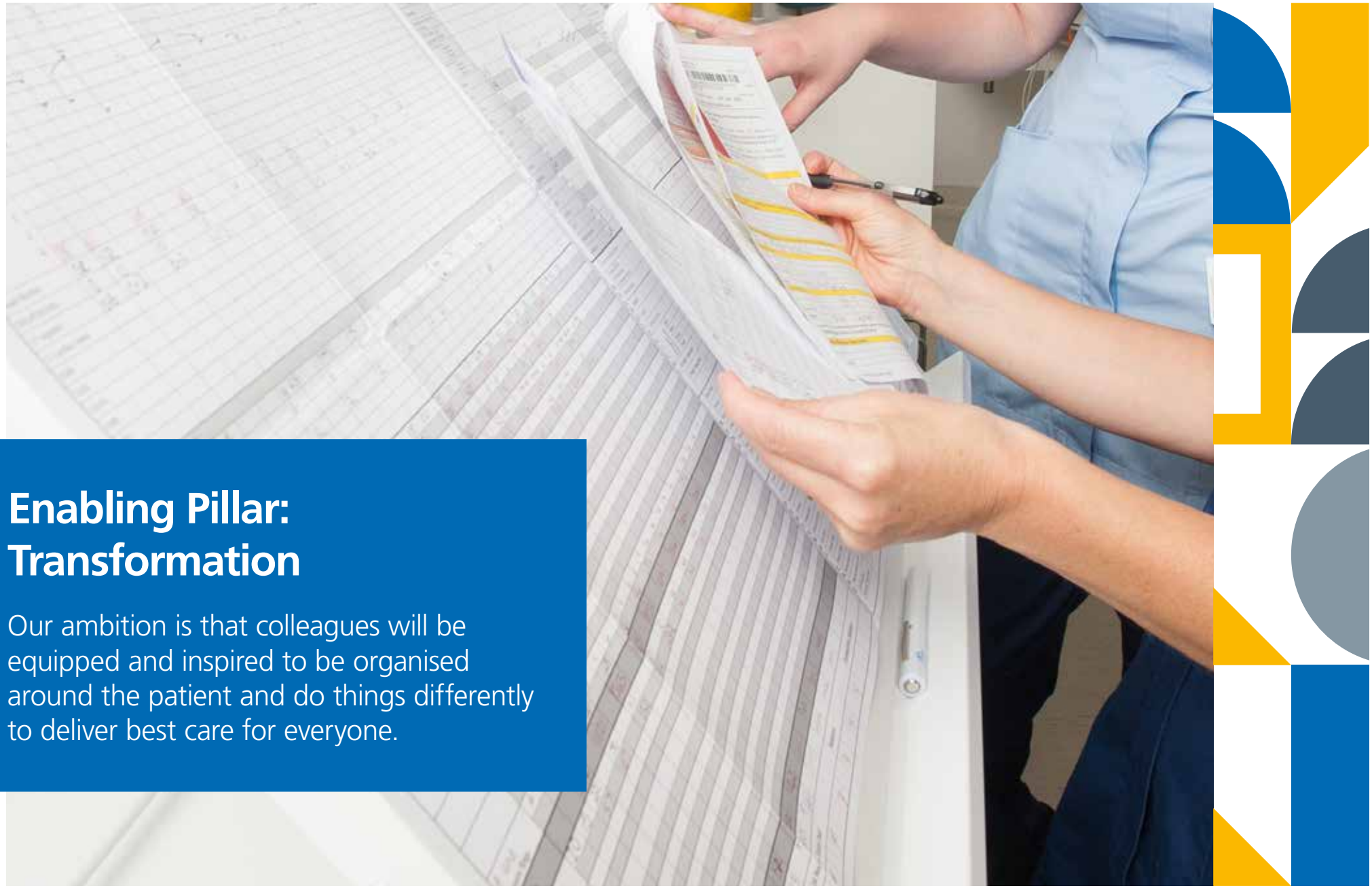
What patients would say

"I can see the staff are happy and positive"

"I know who is in charge in my ward"

"My needs and differences are well respected and recognised"

"I feel I am well cared for and safe"



Enabling Pillar: Transformation

Our ambition is that colleagues will be equipped and inspired to be organised around the patient and do things differently to deliver best care for everyone.

Enabling Pillar: Transformation

Our workforce will embody the spirit of driving change to make improvements and striving for excellence at the heart of the service we provide for patients, colleagues and partners.

To achieve this we will focus our priorities on education and professional development, research, patient pathway and service redesign within our Trust and with the Integrated Care System (ICS), design of new roles for staff and improve the digitisation of People processes such as rostering, job planning, temporary staffing and self-service technologies to be as efficient as we can.

The initiatives listed below are key to deliver upon Trust objectives. Over a period of one to five years, milestones have been suggested. These are not an exhaustive list and as the strategy is delivered, some may be amended or added to accordingly.

Key initiatives	Year 1–2 milestones	Years 3–4 milestones	Year 5
Deliver the best professional education, learning and development	Ensure continuous improvement of education content, material and methods of delivery	Deliver upon the education requirements of nurse, midwifery, Allied Health Professionals and Health Care Scientist career pathways	Be recognised as a learning organisation
	Support and develop programmes which enable colleagues to develop personal skills via either accredited or non- accredited means		Be recognised as having an embedded coaching and improvement culture
	Target the needs of colleagues as linked to the operational workforce plans and implement programmes which span pre-employment, on-boarding and ongoing development		

Enabling Pillar: Transformation

Key initiatives	Year 1–2 milestones	Years 3–4 milestones	Year 5
Deliver new patient pathways within the Trust and the Integrated Care System	Ensure colleagues are engaged and contribute to changes in service delivery	Colleagues will transition into new pathways and services with ease	Colleagues will reflect that the change processes for them was engaging and well managed
	Colleagues will report an improvement in their views on quality of care and their ability to deliver this to match national averages	Nursing Assessment and Accreditation System (NAAS) ratings are blue	Colleagues will report an improvement in their views on quality of care and their ability to deliver this to match best in class Acute Trusts
	Nursing Assessment and Accreditation System (NAAS) ratings are all green		
Deliver digital and technological efficiencies for people processes	Deliver upon a technological solution for temporary staffing	Technological solutions for temporary staffing and the Employee Relations tracker have reduced costs – temporary staffing spend, sick pay, legal costs and improved staff experience	
	Introduce the Employee Relations tracker to enable HR Advisory services to better support staff and managers with grievances, sickness management and disciplinary cases	Implement further self service and Manager modules on ESR	
	Deliver improved demographic data capture relating to protected characteristics on ESR to enable improved reporting on staff experience		

Enabling Pillar: Transformation

Key initiatives	Year 1–2 milestones	Years 3–4 milestones	Year 5
Deliver digital and technological efficiencies for people processes (cont'd)	Safer staffing levels are consistently achieved at ward level		
	Improve job planning compliance		
	Broaden electronic rostering to all front line clinicians		
Deliver upon University Hospital Status	Scope the opportunity, benefits and requirements for becoming a University Hospital	Develop additional research projects with a focus on education	Maximise the opportunities presented by being an Accredited University Hospital
	Develop further research funding sources		

Enabling Pillar: Transformation

Key metrics

- The trust has become a University Teaching Hospital
- Staff survey results show colleagues believe they provide the best services possible
- Staff are actively involved in more research and innovation
- The patient is at the heart of integrated pathways
- Digitalisation has made simple tasks more efficient
- Colleagues can recognise the multiple opportunities available for them in their professional development across the Integrated Care System

What colleagues will say

"I have lots of opportunities to learn and grow"

"I am able to participate in research and teaching"

"I am able to provide patients the care I aspire to give"

"I can complete tasks like booking bank shifts more easily"

"I am proud to work at a university hospital"

What patients will say

"I know I am getting the best care"

"The staff here are highly skilled, well trained and kind"

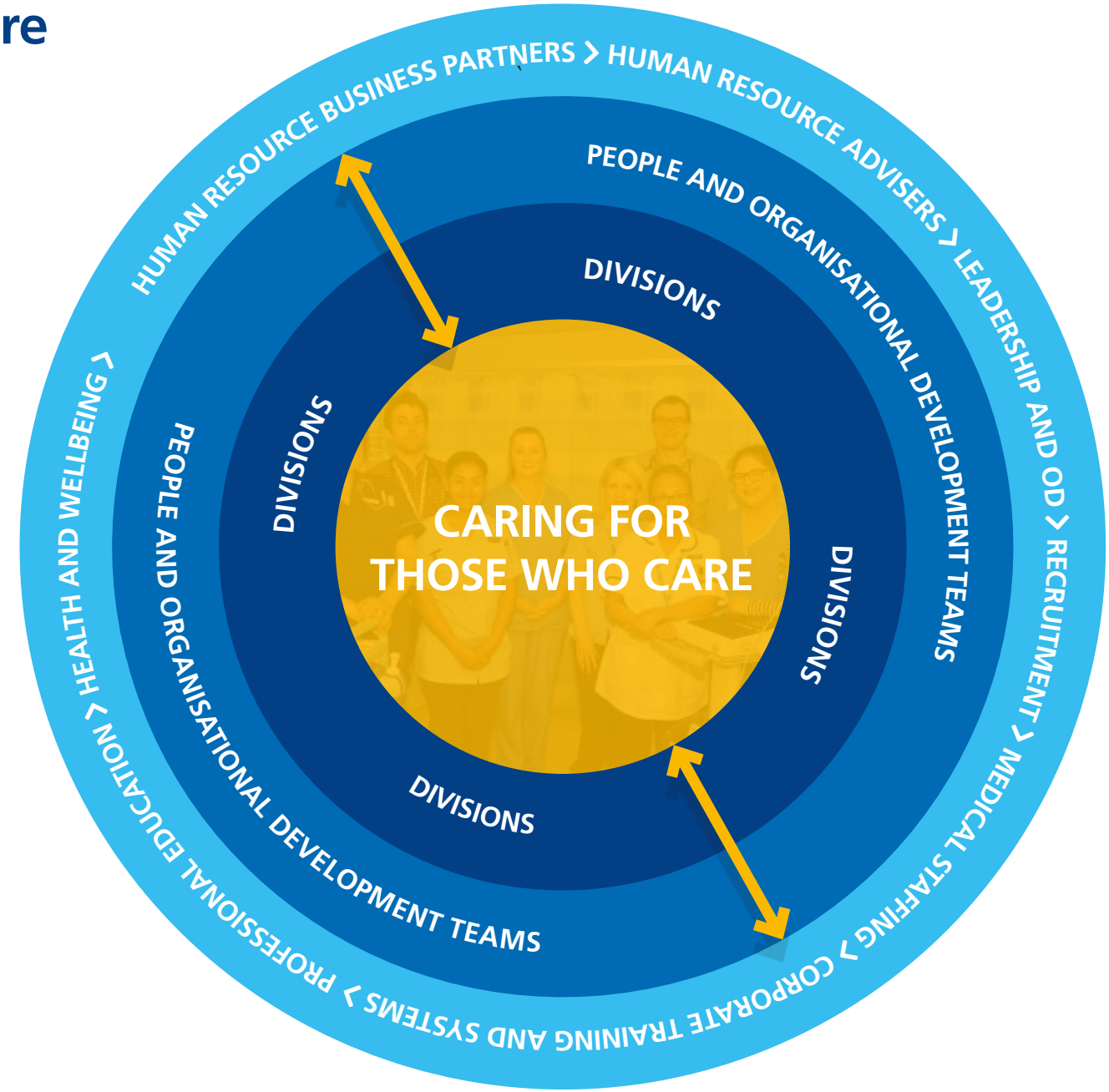
"New ways of working have made access easier for me"

"I know the service is well organised and focuses on me"

Caring for those who care

This model describes how the People and Organisational Development teams work on your behalf.

We aim to live our values and ensure our services are well connected so you can get the best from us.



Human Resource Business Partners

Working collaboratively with leaders to achieve Trust and divisional objectives and ambitions by designing, delivering and implementing the best people solutions

Human Resource Advisers and Workforce Information

Providing accurate and timely information and advice to enable support to Managers to achieve the best staffing outcomes to deliver the high quality patient care and/or services.

Leadership and Organisational Development

Providing solutions to deliver transformational change, improve staff engagement, develop talented colleagues and deliver innovative leadership development solutions

Recruitment

Transforming the way we attract, recruit and on board high quality staff and colleagues who share our caring, listening and improving values.

How do we support the vision of the **BEST CARE FOR EVERYONE** and care for those who care?

Medical Staffing

Providing medical colleagues with support throughout their career including attraction, recruitment, appraisal, job planning and career development.

Corporate Training and systems

Delivering and developing induction and mandatory training, providing support for professional registration, expenses and Smartcards, overseeing training and appraisal systems and innovating provision of education through a learning technology team.

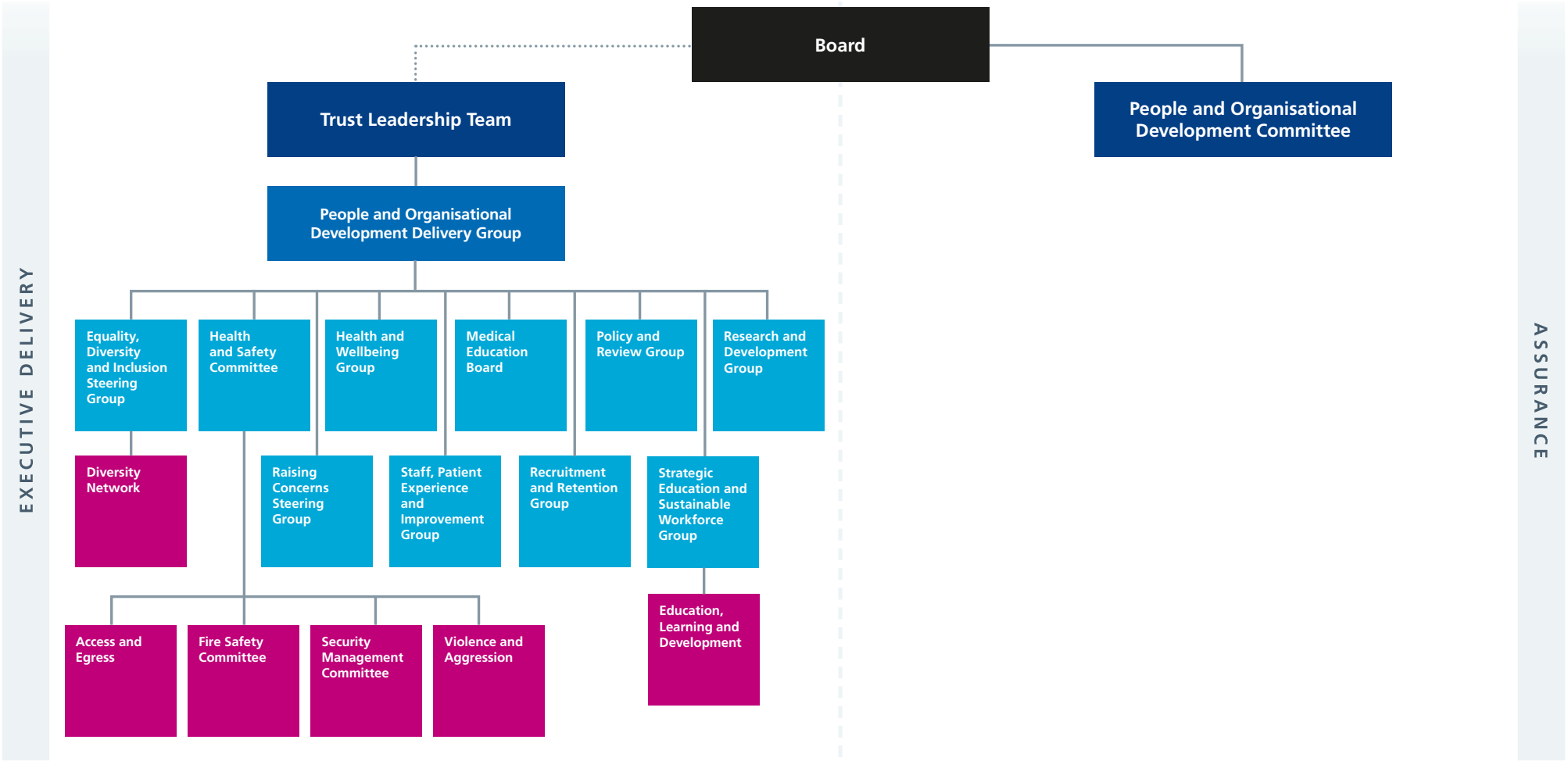
Professional Education and Lifelong Learning

Providing learning opportunities that meet the changing needs of our services and practice. Working with partners to deliver apprenticeships, overseas nurse programme, professional education and undergraduate student placements; enabling our employees to access career pathways and role development.

Health and Wellbeing

Supporting colleagues through the promotion of a healthy, happy and safe environment by embedding staff health and wellbeing in everything we do. Specifically oversee the Staff Advice and Support Hub, Occupational Health services and Employee Assistance programmes and schemes.

People and Organisational Development governance chart



Annex 1: Strategic and divisional objectives

To ensure that the objectives are met, a number of measures will be reviewed in executive meetings and at assurance committees.

These will help to deliver our aspirations and also focus our activities on the key priorities. Strategic measures will form part of the new dashboard for the People and Organisational Development committee and operational measures will be reviewed as part of the Executive review process.

