Gloucestershire Hospitals NHS
NHS Foundation Trust

PUBLIC BOARD AGENDA

Meeting: **Trust Board meeting held in public**

Date/Time: Thursday 9 January 2020 at 13:00

Location: Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital

	Welcome and Apologies			13:00
1	Declarations of Interest			13:01
2.	Patient Story			13:02
3.	Minutes of the Previous Meeting	**PAPER** (Peter Lachecki)	**For approval**	13.30
4.	Matters Arising	**PAPER** (Peter Lachecki)	**For approval**	13.35
5.	Chief Executive's Report	**PAPER** (Deborah Lee)	**For assurance**	13.40
6.	Trust Risk Register	**PAPER** (Emma Wood)	**For assurance**	13.55
7.	**Quality & Performance:** • Quality & Performance Report	**PAPER** (Steve Hams Mark Pietroni Rachael de Caux)	**For assurance**	14.05
8.	**Finance & Digital:** • Assurance Report of the Chair of the Finance & Digital Committee held on 19 December 2019	**PAPER** (Rob Graves)	**For assurance**	14.15
	• Financial Performance Report	**PAPER** (Karen Johnson)	**For assurance**	14.20
BREAK				14.30
9.	**People & Organisational Development:** • Assurance Report of the Chair of the People & Organisational Development Committee held on 16 December 2019	**PAPER** (Balvinder Heran)	**For assurance**	14:35
	• People & Organisational Development Report	**PAPER** (Emma Wood)	**For assurance**	14:40
10.	Fit For The Future – Engagement Report	**PAPER** (Simon Lanceley)	**For information**	14:50
GOVERNOR QUESTIONS				
11.	A period of ten minutes will be available for Governors to ask questions.			15.10

STAFF QUESTIONS

12.	A period of ten minutes will be available for members of staff to ask questions.		15.20

PUBLIC QUESTIONS

13.	A period of ten minutes will be available for members of the public to ask questions submitted in accordance with the Board's procedure.		15.30
14.	New Risks Identified	**VERBAL** (All)	15.40
15.	Items for the Next Meeting	**VERBAL** (All)	15.42
16.	Any Other Business		15.45

CLOSE 15.50

Date of the next meeting: Thursday 13 February 2020 in the Lecture Hall, Redwood Education Centre, Gloucester Royal Hospital at 12:30

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

Board Members

Peter Lachecki, Chair

Non-Executive Directors	**Executive Directors**
Claire Feehily	Deborah Lee, Chief Executive
Rob Graves	Emma Wood, Director of People and Deputy Chief Executive
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
Elaine Warwicker	Karen Johnson, Director of Finance
Associate Non-Executive Directors	Simon Lanceley, Director of Strategy & Transformation
Marie-Annick Gournet	Mark Pietroni, Director of Safety and Medical Director
Bilal Lala	

MINUTES OF THE MEETING OF THE TRUST BOARD
HELD IN THE LECTURE HALL, REDWOOD EDUCATION CENTRE,
GLOUCESTERSHIRE ROYAL HOSPITAL, GLOUCESTER
ON THURSDAY 19 DECEMBER 2019 AT 14:30

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 Officer
Claire Feehily	CF	Non-Executive Director
Steve Hams	SH	Director of Quality and Chief Nurse
Balvinder Heran	BH	Non-Executive Director
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
Jonathan Shuter	JS	Interim Director of Finance
Elaine Warwicker	EWa	Non-Executive Director
Emma Wood	EW	Director of People and Organisational Development and Deputy Chief Executive Officer

IN ATTENDANCE:

Suzie Cro	SC	Deputy Director of Quality (Item 246/19)
Sim Foreman	SF	Trust Secretary
Alison McGirr	AMc	Director of Unscheduled Care & Medicine and Deputy Chief Operating Officer (Item 259/19)
Hannah Osborne	HO	Patient Story (Item 246/19)
Simon Pirie	SP	Guardian for Safe Working (Item 261/19)
Tim Pittaway	TP	Patient Story (Item 246/19)
Vicky Stacey	VS	Patient Story (Item 246/19)
Ben King	BK	Patient Story (Item 246/19)
Kerry Wilkinson	KW	Patient Story (Item 246/19)
Andrew Brearley	AB	Patient Story (Item 246/19), Health Education England

MEMBERS OF THE PUBLIC/PRESS/STAFF/GOVERNORS:

Hilary Bowen	HB	Public Governor, Forest of Dean
Anne Davies	AD	Public Governor, Cotswolds
Craig MacFarlane	CM	Head of Communications
Alan Thomas	AT	Public Governor, Cheltenham and Lead Governor

There was one member of staff present for the Patient Story.

APOLOGIES:

Rachael De Caux	RdC	Chief Operating Officer
Rob Graves	RG	Non-Executive Director
Marie-Annick Gournet	MAG	Associate Non-Executive Director
Bilal Lala	BL	Associate Non-Executive Director
Alison Moon	AM	Non-Executive Director
Mike Napier	MN	Non-Executive Director

ACTION

244/19 WELCOME AND APOLOGIES

The Chair welcomed all to the meeting and apologies were NOTED from RdC, RG, MAG, BL, AM and MN.

245/19 DECLARATIONS OF INTEREST

DL declared an interest in item 260/19 as she chaired the West of England Pathology Network.

Resolution: The Board REGISTERED the declaration of interest.

246/19 PATIENT STORY

MP, executive lead for Simulation Training, introduced the team and went on to demonstrate a multi-disciplinary team simulation exercise focused on a patient experiencing a heart attack; followed by a simulated de-brief session.

Board members commended the team for the demonstration and asked a number of questions including how realistic if felt and how feedback for participants from the Simulation was managed? Feedback from the exercises was reviewed by the Team and where appropriate, a follow up would be arranged quickly.

The simulation also highlighted and reinforced the importance of civility and kindness in caring, the benefit of the recently introduced yellow name badges and the debrief process. The Board noted comments from the Team that simulated exercises carried a different type of stress to real practice but were none the less invaluable and briefly discussed links between psychological safety, kindness and values.

The Team felt that more access to Simulation Training would be beneficial and tremendous progress had been made over the past two years but inevitably, operational pressures sometimes meant this still happened. It was disappointing if a planned Simulation was cancelled however the team did have the option of a "live" system test and whilst positive feedback had been received, they remained cautious about disengaging staff if there were too frequent. Four major planned Simulation exercises take place each year as well as service specific ones.

BH joined the meeting at 14:55 and CF left the meeting at 15:08.

247/19 MINUTES OF THE PREVIOUS MEETING

RESOLVED: The minutes of the meeting held on Thursday 14 November 2019 were APPROVED as a true and accurate record for signature by the Chair.

248/19 MATTERS ARISING

RESOLVED: The Board APPROVED the closed items.

249/19 CHIEF EXECUTIVE'S REPORT

DL presented the report and advised, following cessation of purdah, that Fit For The Future (FFTF) activities would resume with recruitment now underway for the Citizens' Jury on 20 January 2020.

DL commended MH and his team for the magnitude of benefits realised through the Electronic Patient Record (EPR) and the pace at which they had been delivered. The Chair seconded this and advised the

presentation to the Council of Governors had reinforced the benefit of contact with patients and how EPR was changing the way in which we work and improving care i.e. reduced call bells and falls. The Chair would formally thank MH and the team for this work. **ACTION.** **PL**

DL updated that the Staff Awards had been a success, with the recognition of Sandra Attwood being a particular highlight. DL recorded thanks to Kate Jeal for leading the work on the awards.

DL reported that the Board had held a very successful session with Professor Michael West looking to at compassion and behaviours and further work would take place following this.

The inaugural BAME conference had taken place and a number of issues had been raised by BAME staff present which the Diversity Network were committed to taking forward. DL recorded her thanks to senior nurse Coral Boston for organising the event.

RESOLVED: The Board NOTED the Chief Executive's report.

250/19 TRUST RISK REGISTER

EW presented the paper and updated on the risks outlined.

Risk C2719COO relating to safety within the GRH Tower Block, as a result of fire training and equipment not being in place, had been added due to having a consequence score of five. Plans were in place to ensure key performance indicators were being met which would further reduce the likelihood score.

One patient experience risk had been upgraded (consequence increased from three to four) related to overcrowding in Emergency Departments (ED). The Chair sought details on the mitigation plans and it was reported that a business case had been supported to provide an additional 50 staff in ED, extend the hours of the AMIA to divert 24 patients per day, provide additional nursing resource in AMU and open a ward at CGH in early January. Discussion took place on needs and privacy of patients cared for in corridors and it was confirmed that privacy and dignity screens were available (following Tiff Cairns patient story at a previous meeting).