Workforce sustainability

Strategic measures

- Improve nurse retention by 2% by 2025 (Long Term Plan) and aim for a Vacancy factor of 5% (subject to national supply chain improvements) by 2028
- Improve retention from 11% - 9% by 2024 with a minimum 0.5% improvement year-on-year
- Reduce Vacancy factor currently at 9% to 5%, reduce by a minimum of 0.75-1% per annum
- Reduce turnover to meet top quartile in model hospital. Aim in year 1 to achieve national median and in year 2 next best peer. By year 5 match best in model hospital peers (moving year-on-year target)
- Reduce turnover in roles identified annually. In year 1-2 reduce Health Care Assistant turnover from 15.5% to 10% from 2019 to 2024 by reducing 1% year on year. Admin and clerical turnover to reduce from 13% to 10% by reducing 0.75% year-on-year
- Improve retention measured by stability index against Model Hospital data. Aim to be in top quartile of good and outstanding large university trusts. 1% each year until reach 92% and thereafter to maintain to be best in group
- Delivery of grow your own / succession planning schemes (identify most important as linked to sustainability, Integrated Care System and Long Term Plan) In year 1–2. Grow Nursing Associates by 2 X 25 per annum and thereafter at a rate to achieve 2 Nursing Associates on each ward by 2023. Advanced Clinical Practitioner role development and delivery into roles in year 1–2 in Stroke, ICU, Frailty and Acute Response Team. Year 1–2 implement Associate Specialist role in Acute Medicine and in year 3–5 in Audiology, Pathology, Theatre/ODP and Radiography. In year 1–2 Assistant General Manager – General Manager route developed and pathway to Deputy Director of Operations. In year 1–2 radiography in house training programmes commence. Chief Nurse Fellows year 2–5–15 per annum
- Improved attraction and pipeline of nurses – establish a pipeline that looks to improve supply by 5 - 10% annually
- Improve attraction and pipeline of hard to fill medical roles – Doctors in training, consultant posts in Care of the Elderly, Acute, Radiographers, Cardiac Physiologists, Paediatric Nurses. Establish a pipeline and consider alternatives for attraction and develop sources. Reduce vacancies to match peers

Operational measures

- Appraisal 90%
- Mandatory training 90%
- Apprenticeship growth in division for basic roles to meet national targets by year 2 (currently 170, GRH have 130 apprentices). 10 apprentices additional in each division
- Staff in Accelerated Development Pool to be represented across all divisions. Steady growth of staff in the pool to reach 5% of headcount (based on natural distribution of talent – bell distribution by year 2)
- Divisions to support innovations of new role and career opportunities as linked to shortage and hard to fill areas/roles
- Divisions to deliver upon retention programmes to reduce turnover by at least 1% point per annum
- Divisional responsibility for delivering work force plans as agreed in the operational and 5 year plan (delivered at end year 1)

Colleague experience

Strategic measures

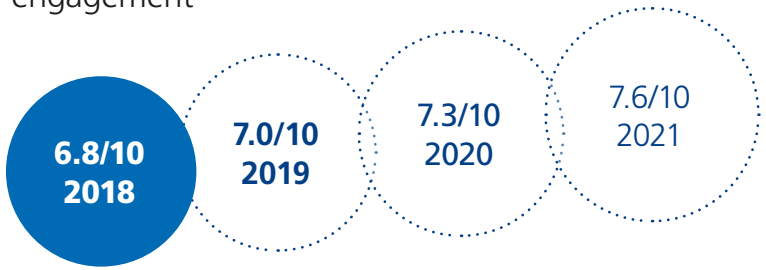
- Staff survey improvements specifically under themes; Staff engagement and Morale, Equality Diversity and Inclusion, Health and Wellbeing, Immediate Managers, and morale see table below for next 3 years (based on 2018-19 best in class Acute performance). Years 4 and 5 to be assessed in year 3
- Improvements in Workplace Race Equality Standard and Workplace Disability Equality Standard by year 5 to show closure of gaps in experience for BAME and disabled staff
- Improved reporting of Bullying and Harassment and resolution of 85% of cases within 6 weeks by year 2. Reductions year on year in grievances relating to Bullying and Harassment
- Delivery of the Health and wellbeing business case benefits
- Delivery of corporate Health and Safety objectives as set and agreed and measured by People and Organisational Development Committee
- Percentage of total incidents not reviewed within 7 day timeframe
- Incident with greatest number of days overdue following expiry of 7 day timeframe
- Percentage of total incidents not investigated within the 20 day timeframe
- Incident with greatest number of days overdue following expiry of 7 day timeframe
- All risk assessments reviewed annually by March 2021 (to be reviewed by the Health and Safety committee and exception reports escalated)

Operational measures

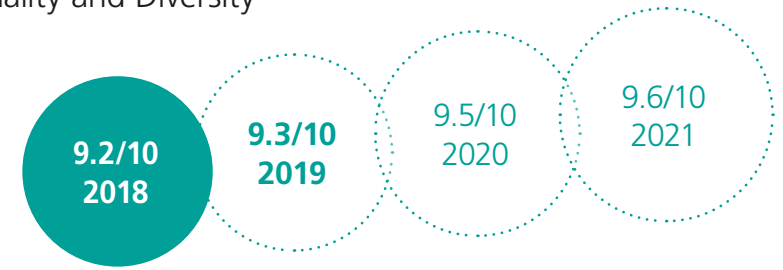
- Complaints and grievances regarding Bullying and Harassment within division and improvement in cases reported and resolved in times lines set
- Number of staff, managers and supervisors undertaking Bullying and Harassment training and people management programmes. Percentage of overall staff with management responsibilities undertaking this training. Ambition to ensure 80% of colleagues trained in year 1, 90% in year 2 and 95% by year 3
- Membership and activity in the Diversity Network and with Equality and Diversity initiatives of divisional senior team
- Local staff survey result improvements by division and role as per divisional aspirations and achievement of staff survey action plan (Tri or department lead with Human Resources Business Partner to select key areas per division per annum)
- Absence rate to meet best peers from model and aim to reduce by 1% per annum
- Improved Health and Safety risk management - 15% reduction in the annual number of sharps injury in year 1
- 10% reduction in lost time for stress related illness by year 2
- 10% reduction in lost time for manual handling injuries by year 2
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) reporting in statutory timeframes

Staff survey objectives

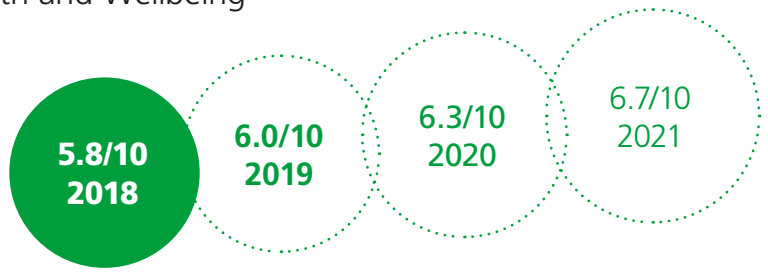
Staff engagement



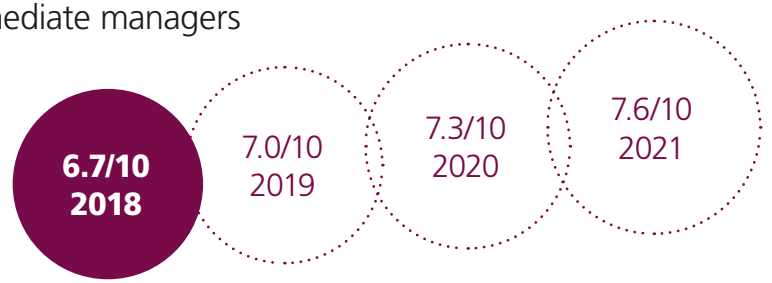
Equality and Diversity



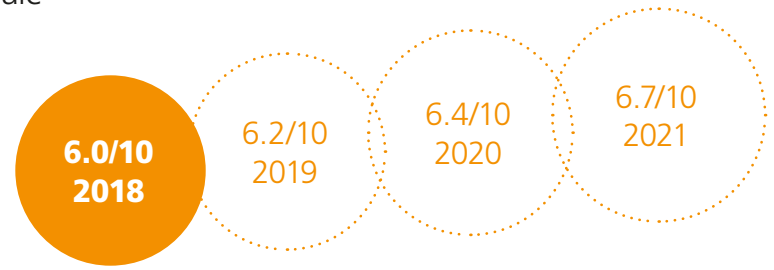
Health and Wellbeing



Immediate managers



Morale



Transformation

Strategic measures

- Successful delivery of Integrated Care System integration pathways (to be quantified each year as pathway change is operationalised)
- University hospital status and progress made as per programme delivery phases
- Improved digitalisation of People systems –realise benefits from the Employee Relations tracker by year 2 and Implementation of ESR self service and manager service to ensure electronic management of items such as absence, appraisal and annual leave by year 2
- Act as lead in apprenticeship hub model for Integrated Care System by 2022 and add at least five more apprenticeship opportunities per year to the Trust's portfolio
- Increase number of apprentices by 10% year on year and maximise levy spend
- Become an apprenticeship provider by 2024 to provide clinical and health service levels 2-5
- Improved quality of care indicators in staff survey from 76% (GRH) to 80% (average) by year 2 and best in class by year 5 currently 89%
- Improved measure of aspiring to deliver the best care from 62% (GRH) to 67% (average) in year 2 and 81% by year 5
- Improve coaching and mentoring offers through Leadership and OD and Academy by 10% year-on-year

Operational measures

- Rostering and job planning improvements and compliance (baseline where now and improvement) 100% job planning by end 19/20 inclusive of uploading and compliance with the medical operational dashboard
- Temporary staffing improvements such as divisions meeting agency ceiling, automating medical interims, reducing agency use and increasing bank offers
- Safer staffing/live safe implementation across all wards by year 1
- Wider Nurse Assessment Accreditation System (NAAS) implementation with further wards attaining green and blue status

Equality, Diversity, Inclusion and Human Rights

Strategic measures

- Improvements in staff survey reports against the 9 Protected Characteristics but specifically for disabled staff members
- Drive improvements in staff experience for bullying, abuse, harassment or violence as evidenced within the staff survey, grievance and disciplinary cases and Freedom to Speak Up reports
- Workplace Race Equality Standard and Workplace Disability Equality Standard and Gender Pay audit report data to show continual improvements year on year to reach the ambition that staff with disabilities and those of a BAME background report the same experiences as their non disabled and white counterparts. Our gender pay gap will continue to narrow
- Integration of Human Rights principles in staff recruitment, performance management and development (fairness, respect, equality, dignity and autonomy)
- Meet objectives and outcomes identified in the Equality of Opportunity, Diversity and Inclusion action plan (set annually)

Operational measures

- Reduced divisional reports of inequitable treatment as measured through Freedom to speak up, discipline, grievance and dignity at work issues
- Divisional support for staff with protected characteristics to apply and be recommended for inclusion in the Accelerated Development Pool

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People and Organisational Development Strategy

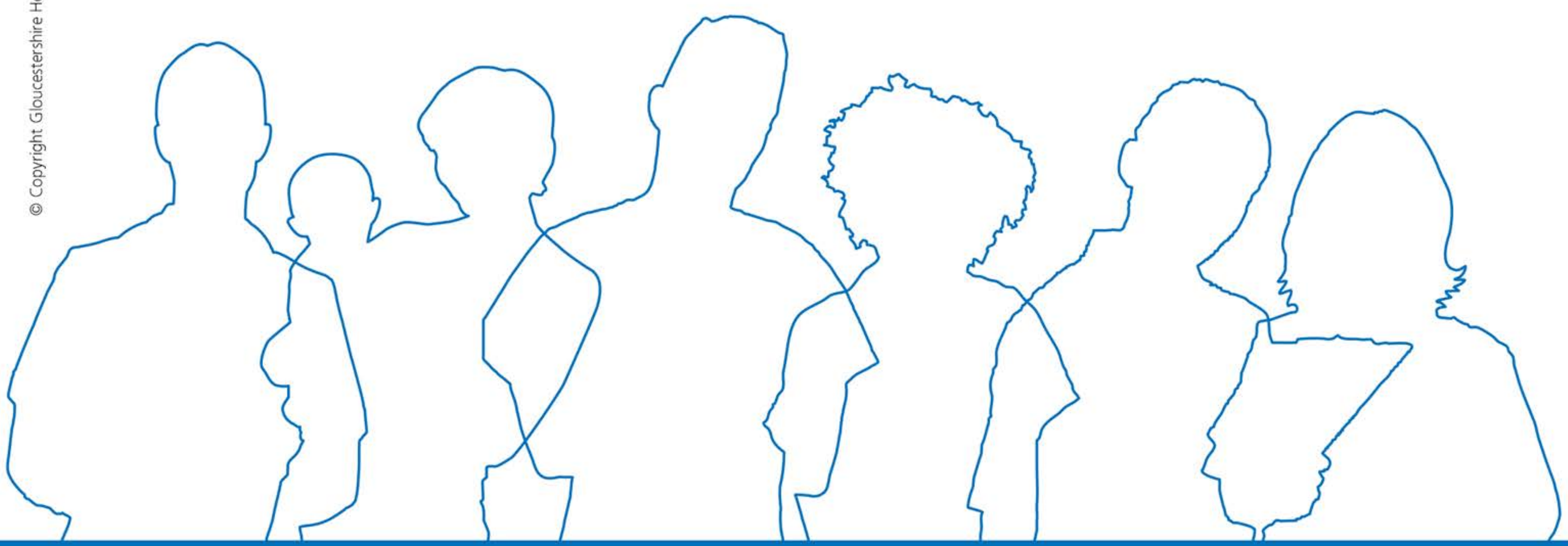
V3, May 2019

Gloucestershire Hospitals
NHS Foundation Trust

People and OD Strategy: 2019 to 2024

Analysis of themes and priorities

Annex 1



Introduction

In order to agree and describe a new People and OD strategy internal and external sources of data and information was collected and reviewed.

This slide deck outlines this journey, commencing with the first J2O discussions held a year ago, and acts as supportive evidence for the priorities presented in the new strategy

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Internal sources of intelligence and feedback from staff on potential staff objective themes .....

Divisional J20 Feedback: Themes

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Staff will **feel**…

- They can contribute to decisions
- Ownership of the services they deliver, pride in delivering them, and that they are good enough for their own family
- Valued, supported and engaged
- Included in service design
- Their H&WB is taken seriously and acted upon
- They are delivering Best Care every day
- They can act autonomously to make the right decisions, and quickly
- They can enact continuous quality improvement

J20 Feedback: Staff Outstanding feels like….

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Fully recruited
Staffing meets demand
Staff retention
Cuture of innovation and positive change, learning both from experience and excellence
Strive towards, achieve and share national and international best practise and reputation
Employer of choice - as a Trust and as individual departments/services
Training and career development opportunities
Staff are compassionate and kind, enthusiastic, honest and enjoy working here
Staff will recommend us as an employer, and as a centre for learning
Sickness and turnover are at the right levels
Staff will have access to advanced digital technology
Divisional CNOs and CCIOs working to Exec CIO towards the digital stategy
There is a culture of openness and honesty, and staff can speak up when concerned
Implement new ways of working
Staff feel they can contribute to decision-making
Staff feel a sense of ownership of the services they deliver, pride in delivering them, and confidence that they are good enough for their own family
Staff feel…valued and supported
Staff feel…engaged
Staff feel…included in service design
Staff feel…their Health & Wellbeing is taken seriously and acted upon
Staff feel…they are delivering Best Care every day
Staff feel…they can act autonomously to make the right decisions
Staff feel…they can act autonomously to make quick decisions
Staff feel…they can enact continuous quality improvement

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People & OD J2O feedback

Early J20 output, and shaping our priorities first ideas

Workforce Sustainability	Staff Experience	Transformation
• Recruitment • Retention • Role Development • Career Pathways • Talent Development • Workforce Planning • CIP	• Staff Engagement • Behaviour • Values • Leadership • Health and Wellbeing • Equality, Diversity and Inclusion	• Service Delivery and Customer Service • Education • Professional Development • ICS Integration • University Hospital status • One Place development • HR Systems and Digital Infrastructure.

Developing our Journey to Outstanding – Proposed Strategy People and OD Strategic Build

People and OD team's ambition *'Caring for those who care.'*

Our Staff ideas (Board)

Gloucestershire Hospitals NHS Foundation Trust

- Put patient outcomes and customer first – do the right thing / behaviour & culture
- Right people, right place, right time – sustainable workforce
- Ambition to be Employer of Choice
- Be very best version of 'me' / achieve potential

Objectives

- Develop and implement effective workforce planning process to address future needs of the org (or pts and staff?)
- Develop and implement a future ELD plan that achieves the workforce plan and delivers individual potential
- Improved set of patient and staff metrics which demonstrate staff are doing the right thing by patients and customers
- Improve retention, attract, conversion, reduce vacancies, etc. and be in top quartile

New staff goals discussed at Board seminar

Our staff will….

1. Put patient outcomes first and do the right thing
2. Be in the right place at the right time with the right skills (sustainability)
3. Recognize the Trust as an employer of choice
4. Achieve their potential and be the very best version of themselves

New Objectives

1. Improve patient and staff satisfaction and engagement in order to demonstrate that staff are doing the right things
2. Develop and implement an education, learning and development plan which achieves the Trusts current and future workforce needs and assists staff to reach their potential
3. Develop and implement an effective workforce planning process to address the future needs of the Trust, its services and patients
4. Improve attraction and retention of staff

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Exec feedback and first ideas

BAF#	2018/19 Objective	BAF Status [1]
2.1	Have an Engagement Score in the Staff Survey of at least 3.9	Amber
2.2	Have a staff turnover rate of less than 11%	Amber
2.3	Have a minimum of 65% of our staff recommending us as a place to work through the staff survey	Green
2.4	Have trained a further 900 bronze, 70 silver and 45 gold quality improvement coaches	Amber
2.5	Be recognised as taking positive action on health and wellbeing, by 95% of our staff responding Definitely or To some extent in the staff survey	Amber

BAF#	2019-24 Objective	Years 1 - 2	Years 3 - 5
2.1	**New** staff engagement objective		
2.2	*Not carried forward – to be tracked as operational metric*		
2.3	**New** staff recommendation objective to align with outstanding Trusts/ upper quartile		
2.4	*Closed*		
2.5	**New** Health & Wellbeing and Equality & Diversity objectives		

[1] As at November 2018

Staff engagement (workshop outputs) on proposed first ideas

Gloucestershire Hospitals NHS Foundation Trust

Idea	Proposed/ Added	Votes	Notes/comments/enablers
New staff engagement objective …	Original	23	Includes: - Recognition and role modelling (x1) - Enforce departmental "engagement and improvement meetings/reviews" (x1)
New staff recommendation objective…	Original	4	
New physical and emotional wellbeing objective…	Original	63	Includes: - Improved mental health support for staff (x3) - Encourage staff to be responsible for their own health and wellbeing, i.e. weight exercise, diet etc. (x7)
New Equality & Diversity objective…	Original	15	Includes: - BAME leadership (x1) - Should this underpin all others instead of being an item 'on its own'?
Workforce and retention	100 Leaders	80	Includes: - Flexibility and accessibility of offers i.e. education & development (x1) - Education & training to aid recruitment pipeline and retain quality workforce (x8) - Focused training (x1) - Leadership competence and confidence (x2) - Resilience programme (x2) - Quicker performance management process (x3) - Focus on 'grow our own', e.g. general management pipeline from Med Secs, Admin, etc. (x1) - Usutainable workforce and new ways of working across ICS (x4) - Invest in advanced practice (from ELN Clinical) (x4) - Improved staff retention (x9) - More focus/structure on succession planning (x8) - Workforce planning, sustainable recruitment initiatives, alternative roles, etc. (x9) - Speed up recruitment process to ensure best candidates are secured and not lost to other orgs, and to reduce impact of vacant posts on services and staff morale (x6) - Provide staff with skills that allow them to develop so they could leave, but treat them in such a way that they don't want to (x4) - Look after current staff (x9) - Increase autonomy for clinical leaders and reduce centralisation (x4)
		185	

On line staff engagement responses (c245)

Key themes of importance to staff

Gloucestershire Hospitals NHS Foundation Trust

Health and wellbeing focus (50%)	Staff engagement (31%)	Great place to work (11%)	Reduce inequalities (8%)
Staff recruitment, attraction and retention - New roles, alternative and advanced - Flexible L&D offers	Improved management of change (operational) Leadership confidence	Giving best care possible	Improved training and development. Grow your own
Fair treatment	Staff morale and satisfaction	Digital literacy and HR technology	Mental health provision
Improved middle management training	Full disclosure to all (no inner circles)	Faster recruitment	Enough staff suitably qualified and trained -workforce planning - Succession planning

Staff Survey 2018 themes

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- Top 3 themes to focus on in 2019/20
  - Health and wellbeing
  - Quality of appraisals
  - Bullying and harassment (managers)

Other areas where we are below national averages:

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Immediate Manager

- Support from immediate manager
- Clear feedback from manager on my work
- Manager asking my opinion before decisions made which affect me
- Manager supporting me to receive training, learning & development

Morale

- Involved in deciding changes that are introduced
- Unrealistic time pressures
- Choice in deciding how to do my work
- Relationships at work strained
- Manager encourages me at work

Quality of Care

- Satisfied with quality of care I give to patients/service users
- Able to deliver the care I aspire to

Safety Culture

- When errors, near misses reported, Trust takes action to ensure they don't happen again
- Given feedback in response to reported errors, near misses
- Confident my organisation would address concerns of unsafe practice
- Organisation acts on concerns raised by patients/service users

Staff Engagement

- I look forward to going to work
- Enthusiastic about my job
- Time passes quickly when I am working
- Able to make improvements happen in my area of work
- Care of patients my organisation's top priority
- I would recommend this as a place to work
- If a friend or relative needed treatment, I'd be happy with standard of care at this organisation

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Other data sources reviewed for themes

- Freedom to Speak up issues and complaints
- HSE inspection observations
- Exit interview data
- Staff and Patient Experience and Improvement themes and topics from triangulation of data
- Themes from grievance and disciplinary matters
- Themes from Executive reviews
- Staff engagement exercises such as Involve, workshops…
- Drafts of other enabling strategies

Hierarchy / position for Our Enabling Quality Strategy

Gloucestershire Hospitals NHS Foundation Trust

Best care for everyone

Strategic objectives

Our vision

Our priorities

Our values

* Caring * Improving *Listening

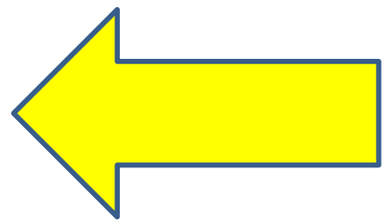
Our clinical services

Our clinical strategy

Our enabling quality strategy

Quality Strategy - Patient First

- Improve safety
- Improve experience
- Improve outcomes & effectiveness



Programme 1 – Well Led

Patient First

Programme 1

Well Led

Transforming our quality management and improvement systems

- Putting the patient at the centre of QI
- Building improvement skills at all levels
- Building a culture of improvement
- Applying systems thinking
- Staff /patient engagement and involvement (co-design)
- Making data count

Our Enabling Quality Improvement Strategy

-Our leadership, governance and culture are used to drive and improve the delivery of high-quality person-centred care.

Programme 2 – Improve experience

Patient First

Programme 2

Improve experience

Delivering and improving care by being people centred

- Getting the basics right first time, every time
  1. kindness, respect and compassion
  2. Privacy and dignity
  3. Involvement in decisions
- Making experience and insight data count to drive improvement and learning
- Using patient experience QI methodologies and rapid process improvement techniques
- Setting clear priorities for patient experience quality improvement that are aligned and where the need for improvement is greatest

Our Enabling Quality Improvement Strategy

- People are truly respected and valued as individuals and are empowered as partners in their care, practically and emotionally.

Programme 3 – Improve safety

Patient First

Programme 3

Improve safety

Listening, learning and improving

- A just culture
- Openness and transparency
- Continuous safety improvement
- Freedom to speak up
- Setting clear priorities for safety quality improvement that are aligned and where the need for improvement is greatest

Our Enabling Quality Improvement Strategy

- People are protected by a strong comprehensive safety system, and a focus on openness, transparency and learning when things go wrong.

Programme 4 – improve outcomes

Patient First

Programme 4

Improve outcomes and effectiveness

Achieving and excelling equally

People's care and treatment achieves g outcomes, promotes a good quality of life, and is based on the best available evidence.

Innovative and efficient ways to deliver more joined-up care to people who use services (co-design)

Outcomes for people who use services are consistently better than expected when compared with other similar services

Clear priorities for quality improvement that are aligned and where the need for improvement is greatest

Our Enabling Quality Improvement Strategy

- Outcomes for people who use services are consistently better than expected when compared with other similar services.

Digital strategy

Gloucestershire Hospitals NHS Foundation Trust

- Top themes for 2019 - 2024

  - Digital landscape. Implementing an EPR, Implementing electronic prescribing and being able to interface with partner clinical systems;

  - Digital workforce. Enable and support our staff to work effectively, efficiently and confidently. From emails to accessing electronic pay slips to using a clinical system, digital ways of working;

  - Digital infrastructure. To provide an insight-driven culture which embeds analysis, data and intelligence to improve decision making, outcomes and quality improvement.

Finance strategy

Gloucestershire Hospitals NHS Foundation Trust

Draft Strategic Objectives:

- We will be outstanding in our use of resources;
- We will be a financially literate organisation with all staff who have a budgetary responsibility receiving training and complete, timely information to enable them to make the best decisions for their patients.

Outcomes:

- Good use of resources assessment – CQC (1-2 years);
- Outstanding use of resources assessment – CQC (3-5 years);
- Medium term financial plan that outlines the route to sustainability is delivered.

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External sources of intelligence and information impacting upon potential staff objective themes

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NHS 10 Year Plan: Key People themes

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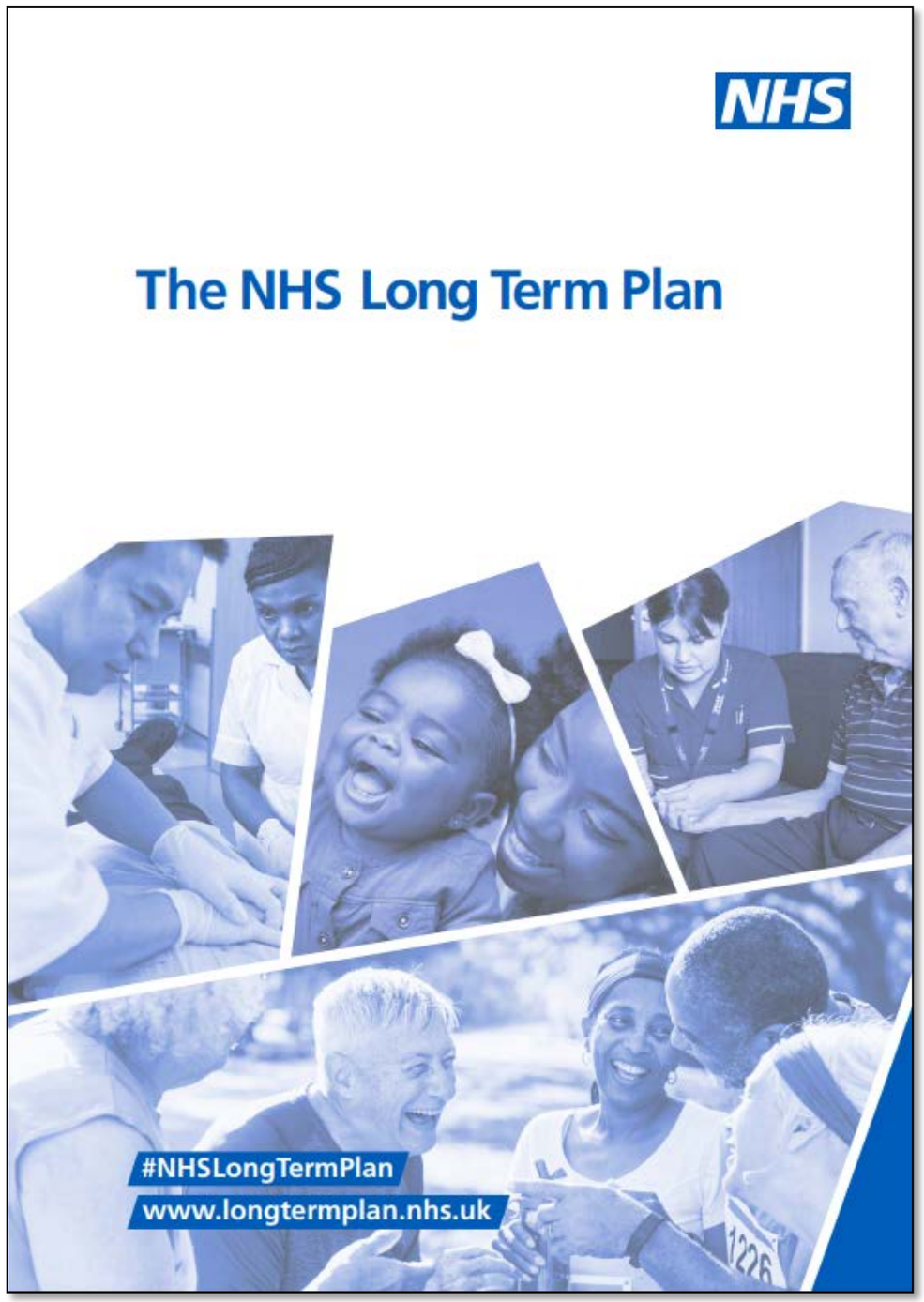

- Expand international recruitment by 2024
- Improve nurse retention by 2% by 2025
- Improve nursing vacancy to 5% by 2028
- 7,500 NA by 2020 (50% increase on 2018 baseline of 5,000)
- Trusts consider apprentices for all entry level posts
- Evidence based approach to ward staff number by 2023
- Organisational target for BAME representation at leadership level and broader by 2022
- Lead employer for apprentices for partner trusts by 2020
- Electronic rosters and job plans by 2021
- Double volunteers by 2022

ICS Workforce and OD plan
Key Theme summary

Gloucestershire Hospitals NHS Foundation Trust

Leadership	Ensure system leadership is in place to deliver the STP's strategic and organisational development plans.
Workforce	Ensure that our workforce has the skills and behaviours to work effectively within new models of care and to work collaboratively to meet the 5 year forward gaps.
Roles	Actively support the development of new roles to help us to bridge the workforce gaps, to widen access to the healthcare professions and respond to national directions.
Sustainable supply	Develop a sustainable primary care, nursing and AHP (including healthcare scientists) workforce

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New Strategic objectives

#	Theme	Description
1	Outstanding Care	We are recognised for the excellence of the care and treatment we deliver to all of our patients and their families, evidenced by our CQC Outstanding rating and delivery of all of the NHS constitutional waiting time standards
2	Compassionate Workforce	We have a compassionate, skilful and sustainable workforce, organised around the patient, who describe us as an outstanding employer that attracts, develops and retains the very best people
3	Quality improvement	Quality improvement is at the heart of what we do; our staff feel empowered and equipped to do the very best for their patients and each other
4	Care Without Boundaries	Health and social care across Gloucestershire is experienced 'without boundaries'. Patients, carers and staff design, receive and deliver integrated care across organisations, with the patient and their family and carers at the heart of all we do
5	Patient Involvement	Patients and the public tell us that they feel involved in the planning, design and evaluation of services that are increasingly provided in ways that reflect the needs and wishes of our local communities
6	Centres of Excellence	We will have established Centres of Excellence, on our two hospital sites, to enable our services to provide urgent, planned and specialist care to the standards of the best, and ensure as many Gloucestershire residents as possible receive care within the County
7	Financial Balance	We are a Trust in financial balance, with a sustainable financial footing reflected through our NHSI Outstanding rating for Use of Resources
8	Fit For Purpose Estate	We will make best use of our estate to deliver our vision of Best Care For Everyone, and increasingly utilise the estate of our integrated care system partners to provide care that is accessible and joined up
9	Digital Future	We are using technology to drive safe, reliable and responsive care. Our electronic patient record is embedded and has released staff time to care and treat our patients; it 'talks' to our partners in the health and care system to ensure care for the patient is joined up
10	Driving Research	We are a research active Trust providing access for our patients to innovative and ground breaking treatments; through their endeavours, staff from all disciplines will be contributing to tomorrow's evidence base and be amongst the best University Hospitals in the UK

Gloucestershire Hospitals
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How did we pull it all together

- All inputs were reviewed and considered against the new strategic objectives and the original 3 enabling themes defined by the People and OD team; workforce sustainability, staff experience and transformation;
- In depth qualitative data from the staff survey was themed against these 3 enabling themes (see annex1)
- The People and OD team considered if anything was missing given data and information sources (health and safety and reference to Human Rights (annex 2) were identified);
- Language amends were made to emphasise the culture we aspired to achieve;
- Activities, outcomes and objectives were aligned to these 3 enabling themes and a view taken on what would be different for colleagues and patients;
- The People and OD team presented draft iterations at the October and April People and OD Committee and approval was achieved through the executive delivery architecture of the People and OD Delivery Group, and Trust Leadership Team

Annex 1
People and OD Strategy: Comments from NHS Staff Survey*

Gloucestershire Hospitals NHS Foundation Trust

*Comments have been themed under headings where there are large numbers.

Pillar: Workforce sustainability
Recruitment and retention themes

Concerns expressed:

- over how long the recruitment process is
- lack of transparency and not following fair recruitment procedures in relation to senior management appointments
- staffing levels on 'shop floor' and imbalance against senior management resourcing
- poor retention rates and impact

Career development related themes

Concerns expressed:

- Lack of opportunity (lower bands, particular roles)
- Over equal opportunity (ageism)
- Accessibility (eg requests blocked by managers, divisional training 'on hold')
- Financing of training and development

Pillar: colleague Experience

Engagement themes

Concerns expressed:

- Inconsistency in engagement with staff
- Poor engagement with clinical staff
- Engagement is ‘lip service’/failure to tackle real problems
- There were a number of positive comments in relation to the improvement in engagement in the Trust.

Morale themes

Concerns expressed:

- Over low levels of morale (some in relation to level of morale eg never seen it so low)
- Focus on finance/money saving ahead of staff morale
- Staffing levels impacting morale
- Poor communication and lack of involvement in decision making impacting morale levels
- Poor/unclean working environments impacting morale
- Negative impact on staff retention and patient care
- Removal of little things eg tea, coffee in theatres

Values themes

Concerns expressed:

- focus on finance at expense of values
- values regarded as tokenistic
- wilful abdication by leadership
- Positive comments in relation to new executive team and feeling valued.