No risks were downgraded or closed but since the paper had been written, the Care Quality Commission (CQC) had discharged an improvement notice related to radiation safety and the resultant risk was expected to reduce.

RESOLVED: The Board NOTED the Trust Risk Register report.

QUALITY AND PERFORMANCE

251/19 ASSURANCE REPORT OF THE CHAIR OF QUALITY AND PERFORMANCE COMMITTEE HELD ON 27 NOVEMBER 2019

The Board were reminded that the December meeting had been brought forward and was held the previous day. There were no questions on the Chair's report from 27 November 2019.

RESOLVED: The Board RECEIVED the report as assurance of the

scrutiny and challenge undertaken by the Committee.

252/19 QUALITY AND PERFORMANCE REPORT

MP and SH presented the report. It was explained that the Summary Hospital Mortality Indictor (SHMI) had been incorrectly shown as "Red" when in fact it was "Green".

SH reported that reporting via Statistical Process Control (SPC) charts had commenced at Quality & Performance Committee and been positively received. The Board would start to get this information from January 2020. The charts would show six data points although it was explained that there were no formal threshold or metrics for the Board or Committee to consider a need to act, instead this would be remain a judgement call to act when appropriate. SH confirmed that there would be dual running of the reporting for a while. DL asked for further thought be given to the threshold issue, linked to the Board's risk appetite.

RESOLVED: The Board NOTED the Quality and Performance report.

253/19 LEARNING FROM DEATHS QUARTERLY REPORT

MP presented the report which updated on learning from deaths and serious incidents and outlined changes to the medical examiner process. No areas of overt concern were identified.

SH advised the Gloucestershire Learning from Deaths of those with a Learning Disability ("LeDeR") had been discussed in detail at Quality & Performance Committee the previous day. MP confirmed a Structured Judgement Review (SJR) process, led by the Clinical Commissioning Group (CCG), took place for all deaths of hospital and community deaths of patients with learning disabilities. This could often take up to six to 18 months after the death and there was a need for more effective partnership working across the county to improve this and align the LeDeR process to the Trust's process to review all deaths. MP would lead on this work. **ACTION.** **MP**

RESOLVED: The Board NOTED the Learning from Deaths Quarterly Report and the Gloucestershire LeDeR report.

254/19 QUALITY STRATEGY

SH presented the item and confirmed that following wide and extensive engagement, the Quality Strategy had been reviewed by the Quality and Performance Committee in October 2019 and was being presented for approval by the Board. SH recorded thanks to all colleagues involved in the development and creation of the Strategy. It was noted that the strategy was aligned to the National Patient Safety Agency (NPSA) strategy.

It was recognised that regularly reviewing the strategy would help to keep live as could be seen through with the People and Organisational Development Strategy.

SH reported that the Quality Account had been reviewed alongside the Strategy and preparations were being finalised to present this to governors. It was noted that the governors had been vocal on the selection of indicators for the Quality Account and it was important to get

this right.

DL and PL noted that the selection process for the Governors' Quality Indicator had not gone well for two consecutive years and asked for attention to be given to this earlier than in previous years, to avoid a repetition. **ACTION.** **SH**

RESOLVED: The Board APPROVED the Quality Strategy.

FINANCE AND DIGITAL

255/19 ASSURANCE REPORT OF THE CHAIR OF FINANCE AND DIGITAL COMMITTEE HELD ON 28 NOVEMBER 2019

BH presented on behalf of RG and highlighted the focus and discussion on the following topics; Electronic Patient Record (EPR), detailed review on Month 7 income, Cost Improvement Plans were better than planned and cash balances were high and reasons understood. The Committee had also received assurance that Q3 position was on plan and Q4 was under review but looking more positive than previously. The Chair added that he had attended the meeting earlier in the day and scrutiny and challenged applied gave powerful assurance to the Board.

RESOLVED: The Board RECEIVED the report as assurance of the scrutiny and challenge undertaken by the Committee.

256/19 FINANCIAL PERFORMANCE REPORT

JS presented the paper and highlighted that Month 7 was showing a £9.1m deficit (£700k favourable to plan) with, as stated above, CIP also ahead of plan (with an increase required in the second half of the year) and the cash position very favourable at £23m. The Board heard that work to close the gap in Q4 continued to take place and there was a commitment to deliver the agreed control total for the Trust.

The Chair reinforced this message and explained the report from December 2019 Committee presented to January 2020 Board would provide this assurance of actions to achieve the control total.

RESOLVED: The Board NOTED the report as a source of assurance.

ESTATES AND FACILITIES

257/19 ASSURANCE REPORT OF THE CHAIR OF THE ESTATES AND FACILITIES COMMITTEE HELD ON 11 NOVEMBER 2019

The Chair presented the report of MN. The key discussion areas were highlighted as cleaning (in particular working to improve clarity of use of audit and standards) and the very helpful review of 1:200 scale plans for the Strategic Site Development.

RESOLVED: The Board RECEIVED the report as assurance of the scrutiny and challenge undertaken by the Committee.

AUDIT AND ASSURANCE

258/19 ASSURANCE REPORT OF THE CHAIR OF THE AUDIT AND ASSURANCE COMMITTEE HELD ON 19 NOVEMBER 2019

RESOLVED: The Board RECEIVED the report as assurance of the scrutiny and challenge undertaken by the Committee.

259/19 WINTER PLAN

Alison McGirr, Director of Unscheduled Care & Medicine and Deputy Chief Operating Officer joined for this item.

AMc presented the paper on behalf of RDC and updated on the work that had taken place since the first draft of the plan in August 2019. It was confirmed that the Clinical Decision Unit (CDU) would not be considered until the next financial year although other solutions has been worked up instead such as the elective ward in Orthopaedics at CGH providing 13 beds for a three month period for those with a delayed discharge from hospital.

A winter summit had taken place in October and November to consider activity and demand and determine best areas for investment to improve patient flow. Staffing in the Emergency Department (ED) would be bolstered and admission avoidance, through AMIA, was identified as a key area.

It was reported that patients with flu-like symptoms were starting to present and MP confirmed that it was expected cases would increase at this time of year. SH explained that Norovirus had occurred earlier than usual and continued to affect beds.

EWa asked whether AM had any concerns with parts of the plan and she responded that the issues remained the risk of poor discharge processes and a failure to challenge and prevent admissions that could be avoided. AM also added staff fatigue as a concern, in light of winter pressures having started early leading to more frail and complex patients having greater lengths of stay. SH confirmed that MP, RDC and he had visited teams to speak to them and assure them that the Executives and Senior Leadership Team were available to support them.

AMc updated on work to revise the Escalation Policy and MP added that, in his third winter at the Trust, he could see learning was better each year and that planning for extra capacity in advance had been beneficial and allowed response to issues arising much sooner i.e. Norovirus, AMIA funding etc.

RESOLVED: The Board APPROVED the Trust Winter Plan 2019/20 and NOTED further updates would be presented to the Quality & Performance Committee.

260/19 WEST OF ENGLAND PATHOLOGY NETWORK STRATEGIC OUTLINE CASE

DL restated her declaration of interest as Chair of the Network and SL presented the paper which seeks approval for the Strategic Outline Case (SOC) and investment to develop the Outline Business Case (OBC). Two of the six organisations had approved this to date.

Part of the work to develop the OBC will include validation of the proposed NHSI savings and evidence of the additional benefits associated with consolidation given a number had already been achieved without this step through closer working e.g. the Managed Service Contract Shared Procurement. DL alerted the Board that the OBC would not proceed to Full Business Case (FBC) if appropriate assurance and evidence cannot be obtained on the benefits i.e. it would not be "change for changes sake".

In response to a question from EWa on the process to be followed if all six organisations failed to obtain approval for the SOC, DL explained that depending on which organisations declined to support, it would be revisited but advised that all were expected to support the SOC.

It was noted that the process would take about six months with a further paper to be scheduled for the September or October Board. **ACTION.** **SL/SF**

RESOLVED: The Board supported the recommendations in the paper and;

- APPROVED the SOC.
- Confirmed SUPPORT for the development of the three shortlisted options into an OBC, noting this requires GHFT to commit £19,871 over FY 2019/20 and 2020/21.
- APPROVED the MoU, which sets out the basis on which the network organisations will work together to develop the OBC.

261/19 QUARTERLY GUARDIAN REPORT ON SAFE WORKING HOURS FOR DOCTORS AND DENTISTS IN TRAINING

Dr Simon Pirie, Guardian for Safe Working joined for this item.

SP presented the report and the Board noted a reduction in the number of exception reports logged (104 down from 132) and that there had been no fines, or any correlation with Datix clinical incident reports, during the period.

SP highlighted changes to rotas in Emergency Departments and Paediatrics, setting a maximum frequency of one in three for on-call and the Estates and Facilities Charter as positive actions in this area. The Junior Doctor forum was meeting bi-monthly with rotation between sites which also worked very well.

EWa challenged whether there were known exceptions not being reported and SP explained there was a reliance on the individual trainee having the mind-set to report, but regular induction sessions reinforced the importance of doing so and the role of the Guardian. Consultants were also reminded of the importance of creating a culture where juniors did not worry about repercussions from reporting.

SH explained there was cross-over with other work taking place in the Trust on the importance of rest and a meeting was planned for January 2020 to align these workstreams. DL endorsed this and reinforced the importance of reporting to provide the insight and identify areas for change.

BH queried whether there was any correlation between reporting levels

and performance in particular areas. MP stated there was no formal linkage.

DL cited an example provided in a board development session with Professor Michael West on compassionate care, where a junior doctor had resigned from another Trust due to being unable to change a rota for their wedding and asked whether these were issues affecting the Trust as she had seen a similar scenario play out over social media involving a GRH trainee, where she had had to intervene. SP reported there had been some issues historically although things had improved considerably now, particularly in Medicine, through rota meetings although trainees who were less than full time had some complexities due to the way in which they moved about. MP flagged that giving junior doctors autonomy to set their own rotas was immensely powerful.

RESOLVED: The Board NOTED the report and that special notice should be taken of the new Doctor's contract and the BMA Fatigue and Facilities charter, which would likely impact on work schedules. The Trust would need to closely monitor the reporting of missed breaks, which is currently minimal and unlikely to be reflective of current practice.

262/19 THE BIG GREEN CONVERSATION

SH presented the item on behalf on many colleagues and staff and highlighted the effect of climate change on public health and that 5.4% of UK emissions related to healthcare. The NHS Long Term Plan reinforced the important role the NHS plays in tackling climate change. The Board were asked to consider becoming the fifth Trust in the UK to declare a "climate emergency" and commit to public and collaborative action with partners to reduce emissions and deliver a net carbon neutral position for the Trust by 2050.

Although it was remarked that 2050 seems some way off, discussion took place on the good progress being made by Gloucestershire County Council (GCC) to deliver an 80% reduction by 2030 and what the consequences of declaring a *climate emergency* were for the Trust and the need to set and drive the culture to from the top.

DL explained that this linked to the strategic objectives and that there would be a need for some investment. GCC had provided assistance and support to help develop Trust plans and there had been 105 ideas from staff which would lead to carbon reduction and cost savings. A "green" cost improvement work stream was being considered to help realise these gains by committing to a reinvestment of a proportion of the savings into carbon reduction initiatives.

Following further discussion, the Chair stated that from conversations with colleagues, he was assured that this was recognised as a serious issue and the Trust was not taking this lightly. EWa endorsed the comments and paper although highlighted that prioritisation against other projects would be challenging and require focus. The Chair confirmed that both AM and MN had also expressed their support for the recommendations to him.

RESOLVED: The Board APPROVED the recommendations to;

- Declare a 'Climate Emergency'
- Work with partners to identify what measures would be needed to

deliver a stepped target of 80% carbon reduction by 2030
- Pledge for Gloucestershire Hospitals to join civic partners in delivering a net carbon neutral Gloucestershire by 2050.

263/19 MINUTES OF THE COUNCIL OF GOVERNORS HELD ON 16 OCTOBER 2019

RESOLVED: The Board NOTED the Minutes of the Council of Governors' meeting held on 16 October 2019.

264/19 GOVERNOR QUESTIONS

In response to a query from AD on the use of fans in the Trust, it was explained that the use of all fans had been suspended pending removal of fans of a particular model that had caught fire being removed.

AD wished to put on record her thanks and appreciation to all staff involved in the work on Sunrise and the Electronic Patient Record (EPR) and thanked the Board. AT echoed this and reported that the Council of Governors had been briefed on this the previous evening and seen a demonstration of the benefits.

AT welcomed seeing and hearing the human factors training within the Patient Story simulation.

AT thanked both AD and HB for attending the meeting and in his capacity as Lead Governor, formally thanked all staff who attended Governor meetings.

265/19 STAFF QUESTIONS

There were none.

266/19 PUBLIC QUESTIONS

As per Minute 241/19 the Board noted the following public questions from Bren McInerney and responses deferred from the November meeting.

How does the evaluation report on Workforce Race Equality Standard (WRES), see attached, support and enhance the work of the Gloucestershire Hospitals NHS Foundation Trust in implementing the WRES?

Our initial review of the report confirms that the focus on increasing the number of BAME colleagues in leadership positions should be a priority. This is already reflected in our 5-year People & OD Strategy. Specific milestones relating to BAME colleagues are:

- 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
- At least 5% of staff will be in the Accelerated Development pool and there will be a fair representation of diversity and protected characteristics

- Take action to encourage BAME colleagues to participate in organisation and ICS-wide Leadership Development Programmes
- 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

How will the Trust evidence the use of the WRES information has made a meaningful and positive impact to Workforce Race Equality at Gloucestershire Hospitals NHS Foundation Trust?

We can already begin to demonstrate how the WRES data from previous years has informed the actions we have taken to address and reduce inequity in the experience of WRES colleagues. For example, we have:

- Following evidence identified in indicator 2 of the WRES, in 2018 we introduced mandatory unconscious bias training for all lead recruiting managers. In our latest WRES report we observed an improvement in this score. We have continued to mandate Unconscious Bias training for all lead recruiting managers and this year have extended this offer to everyone who attends our senior leadership network (100 Leaders).
- Linked to indicators 1, 2 and 9, this year we have introduced BAME Panellist for job roles which are advertised at band 8a+. We have trained 15 BAME colleagues specifically to participate in interview panels with a focus on Equality and Diversity. A number of these have since participated in the process. Anecdotally the experience and their contributions have been very rich and valuable both for the other panel members and the interviewees. We are now working with our Recruitment team to formalise the process for how BAME panellists are invited to be involved in all 8a+ interview panels.
- Linked to indicator 9, our Executive Board Champion for Race attended a WRES conference earlier this year along with the BAME Lead in our Colleague Diversity Network. All Board members champion at least one of the protected characteristics and the Board will this month undertake a review of who is championing what following a couple of recent departures from the Executive Team.
- Linked to indicators 5, 6 and 8, this autumn we have launched the “Civility Saves Lives” campaign and linked this into a broader engagement with colleagues to identify a new behaviour framework which will be launched later this year alongside our refreshed/condensed values.

We will continue to monitor and review the WRES indicators year on year, and identify trends/movements/stagnation to evaluate the impact of our work and inform the priorities for the future. We will also use WRES to monitor the delivery of the milestones in our People & OD Strategy.

There were no further public questions.

267/19 NEW RISKS IDENTIFIED

There were none.

268/19 ITEMS FOR THE NEXT MEETING

There were none.

269/19 ANY OTHER BUSINESS

There were no items of any other business.

The meeting closed at 17:08.

DATE AND TIME OF THE NEXT MEETING

The next meeting of the main board will take place at 13:00 on Thursday 9 January 2020 in the Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital.

Signed as a true and accurate record:

Chair
19 December 2019

Gloucestershire Hospitals NHS
NHS Foundation Trust

MAIN BOARD (PUBLIC) – MATTERS ARISING

Minute	Action	Owner	Target Date	Update	Status
19 December 2019					
249/19	**Chief Executive's Report:** The Chair would formally thank MH and the team for this work on EPR.	PL	January 2020	Letter of thanks sent to MH and his team.	**CLOSED**
253/19	**Learning From Deaths Quarterly Report:** MP to lead on work to align the LeDeR process to the Trust's process to review all deaths.	MP	March 2020		CLOSED
254/19	**Quality Strategy:** Attention to be given to selction process for Governors' Quality Indicator	SH	February 2020		OPEN
260/19	**West of England Pathology Network Strategic Outline Case (SOC):** Schedule for follow up paper in six to eight months.	SL/SF	September / October 2020	Added to Board work programme for September/October 2020 with reminders to be issued.	CLOSED

TRUST BOARD JANUARY 2020

REPORT OF THE CHIEF EXECUTIVE

1. The Trust

1.1 Firstly a warm welcome from myself to 2020 and a heartfelt thank you to all colleagues who have worked throughout the festive period, many forgoing time with their own family and friends to care for our patients.