Management/leadership themes

Concerns expressed:

- Visibility/contact with line managers and senior managers
- Competencies/ poor quality/inexperience of management
- Certain behaviours eg bullying, challenging behaviour
- Lack of support provided by managers
- Encouragement/provision of development opportunities
- Recognition (eg thanks)
- Focus by managers on money
- Levels of trust between staff and managers
- About divide between clinical and non-clinical management
- Cover for a line manager if absent through sickness or awaiting a new appointment
- Over communication and being listened to (eg invited to speak up but actions/decisions suggested already determined, being left in the dark, lack of transparency)
- Over use of senior managements "Twitter" activity/missing out if not on Twitter
- More face to face executive out of hours staff engagement walk about rather than electronics/social media
- Lack of involvement of front line staff in decision making resulting in poor decisions
- Expectations of senior leadership unrealistic/unachievable targets
- Communication with senior leaders poor
- Little concern from higher management when bringing in major change
- Top heavy
- Disregard of concerns raised
- Failure to challenge poor line/middle management behaviours
- Thinking a corporate trouble shooter will solve problems

Health and Wellbeing related including stress themes

Stress reported as a result of:

- a lack of involvement in decision making
- poor management of change/restructuring - constant change and pace
- not being listened by management- poor communication
- poor working environment- lack of equipment/resources, poorly functioning IT systems
- lack of staff car parking
- rota errors
- low staffing levels/inappropriate staffing decisions being made
- managers/staff off sick and no arrangements in place to cover/replace temporarily
- increased workload/backlogs/time constraints
- aggressive patients
- patient transfers before ward ready/lack of beds

Concerns expressed

- Stress levels negatively impacting on service delivery/patient care/longer waiting times and staff morale
- Lack of support
- Long delays in accessing support/appointments for stress
- Degree of stress reported severe eg broken, never seen levels like it before, in a tunnel

Other concerns in relation to health and wellbeing

- to health and wellbeing and impact on mental health
- need for the organisation to give it greater priority, consideration (rather than hostility) and flexibility for staff with mental health conditions
- acknowledgement that those with caring responsibilities/physical and mental health issues who can't go the 'extra mile', join the 'talent pool' are just as valued for coming in and doing the job they are paid to do

Violence and aggression comments

- *We have to deal with verbally rude and aggressive patients daily and this is proving extremely stressful to all members of staff.*
- *Bullying and aggressive behaviour is tolerated within the department and never resolved so the staff involved are never dealt with within Trust Policy or Guidelines. This causes behaviours to continue. Supervisors are biased and support the staff that are not either following Trust Policy's, Guidelines and being respectful to other staff. The department has an atmosphere that is blamed on other staff as it is easier than dealing with the problems or issues that are causing it.*
- *With respect to higher management, on the occasions I've had dealings with them, their tone has been quite aggressive and confrontational. We have had a number of bullies in our department who made our lives miserable. Despite reporting this through the proper channels nothing gets done about it and nothing changes. We now no longer report it because there is no point. I feel that higher management do not listen to the staff further down the chain of command and I feel they are out of touch with how we feel.*

Equality, diversity, inclusion comments

- *I wish my organisation address equality and diversity to staff in order BAME background staff feel valued, have equal opportunities to progress their career and their voice to be heard.*
- *The department and organisation is riddled with racism and nepotism. In surgery there is a hierarchy and people are not listened to unless they are at the top/senior. Ethnic minorities are treated as school children. Management do nothing to listen to any concerns unless they come from a select group of senior consultants.*

Pillar: Transformation

See other enabling strategy document for themes related to: **quality, research, clinical, digital**
See above career development for **professional development**; see above health and wellbeing for **service redesign, rostering**

Education related themes:
Concerns raised:

- Little support for nurses once finished preceptorship
- Biomedical science role totally different in lab from university/education setting impacting staff retention
- Over funding for education (unless you are a doctor)

Pillar: Equality Diversity Inclusion

Disability/long term conditions comments

- *My own experiences have had a huge toll on my health and have found the systems which are designed to help unsupportive and increasingly stressful. I feel very strongly that the Trust needs more insight on how to work with people with protected characteristics. You already feel vulnerable before you even start no matter what degree your disability.*
- *I have experienced a deterioration of a long term health condition over the last year and it has been very stressful trying to get my hours reduced at work due to this. I thought the NHS would be the role model of helping staff stay in work with chronic health conditions but I've found out this isn't the case which is disappointing. There should be better procedures in place*
- *Unsupported after returning from period of depression*

Annex 2

Gloucestershire Hospitals NHS Foundation Trust

Main relationships of our human rights principles to European Convention on Human Rights Articles (as incorporated into the Human Rights Act 1998) and the Equality Act 2010.

Fairness	• Article 6 – right to a fair trial (includes a range of processes for fairness beyond a legal trial)
Respect	• Article 8 – right to respect for family and private life, home and correspondence • Article 9 – right to freedom of thought, conscience and religion • Article 1 of Protocol 1 – right to peaceful enjoyment of possessions
Equality	• Article 14 – right not to be discriminated against in relation to other rights contained in the European Convention • Note that we are also using this principle to cover CQC statutory duties under the Equality Act 2010 to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between people
Dignity	• Article 8 – right to respect for family and private life, home and correspondence • Article 3 – right not to be tortured or treated in an inhuman or degrading way
Autonomy	• Article 8 – right to respect for family and private life, home and correspondence • Article 5 – the right to liberty
Right to life	• Article 2 – the right to life
Human rights for staff/ staff empowerment around human rights	• All articles as they apply to staff or to empowerment of staff to act to protect the human rights of people who use services

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – JULY 2019

Lecture Hall, Sandford Education Centre commencing at 12:30

Report Title
Annual Equality Report 2018/19
Sponsor and Author(s)
Authors: Abigail Hopewell, Head of Leadership and OD; Vice-Chair, Equality Diversity Inclusion Steering Group Suzie Cro, Deputy Director of Quality; Freedom to Speak Up Guardian Katie Parker, Head of Quality and Patient Experience Lucy Morris, Staff Experience Coordinator Sponsor: Emma Wood, Director of People & OD/Deputy CEO
Executive Summary

Purpose

There is a requirement on NHS Trusts to annually publish an Equality Report as part of the Public Sector Equality Duty. This must be available to download from the Trust website; the report details:

- Overview and context of legislative and reporting requirements
- Summary of progress against previous equality objectives (set in 2015/16)
- Summary of activity in 2018/19 to further the staff equality agenda
- Summary of activity in 2018/19 to further the patient equality agenda
- New equality objectives to cover the next four years 2019-2023
- An appendices listing Gloucester population demographics, patient demographics and staff demographics

Key issues to note

- As part of our Public Sector Equality Duty, our Trust is required to publish an annual equality report to highlight our progress and activities which support the equality, diversity and inclusion agenda.
- The latest report is more thorough than some of the more recent equality reports published in the last few years. There is now a better balance of information about the work we have been doing for patients and staff (previous reports, and our old equality objectives, have been very staff-focused).
- Following a number of staff and public engagement events, all EDS2 outcomes have been graded as “developing”.
- A summary of our approach to completing the EDS2 is included along with our new equality objectives.
- We have included specific mention of Human Rights which is now incorporated into all Equality Diversity and Inclusion (EDI) activity and monitoring.
- Following discussion at last year’s People & OD Committee, the appendices of demographic information (covering the local population, patient, and staff) now includes a short narrative against each protected characteristic. Further work will be undertaken with some of these observations as we develop our new EDI action plan for 19/20.

Conclusions

The equality report highlights our key achievements in 2018/19, and outlines the overarching approach/EDI priorities we will focus on in 19/20 and beyond.

Implications and Future Action Required

Following approval at the Trust Board, the report will be formatted by the Communications team and published on the Trust’s website, Our Commissioners will be informed.

The report went to the People & OD committee before TLT (on 17th June) due to the way the meetings fell (otherwise it would not go to Board until 12th September).

Recommendations

- Trust Board to **approve** the annual equality report 2018/19, and for subsequent publication on our website.

Impact Upon Strategic Objectives

EDI activity supports the delivery of both the new People & OD Strategy and the new Quality Strategy.

Impact Upon Corporate Risks

Delivery of equality objectives helps to mitigate risk in relation to staff turnover and morale; sickness absence; discrimination and litigation from staff and patients related to legally protected characteristics; patient satisfaction; quality of patient care and experience; annual survey results.

Regulatory and/or Legal Implications

The Public Sector Equality Duty is fulfilled in the NHS by the Equality Delivery System which requires us to identify new equality objectives every 4 years.
Commissioners monitor the Trust's delivery of Equality Diversity and Inclusion plans and this forms part of our contractual agreements. Failure to publish our annual Equality Report in a timely fashion would mean that we are in breach of our contractual requirements.

Equality & Patient Impact

Work to improve equality, diversity, inclusion and human rights will have a positive impact on the broader patient experience, and improve relationships between staff and with our service users.

Resource Implications

Finance		Information Management & Technology	
Human Resources	X	Buildings	

Action/Decision Required

For Decision		For Assurance		For Approval	X	For Information	

Date the paper was presented to previous Committees

Divisional Board	Trust Leadership Team Sub-group	Other (Specify)
	3rd July 2019	People & OD Committee – 17th June 2019 People & OD Delivery Group – 4th June 2019

Outcome of discussion when presented to previous Committees

- No comments received in People & OD Delivery Group
- No comments received in People & OD Committee
- TLT – suggestion to incorporate focus around how we can collaborate with our system partners on the equality, diversity, inclusion and human rights agenda. A sentence has been added to reflect this in section 4.4 (page 14).

Gloucestershire Hospitals
NHS Foundation Trust

Annual Equality Report 2018/19

(Equality, Diversity, Inclusion and Human Rights)

Best Care for Everyone 2018/19

Contents

We are committed to making our publications as accessible as possible. If you need this document in an alternative format, for example, large print, Braille or a language other than English, please contact the Communications Office by email or by calling:

Communications Team Tel: 0300 422 3563/3120 Email: ghn-tr.coms@nhs.net

Introduction

Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) was rated by our regulators, the Care Quality Commission (CQC), as “Good” in January 2019. A number of factors within the CQC’s inspection regime are linked with equality and diversity. The CQC inspection report helps to demonstrate how we are progressing in delivering fair, equitable and inclusive services, as both a healthcare provider and as an employer.

Respecting diversity, promoting equality and ensuring human rights helps to ensure that everyone using our services receives safe and good quality care - our core purpose. A human rights approach helps us to apply our values - Caring, Listening, and Excelling - so that we consistently integrate human rights into the way we operate and deliver services.

Equality, diversity, inclusion and human rights are fundamental components of a positive experience for our staff and our patients alike. They underpin our vision of “best care for everyone” and act as key enablers for an engaged workforce and safe, high quality patient care.

About this report

Our annual equality report has been written to demonstrate compliance with the Equality Act 2010, specifically the Public Sector Equality Duty contained within it. The Act states people interacting with public services should: be treated fairly, have equitable access to services, and not experience discrimination or harassment because of:

1. their age
2. any disabilities they may have
3. their sex
4. their gender identity
5. being in a marriage or civil partnership
6. pregnancy or having recently had a baby
7. their race
8. their religion or belief system
9. their sexual orientation

The report is also driven by a number of other legal and regulatory drivers which include:

- Equality and Human Rights Commission - codes of practice
- Human Rights Act 1998
- The NHS Equality Delivery System 2 (EDS2)
- The NHS Constitution
- CQC - The Fundamental Standards (Health and Social Care Act 2008 (Regulated Activities) Regulations 2014)

We are committed to demonstrating compliance with, and ultimately becoming an exemplar regarding, the Public Sector Equality Duty and the EDS2.

Who benefits from this report

This report can be used by those who interact with our services, partners, local charities and commissioners to review any barriers to access, outcomes or quality of experience. Publishing this report is an important part of demonstrating transparency and acts as an enabler to communicate how we are tackling inequity as a lever to improve quality.

2. Public Sector Equality Duty: overview

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

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

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

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

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

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

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

Refer to **section 4.4** to read more about the new 4-year equality objectives which we will deliver during 2019-2023.

3. Equality Delivery System (EDS2): overview

As an organisation we need to be more intelligence driven and so collecting and analysing our data allows us to see if it we are meeting both our strategic corporate objectives and our equality objectives. Our data helps to us demonstrate if services are being delivered in a safe and effective way and are of high quality. Our data can also highlight areas where we need to improve and opens the door to inclusive engagement with our relevant stakeholders. In order for us to understand our intelligence/data we have completed the Equality Delivery System (EDS2) toolkit.

The EDS2 toolkit is designed to help us analyse how we can:

- improve the services we provide for our local communities
- consider health inequalities in our locality
- provide better working environments for our staff, who work in the NHS.

The EDS2 has been adopted by our Trust and has helped us to:

- meet the Public Sector Equality Duty of the Equality Act 2010 (see **section 2**)
- deliver on the NHS Outcomes Framework and the NHS Constitution
- meet the Care Quality Commission's "Essential Standards of Quality and Safety"

Within EDS2 there are four overarching goals:

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

In late 2018/19 we used the EDS2 toolkit to help us identify a new set of 4-year Equality Objectives. Refer to **section 4.4** for more details.

4. Equality Objectives

4.1 Looking back: previous Equality Objectives

In 2015/16 our Trust identified two equality objectives:

Equality Objective 1 – Black, Asian, and Minority Ethnic people (BAME)
Engaging with this group of staff will support further development that is being built upon through the Workforce Race Equality Standard. We will look to set up a BAME network within the Trust to provide a voice for this group of staff

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

The link between how organisations treat their staff and patient experience is widely publicised. Equality and diversity is a priority for the Trust as we recognise the links between strong staff engagement and high quality services.

We acknowledge that the equality objectives identified in 2015/16 focused purely on the experience of staff as this had been identified as a priority area for our Trust. Equality, Diversity and Inclusion (EDI) activities and focus have evolved considerably since these objectives were first written. This has meant that some of our actions have been more general rather than specifically focused purely on BAME staff or those with disability/long-term health condition. See below for an overview of achievements in 2018/19.

4.2 Looking back: How the Trust supported the staff equality agenda in 2018/19

- We published our first Gender Pay Gap report.
- We published an Equality of Opportunity Action Plan for the Trust, which incorporated recommendations from the Workforce Race Equality Standard (WRES) and Gender Pay Gap report.
- We launched Unconscious Bias training and mandated this for all managers who lead the recruitment process.
- We identified Board members (both Executive and Non-Executive) to be champions for each of the protected characteristics.
- We identified volunteers in the Diversity Network who have agreed to act as staff “Diversity Leads” for BAME, LGBT+ and Disability/long-term health conditions.
- We reviewed and strengthened our approach to responding to requests for reasonable adjustments in the workplace. This will become part of the Trust’s new Staff Advice and Support Hub, scheduled launch May 2019, which will support and signpost staff and managers regarding any aspect of their physical, mental and financial health-wellbeing.
- Following the launch of the Diversity Network in 2017, in 2018/19 we increased the membership by 40% and now have over 100 members. We increased visibility of the network by developing a brand and marketing materials which have helped to increase awareness and membership.
- We invited members of the Diversity Network to participate in HR Policy and Governance Reviews.
- We completed a detailed analysis of 2017 staff survey results against available protected characteristic data, and agreed to repeat this again in 2019/20 with the 2018 staff survey results and undertake a comparative analysis.

- We reviewed the Clinical Excellence Award (CEA) process for medical staff, held workshops to encourage more applications from women, and completed an Equality Impact Assessment to support the launch of the new CEA process (from NHS Employers).
- We participated in the Stonewall Workplace Equality Index.
- We participated in the annual “Pride in Gloucestershire” parade to celebrate and recognise LGBT+.
- We recognised World Mental Health Day with a video from our CEO talking about her experiences of mental health. We hosted a Diversity Network event focusing on mental health, which was facilitated by the Head of Diversity & Inclusion (NHS Employers).
- We delivered an EDI workshop to senior leaders, facilitated by the Head of Diversity & Inclusion (NHS Employers) in our quarterly 100 Leaders event.
- We formally engaged with a range of staff, patients and families to discuss, identify and agree new equality objectives (see section 4.4 below).
- We employed a Chaplain who holds a Muslim faith.
- We launched our Freedom to Speak up Policy and the Freedom to Speak up Guardian has continued to support and advise our staff.

4.3 Looking back: How the Trust has supported the patient equality agenda in 2018/19

Patients and their families still experience differences in NHS services both in terms of access, and their treatment and outcomes. Our aim as a Trust is to improve the patient experience for everyone, regardless of any protected characteristic. We welcome the introduction of the Accessible Information Standard which sets minimum requirements for all public sector services.

We might not have had any specific objectives for improving equality for our patients, their carers and their families but this does not mean that we have stood still. We have been working on improving our:

- Care to people with a learning disability with our Hospital Liaison Learning Disability Nurses Team
- Care to people who have Dementia
- Communication support services e.g. British Sign Language interpreters
- Compliance to meet the NHS Accessible Information Standard
- Overseas language interpretation and translation services

4.3.1 Examples of our work

See below for more information for examples of our progress and improvement work.

No. 1	**Improving care for people with learning disabilities**
Background	Our Learning Disability Hospital Liaison Nurses are highly trained and experienced learning disability nurses, who work across Gloucestershire Royal Hospital and Cheltenham General Hospital. They help to make sure people with a learning disability have a positive patient experience by making sure ‘reasonable adjustments’ are made. Some examples of ‘reasonable adjustments’ include: • Visiting the patient at home to assess their needs before their hospital visit • Giving advice and support to carers and care workers

	• Talking with ward/department staff about the individual patient's needs Working with the ward/department to make the adjustments needed to meet the individual patient's needs: • Reducing the waiting time to avoid increased anxiety, or providing a quiet waiting area • Providing information in a format the patient can understand • Making small changes to treatment to meet the patient's needs. • Making it possible for a carer to support the patient during investigations or when going to theatre for example • Arranging for a carer to stay with the patient if needed www.gloshospitals.nhs.u • Helping with communication between the patient, carers and hospital staff when needed. • Helping the ward/department staff with discharge planning. We want to make reasonable adjustments for people in our care and also learn and make improvements by reviewing their care after death
Improvement	We have a Learning Disability Hospital User Group HUG and we co-produce and co-design patient information to meet peoples' needs with learning disability. Also the Trust takes part in the Learning Disabilities Mortality Review (LeDeR). It is the first national programme of its kind aimed at making improvements to the lives of people with learning disabilities. Reviews are being carried out with a view to improve the standard and quality of care for people with learning disabilities. People with learning disabilities, their families and carers have been central to developing and delivering the programme. The CQC said… Outstanding practice *"In urgent and emergency care a specialist team pro-actively engaged with patients with learning disabilities to ensure their individual needs were understood and accommodated during emergency attendances. There was excellent support provided to families and a team designated to ensure challenges and concerns could be swiftly resolved".*

No. 2	**Accessible information standard - improvement work for people who are deaf and BSL users** Ensuring all people who are Deaf and use British Sign Language (BSL) have effective communication with our Trust https://www.gloshospitals.nhs.uk/about-us/our-trust/accessible-information-standard-statement/
Background	Not all people who are Deaf and who use our services were able to access interpreters in a timely way.
Improvement	We introduced a number of initiatives which improved our two-way communication. • We now have Visual Alerts which identify communication needs (hearing impairment, sight impairment, dementia, and interpreter needs) and alerts staff that they need to be mindful of additional needs that the patient may have. • We created a card for Deaf BSL users to show to reception staff to show that

	they required an interpreter to enable them to communicate with us. • We held a number of focus groups and continue to regularly meet with Refer to **Appendix C** for more information and examples of the work we have been doing.

No. 3	**Accessible information standard - improvement work** Patient health information service - (for anyone to post their health requirement information needs). https://www.gloshospitals.nhs.uk/work-us/training-staff/library-services/patient-health-information-signposting-service/
Background	Using search engines can bring up a plethora of information and so how can we help our patients sort this information so that they know it is reliable and useful.
Improvement	Our library service can direct you to quality health information available if people complete a short form. The library will search and direct patients to reliable accurate health information.

No. 4	**S**upport and **H**elp for **E**very **D**ad - SHED is for dads with babies on our neonatal unit
Background	S.H.E.D is a new group for fathers of babies who start their life at Gloucester's neonatal unit. S.H.E.D was established this year to run alongside the broader support group HOPE and offers peer support for Dads who are coping with the wide range of issues associated with having a baby on the unit.
Improvement	The group has been supported in its establishment by Trust staff members led by Sister Betty Tenn-Stewart and is looking to help make the journey through neonatal care less stressful. Gloucestershire's Better Births improvement programme has funded a new video that focuses on the stories of fathers who have had their babies cared for on our unit. Rob Harrison, one of SHED's founding members says: *"S.H.E.D wants to bring together these Dads to ensure that everyone has the opportunity to speak, learn or listen to other fathers who have walked the same journey; balancing caring for a new child, partner, siblings and families – whilst in many cases having to continue to work to provide for their family."* Refer to **Appendix C** for more information.

No. 5	**No surprises - Reasonable adjustments**
Background	Many patients arriving on the Day Unit at Cheltenham General Hospital or at the Surgical Assessment Services (SAS) had individual care needs that needed to be highlighted to the areas involved in their stay within hospital but these needs had not been highlighted in many cases despite the information being given by the patient in Pre-assessment. This meant that necessary equipment was not made available, reasonable adjustments could not be made in time or their placement on the ward was not conducive with delivering safe care meaning we are less likely to create a good patient experience.
Improvement	We introduced a simple tick box sheet to Pre- assessment for them to highlight the relevant information. This would then be picked up Day Surgery/SAS when the notes are checked the day before admission allowing for equipment to be ordered and adjustments to be made. Day Surgery/ SAS would then be responsible for disseminating that information to the other are- as involved in the patient's. We then re-audited to see if the rate of patients having their care needs cascaded has improved and made suggestions of our next steps.

No. 6	Guidance on Muslim Patient Care in Gloucestershire
Background	Feedback was given to the Chaplaincy team that staff do not always know how to care for our Muslim Patients.
Improvement	This booklet was created to facilitate health workers unfamiliar with Islam in their treatment of Muslim patients. The information contained within this booklet does not assume to give the reader a comprehensive understanding of the Islamic Creed nor the individual practises one may have observed. See **Appendix C** for more information.

4.3.2 Our data

Reviewing our data has been challenging because equality and human rights data is generally poorly developed compared with other areas, such as patient safety or effectiveness of healthcare treatments. Additionally, there are few nationally agreed measures for equality and human rights in health and social care. We have used our key National Patient Surveys whether people are treated with dignity and respect, namely:

- Adult Inpatient Survey
- Maternity Survey
- Children and Young People Survey
- Emergency Department Survey
- Cancer Survey

4.3.2.1 Adult Inpatient Survey (2018)

The Adult Inpatient Survey showed that the Trust was rated the "**about the same**" in most of the sections except that the Trust was rated "**worse**" in 1 question which was the 'overall views of care and services' compared to 2016 results

The question that scored lowest was "**Patients** being **asked to give their views** about the quality of their care, during their hospital stay". We scored 0.7/10 and in comparison, Northumbria HC Trust (rated outstanding) scored 1.8 and they have had established feedback systems for many years.

This feedback has now enabled the Trust to make the decision to reinstate a real-time feedback electronic monitoring system. Our aim will be to introduce specific real-time surveys for each of the core services focused on the questions or sections that we aspire to improve for each survey within 5 years.

Across the survey questions, as a benchmark we have looked at privacy, respect and dignity and involvement in decisions as three key areas that we want to improve on through our values work with staff. Below will be our benchmark scores across all the surveys that we want to improve on.

Table: Adult Inpatient Survey scores for caring behaviours

Caring behaviours	Score
Privacy for being given enough **privacy** when being examined or treated in A&E	**8.7/10**
Respect and dignity for being treated with **respect and dignity**	**9.0/10**
Involvement in decisions for being **involved** as much as they wanted to be in decisions about their care and treatment	**7.2/10**

Our aim will be provide care to the highest standards to people as measured by specific key questions within the National Survey Programmes related to privacy, dignity and involvement in decisions.

The latest Adult Inpatient Survey (2019) is about to be published. We have our results for 2018 which are for internal use only and will be published by CQC at the end of June 2019. In quarter 1 2019/20 we will report on these scores.

4.3.2.2 Maternity Survey (2018)

The Maternity Survey showed that the Trust was rated the "**about the same**" as other Trusts in all sections.

The Maternity Department have 4 improvement projects continuing from the previous maternity survey and as such improvements to these will not be reflected in the most recent results. A workshop took place on 1st November 2018; it included the senior maternity team led by Picker reviewing the results identifying areas for improvement. The areas were discussed and reviewed and 4 areas were decided upon: -

- Improving the opportunity for birth reflections service to help improve understanding of experiences
- Opportunity for birth partners to stay overnight to support the mother
- Improve the management of pain during the latent stage (Sweeney Project)
- Provide transitional care beds to avoid separation of mother and baby where possible

Across the questions, as a benchmark we have looked at privacy, respect and dignity and involvement in decisions as three key areas that we want to improve on through our values work with staff. Below will be our benchmark scores across all the surveys that we want to improve on.

Table: Maternity Survey scores for caring behaviours

Caring behaviours	Score
Respect and dignity Being treated with **respect and dignity** during labour and birth	**9.4/10**
Kind and understanding care Being treated with **kindness and understanding** by **staff** after the birth	**8.6/10**
Partners involvement in decisions for being **involved** as much as they wanted to be in decisions about care and treatment	**9.8/10**
Women Involvement in decisions Being **involved** enough in **decisions** about their care during labour and birth	**8.8/10**

4.3.2.3 Children and Young People Survey (2017)

The Children and Young People Survey published in 2017 showed that the Trust was rated the "**about the same**" as other Trusts in all sections.

Below will be our benchmark scores across all the surveys that we want to improve on.

Continuing from the previous children's & young people survey the staff are working on a QI project titled, ***Children's and Young People's Involvement in Decision Making with their Care***

Table: Children Survey scores for caring behaviours

Caring behaviours	Score
Dignity and respect for parents and carers saying they were treated with dignity and respect by staff looking after their child	**9.0/10**
Privacy for children and young people feeling they had enough privacy during their care and treatment *We asked patients aged 8-15 this question*	**9.0/10**
Involvement for children and young people saying that they were involved in decisions about their care and	**5.6/10**

Caring behaviours	Score
treatment *We asked patients aged 8-15 this question*	

4.3.2.4 Emergency Department (ED) Survey (2018)

The ED Survey showed that the Trust was rated the "**about the same**" as other Trusts in all sections. The Trust has received the ED Survey results for 2018 and they are currently being reviewed internally.

Across the questions, as a benchmark we have looked at privacy, respect and dignity and involvement in decisions as three key areas that we want to improve on through our values work with staff. Below will be our benchmark scores across all the surveys that we want to improve on.

Table: ED Survey scores for caring behaviours

Caring behaviours	Score
Respect and dignity for being treated with **respect and dignity**	**8.9/10**
Privacy at reception for having **enough privacy** when discussing their condition with the receptionist	**7.1/10**
Involving family or friends for family, or someone else close to them, having enough **opportunity to talk to a doctor** if they wanted to	**7.9/10**
Privacy for being given **enough privacy** during examinations and treatment	**9.2/10**
Involvement in decisions for being **involved** as much as they wanted to be in **decisions** about their care and treatment	**8.1/10**

4.3.2.5 National Cancer Experience Survey (2018)

The table shows that the Trust has improved its position from its scores last year (24 questions scored higher than last year, 10 the same and 17 worse). However, compared to national average the 2017 results have not kept up with national improvements (22 questions scored better or similar than national averages in 2017 compared to 34 in 2016). Patients scored our care as 8.8 out 10 (same as national average) and this the same score as last year. A QI collaborative will commence in Q4 and this is currently being scoped.

Table: Cancer Survey scores for caring behaviours

Score	Caring
76%	of respondents said that they were definitely involved as much as they wanted to be in decisions about their care and treatment
87%	of respondents said that, overall, they were always treated with dignity and respect while they were in hospital

We will be continuing to develop our human rights approach to care – Best Care for Everyone. We want to be able to always recognise the rights of everyone in a situation – as the point of human rights is that they are universal. Therefore, it is vital that we consider the rights that staff have, alongside the rights of people who use our services.

4.4 Looking Forward: New Equality Objectives 2019-2023

Our over-arching equality objectives set in 2015/16 were due to be updated and we were also keen to identify patient-related objectives which were not previously included.

Using the EDS2 toolkit, in February 2019 we engaged with stakeholders to identify a new set of equality objectives, as follows:

Engagement events to support the EDS2 grading:
- Diversity Network (15 attendees)
- Four multidisciplinary staff engagement events (53 attendees)
- Public engagement event (~50 attendees)

We also used other groups to help us identify new equality objectives:
- Events as above, plus
- Governors meeting
- Senior leaders forum (100 Leaders) and middle managers forum (Extended Leadership Network)
- Online survey for staff (245 responses)

The new equality objectives we will focus on during 2019-2023 are:

Patient-focused equality objectives
1. Develop "conversations in the community" engagement events to reach out to different areas served by the Trust, covering different socio-economic and geographical areas.

2. Develop a Person-Centred Care Charter (Dignity & Respect) for patients which clearly states that our Trust is committed to providing services that are non-discriminatory and ensures equitable provision for all regardless of any protected characteristic.

Staff-focused equality objectives
3. Significantly strengthen the support provided to staff with disabilities, mental health and long-term health conditions; including implementation of an education/ awareness campaign aimed at managers and staff to ensure people with these conditions feel safe, valued and have equal opportunity in the Trust.

4. Improve the support and reporting mechanisms for staff when they experience or witness bullying, abuse, harassment or violence in our Trust to ensure staff feel able to respond effectively and receive the support they need.

Alongside delivery of these objectives we will also explore opportunities to collaborate more closely with our partners on equality, diversity, inclusion and human rights matters affecting patients and colleagues across One Gloucestershire Integrated Care System (ICS).

Our human rights approach

Through all of our EDI activities and engagement with staff and patients we want to be able to

achieve these principles for people who use our services.

- **Fairness –** people who use and provide our services, and people acting on their behalf, have access to clear and fair processes for getting their views heard, for decision- making about care and treatment and to raise and resolve concerns or complaints.

- **Respect –** people who use and provide our services are valued as individuals and are listened to, and what is important to them is viewed as important by the service. People acting on behalf of others, such as family and friends, are also valued and listened to.

- **Equality –** people who use and provide our services do not experience discrimination and have their needs met, including on the grounds of age, disability, gender, race, religion and belief, sexual orientation, gender reassignment and pregnancy and maternity status. This includes looking at the needs of people who may experience multiple discrimination or disadvantage on more than one ground.

- **Dignity** – people who use and provide our services are always treated in a humanitarian way – with empathy and compassion and in a way that values them as a human being and supports their self-respect, even if their wishes are not known at the time.

- **Autonomy** – people who use and provide our services can exercise the maximum amount of choice and control possible – in care planning, in their individual care and treatment, in service development, in their relationships with others such as family and friends and as citizens beyond the services that they are using. Autonomy covers the concept of ‘personalisation’ of care.

- **Right to life** – people who use and provide our services will have their right to life protected and respected by the services that they use. This means that we will fulfil our obligation to protect the right to life, to refrain from unlawfully interfering with the right to life, and to carry out an effective investigation if a person dies, for example, while in our care.

5. Conclusion

As a Trust, we are committed to continuous improvement. We know that there can be no quality of care without equality for people using services and without their human rights being respected.

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

We have made significant progress in 2018/19 and have identified new equality objectives for the next four years using the EDS2 toolkit.

We look forward to growing and strengthening our EDI activities in 2019/20 as we deliver our annual EDI action plan and begin work on the new 4-year equality objectives. We know EDS3 is being developed and once published we will review this new toolkit and will use our intelligence to focus our improvement work to where it is most needed.

Appendix A - Data on the population of Gloucestershire against protected characteristics, and the demographics of our patients

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

Data downloaded from Gloucestershire County Council Population Profile 2018
Source: https://www.gloucestershire.gov.uk/media/12777/equality-profile-2019-final.pdf

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

***Notes for inpatient data**:*

- *Discharges between 1st April 2018 and 31st March 2019*
- *Data excludes well babies.*

***Notes for outpatient data**:*

- *Attendances between 1st April 2018 and 31st March 2019*
- *Includes face-to-face and telephone attendances.*
- *Excludes patients who did not attend and cancelled appointment.*

Age

Table 1: Gloucestershire population by broad age group, 2017[3]

	Number of people	% of population		
		0-19	20-64	65+
Cheltenham	117,128	22.5	58.5	19.0
Cotswold	87,509	20.4	54.3	25.2
Forest of Dean	85,957	21.5	54.6	23.9
Gloucester	129,083	24.9	58.7	16.4
Stroud	118,130	22.3	55.5	22.2
Tewkesbury	90,332	22.4	55.6	22.1
Gloucestershire	**628,139**	**22.5**	**56.4**	**21.0**
England	55,619,430	23.7	58.3	18.0

Table 2: Population change in Gloucestershire, 2007-2017[5]

	0-19			20-64			65+		
	Number of people		% change	Number of people		% change	Number of people		% change
	2007	2017	2007 to 2017	2007	2017	2007 to 2017	2007	2017	2007 to 2017
Cheltenham	25,774	26,351	2.2	67,979	68,525	0.8	18,758	22,252	18.6
Cotswold	18,394	17,870	-2.8	47,764	47,561	-0.4	17,044	22,078	29.5
Forest of Dean	19,067	18,444	-3.3	47,612	46,931	-1.4	15,325	20,582	34.3
Gloucester	30,110	32,157	6.8	70,226	75,782	7.9	16,889	21,144	25.2
Stroud	26,799	26,340	-1.7	64,081	65,576	2.3	20,189	26,214	29.8
Tewkesbury	18,304	20,191	10.3	46,043	50,199	9.0	15,057	19,942	32.4
Gloucestershire	**138,448**	**141,353**	**2.1**	**343,705**	**354,574**	**3.2**	**103,262**	**132,212**	**28.0**
England	12,486,551	13,169,095	5.5	30,769,374	32,419,824	5.4	8,125,168	10,030,511	23.4

Inpatients by Age Band	Discharges	Percentage
0 Years	3,561	2.2%
01 to 05 Years	4,534	2.8%
06 to 15 Years	4,169	2.6%
16 to 40 Years	34,595	21.5%
41 to 65 Years	47,847	29.7%
66 to 80 Years	45,325	28.1%
80+ Years	21,242	13.2%
Total Discharges	**161,273**	

Outpatients by Age Band	Attendances	Percentage
0 Years	5,545	0.7%
01 to 05 Years	21,337	2.8%
06 to 15 Years	37,063	4.9%
16 to 40 Years	146,296	19.4%
41 to 65 Years	239,259	31.7%
66 to 80 Years	218,552	28.9%
80+ Years	87,050	11.5%
Total Attendances	**755,102**	

What does this tell us?

The data in the table above shows that patients aged 41-80 and above, required more medical care particularly as inpatients. This is not unusual as it is acknowledged that access to healthcare is greater as people get older.

Sex

Table 10: Population by sex, Gloucestershire 2017[25]

	% of population	
	male	female
Cheltenham	49.0	51.0
Cotswold	48.4	51.6
Forest of Dean	49.2	50.8
Gloucester	49.5	50.5
Stroud	49.2	50.8
Tewkesbury	48.8	51.2
Gloucestershire	**49.1**	**50.9**
England	49.4	50.6

Inpatients by Sex	Discharges	Percentage
Female	91,344	56.6%
Male	69,925	43.4%
Not specified	4	0.0%
Total Discharges	**161,273**	

Outpatients by Sex	Attendances	Percentage
Female	427,657	56.6%
Male	327,438	43.4%
Not specified	7	0.0%
Total Attendances	**755,102**	

What does this tell us?

The table above shows analysis by sex indicating that the breakdown of female and male patients is broadly representative of our local population. Female patients appear to use our inpatient and outpatient services more than male patients. The slight increase might also be attributable to women using gender specific services e.g. Maternity or Gynaecology.

Marriage and Civil Partnership

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

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

Inpatients by Marital Status	Discharges	Percentage
Divorced/person whose civil partnership has been dissolved	5,004	3.1%
Married/civil partner	58,893	36.5%
Separated	956	0.6%
Single	36,494	22.6%
Widowed/surviving civil partner	4,121	2.6%
Not stated	55,805	34.6%
Total Discharges	**161,273**	

Outpatients by Marital Status	Attendances	Percentage
Divorced/person whose civil partnership has been dissolved	24,294	3.2%
Married/civil partner	282,675	37.4%
Separated	4,156	0.6%
Single	183,054	24.2%
Widowed/surviving civil partner	16,190	2.1%
Not stated	244,733	32.4%
Total Attendances	**755,102**	

What does this tell us?

For both inpatients and outpatients, over 32% of patients have not stated their marital status. More work needs to be done to understand if this is because the question is not being asked, or people do not feel comfortable to answer.

Ethnicity

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

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

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

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

Inpatients by Ethnicity	Discharges	Percentage
African	336	0.2%
Any other Asian background	469	0.3%
Any other Black background	275	0.2%
Any other ethnic group	1,030	0.6%
Any other mixed background	585	0.4%
Any other White background	4,478	2.8%
Bangladeshi	228	0.1%
Caribbean	514	0.3%
Chinese	183	0.1%
Indian	958	0.6%
Pakistani	163	0.1%
White and Asian	263	0.2%
White and Black African	174	0.1%
White and Black Caribbean	615	0.4%
White British	134,910	83.7%
White Irish	761	0.5%
Not known	5,901	3.7%
Not stated	9,430	5.8%
Total Discharges	**161,273**	

Outpatients by Ethnicity	Attendances	Percentage
African	1,884	0.2%
Any other Asian background	2,594	0.3%
Any other Black background	1,181	0.2%
Any other ethnic group	4,626	0.6%

Any other mixed background	2,292	0.3%
Any other White background	19,021	2.5%
Bangladeshi	1,083	0.1%
Caribbean	3,006	0.4%
Chinese	1,125	0.1%
Indian	6,123	0.8%
Pakistani	968	0.1%
White and Asian	1,390	0.2%
White and Black African	735	0.1%
White and Black Caribbean	2,741	0.4%
White British	626,817	83.0%
White Irish	3,188	0.4%
Not known	34,000	4.5%
Not stated	42,328	5.6%
Total Attendances	**755,102**	

What does this tell us?