1.2 Despite a relatively mild winter so far, demands on health services are more redolent of the peak of colder periods and influenza is on the rise. Attendances at A&E remain high with Gloucestershire reflecting the national picture and greater acuity of need characterising those admitted, meaning longer stays are being experienced and impacting on the flow of patients through our hospitals. Regrettably, A&E waiting time performance has been impacted although, thanks to the efforts of all staff, we continue to perform better than many hospitals. Additionally, I have been personally heartened by the many emails and social media posts reflecting thanks from patients and their families for the quality of care received, often alongside expressions of admiration for the compassion and professionalism of our teams.

1.3 Thanks to additional national funding, we are currently expanding the capacity of our Acute Medical Initial Assessment Unit (AMIA) to enable all patients referred for admission by their GP, to be assessed without the need for long waits in the Emergency Department (ED). This approach has the added benefit of reducing crowding and queuing for those that need ED care whilst also reducing the number of GP referred patients who go on to be admitted following a comprehensive assessment in AMIA.

1.4 With this picture emerging so early in the winter season, there remains a huge focus on staff wellbeing and resilience in all areas across the Trust but especially in those services which are most impacted by these pressures. This includes a review (and enhancement where needed) of staff rest areas and a renewed focus on ensuring staff are supported to take their breaks (and that those breaks are of high quality). Staff morale remains positive and it's clear that the small tokens of appreciation given to staff across the festive period, including free parking, have been very well received.

1.5 A month on from our first phase of roll-out of our Electronic Patient Record (EPR) programme, the signs remain very positive with numerous benefits for staff and patients being reported. Many of these benefits, such as reduced falls and fewer call bells being activated, reflect the increased presence of nursing staff in the ward bays as they undertake electronic note taking on mobile computers, rather than being remotely located at the nurses' station or in offices. Nursing staff have also described the system as intuitive and whilst medical staff are not yet using the system, many are choosing to access it and reporting similar benefits.

1.6 Given the success of the GRH deployment, we will be bringing forward the go-live of nursing documentation at Cheltenham General Hospital and rolling out to these wards in early February. Phase two will commence in early summer with the introduction of electronic observations and, in autumn next year, electronic ordering (and resulting) of diagnostic tests.

1.7 Those involved in the preparation for, and support to, the go-live have worked unrelentingly and a huge debt of gratitude goes to each of them. I had the pleasure of spending time with Mark Hutchinson, Chief Digital & Information Officer and his team celebrating the go-live and it was joyous to see and hear the pride that each and every

member of staff felt as a result of being part of this success. A tweet at the time summed up my feelings when reflecting on just how many different professions make the NHS what it is "*it's not just clinicians who are patient centred #NoSuchThingAsBackOffice*".

1.8 On the 19 December 2019, the Board took the bold step of joining a small number of other NHS organisations in becoming the fifth Trust to declare a *climate emergency*. Our second #BigGreenConversation took place on the 20 December and staff applauded this decision by the Board. Elaine Warwicker, recently appointed Non-executive Director (NED) Sustainability Champion addressed the meeting and shared her passion, experience and ambition for the Trust. Of particular note was a presentation by colleagues from Gloucestershire Managed Services (GMS) who impressed everyone in the room when they shared just how much GMS has already achieved in this area and the exciting plans ahead. Again, of note, was the wide range of staff who attended the meeting and contributed ideas for how we take this increasingly important agenda forward. To mark the occasion, I had the privilege of joining Steve Hams and Elaine Warwicker in a commemorative tree planting outside the Redwood Education Centre. This important agenda will now be overseen by the Board's Estates and Facilities Committee, under the chairmanship of Mike Napier, NED.

1.9 The Trust has joined the County Council and other health partners in funding a joint appointment to oversee the strategic coordination and communication in relation to sustainability. Exciting times!

1.10 This month sees more "comings and goings" in the senior finance team as the Board welcomes Karen Johnson to her first official board meeting as the Trust's new Director of Finance. Sadly, it is also Jonathan Shuter's last week in the Trust before he heads home to work in his local Trust, Leicestershire Royal Infirmary. Jonathan has made a huge contribution to operational finance since he joined the Trust two years ago and we wish him well in his next venture.

1.11 Looking ahead to 2020, it is set to be another exciting year filled with challenges and opportunities which we are determined to rise to and seize. Our strategic objectives provide a clear focus for the whole organisation on our future priorities and the ongoing work to finalise the Trust's values and, most importantly, our individual and collective behaviours, provides a compelling context for us all. We can expect a number of landmarks in 2020 which include;

- Consulting upon and finalising our long-term clinical strategy, designed around our vision for establishing centres of excellence for emergency, planned and cancer care
- A "visit" from the Care Quality Commission as part of their comprehensive assessment of healthcare providers. *CQC Ready Everyday* remains our mantra.
- Approval of the Full Business Case for our £39.5m strategic capital developments at GRH and CGH enabling us to commence construction later next year.
- Implementation of phase two of our Electronic Patient Record (EPR), releasing time to clinical staff whilst enhancing the safety and reliability of care.
- Launching our Pathway to Excellence (P2E) programme with a renewed focus on fundamentals of nursing care and improved retention & retention of nursing staff.
- Approval of the Full Business Case for phase 1 of our vision for the expanded Gloucestershire Cancer Institute, developing an environment befitting of the quality of care provided by our staff.
- Translating our *climate emergency* declaration into operational planning and decision-making which ensures the Trust delivers its contribution to a net carbon neutral county by 2030.

- Bringing to life the vision of truly integrated health and social care characterised by joint working with our system partners, for the benefit of patients and their families / carers.
- Continuing to improve how we work together and care for each other through our work on equality and diversity, values and behaviours embodied in our commitment to developing a truly compassionate culture throughout the Trust.

2. The System

Given the pause in our *Fit For The Future* programme, the system focus has been on preparing for winter and developing our Long Term Plan (LTP) submission which we are required to submit in final form on the 10 January. The LTP submission continues to challenge all partners, with the system not yet in a position to submit a financially balanced plan or one that delivers all of the national standards. This position is however reflective of many systems nationally and a final update will be provided to the Board meeting on the 9 January 2020.

This month we welcome Dame Gill Morgan as the new Chair of the One Gloucestershire Integrated Care System (ICS). Gill has enjoyed a distinguished career in the NHS and voluntary sector at national, regional and local levels and will be a major asset to the county. Throughout her career, Gill has shown great passion for high quality care, championing the rights and needs of vulnerable individuals and innovation in services and support. She has extensive leadership experience having held a number of senior roles including public health consultant, Chief Executive of North & East Devon Health Authority, Chief Executive of the NHS Confederation, Chair of the Alzheimer's Society and most recently Chair of NHS Providers.

Deborah Lee
Chief Executive Officer

31 December 2019

Gloucestershire Hospitals
NHS Foundation Trust

PUBLIC MAIN BOARD – 9 JANUARY 2020

Report Title
Trust Risk Register
Sponsor and Author(s)
Author: Mary Barnes – Risk Co-ordinator, Andrew Seaton – Quality Improvement & Safety Director Sponsor: Emma Wood, Director of People & OD, Deputy Chief Executive
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 (appendix 1) 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

There are no changes to the Trust Risk Register presented at the December Board meeting as the Trust Leadership Team (TLT) meeting is not due until 8 January 2020. Any updates to the register following this meeting will be presented to the Board on 13 February 2020.

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 NOTE the Trust Risk Register and raise any queries of the Executive.
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). The risk of non-compliance to ER(M)ER.
Equality & Patient Impact
Potential impact on patient care, as described under individual risks on the register.

Resource Implications			
Finance	**X**	Information Management & Technology	X
Human Resources	X	Buildings	**X**

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

Date the paper was presented to previous Committees and/or TLT							
Audit & Assurance Committee	**Finance and digital Committee**	**GMS Committee**	**People and OD Committee**	**Quality & Performance Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
						4 December 2019	Directors Operational Group 27 November 2019; Board 19 December 2019
Outcome of discussion when presented to previous Committees/TLT							
The Board NOTED the Trust Risk Register at the meeting held on 19 December 2019.							