The table above shows analysis by ethnicity indicating that the breakdown of patients is broadly representative of our local population. Approximately 10% of our inpatients and outpatients, however, have their ethnicity recorded as not known or not stated. More work needs to be done to understand if this is not being asked, or patients are choosing not to share this information.

Religion/belief/no belief

Table 23: Religion in Gloucestershire 2011[54]

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

Inpatients by Religion	Discharges	Percentage
Agnostic	182	0.1%
Anglican	184	0.1%
Atheist	402	0.2%
Baha'i	6	0.0%
Baptist	648	0.4%
Brethren	21	0.0%
Buddhist	108	0.1%
Catholic: Not Roman Catholic	42	0.0%
Christadelphian	6	0.0%
Christian	4,247	2.6%
Christian Scientists	10	0.0%
Church in Wales	25	0.0%
Church of England	54,727	33.9%

Church of God of Prophecy	7	0.0%
Church of Scotland	308	0.2%
Congregationalist	126	0.1%
Evangelical Christian	20	0.0%
Free Church	22	0.0%
Greek Orthodox	85	0.1%
Hindu	222	0.1%
Humanist	3	0.0%
Ismaili Muslim	23	0.0%
Jehovah's Witness	220	0.1%
Jewish	75	0.0%
Lutheran	22	0.0%
Methodist	1,399	0.9%
Moravian	3	0.0%
Mormon	62	0.0%
Muslim	756	0.5%
New Testament Pentacostalist	4	0.0%
Nonconformist	80	0.0%
Not Religious	11,982	7.4%
Orthodox Christian	18	0.0%
Pagan	69	0.0%
Pentecostalist	159	0.1%
Plymouth Brethren	4	0.0%
Presbyterian	99	0.1%
Protestant	228	0.1%
Quaker	107	0.1%
Rastafari	3	0.0%
Roman Catholic	6,412	4.0%
Romanian Orthodox	4	0.0%
Russian Orthodox	14	0.0%
Salvation Army Member	101	0.1%
Serbian Orthodox	12	0.0%
Seventh Day Adventist	39	0.0%
Sikh	40	0.0%
Spiritualist	97	0.1%
Unitarian	8	0.0%
United Reform	141	0.1%
Patient Religion Unknown	53,696	33.3%
Not stated	23,995	14.9%
Total Discharges	**161,273**	

Outpatients by Religion	**Attendances**	**Percentage**
Agnostic	749	0.1%
Anglican	1,445	0.2%
Atheist	1,709	0.2%
Baha'i	25	0.0%
Baptist	3,316	0.4%
Brethren	107	0.0%

Buddhist	490	0.1%
Catholic: Not Roman Catholic	152	0.0%
Christadelphian	41	0.0%
Christian	20,862	2.8%
Christian Scientists	89	0.0%
Church in Wales	101	0.0%
Church of England	263,238	34.9%
Church of God of Prophecy	52	0.0%
Church of Scotland	1,421	0.2%
Congregationalist	505	0.1%
Druid	2	0.0%
Evangelical Christian	165	0.0%
Free Church	62	0.0%
Greek Orthodox	407	0.1%
Hindu	1,738	0.2%
Humanist	2	0.0%
Indian Orthodox	5	0.0%
Ismaili Muslim	156	0.0%
Jehovah's Witness	1,320	0.2%
Jewish	332	0.0%
Lutheran	64	0.0%
Methodist	6,853	0.9%
Moravian	13	0.0%
Mormon	199	0.0%
Muslim	4,054	0.5%
New Testament Pentacostalist	7	0.0%
Nonconformist	472	0.1%
Not Religious	57,804	7.7%
Orthodox Christian	46	0.0%
Pagan	272	0.0%
Pentecostalist	760	0.1%
Plymouth Brethren	34	0.0%
Presbyterian	385	0.1%
Protestant	1,030	0.1%
Quaker	505	0.1%
Rastafari	21	0.0%
Religion not given Patient refused	3	0.0%
Roman Catholic	30,674	4.1%
Romanian Orthodox	3	0.0%
Russian Orthodox	38	0.0%
Salvation Army Member	440	0.1%
Serbian Orthodox	29	0.0%
Seventh Day Adventist	188	0.0%
Sikh	302	0.0%
Spiritualist	450	0.1%
Unitarian	46	0.0%
United Reform	753	0.1%
Patient Religion Unknown	265,385	35.1%

Not stated	85,781	11.4%
Total Attendances	**755,102**	

What does this tell us?

For approximately 50% of both inpatients and outpatients, the patients religion has not been stated or is not known, meaning we cannot understand how representative this is of our population. We will be looking at how we can support teams to feel confident in asking these questions of our patients, explaining why we ask for this information and how we use it.

Gaps in our data

As a Trust we do not have inpatient or outpatient data for the following protected characteristics:

- Disability
- Gender Reassignment
- Sexual Orientation
- Pregnancy

This is due to issues of reliability and availability within Trakcare, the Trust's patient administration system. The Trust is currently developing a new electronic patient record (EPR), and as part of this process, we will look at how we capture protected characteristics information about patients, to ensure that we are providing equitable outcomes for our local population.

Although we do not have this data available for our inpatients and outpatients, below is the data on the population of Gloucestershire against these four protected characteristics.

Sexual Orientation

Table 26: Stonewall estimates of the number of Lesbian, Gay and Bisexual people living in Gloucestershire[68]

	Lower Estimate		Upper Estimate	
	Number	%	Number	%
Cheltenham	4,800	5	6,800	7
Cotswold	3,700	5	5,100	7
Forest of Dean	3,600	5	5,000	7
Gloucester	5,200	5	7,200	7
Stroud	4,900	5	6,800	7
Tewkesbury	3,700	5	5,200	7
Gloucestershire	**25,800**	**5**	**36,100**	**7**
England	2,249,100	5	3,148,700	7

Note: Figures may not sum due to rounding

Table 27: Annual Population Survey Estimates of Sexual Orientation[69].

	Number of people aged 16 or over	Gay, lesbian, or bisexual (% in England)
Cheltenham	2,000	2.1
Cotswold	1,500	2.1
Forest of Dean	1,500	2.1
Gloucester	2,200	2.1
Stroud	2,000	2.1
Tewkesbury	1,500	2.1
Gloucestershire	**10,800**	**2.1**
England	944,600	2.1

Note: Figures may not sum due to rounding

Pregnancy and Maternity

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

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

Gender reassignment

Table 13: Estimates of gender reassignment, 2017[39]

	Lower Estimate		Upper Estimate	
	Number of people	% of 16+ population	Number of people	% of 16+ population
Cheltenham	579	0.6	965	1.0
Cotswold	440	0.6	733	1.0
Forest of Dean	431	0.6	718	1.0
Gloucester	618	0.6	1,031	1.0
Stroud	582	0.6	970	1.0
Tewkesbury	442	0.6	737	1.0
Gloucestershire	**3,092**	**0.6**	**5,154**	**1.0**
England	269,889	0.6	449,815	1.0

Note: Figures may not sum due to rounding

Disability

Table 5: Percentage of people with a long-term limiting health problem or disability, by broad age group, Gloucestershire, 2011[9]

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

Table 8: Visual and hearing impairments[22]

	Gloucestershire			England		
	2016	**2017**	**2018**	**2016**	**2017**	**2018**
% reporting blindness or partial sight	1.0	1.0	1.6	1.0	1.0	1.6
% reporting deafness or hearing loss	4.2	3.8	7.0	3.8	3.8	6.6

Appendix B – Data on Trust Staff against protected characteristics

With over 7,000 employees, our Trust is the largest employer in the county. The majority of Trust staff live in the local communities so they and their families are also users of our services. The Trust has always been very clear on the link between a skilled, committed and engaged workforce and the delivery of high quality patient care and this underpins many of our plans for staff development and engagement.

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

- Recruitment Data
- Workforce Data

Workforce Data

Section 1 - Recruitment Data
The following tables provide information between April 2018 and March 2019 about our staff recruitment, comparing it to the nine protected characteristics if available.

Whilst significantly more information regarding applicants' protected characteristic data is now gathered at recruitment stage, much of this is voluntary and must not be considered in recruitment decisions.

Recruitment by Gender

Description	Applications	% of all applications	Shortlisted	% of people Shortlisted	Appointed	% all people Appointed
Male	4,249	24.8%	1363	19.3%	273	16.3%
Female	12,844	74.9%	5698	80.5%	1397	83.4%
Undisclosed	47	0.3%	13	0.2%	5	0.3%

What does this tell us?
The data indicates that we receive an overwhelming majority of job applications from females. This reflects the dominant female workforce in certain staff groups such as nursing, additional clinical services, Allied Health Professionals and Admin & Clerical. We appear to be appointing more females relative to the number of applications. More investigation needs to be done to better understand the reasons for the differences in applications vs. appointments.

Recruitment by Disability
Table 1 - Recruitment by Disability, mental health or long-term health conditions

Description	Applications	% of all applications	Shortlisted	% all people Shortlisted	Appointed	% all people Appointed
Yes	646	3.8%	343	4.8%	58	3.5%
No	16,073	93.8%	6598	93.3%	1595	95.2%
Undisclosed	421	2.5%	133	1.9%	22	1.3%

Table 2 - Breakdown of self-declaration rates regarding individual disabilities/impairments/health conditions:

Description	Applications	% of all applications	Shortlisted	% of all people shortlisted	Appointed	% of all people Appointed
Physical Impairment	164	21.1%	85	20.6%	6	9.2%
Sensory Impairment	91	11.7%	55	13.3%	15	23.1%
Mental Health Condition	111	14.3%	55	13.3%	8	12.3%
Learning Disability Difficulty	167	21.5%	93	22.5%	18	27.7%
Long-Standing Illness	166	21.4%	83	20.1%	12	18.5%
Other	77	9.9%	42	10.2%	6	9.2%

Note: The total number of those declaring an impairment/disability/long-term condition varies slightly from the numbers who declare a disability. This could be because some people choose to declare a condition but would not consider themselves to be disabled.

Table 3 - Shortlisting/appointments relative to their declaration status:

Description	No. Applications	No. Shortlisted	% Shortlisted	No. Appointed	% Appointed from application	% Appointed from shortlisting
Declared they didn't have a disability	16,703	6598	41.1%	1595	9.9%	24.2%
Didn't declare either way	421	133	31.6%	22	5.2%	16.5%
Declared they have a disability	646	343	53.1%	58	9.0%	16.9%
Physical Impairment	164	85	51.8%	6	3.7%	7.1%
Sensory Impairment	91	55	60.4%	15	16.5%	27.3%
Mental Health Condition	111	55	49.6%	8	7.2%	14.6%
Learning Disability/ Difficulty	167	93	55.7%	18	10.8%	19.4%
Long-Standing Illness	166	83	50.0%	12	7.2%	14.5%
Other	77	42	54.5%	6	7.8%	14.3%

What does this tell us?

We have a lower percentage of applicants declaring disability compared to those declaring no-disability i.e. the Trust attracts fewer applicants who declare disability compared to applicants who declare no-disability. Of those declaring disability, a high proportion of this group is shortlisted (table 1). This indicates that the Two Ticks Disability Confident scheme that we are signed up firstly encourages individuals to disclose their disability status, and secondly ensures that those with a disability who meet the essential criteria are shortlisted. We appear to appoint disabled individuals in fairly similar proportions relative to the percentage of applications.

Of those who declare the **nature** of their disability or long-term health condition, the data shows that applicants are being shortlisted in proportion to those who declare they have a disability (table 3). We can see that the percentage of those with a disability who are appointed from shortlisting is relatively lower compared to the non-disabled group, with the exception of those declaring a sensory impairment.

Recruitment by Age

Description	Applications	%	Shortlisted	% Shortlisted	Appointed	% Appointed
Under 18	148	0.9%	65	0.9%	12	0.7%
18 to 19	650	3.8%	299	4.2%	84	5.0%
20 to 24	2,278	13.3%	1015	14.3%	290	17.3%
25 to 29	3,747	21.9%	1230	17.4%	309	18.4%
30 to 34	2,668	15.6%	997	14.1%	241	14.4%
35 to 39	1,786	10.4%	718	10.1%	176	10.5%
40 to 44	1,388	8.1%	663	9.4%	166	9.9%
45 to 49	1,586	9.3%	767	10.8%	157	9.4%
50 to 54	1,299	7.6%	615	8.7%	107	6.4%
55 to 59	1,010	5.9%	454	6.4%	82	4.9%
60 to 64	492	2.9%	213	3.0%	40	2.4%
65 to 69	60	0.4%	22	0.3%	6	0.4%
70 and over	18	0.1%	8	0.1%	3	0.2%
Undisclosed	10	0.1%	8	0.1%	2	0.1%

What does this tell us?

The majority of applicants to roles in the Trust come from people aged 20-29 and this is replicated in the number of those who are appointed.

The data indicates there are no significant differences between the percentages of people applying from different age groups, relative to the percentages of people who are shortlisted and then appointed.

Recruitment by Religion

Description	Applications	%	Shortlisted	% Shortlisted	Appointed	% Appointed
Atheism	2,801	16.3%	1354	19.1%	363	21.7%
Buddhism	156	0.9%	49	0.7%	7	0.4%
Christianity	8,555	49.9%	3683	52.1%	864	51.6%
Hinduism	523	3.1%	158	2.2%	30	1.8%
Islam	1,269	7.4%	263	3.7%	44	2.6%
Jainism	12	0.1%	3	0.0%	1	0.1%

Judaism	12	0.1%	4	0.1%	0	0.0%
Sikhism	46	0.3%	16	0.2%	2	0.1%
Other	2,035	11.9%	816	11.5%	190	11.3%
Undisclosed	1,731	10.1%	728	10.3%	174	10.4%

What does this tell us?

The data shows us that we attract applicants from a wide range of religious, faith and belief communities. The most popular religion/belief of applicants and appointees is Christianity, followed by atheism which reflects general trends in society.

We can see that those declaring Islam or Hinduism as their faith are less likely to be shortlisted and appointed relative to the number of applications. We will be exploring this in more detail through our work with the Diversity Network and shall continue to deliver mandatory Unconscious Bias training for all lead recruiting managers.

Recruitment by Sexual Orientation

Description	Applications	%	Shortlisted	% Shortlisted	Appointed	% Appointed
Heterosexual	15,792	92.1%	6476	91.5%	1558	93.0%
Gay/Lesbian	336	2.0%	159	2.2%	33	2.0%
Bisexual	243	1.4%	129	1.8%	25	1.5%
Other	18	0.1%	11	0.2%	5	0.3%
Undecided	70	0.4%	23	0.3%	3	0.2%
Undisclosed	681	4.0%	276	3.9%	51	3.0%

What does this tell us?

The data indicates there are no significant differences between the percentages of people applying with different sexual orientation, relative to the percentages of people who are shortlisted and then appointed.

Recruitment by Ethnicity

Description	Applications	%	Shortlisted	% Shortlisted	Appointed	% Appointed
WHITE - British	10,929	63.8%	5160	72.9%	1243	74.2%
WHITE - Irish	95	0.6%	61	0.9%	15	0.9%
WHITE - Any other white background	1,107	6.5%	366	5.2%	77	4.6%
ASIAN or ASIAN BRITISH - Indian	1,356	7.9%	545	7.7%	109	6.5%
ASIAN or ASIAN BRITISH - Pakistani	475	2.8%	81	1.1%	10	0.6%
ASIAN or ASIAN BRITISH - Bangladeshi	144	0.8%	29	0.4%	3	0.2%
ASIAN or ASIAN BRITISH - Any other Asian background	393	2.3%	154	2.2%	50	3.0%
MIXED - White & Black Caribbean	173	1.0%	64	0.9%	26	1.6%
MIXED - White & Black African	136	0.8%	18	0.3%	5	0.3%
MIXED - White & Asian	99	0.6%	40	0.6%	10	0.6%

MIXED - any other mixed background	111	0.6%	42	0.6%	4	0.2%
BLACK or BLACK BRITISH - Caribbean	230	1.3%	101	1.4%	23	1.4%
BLACK or BLACK BRITISH - African	1,124	6.6%	228	3.2%	58	3.5%
BLACK or BLACK BRITISH - Any other black background	73	0.4%	12	0.2%	5	0.3%
OTHER ETHNIC GROUP - Chinese	55	0.3%	16	0.2%	5	0.3%
OTHER ETHNIC GROUP - Any other ethnic group	397	2.3%	74	1.0%	17	1.0%
Undisclosed	243	1.4%	83	1.2%	15	0.9%
TOTAL WHITE	**12,131**	**71.8%**	**5,587**	**79.9%**	**1,335**	**80.4%**
TOTAL BAME	**4,766**	**28.2%**	**1,404**	**20.1%**	**325**	**19.6%**

What does this tell us?

The data indicates that we have a high number of BAME applicants to our roles, relative to the last census data for Gloucestershire (28.5% vs. 4.6%). Numbers who are shortlisted are lower for BAME and higher for White applicants relative to numbers that apply. However, shortlisted candidates are appointed in relatively similar levels regardless of whether they are White or BAME.

Recruitment by Marital Status

Description	Applications	%	Shortlisted	% Shortlisted	Appointed	% Appointed
Married	6,098	35.6%	2657	37.6%	657	39.2%
Single	8,733	51.0%	3528	49.9%	828	49.4%
Civil partnership	449	2.6%	199	2.8%	49	2.9%
Legally separated	127	0.7%	65	0.9%	13	0.8%
Divorced	866	5.1%	379	5.4%	80	4.8%
Widowed	56	0.3%	25	0.4%	6	0.4%
Undisclosed	811	4.7%	221	3.1%	42	2.5%

What does this tell us?