Public Main Board - December 2019
Trust Risk Register as at 5/12/19

Ref	Inherent Risk	Controls in place	Action / Mitigation	How would you assess the status of the controls?	Consequence	Likelihood	Score	Division	Highest Scoring Domain	Executive Lead title	Title of Assurance / Monitoring Committee	Review date	Operational Lead for Risk
F2927	Risk that the Trust does not achieve the required cost improvement resulting in failure to deliver the Financial Recovery Plan for FY20	1. PMO in place to record and monitor the FY20 programme 2. Finance Business Partners to assist budget holders 3. Fortnightly CIP Deep Dives 4. Monthly monitoring and reporting of performance against target 5. Monthly Financial Sustainability Delivery Group 6. Monthly Finance and Digital Committee scrutiny 7. Monthly and Quarterly executive reviews 8. NHSI monitoring through monthly Finance reporting		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	19/12/2019	Stansfield, Sarah
M2473Emer	The risk of poor quality patient experience during periods of overcrowding in the Emergency Department	Identified corridor nurse at GRH for all shifts; ED escalation policy in place to ensure timely escalation internally; Cubicle kept empty to allow patients to have ECG / investigations (GRH); Pre-emptive transfer policy patient safety checklist up to 12 hours Monitoring Privacy & Dignity by Senior nurses	CQC action plan for ED Development of and compliance with 90% recovery plan Winter summit business case	Incomplete	Major (4)	Almost certain - Daily (5)	20	Medical	Quality	Director of Quality / Chief Nurse	Divisional Board, Quality and Performance Committee, Trust Leadership Team	18/12/2019	Blake, Anna
S2275	A risk of sub-optimal surgical staffing caused by a combination of insufficient trainees, senior staff and increased demand resulting in compromised trainee supervision, excessive work patterns and use of agency staff impacting on the ability to run a safe and high quality surgical rotas. Impact of any changes to non-contractual clinical support to services. Impact of any risk through workload leading to deanery withdrawal of trainees.	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. Guardian of Safe working Hours.	Escalation Attempts to recruit 1. Agency/locum cover for on call rotas 2. Nursing staff clerking patients 3. Prioritisation of workload 4. exisiting junior doctors covering gaps where possible 5. consultants acting down 6. Ongoing recruitment for substantive and locum surgeons for rota including international opportunities 7. Health and well being hub will offer greater emotional well being services Launch of Locum's Nest software for advertising and allocating locum shifts	Partially complete	Major (4)	Likely - Weekly (4)	16	Surgical	Workforce	Medical Director	People and OD Committee, Trust Leadership Team	30/12/2019	Taylor, Cassie
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, as a consequence of the Trust's inability to generate and borrow sufficient capital.	1. Board approved, risk assessed capital plan including backlog maintenance items; 2. Prioritisation and allocation of cyclical capital (and contingency capital) via 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 provide oversight for risk management/works prioritisation; 6. Trust Board provide oversight for risk management/works prioritisation; 7. GMS Committee provide oversight for risk management/works prioritisation; 8. Prioritisation of Capital managed through intolerable risk process 2019-20 – Complete 30/4/19 and revisited periodically through Capital contingency funds; 9. On-going escalation to NHSI for Capital Investment requirements – Trust recently awarded Capital Investment for replacement of diagnostic imaging	1. Prioritisation of capital managed through the intolerable risks process for 2019/20 Ongoing escalation to NHSI and system	Partially complete	Major (4)	Likely - Weekly (4)	16	Corporate, Gloucestershire Managed Services	Environmental	Chief Operating officer	Executive Management Team	31/01/2020	Makinde, Akin
			Task and Finish group in situ to review all possible mitigations, meeting weekly										

S3038	A risk of sub-optimal care for emergency surgery patients requiring surgical treatment caused by limited day time access to emergency theatres resulting in increased length of stay and poor patient experience.	2 slots are allocated in GRH to the gynaecology emergencies first thing Regularly negotiate with other specialities to prioritise cases according to clinical need The vascular service in CGH reutilises their elective sessions to compensate for the inadequate emergency list provision	Fit for the Future engagement process re emergency general surgery	Incomplete	Major (4)	Likely - Weekly (4)	16	Surgical	Quality	Medical Director	Trust Leadership Team	30/12/2019	Taylor, Cassie
C3089COOEFD	Risk of failure to achieve the Trust's performance standard for domestic cleaning services due to performance standards not being met by service partner.	1. Domestic Cleaning Services are currently provided by the Service Partner with defined performance standards/KPIs for functional areas in the clinical & non-clinical environment. (NB. Performance Standards/KPIs are agreed Trust standards that marginally deviate from guideline document 'The National Specifications for Cleanliness in the NHS – April 2007'); 2. Cleaning Services are periodically measured via self-audit process and performance is reported against the agreed Performance Standards/KPIs to the Contract Management Group (bi-monthly, every two months); 3. Scope of Cleaning Service currently agreed with the Service Partner includes – Scheduled & Reactive Cleaning, Planned Cleaning, Barrier Cleaning, Deep Cleaning and other Domestic Duties; 4. Provision of an Ad-hoc cleaning service is provided by the Service Partner with defined rectification times for the functional areas; 5. Cleaning activities and schedules are noted as being agreed at local levels (e.g. departmental/ward level) between Trust	Review, Assess and enact agreed future actions/controls	Incomplete	Major (4)	Likely - Weekly (4)	16	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Quality	Akin Makinde	Divisional Board, Trust Leadership Team	31/12/2019	Makinde, Akin
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 6. Audit of picking practice to be undertaken over 2 week period manually	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	13/12/2019	Taylor-Drewe, Felicity
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. Financial Sustainability Delivery Group 5. Quarterly Executive Reviews	Establish Workforce Committee Complete PIDs for each programme Reconfiguring Structures Agency Programme Board recieving detailed plans from nursing medical workforce and operational working groups 1. Convert locum/agency posts to substantive 2. Promote higher utilisation of internal nurse and medical bank 3. Implementation of healthRoster 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	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	19/12/2019	Murrell, Mel

			8. Creation of a health and wellbeing hub aimed at reducing absence and reliance on costly temporary solutions										
C2667NIC	The risk to patient safety and quality of care and/or outcomes as a result of hospital acquired C .difficile infection.	1. Annual programme of infection control in place 2. Annual programme of antimicrobial stewardship in place 3. Action plan to improve cleaning together with GMS	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 envi	Partially complete	Major (4)	Likely - Weekly (4)	16	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Director of Quality and Chief Nurse	Infection Control Committee, Quality and Performance Committee	31/12/2019	Bradley, Craig
C2997RadSafety	The risk of statutory prosecution due to failure to comply with the Ionising Radiation (Medical Exposure) Regulations 2017. Failure to comply the CQC Improvement Notice, specifically the requirement for sufficient written procedures as defined in schedule 2 of IR(ME)R (a)-(n)and a suitable governance structure by 24 October 2019.	1.Radiation Protection Advisors in place to advise specialties 2. Some procedures in place i.e. Radiology (although outdated) 3. Practices in place in specialties 4. Radiation Safety Committee reports to H&S Committee 5. Radiation Safety Policy 6. Radiation Risk Assessments 7. Training packages available for practitioner or operator engaged by the employer to carry out exposures 8. Reviews are undertaken at a local level, to evaluate the reasons why diagnostic reference levels (DRLs)have been consistently exceeded 9. Local practices to protect those of child bearing age 10. Clinical audit programme 11. Information about effects of ionising radiation and education about dose and reporting 12. Dose constraints for research exposures where no direct medical benefit for the individual is expected 13. Guidance for carers and comforters 14. Clinical evaluation of the outcome of each exposure, other than exposures to carers and comforters, is recorded. 15. Audit records (for some specialties only) 16. Written instructions and information in cases where radioactive substances are administered	Weekly update calls with Emma Wood Set up task and finish group Review governance for radiation safety Increase the frequency of the Radiation Safety Committee. Chair to pass to Mark Pietroni Run briefing session for Risk Managers and Workshops for Radiation Leads To produce a suitable quality set of IRMER Procedures and SOPs To produce a suitable set of IRMER procedures and SOPs	Partially complete	Major (4)	Likely - Weekly (4)	16	Corporate, Diagnostics and Specialties, Medical, Surgical	Statutory	Medical director	Other, People and OD Committee, Radiation Safety Board, Trust Health and Safety Committee	06/01/2020	Dix, Tony
S2930	A risk to patient safety caused by insufficient senior surgical cover resulting in delayed senior assessment and delays to urgent treatment for patients.	Criteria of patients suitable for transfer to SAU is in place (e.g. NEWS < 2 and specific conditions described in SOP that are suitable for SAU) Limited (one wte) ANP cover for SAU with a plan in place for training of additional ANPs. Current cover (1) Medical: team cover admissions and operating theatre (reducing availability of senior decision makers when they are operating). Consultant 24/7, Specialty trainee (registrar) 24/7, CT (sho) 08:00-00:00, F1 24/7 (2) ANP: 1 wte 37.5 hours/week (3) Nursing: SAU coordinator (band 5/6) 3 trained and 3 HCA (3/2 overnight). Minimum of 1 trained and 1 HCA cover SAU chair area (Bay C) Discretionary informal mitigations by our medical staff include reviewing and operating on emergency patients in the evening, taking emergency patients to elective lists in the event of elective cancellations / DNA's / under-running lists, second Saturday ward round which is unfunded and not job planned, flexibility from juniors in the event of rota gaps	Transformation Delivery Group Risk to be discussed at Surgical Board Fit for the Future engagement process re emergency general surgery Task and Finish group in situ to review all possible mitigations, meeting weekly	Incomplete	Moderate (3)	Almost certain - Daily (5)	15	Surgical	Quality	Director of Safety and Medical Director	Trust Leadership Team	30/12/2019	Taylor, Cassie

S3035	A risk to safe service provision caused by an inability to provide an appropriate training environment leading to poor trainee feedback which could result in a reduction in trainee allocation impacting further on workforce and safety of care	Current service configuration does not lend itself to creating an environment for improved training and therefore the risk of poor feedback and the associated implications are not mitigated.	Fit for the Future engagement process re emergency general surgery Task and Finish group in situ to review all possible mitigations, meeting weekly	Incomplete	Catastrophic (5)	Possible - Monthly (3)	15	Surgical	Workforce	Medical Director	Divisional Board	30/12/2019	Taylor, Cassie
S3036	A risk of sub-optimal care for patients with specialist care and other sub-specialty conditions caused by a lack of ability to create sub-specialty rotas resulting in inequitable care and different clinical outcomes	An upper GI surgeon is the on call surgeon approximately 50% of the time so patients admitted with gallbladder disease when this is the case do get this optimal treatment. In the event of UGI elective theatre cases being cancelled or DNA emergency gallbladder disease cases may be operated on due to unexpected surgeon availability.	Lap Chole Pathway Mapping workshop	Incomplete	Moderate (3)	Almost certain - Daily (5)	15	Surgical	Quality	Medical Director	Divisional Board	30/12/2019	Taylor, Cassie
C1798COO	The risk of delayed follow up care due outpatient capacity constraints all specialities. (Orthodontics; ENT; Urology; Oral Surgery; Diabetic Medicine; Paediatric Urology; Endocrinology; Cardiology; Paediatric Surgery; Neurology; Colorectal and GI Surgery) Risk to both quality of care through patient experience impact(15)and safety risk associated with delays to treatment(4).	1. Speciality specific review administratively of patients (i.e. clearance of duplicates) (administrative validation) 2. Speciality specific clinical review of patients 3. Utilisation of existing capacity to support long waiting follow up patients 4.Weekly review at Check and Challenge meeting with each service line 5.Do Not Breach DNB (or DNC)functionality within the report for clinical colleagues to use with 'urgent' patients. 6. Use of telephone follow up for patients - where clinically appropriate 7. Additional capacity (non recurrent) for Ophthalmology and ENT specialities to support follow up capacity - completed 8. Review of good practice across Divisions to feed through to corporate approach 9. Review of % over breach report with validated administratively and clinically the values	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 specialiities 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	13/12/2019	Taylor-Drewe, Felicity
C2819N	The risk of serious harm to the deteriorating patient as a consequence of inconsistent use of NEWS2 which may result in the risk of failure to recognise, plan and deliver appropriate urgent care needs	Ongoing education on NEWS2 to nursing, medical staff, AHPs etc o E-learning package o Mandatory training o Induction training o Targeted training to specific staff groups, Band 2, Preceptorship and Resuscitation Study Days o Ward Based Simulation o Acute Care Response Team Feedback to Ward teams o Following up DCC discharges on wards • Use of 2222 calls – these calls are now primarily for deteriorating patients rather than for cardiac arrest patients • Any staff member can refer patients to ACRT 24/7 regardless of the NEWS2 score for that patient • ACRT are able to escalate to any department / specialist clinical team directly • ACRT (depending on seniority and experience) are able to respond and carry out many tasks traditionally undertaken by doctors o ACRT can identify when patient management has apparently been suboptimal and feedback directly to senior clinicians	Monthly Audits of NEWS2. Assessing completeness, accuracy and evidence of escalation. Feeding back to ward teams Development of an Improvement Programme	Complete	Major (4)	Possible - Monthly (3)	12	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Director of Quality and Chief Nurse	Quality and Performance Committee	01/12/2019	King, Ben

M2268Emer	The risk of patient deterioration (Safety) due to lack of capacity leading to ED overcrowding with patients in the corridor	RGN and HCA now identified on every shift to have responsibility for patients in the ambulance assessment corridor. Where possible room 24 to be kept available to rotate patients 9(or identified alternative where 24 occupied) (GRH) 8am - 12mn consultant cover 7/7 (GRH) reviewed by fire officers safety checklist; Escalation to silver/gold on call for extra help should the department require to overflow into the third (radiology) corridor. Silver QI project undertaken to attempt to improve quality of care delivered in corridor inc. fleeced single use blankets and introduction of patient leaflet to allow for patients to access PALS. 90% recovery plan May 2019.	Compliance with 90% recovery plan	Incomplete	Moderate (3)	Likely - Weekly (4)	12	Medical	Safety	Director of Quality and Chief Nurse	Divisional Board, Trust Leadership Team	30/12/2019	Cairns, Tiffany
C3034N	The risk of patient deterioration, poor patient experience, poor compliance with standard operating procedures (high reliability)and reduce patient flow as a result of high registered nurse vacancies within adult inpatient areas at Gloucestershire Royal Hospital and Cheltenham General Hospital.	1. Temporary Staffing Service on site 7 days per week. 2. Twice daily staffing calls to identify shortfalls at 9am and 3pm between Divisional Matron and Temporary Staffing team. 3. Out of hours senior nurse covers Director of Nursing on call for support to all wards and departments and approval of agency staffing shifts. 4. Band 7 cover across both sites on Saturday and Sunday to manage staffing and escalate concerns. 5. Safe care live completed across wards 3 times daily shift by shift of ward acuity and dependency, reviewed shift by shift by divisional senior nurses. 6. Master Vendor Agreement for Agency Nurses with agreed KPI's relating to quality standards. 7. Facilitated approach to identifying poor performance of Bank and Agency workers as detailed in Temporary Staffing Procedure. 8. Long lines of agency approved for areas with known long term vacancies to provide consistency, continuity in workers supplied. 9. Robust approach to induction of temporary staffing with all Bank and Agency nurses required to complete a Trust local Induction within first 2 shifts worked. 10. Regular Monitoring of Nursing Metrics to identify any areas of concern.	To review and update relevant retention policies Set up career guidance clinics for nursing staff Review and update GHT job opportunities website Support staff wellbing and staff engagment Assist with implementing RePAIR priorities for GHFT and the wider ICS Devise an action plan for NHSi Retention programme - cohort 5 Trustwide support and Implementation of BAME agenda Devise a strategy for international recruitment	Incomplete	Moderate (3)	Likely - Weekly (4)	12	Medical, Surgical	Safety	Director of Quality and Chief Nurse	Quality and Performance Committee	31/12/2019	Webster, Carole
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. 5. Trustwide rapid learning from the most serious pressure ulcers, RCAs completed within 72 hours and reviewed at the weekly Preventing Harm Improvement Hub.	1. To create a rolling action plan to reduce pressure ulcers 2. Amend RCSA for presure 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 collabborative work in 2018 to support evidence based care provision and idea sharing Discuss DoC letter with Head of patient investigations Advise purchase of mirrors within Division to aid visibility of pressure ulcers update TVN link nurse list and clarify roles and responsibilities implement rolling programme of lunchtime teaching sessions on core topics	Incomplete	Moderate (3)	Likely - Weekly (4)	12	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Director of Quality and Chief Nurse	Quality and Performance Committee	31/12/2019	Bradley, Craig