The data indicates there are no significant differences between the percentages of people applying with different marital status, relative to the percentages of people who are shortlisted and then appointed.

Workforce Data

The following tables provide information between April 2018 and March 2019 about the makeup of our full workforce, comparing it to the nine protected characteristics if available.

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

Due to the permanence of many of our staff, most of the data we hold historically on them will not include all of the 9 protected characteristics. As we see the turnover of these staff, the data overtime will become more meaningful for the purposes of this report.

Total of Workforce – Staff Group v Gender

Row Labels	Female	Male
Add Prof Scientific and Technic	223	62
Additional Clinical Services	1231	167
Administrative and Clerical	1418	265
Allied Health Professionals	362	54
Estates and Ancillary	15	38
Healthcare Scientists	187	67
Medical and Dental	434	481
Nursing and Midwifery Registered	2231	182
	6101	**1316**

What does this tell us?

Overall there is 82.3 % female and 17.7% male. All staff groups have majority female with the exception of Estates and Ancillary, and Medical & Dental where there are marginally more males. This data reflects the dominant female workforce across the NHS in certain staff groups.

Total of Workforce – Gender v Full/Part Time

Gender	Full Time	Part Time
Female	2918	3182
Male	1097	219

What does this tell us?

There is a fairly even split between females who work full time compared to part-time, with slightly more working part-time (52.2%). This is in stark contrast to a much lower percentage of men who work part-time (16.6%). This reflects a societal trend that women are more likely to reduce their working hours in order to improve work-life balance and look after family. This also indicates the Trust's flexibility towards staff who have other commitments beyond their work.

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

	Full Time		Part Time	
Row Labels	Female	Male	Female	Male
Apprentice	36	10	1	1
Associate Specialist	2	10	4	1
Band 1	7	7	16	2
Band 2	442	107	794	73
Band 3	352	55	364	11
Band 4	187	48	180	5
Band 5	790	183	721	30
Band 6	413	98	654	28

Band 7	240	82	263	11
Band 8 - Range A	85	27	41	1
Band 8 - Range B	31	23	9	1
Band 8 - Range C	10	8	5	1
Band 8 - Range D	7	5	1	
Band 9	4	2		
Clinical Assistant			3	2
Consultant	80	222	54	33
Foundation Year 1	33	18	2	
Foundation Year 2	32	21	1	
Hospital Practitioner				2
Non AfC	9	12	5	10
Senior House Officer	3	3		
Specialty Doctor	15	26	24	7
Specialty Registrar	140	130	40	

What does this tell us?

There are opportunities for part-time working arrangements across all levels of the organisation. Part-time working appears to be most popular in band 2 roles for both men and women. There are similar or higher levels of female part-time workers for bands 1 through to band 7. Part-time working becomes less common in senior roles.

Total Workforce – Staff Group v Age

Row Labels	<=20 Years	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	>=71 Years
Add Prof Scientific and Technic		20	43	45	55	27	30	32	20	10	2	1
Additional Clinical Services	87	161	163	193	140	131	156	151	119	75	17	5
Administrative and Clerical	56	110	152	134	137	137	234	266	285	131	31	10
Allied Health Professionals		60	75	53	69	44	25	48	30	11	1	
Estates and Ancillary		1		1	2	1	4	8	6	18	7	5
Healthcare Scientists		24	31	31	30	27	36	39	23	11	1	1
Medical and Dental		62	159	160	109	98	113	109	72	25	4	4
Nursing and Midwifery Registered		131	318	345	284	340	333	336	242	77	4	3
Grand Total	**143**	**569**	**941**	**962**	**826**	**805**	**931**	**989**	**797**	**358**	**67**	**29**

What does this tell us?

The workforce is spread fairly evenly across all age groups with the exception of under 20, 20-25 years, and 61+ years. This would reflect general trends in society of younger people being in the education system and older people taking retirement.

Total Workforce – Pay Band v Ethnicity

	Asian	Black	Chinese	Mixed	Not Stated	Other	White
Apprentice	1			3	1		43
Band 1	1			2			29
Band 2	93	37	4	12	39	24	1208
Band 3	19	13		14	25	8	703
Band 4	5	8		3	11	2	391
Band 5	214	66	6	15	73	159	1191
Band 6	36	10	5	8	44	18	1072
Band 7	13	8	3	3	20	6	543
Band 8 - Range A	3		1	4	1		145
Band 8 - Range B	3	3			1		57
Band 8 - Range C	1				1		22
Band 8 - Range D							13
Band 9							6
Non AfC					3		28
Non Medical Staff Total	**389**	**145**	**19**	**64**	**219**	**217**	**5451**
Associate Specialist	5		1			2	9
Clinical Assistant							5
Consultant	58	5	2	5	8	8	303
Dental Core Training 1	1						6
Foundation Year 1	2	1	2		5		43
Foundation Year 2	3	2	4	6	2	1	36
Hospital Practitioner	1						1
Specialty Doctor	19	1		1	3	8	40
Specialty Registrar	35	10	4	9	27	4	220
Medical Staff Total	**119**	**19**	**12**	**21**	**45**	**21**	**649**
OVERALL TOTAL	**513**	**164**	**32**	**85**	**264**	**240**	**6114**
% of Workforce	**6.90%**	**2.20%**	**0.40%**	**1.10%**	**3.60%**	**3.20%**	**82.50%**

What does this tell us?

As per our previous WRES submissions, we can see that there is a concentration of BAME staff in lower bands of the organisation and there is little or no BAME representation in senior non-medical roles.

In the medical workforce, we can observe more Asian colleagues than black colleagues. Overall we employ more Asian colleagues than any other ethnic minority.

Total Workforce – Staff Group v Ethnicity

	Asian	Black	Chinese	Mixed	Not Stated	Other	White
Add Prof Scientific and Technic	14	7	2	1	7	2	252
Additional Clinical Services	96	36	4	16	43	31	1172
Administrative and Clerical	39	26	3	21	47	3	1539
Allied Health Professionals	8	7	2	4	13		382
Estates and Ancillary	1				2		50

Healthcare Scientists	12	6	4	1	14	2	215
Medical and Dental	124	19	13	21	46	23	669
Nursing and Midwifery Registered	219	63	4	21	92	179	1835
Grand Total	**513**	**164**	**32**	**85**	**264**	**240**	**6114**

	Asian	Black	Chinese	Mixed	Not Stated	Other	White
Add Prof Scientific and Technic	4.91%	2.46%	0.70%	0.35%	2.46%	0.70%	88.42%
Additional Clinical Services	6.87%	2.58%	0.29%	1.14%	3.08%	2.22%	83.83%
Administrative and Clerical	2.32%	1.55%	0.18%	1.25%	2.80%	0.18%	91.72%
Allied Health Professionals	1.92%	1.68%	0.48%	0.96%	3.13%	0.00%	91.83%
Estates and Ancillary	1.89%	0.00%	0.00%	0.00%	3.77%	0.00%	94.34%
Healthcare Scientists	4.72%	2.36%	1.57%	0.39%	5.51%	0.79%	84.65%
Medical and Dental	13.55%	2.08%	1.42%	2.30%	5.03%	2.51%	73.11%
Nursing and Midwifery Registered	9.08%	2.61%	0.17%	0.87%	3.81%	7.42%	76.05%
Grand Total	**6.92%**	**2.21%**	**0.43%**	**1.15%**	**3.56%**	**3.24%**	**82.49%**

What does this tell us?

Again, this table shows that overall we employ more Asian colleagues than any other ethnic minority. This is notable across all staff groups.

We have strongest representation of BAME staff in the Medical and Dental and Nursing & Midwifery staff groups.

Appendix C

No. 2 – Accessible Information Standard – help for people who are deaf and BSL users

Gloucestershire Safety & Quality Improvement Academy

Gloucestershire Hospitals NHS
NHS Foundation Trust

Ensuring all Deaf BSL users experience effective communication with the Trust

Carol McIndoe
Patient Experience Improvement Manager - Disability Equality

About the quality improvement

Ensuring all Deaf BSL users experience effective communication with the Trust

My project aim is for 100% of Deaf BSL users to experience good quality 2-way communication in all of their dealings with the Trust.

Elements of this will be achieved by the end of November 2017 (within 6 months of the start of the project, whilst other aspects will take up to a year to implement and embed into the Trust's systems and processes.

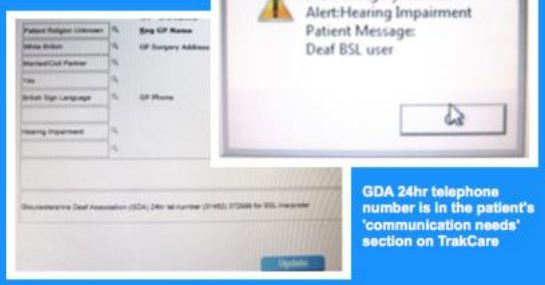
I attended a focus group with Gloucestershire Deaf Association (GDA), where Deaf British Sign Language (BSL) users shared their experiences with us, of coming to our hospitals as patients.

On considering their comments and suggestions for improvement, I realised that as a Trust, we could make several fairly simple adjustments which could significantly improve communication between Deaf BSL users and the Trust.

I returned to give GDA an update.

What the project achieved:

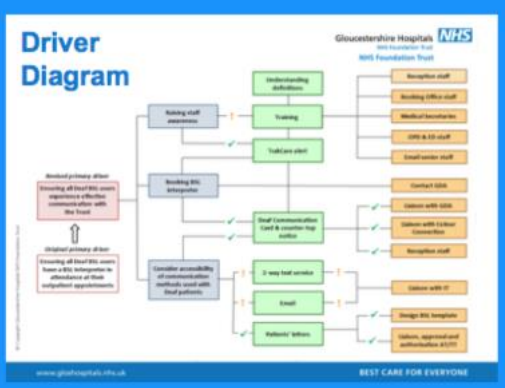
100% of known Deaf BSL users have a communication needs alert on TrakCare

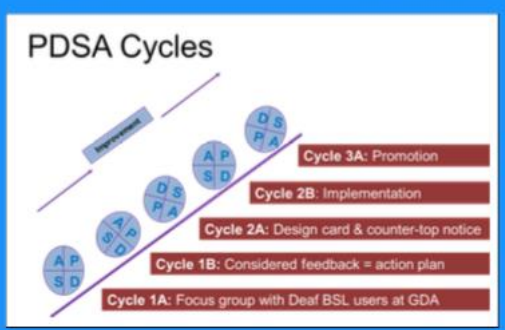


GDA 24hr telephone number is in the patient's 'communication needs' section on TrakCare

The counter-top notice prompts the patient to present their Deaf Communication Card and also provides the receptionist with the GDA 24hr telephone number on the reverse

How it was done:





GDA Living confidently with deafness and hearing loss

In collaboration with Gloucestershire Deaf Association

www.gloshospitals.nhs.uk

BEST CARE FOR EVERYONE

Gloucestershire Safety & Quality Improvement Academy

Gloucestershire Hospitals NHS
NHS Foundation Trust

Developing an online patient information enquiry service

Lisa Riddington

1. Background

The 2016 Picker inpatient survey score showed that our provision of patient information had exceeded the "Picker average" of 19% and we needed to improve. Patients need to agree to consent, are encouraged to self manage their care and we need to ensure person centred care, therefore patients need the best information.

2. Aim

To improve the provision of good quality information to digitally literate patients. The ultimate goal is to decrease the Picker Score, however it is acknowledged that this project is just the start of larger patient information journey.

3. Method

We developed an online enquiry form and used a process map to ensure enquiries received would be dealt with appropriately. User testing helped us measure our processes including access, time taken and satisfaction. The service was launched in Autumn 2018. Posters and flyers have been produced and there is an ongoing publicity plan. As this is an innovative service we have nothing to benchmark against, however evaluations from users will be analysed to ascertain satisfaction and usage rates measured, staff workload is one of our balancing measures.

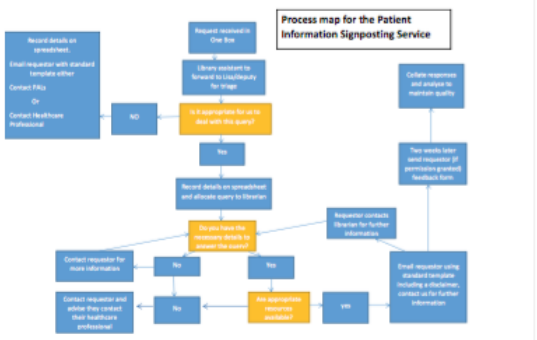
4. Results and the future

The service is operational and several queries received. The service needs to become established and further evaluations received to ascertain the full benefits. There is a potential for working collaboratively with 2gether Library Service to expand the service to all patients in Gloucestershire. There is considerable interest from other library services and this could be easily replicated in other Trusts.

5a. How it was achieved—Driver Diagram

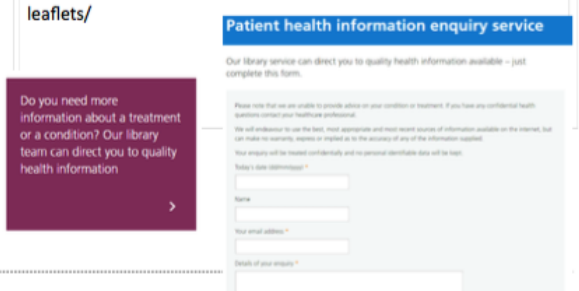
Aim	Primary Drivers	Secondary Drivers	Change Ideas
Development of an online patient information signposting service for digitally literate patients, carers and public	Website presence	Web page	To send a query have a button that links to our email address on the patient information webpage
			Explanation of what the service can/can't do
	Accessibility	Visibility	Appropriate location on Trust webpages and button to be in prominent position
		Awareness	Pilot in a patient letter with friendly/supportive consultant
			Put details on the bottom of the patients leaflets
			Communications plan – internal and external
		Engagement	Take to Trust members group
			Feedback from supportive consultants/matrons
			Meet with PALS (with Suzie)
			Take to Trust board (idea already taken to board by Suzie Cro and met with interest)
	Dealing with the enquiries	Process for library team	Inappropriate enquiries – requestor to be told to contact PALS
			Creation of a resource list
			Creation of a process/pathway
			Create a monitor/audit sheet to record queries
			Training for library team
	Quality assurance	Satisfaction	Send short feedback survey to users
			Analyse responses
		Collect the impact of service to our patients	Further contact with patients to collect impact case
		Expectations	Write a disclaimer and create standard wording/ template for the reply which explains what the service offers and where else to get help

5b How it was achieved — Process Map



6. What was achieved—the service

https://www.gloshospitals.nhs.uk/your-visit/patient-information-leaflets/



7. Future measurements

- **Outcome** - improvement satisfaction and increased usage from patients increased - measured by usage statistics and evaluation analysis
- **Process** - enquiries processed within 24 hours
- **Balancing** - staff workload

8. Next steps

- **Publicity and marketing**— Continue with publicity plan
- **Share** - with NHS Library services to help develop Patient and Public Information Services as per Health Education England strategy

www.gloshospitals.nhs.uk

BEST CARE FOR EVERYONE

No. 4 – SHED: Support and Help for Every Dad

S.H.E.D

Support & Help
for Every Dad!

Join us at this event to celebrate the creation and launch of S.H.E.D.

S.H.E.D. has been formed to support and help every dad, who has had their baby/babies start its' life on the Neonatal Unit.

Our launch event will bring us all together, along with the chance to understand a little more about what the group is about and what activities are underway and planned.

Although S.H.E.D is firmly targeted at dads, this event is also for mums, siblings, the wider family, supporters of the group and of course those special NICU babies!

LAUNCH DAY
SATURDAY 20TH OCTOBER 2018
2.00 – 4.00 P.M.
REDWOOD HOUSE
ROYAL GLOUCESTERSHIRE HOSPITAL
REFRESHMENTS AVAILABLE

No. 5 – No Surprises – reasonable adjustments

Gloucestershire Safety & Quality Improvement Academy

Gloucestershire Hospitals NHS
NHS Foundation Trust

No Surprises

General Surgery

Cheltenham General Hospital

Background

Many patients arriving on the Day Unit CGH or SAS CGH had individual care needs that needed to be highlighted to the areas involved in their stay within hospital but these needs had not been highlighted in many cases despite the information being given by the patient in Pre-assessment. This meant that necessary equipment was not made available, reasonable adjustments could not be made in time or their placement on the ward was not conducive with delivering safe care meaning we are less likely to create a good patient experience.

Aim

For 100% of all patients undergoing a pre-assessment have their individual care needs cascaded to all areas involved with their care and the relevant documentation to have been completed - SAS, Day Surgery, Theatres, Recovery and Ward. Time frame 6 months.

Our Team

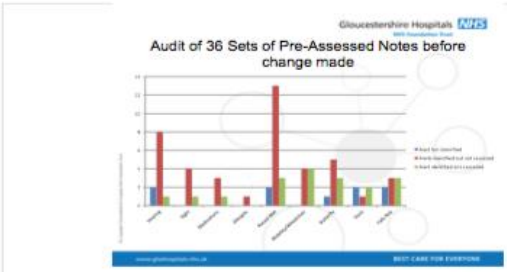
Kate Mennie—Senior Sister Day Surgery/SAS CGH
Cathryn Braithwaite—Sister Day Surgery/SAS CGH
Julie Harvey—Senior Sister Snowshill Ward (Urology/Breast)

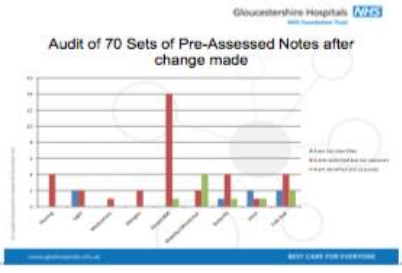
Methods

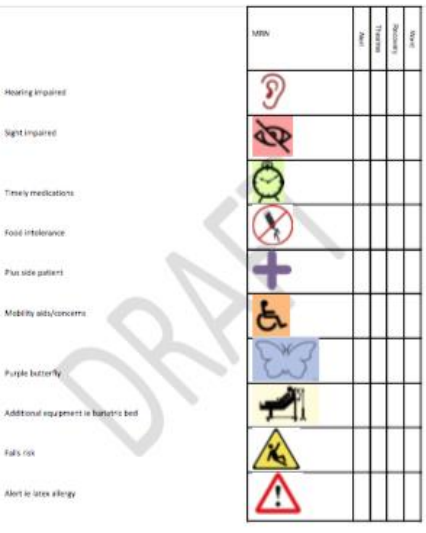
After initially collecting data to highlight what percentage of patients are not having their care needs cascaded we introduced a simple tick box sheet to Pre-assessment for them to highlight the relevant information. This would then be picked up Day Surgery/SAS when the notes are checked the day before admission allowing for equipment to be ordered and adjustments to be made. Day Surgery/SAS would then be responsible for disseminating that information to the other areas involved in the patient's. We then re-audited to see if the rate of patients having their care needs cascaded has improved and made suggestions of our next steps.

Results

The results show that there is a definite increase in the number of patients having individual care needs identified in Pre-assessment. Unfortunately the results also show that with the exception of two areas, visual impairment and mobility aids/concerns, there was a decline in the number of patients having their individual care needs cascaded from Pre-assessment to the Day Unit/SAS. Feedback from the ward areas via Julie Harvey is that they are more prepared for patients with additional care needs as they are getting those care needs communicated to them.







Conclusion

Our conclusion is that the reason that the greater proportion of patients being pre-assessed without their care needs being cascaded to Day Surgery/SAS than expected is due to a lack of understanding of the Pre-assessment staff as to how this missing information impacts on the patients care and experience. Many of the staff have either never worked in the ward area or have not done so for many years meaning that they have not got recent experience of having a patient turning up to have care delivered and not being fully prepared as a department to do so safely. However this process has improved the communication between Day Surgery/SAS and the other areas such as Theatre, Recovery and the Ward areas regarding needs that we have highlighted prior to or at admission of the patients. This will continue to be an ongoing area for improvement and will require more input with Pre-assessment before rolled out to other areas.

www.gloshospitals.nhs.uk BEST CARE FOR EVERYONE

Gloucestershire Safety & Quality Improvement Academy

Gloucestershire Hospitals NHS
NHS Foundation Trust

Facilitating partners to stay overnight on the Maternity Ward

Kerrie Lotsu & Sam Rea, Midwives

1. Background and Problem

Complaints had been received from women that they were unhappy that their partners could not stay overnight either when they were in early labour or newly postnatal. This provision was only available to women staying in side rooms and not to those in four-bedded bays.

This QI project was undertaken to facilitate partners to stay overnight in the four bedded bays if requested.

2. Aim

To increase the percentage of women scoring 8 or above on a satisfaction scale to 50% by December 2018.

3. Method

Outcome Measures

Patient satisfaction: percentage of patients scoring 8/9/10 on a satisfaction scale, with 0 being completely dissatisfied and 10 being completely satisfied. Qualitative and quantitative surveys carried out on different days of the week to account for day to day variation (e.g. no elective surgery on weekends).

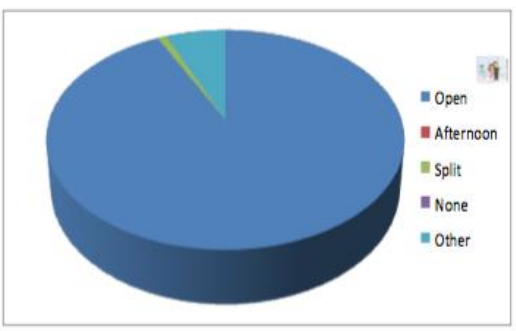
Process Measures

Root causes of success or failure: e.g lack of equipment; reduced capacity.

Balancing Measures

Transient factors that may affect outcomes: e.g. particularly high or low patient numbers.

Aim	Primary Drivers	Secondary Drivers	Change Ideas
To improve patient satisfaction by 50% by December 2018, by allowing partners to stay overnight in 4-bedded bays on the Maternity Ward.	PATIENT	COMMUNICATION	Provide health education to both parents whilst on the ward
			Provide AN information regarding other women's partners' presence (booking pack/AN visits)
		PSYCHOLOGICAL WELLBEING	Assess health and wellbeing of both parents in early PN period
		PERSONAL HEALTHCARE	Provide management of expectations (leaflet/bedside information sheet)
			Teach and assess skills for parenting and feeding
	STAFF	WORKLOAD	Observe for risk of PND/stress in both parents
			Partners taking more active role in non-clinical tasks to reduce staff workload
		CULTURE	Provide education on importance of family bonding/support system
			Visit other units to observe their systems
		POLICY	Produce guidelines/policy
	ENVIRONMENT	ROOM LAYOUT	Consideration of furniture dimensions
			Reducing baggage brought to hospital
		PRIVACY	Discuss single sex occupancy rules with Trust
			Implementation of mobile phone rules
			Introduction of quiet times
		INFECTION CONTROL/ HEALTH & SAFETY	Investigate possibility of partner toilet/shower facilities
			Discuss feasibility with fire officers
	FINANCE	SECURITY	Employ ward clerk/security guard 0900-2100
		EQUIPMENT	Purchasing furniture e.g. recliner chairs
		SUSTENANCE	Investigate costs of meals/drinks for partners and how to fund this



Results of survey taken by patients on the Maternity Ward, showing what they would like visiting hours for their partners to be.

Open	100
Afternoon	0
Split	1
None	0
Other	7
Total	108

6. Results:

Visiting times for other members of the family were changed to reflect the wishes of the patients, despite staff resistance and visiting for partners is going to go to 24 hours from the beginning of October 2018.

7. Our Findings:

We have learnt that the opinions of patients are paramount, and we believe this project will benefit patients and give them an overall better experience.

Gloucestershire Hospitals
NHS Foundation Trust

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

Report Title
Annual Appraisal / Revalidation Board Report – Senior Medical Staff
Sponsor and Author(s)
Author: Dr Elinor Beattie, Associate Medical Director Sponsor: Prof. Mark Pietroni, Medical Director
Executive Summary

Purpose

This is the update on Senior Doctor Appraisal and Revalidation programme which is required to be presented to the Trust Board on an annual basis in line with the national recommendations relating to medical revalidation.

Key issues to note

- Recruitment of appraisers remains difficult while funding of these roles can cause an issue within certain divisions when no central budget is held.

Conclusions

The Appraisal and Revalidation process within the Trust is now embedded and the external and internal processes provide assurance that this is being undertaken to the required standard

Implications and Future Action Required

Support the alignment of the appraisal resource to the Medical Director budget

Recommendations
The board is asked to receive the report as a source of assurance regarding the quality of medical appraisal and revalidation throughout the Trust
Impact Upon Strategic Objectives
Supporting medical staff to achieve the Trust goals in relation to feeling valued and involved and wanting to improve
Impact Upon Corporate Risks
None
Regulatory and/or Legal Implications
Medical revalidation is a statutory requirement of the General Medical Council (GMC)
Equality & Patient Impact
None

Resource Implications			
Finance	**X**	Information Management & Technology	
Human Resources	X	Buildings	

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

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

Annual Appraisal / Revalidation Board Report – Senior Medical Staff

For Presentation to The Main Board, 11th July 2019

1. Purpose of Report

1.1 To provide an up to date review of the Appraisal and Revalidation processes for the Board.

2. Executive Summary

2.1 Revalidation began in December 2012, and the second cycle of revalidation is now in its third year with processes embedded. 532 appraisals were completed last year for a total number of 565 doctors with prescribed connection to this organisation (94%). There were 19 approved delayed appraisals and 14 unapproved. This compared to a completed appraisal rate of 515/554 (93%) in 2017/18

2.2 NHS England request quarterly reports and an end of year report. See Appendix 1 which is the end of year return submitted to NHS England for the financial year of 2018/19.

2.3 A template for the Annual Board Report and Statement of Compliance has been provided by NHS England and NHS Improvement and this is included with this summary.

3. Background

3.1 The appraisal and revalidation team coordinate the appraisal process and support the 360 feedback collection for revalidation. They are supported by a medical staffing manager and the appraisal lead.

3.2 The Responsible Officer, along with the Medical Staffing Manager and Appraisal/Revalidation Officer, ensure that all paperwork required for Revalidation is in place. Once a decision has been made by the RO, the GMC are informed of the outcome, along with the doctor.

3.3 Documents relating to the appraisal and revalidation process have been updated to be compliant with the current national guidance. These are available to staff on the appraisal and revalidation site on the intranet.

3.4 The Revalidation Operation Group meets quarterly to ensure that the Revalidation process is working and to discuss any problems. The group is made up of the Responsible Officer, Appraisal Lead, Medical Staffing Manager, Appraisal/Revalidation Officer and Revalidation Administrator.

3.5 The Appraisal Steering Group meets half yearly. Membership consists of:

- The Appraisal Lead (Chair)
- Responsible Officer (Medical Director)
- LNC representative
- One SAS Doctor
- Two Consultants.

3.6 The present members are:

- Dr Elinor Beattie, Appraisal Lead
- Dr Mark Pietroni, RO
- Dr Steve Cooke, LNC Representative
- Dr Nicol Vaidya, SAS Doctor
- Dr Caroline Harvey, SAS Doctor
- Dr Mark Slade, Consultant
- Dr Alison Rushforth, Consultant

3.7 The Appraisal Officer services these meetings. The Group reports to the Director of Medical Education, Quality Committee, LNC and Trust Board annually.

3.8 There are thirty six appraisers. This includes five appraisers who are currently on "zero hours" contracts having retired but who are employed to continue as appraisers.

3.9 A system has been put in place to capture the appraisal of those doctors who have their main employment within Gloucester Care Commission and Care Services along with those on honorary contracts.

4. Quality Assurance

4.1 Appraisees evaluate their appraisals and this feedback is sent to the Appraisers annually.

4.2 Appraisers are required to reflect on their performance. The number of appraisals they carry out, the number signed off within 28 days and the number of Support Groups they attend are recorded. The Appraisers meet with the Appraisal Lead on a yearly basis to discuss their performance.

4.3 Quality Assurance of the appraisal summaries and personal development plans using a standard tool is carried out annually. This is a peer review process and is completed at the Appraisal Support Groups. We review two summaries from each appraiser are reviewed. Once marked, the overall score is discussed with the appraiser for their education.

4.4 Reporting Form A: All doctors are required to meet with their Speciality Director for an annual meeting which includes a performance review discussion and job plan review. The Form A is completed at this meeting and reviewed at the appraisal by the appraiser.

4.5 Four Appraiser Support Groups take place each year. Appraisers are expected to attend two. This has ensured that all appraisers are up to date with current legislation and changes to the appraisal and revalidation process.

4.6 There is one lay representative appointed to support the appraisal process. At present, they are involved in the recruitment of appraisers and attend the appraiser support groups. They have also observed an appraisal are involved in the quality assurance of appraisal summaries

5. Clinical Governance

5.1 The appraisal process requires links to strong clinical governance processes. The Audit Department provides details of any audits for which senior medical staff have been nominated as lead. This Risk Department send a report to those who have been involved in a Serious Untoward Incident. A nil return is sent to all other Senior Medical Staff by the Appraisal Administrator.

5.2 Any concerns that have arisen in the year between appraisal should be documented on the Form A and included in the appraisal discussion.

5.3 New guidance form NHS England requires all appraisals to be carried out within 12 months of the last one. Extensions should be agreed with the appraisal lead and a postponement form completed.

6. Information Systems

6.1 The patient and Colleague feedback process is administered through the appraisal administration team.

6.2 Appraisals themselves are recorded on the MAG (Medical Appraisal Guide) form. These should be completed and returned to the appraisal administration team within 28 days of the date of the appraisal.

7. Financial Implications

7.1 A review of the funding for appraisers is underway, with outcome pending. At present there is a shortfall of approximately 10 appraisers and additional appraisal activity is funded at a cost of £500 per appraisal.

8. Recommendations – To Note

8.1 The Board is asked to note the current state of progress of medical appraisal and revalidation to national guidelines.

Author: **Dr Elinor Beattie, Associate Medical Director**

Presenting Director: **Dr Mark Pietroni, Medical Director**

Date: **July 2019**

APPENDIX I

Section 2	Appraisal						
2.1	IMPORTANT: Only doctors with whom the designated body has a prescribed connection at 31 March 2019 should be included. Where the answer is 'nil' please enter '0'. **See guidance notes on pages 12-14 for assistance completing this table**	Number of Prescribed Connections	1 Completed Appraisal (1)	1a (Optional) Completed Appraisal (1a)	2 Approved incomplete or missed appraisal (2)	3 Unapproved incomplete or missed appraisal (3)	Total
2.1.1	**Consultants** (permanent employed consultant medical staff including honorary contract holders, NHS, hospices, and government /other public body staff. Academics with honorary clinical contracts will usually have their responsible officer in the NHS trust where they perform their clinical work).	394	375	0	11	8	394
2.1.2	**Staff grade, associate specialist, specialty doctor** (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS, hospices, and government/other public body staff).	76	69	0	7	0	76
2.1.3	**Doctors on Performers Lists** (for NHS England and the Armed Forces only; doctors on a medical or ophthalmic performers list. This includes all general practitioners (GPs) including principals, salaried and locum GPs).	0	0	0	0	0	0
2.1.4	**Doctors with practising privileges** (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade).	0	0	0	0	0	0
2.1.5	**Temporary or short-term contract holders** (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc).	95	88	0	1	6	95
2.1.6	**Other doctors with a prescribed connection to this designated body** (depending on the type of designated body, this category may include responsible officers, locum doctors, and members of the faculties/professional bodies. It may also include some non-clinical management/leadership roles, research, civil service, doctors in wholly independent practice, other employed or contracted doctors not falling into the above categories, etc).	0	0	0	0	0	0
2.1.7	**TOTAL** (this cell will sum automatically 2.1.1 – 2.1.6).	565	532	0	19	14	565

REPORT TO MAIN BOARD – JULY 2019

From Audit and Assurance Committee Chair – Claire Feehily, Non-Executive Director

This report describes the business conducted at the Audit and Assurance Committee on 2nd July 2019, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Counter Fraud update (CF)	Regular update report on Trust's CF arrangements for 2019-20, confirming satisfactory progress in year to date as per plan. Increased work is underway to examine how CF, bribery and corruption risks are assessed, monitored and managed. The Trust has participated in Series 2 of the BBC's Fraud Squad NHS. The Cttee was updated re current CF investigations. A second report addressed resilience of CF team in terms of its significant levels of collective experience and plans to address staffing shortfalls. Plans include restructuring. A Memo or	How can we be assured that differential approaches are not taken to different staff groups when investigating fraud? Are there adequate staff resources available to the service? Does the risk of fraud currently feature within the Trust's wider risk management arrangements? Could doing so provide a way to further extend divisional engagement?	Further report planned on risk-related aspects to September Cttee meeting. The application of corporate policy and relevant professional standards was explained. There was a high level of confidence that an equitable approach between staff is maintained. Resource levels have been agreed and yes, once recruitment plans are implemented, staffing levels will be adequate. Exec agreed to examine the possibility.	

	Understanding with another Trust in the region is a further source of support.			
Internal Audit	Internal audit items included an update on the 2019/20 Internal Audit programme. We considered two audit reports and management responses. RTT Clock stops review received Moderate audit ratings for both the 'Design' and 'Effectiveness' of internal control arrangements. Divisional Governance Audit Report. A briefing was received to demonstrate Executives' response to the IA findings and recommendations and associated action plan for strengthening divisional governance.	Are check and challenge resources adequate and recurrently funded? Are proposed timescales for training in the rules around clock stops sufficiently urgent? The Cttee welcomed the comprehensive approach that is being taken.	Yes and their being a centralised resource is good practice. Yes, given the scale and depth of work required to ensure correct spread of training and compliance. Some areas, eg Opthalmology are already demonstrating good results in these processes.	Quarterly progress updates to Cttee.

External Audit Report 2018/19	The external auditors, Ernst and Young (EY), confirmed their unqualified opinion of the Trust's financial statements for 2018/19. They provided a comprehensive report on the scope and focus of their work. The external audit report was delayed and the Cttee was able to discuss the circumstances with the Audit partner. EY were very clear as to the quality and responsiveness of the work undertaken by the Trust's finance team.	The Cttee commended the Finance Director and her colleagues for the quality f work undertaken in challenging circumstances. The Cttee sought and received assurance from EY that the resources and assumed timings for the GMS audit and the review of the Trust's charitable funds accounts have been confirmed to be adequate. EY agreed to provide a briefing on the circumstances of the delay to the Council of Governors in August.		
National Costing Audit Report	The report covered the NHS Costing Transformation Programme, a national project with the aims of improving costing in the NHS and mandating Patient Level Costing. The audit of Costing in the Trust reported a No Assurance opinion.	The Cttee was assured of intentions to address shortfalls in this area. It has not, hitherto, been a high priority, however an action plan has been developed to address the issues raised. This includes the need to recruit some specialist staffing resources. The Cttee was assured that the timescales appear to be realistic, assuming recruitment is successful.		

Claire Feehily, Chair of Audit and Assurance Committee, July 2019.

ITEM 15

ASSURANCE REPORT OF THE CHAIR OF THE ESTATES AND FACILITIES COMMITTEE – MEETING HELD ON 8 JULY 2019

VERBAL
(MIKE NAPIER)

ITEM 16

GOVERNOR QUESTIONS

Peter Lachecki
Chair

ITEM 17

STAFF QUESTIONS

Peter Lachecki
Chair

ITEM 18

PUBLIC QUESTIONS

Peter Lachecki
Chair

ITEM 19

NEW RISKS IDENTIFIED

VERBAL

ITEM 20

ITEMS FOR THE NEXT MEETING

VERBAL

ITEM 21

ANY OTHER BUSINESS

DISCUSSION