			TVN team to audit and validate waterlow scores on Prescott ward										
C2669N	The risk of harm to patients as a result 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	4. Discussion with Matrons on 2 ward to trial process 1. Falls training 2. HCA specialist training 3. #Litle things matter campaign 4. Discussion with matrons on 2 wards to trial process	Partially complete	Major (4)	Possible - Monthly (3)	12	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Chief Nurse/ Quality Lead	Quality and Performance Committee, Trust Leadership Team	31/12/2019	Bradley, Craig
C2719COO	The risk of compromised safety of our patients and staff within the Tower building in the event of a fire if training and equipment is not in place.	- evacuation exercise was completed in July 2018. - Firesafety committee reinstated Training needs and equipment needs identified Training programme now launched to include drills , education standardising documentation for all areas walkabouts arranged with fire officer -Site team prioritised Consistent messaging cascaded at the site meeting for training and compliance.	Monitoring and ensure all areas received the approrpaite training and drills to evaucate patients safely	Partially complete	Catastrophic (5)	Rare - Less than annually (1)	5	Corporate, Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Chief Operating O fficer	Audit and Assurance Committee, Trust Leadership Team	02/01/2020	McGirr, Alison
C2817COO	Risk of fire in Tower Block ward ducts/vents due to build up of dust over many years. Wards needs to be empty for 24 hrs to clean ducts	Fire dampers are installed and tested annually by GMS. Ward 9A cleaning complete. Tender for remedial works complete and available to call off. GMS minimise risk of spark or electrical failure within ductwork through control of works and lack of electrical installations in ductwork. Kit being ordered	Duct cleaning only possible when ward is fully decanted. Implement ward closure programe to provide access to undertake the works. Ward 3B being assessed for ability to undertake works this Summer	Incomplete	Catastrophic (5)	Rare - Less than annually (1)	5	Corporate, Gloucestershire Managed Services	Safety	Chief Operating officer	Divisional Board, Executive Management Team	05/12/2019	Minett, Rachel

Gloucestershire Hospitals NHS
NHS Foundation Trust

TRUST BOARD – 9 JANUARY 2020

Report Title
QUALITY AND PERFORMANCE REPORT
Sponsor and Author(s)
Author: Felicity Taylor-Drewe, Director Planned Care / Deputy COO Sponsor: Rachael De Caux, Chief Operating Officer
Executive Summary

Purpose

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

The Quality and Performance (Q&P) committee receives the Quality Performance Report (QPR) on a monthly basis. The supporting exception reports from Quality; Emergency Care; Cancer and Planned Care Delivery Groups support the areas of performance concerns.

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.

Quality Summits
Hospital Acquired Pressure Ulcers (HAPU)
The new Electronic Patient Record (EPR) digital system was launched at GRH is now capturing HAPU risk assessments and actions in response to risk assessments. Analysis of the new EPR data will be completed and the improvement plan developed further.
Actions for improvement
- All hospital acquired pressure ulcers are reviewed by ward teams to identify learning.
- Medicine and Surgery have plans to respond and reduce pressure ulcers within their clinical areas.

Falls (with injurious harm)
A Learning Report was received by QDG which was the analysis of complaints, incidents and claims. Within the report it was identified that the Medical Division has the highest number of incidents of falls and the recommendations arising from the investigations were :-

1. Lying and standing Blood pressure not completed
2. Lack of reassessment of risk following a fall
3. Competing demands on busy wards where patients are vulnerable to falls
4. Lack of risk assessment
5. Incomplete falls assessment care bundle
6. Delayed initiation of care rounding following admission.

Also our CQUIN for falls demonstrates that more focused work is required in this area as our results showed that of our 101 patient audit we were 28% compliant for all 3 falls preventative actions against a minimum target of 25% (maximum 80%), the remainder failing to fulfil one or more of the actions:

Action 1: 43% did not have a lying or standing blood pressure taken at least once during their stay.
Action 2: 6 out of 8 patients given hypnotics during stay did not have rationale recorded in notes
Action 3: 39% did not have a mobility assessment within 24 hours of admission; 22 (29.7%) received a walking aid within 24 hours out of eligible 74

Action to improve performance:

- As with HAPU the new EPR digital system is now capturing falls risk assessments and actions in response to risk assessments. Analysis of the new EPR data will be completed and the improvement plan developed further.
- Education has continued around the reasons and the importance of recording a lying/standing BP and there is beginning to be a slight increase in recording or a rationale if not being recorded.
- CQUIN lead has spoken with lead Dr for COTE and Stroke who is going to reiterate to other medics about documenting reasons for medication prescribing.
- Work is continuing with the therapists providing a mobility assessment within 24 hours/providing walking aid - and documenting this.

Performance

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

In November 2019, the trust performance against the 4hr A&E standard was 76.2% including system performance was 83.41%, November saw a 6.8% increase in attendances. A separate winter plan has been developed and shared with system partners.

In respect of RTT, we are reporting 80.03% for November 2019, whilst this is below the national standard, this is above the trajectory set with NHS I. 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, the teams are working to meet the trajectory of 0 breaches by the end of the financial year. Further information is provided within the exception report for specific speciality actions. The Trust is currently achieving the trajectory agreed with NHS Improvement to reduce our long waiting patient breaches.

Our performance against the cancer standard saw delivery in delivery for the 2 week standard at 94.6% (un-validated) for November. Indications are that performance for December will continue to be met for this standard.

The existing Cancer Delivery Plan which identifies specific actions by tumour site to deliver recovery is monitored monthly. As las month, one tumour site (urology) continues to demonstrably impact the aggregate position with significant number of 62 day breaches. A Task and Finish group to support the prostate pathway in particular diagnostic support has been convened, with COO intervention. The Trust have secured support from NHS I to review tumour site pathways, this continues to support our preparedness for future delivery of 28 day next year.

Cancer 62 day Referral to Treatment (GP referral) performance for November was 61.8% (un-validated).

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.

<u>Key issues to note</u>

December's reporting is early and some of the data is subject to validation, this is indicated within the main report.
The focus of operational teams is on delivery against the constitutional targets with particular regard to our longest waiting patients in RTT & Cancer pathways. The focus is also to deliver sustainably against the 62 day trajectory and A&E performance.

RTT performance has been sustained above the agreed trajectory and additionally has remained stable since re-reporting in March, likewise the number of 52 week waiting patients, albeit unacceptable has maintained a downward trajectory and is within the locally agreed trajectory.
Diagnostic 6 week wait continues to deliver to the national performance standards.
For Cancer Delivery we have engaged the support of NHS I to facilitate our timed pathways and prepare for the 28 day standards. The key intervention will be our diagnostic support to change the Prostate Pathway which is commencing in December and so will track through to Q4 performance.

Quality delivery (with the exception of those areas discussed) remains stable, with exception reporting from divisions through QDG for monitoring and assurance.

Recommendations

The Trust Board is requested to receive the Report as assurance that the Executive team and Divisions fully understand the current levels of non-delivery against performance standards 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

Non delivery of 52 week waiting patients subject to National fining regime.

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	People & OD Committee	Remuneration Committee	Trust Leadership Team	Other (specify)
18 Dec 19						

Outcome of discussion when presented to previous Committees

The Committee NOTED the report.

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report

Reporting period November 2019

Presented at December 2019 Q&P and January 2020 Trust Board

Contents

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 November the Trust did not meet the national standards for 62 day cancer standard and the 4 hour standard.

The Trust performance (type 1) for the 4 hour standard in November was 76.24% against the STP trajectory at 86.04% against a backdrop of significant attendances. The system did not meet the delivery of 90% for the system in November, at 83.41%.

The Trust has not met the diagnostics standard for November at 1.06%, this is as yet un-validated performance at the time of the report.

The Trust has met the standard for 2 week wait cancer at 94.6% in November, 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 RTT performance is above trajectory agreed with NHS I, work continues to ensure that the performance is stabilised. Significant work is underway to reduce our longest waiting patients of over 52 weeks, to date we have met the trajectory agreed with NHS I to reduce our breaches.

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 for 2019/20.
RAG Rating: The STP indicators are assessed against the monthly trajectories agreed with NHS Improvement.
Note that data is subject to change.

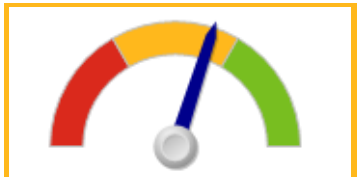
Indicator		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Count of handover delays 30-60 minutes	Trajectory	52	50	48	46	43	40	40	40	40	40	40	40
	Actual	57	53	42	50	77	96	145	120				
Count of handover delays 60+ minutes	Trajectory	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	0	0	0	0	0	1	3	1				
ED: % total time in department – under 4 hours (types 1 & 3)	Trajectory	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
	Actual	90.39%	91.70%	91.05%	92.20%	92.01%	89.13%	86.36%	83.41%				
ED: % total time in department – under 4 hours (type 1)	Trajectory	85.32%	85.37%	85.17%	85.90%	85.22%	85.61%	85.89%	86.04%	85.99%	86.19%	85.36%	85.79%
	Actual	86.01%	87.99%	86.80%	88.53%	88.16%	84.03%	80.58%	76.24%				
Referral to treatment ongoing pathways under 18 weeks (%)	Trajectory	78.00%	78.00%	78.00%	78.30%	78.60%	79.00%	79.30%	79.60%	80.00%	80.30%	80.60%	81.00%
	Actual	79.46%	80.63%	81.11%	81.80%	81.41%	81.38%	81.33%	80.18%				
Referral to treatment ongoing pathways over 52 weeks (number)	Trajectory	95	93	90	86	83	80	74	67	60	40	20	0
	Actual	93	91	90	78	77	78	62	46				
% waiting for diagnostics 6 week wait and over (15 key tests)	Trajectory	0.98%	0.98%	0.99%	0.99%	0.98%	0.99%	0.98%	0.99%	0.98%	0.98%	0.98%	0.98%
	Actual	0.54%	0.67%	1.08%	0.76%	0.84%	0.72%	0.66%	1.06%				
Cancer – urgent referrals seen in under 2 weeks from GP	Trajectory	93.00%	93.00%	93.00%	93.00%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%
	Actual	87.90%	86.50%	89.40%	92.70%	86.00%	96.50%	94.10%	94.60%				
2 week wait breast symptomatic referrals	Trajectory	93.10%	93.20%	93.20%	93.30%	93.3%	93.0%	93.0%	93.1%	93.2%	93.2%	93.2%	93.2%
	Actual	96.90%	97.30%	99.00%	96.30%	98.40%	99.30%	98.10%	96.10%				
Cancer – 31 day diagnosis to treatment (first treatments)	Trajectory	96.10%	96.20%	96.20%	96.20%	96.2%	96.1%	96.1%	96.1%	96.2%	96.2%	96.2%	96.2%
	Actual	92.00%	92.90%	93.50%	92.60%	92.40%	91.30%	98.00%	92.50%				
Cancer – 31 day diagnosis to treatment (subsequent – drug)	Trajectory	98.10%	98.30%	98.20%	98.90%	98.1%	98.00%	99.0%	98.0%	98.9%	98.0%	98.0%	98.0%
	Actual	100.00%	96.20%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%				
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	Trajectory	94.90%	94.40%	94.80%	94.30%	94.0%	95.10%	95.1%	95.1%	95.1%	95.1%	95.1%	95.1%
	Actual	96.40%	97.50%	96.30%	100.00%	83.70%	80.80%	98.80%	95.20%				
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	Trajectory	94.00%	95.50%	95.30%	94.80%	94.4%	95.10%	95.5%	95.4%	95.6%	94.8%	94.8%	94.8%
	Actual	94.00%	95.10%	100.00%	89.60%	89.40%	97.50%	100.00%	97.70%				
Cancer 62 day referral to treatment (screenings)	Trajectory	90.30%	90.90%	91.70%	90.90%	91.4%	91.70%	91.4%	91.4%	92.3%	90.6%	90.6%	90.6%
	Actual	100.00%	96.60%	85.20%	84.60%	100.00%	100.00%	94.50%	96.80%				
Cancer 62 day referral to treatment (upgrades)	Trajectory	100.00%	100.00%	100.00%	100.00%	100%	100.00%	100%	100%	100%	100%	100%	100%
	Actual	44.40%	57.10%	70.60%	100.00%	83.30%	71.40%	71.40%	100.00%				
Cancer 62 day referral to treatment (urgent GP referral)	Trajectory	81.80%	82.30%	82.40%	82.60%	84.3%	85.00%	85.2%	85.0%	85.0%	85.1%	85.0%	85.0%
	Actual	79.70%	70.70%	66.50%	71.70%	72.90%	70.70%	73.90%	61.80%				

Summary Scorecard

NHS
Gloucestershire Hospitals
NHS Foundation Trust

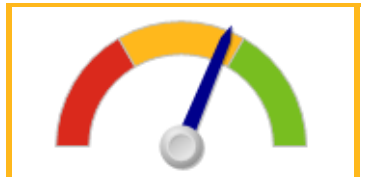
The following table shows the Trust's current monthly performance against the chosen lead indicators within the Trust Scorecard.

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.

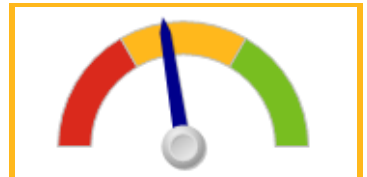


Safe
% of adult inpatients who have received a VTE risk assessment
Number of never events reported
Number of trust apportioned Clostridium difficile cases per month
Number of trust apportioned MRSA bacteraemia
Safety thermometer – % of new harms

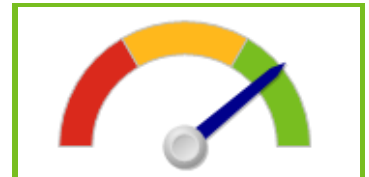
Effective
% C-section rate (planned and emergency)
Emergency re-admissions within 30 days following an elective or emergency spell
Hospital standardised mortality ratio (HSMR)
Hospital standardised mortality ratio (HSMR) – weekend



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:

1) The same month in the previous year
2) The same year to date (YTD) period in the previous year

Measure	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	% change from previous year Monthly (Nov)	YTD
GP referrals	14,814	11,965	14,521	13,202	14,044	13,094	13,415	12,709	12,061	10,302	10,429	11,836	10,648	-28.12%	-15.67%
OP attendances	14,707	11,084	14,083	12,474	13,525	12,663	13,025	13,063	13,856	11,850	13,534	14,545	13,379	-9.03%	-1.88%
Day cases	6,766	5,833	6,167	5,995	6,318	5,815	6,520	6,198	6,955	6,348	6,276	7,142	6,578	-2.78%	6.57%
All electives	7,877	6,837	7,124	6,955	7,465	7,255	7,556	7,213	8,096	7,378	7,238	8,275	7,690	-2.37%	5.83%
ED attendances	12,230	12,639	12,962	11,701	13,245	12,949	13,618	13,072	14,066	13,267	13,240	13,329	13,066	6.84%	6.46%
Non electives	5,088	5,081	5,132	3,085	4,900	4,696	4,861	4,586	4,802	4,698	4,833	5,083	4,837	-4.93%	0.6%

Trust Scorecard – Safe (1)

OVERALL SCORE

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

	18/19	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	19/20 Q2	19/20	Standard	Threshold
Infection Control																		
Number of trust apportioned MRSA bacteraemia	1	0	0	0	0	1	0	1	0	0	0	1	0	0	1	2	Zero	
MRSA bacteraemia – infection rate per 100,000 bed days							0	3.5	0	0	0	3.6	0	0	1.2	0.9	Zero	
Number of trust apportioned Clostridium difficile cases per month	56	4	1	6	5	4	7	6	7	10	9	9	11	12	29	72	2019/20: 114	
Number of hospital-onset healthcare-associated Clostridioides difficile cases per month										7	6	1	10	3	14	36	<=5	
Number of community-onset healthcare-associated Clostridioides difficile cases per month										3	4	8	1	9	15	36	<=5	
Clostridium difficile – infection rate per 100,000 bed days							24.7	20.8	25.5	35.7	32.5	32.8	37.9	42.4	33.7	31.5	<30.2	
Number of MSSA bacteraemia cases	164	4	2	25	30	31	0	1	1	4	1	2	2	1	7	12	<=8	
MSSA – infection rate per 100,000 bed days						31		3.5	3.6	14.3	3.6	7.3	6.9	3.5	8.4	5.3	<=12.7	
Number of ecoli cases	295	4	3	39	41	44	5	4	5	1	4	3	2	5	8	29	No target	
Number of pseudomona cases	59	1	0	11	12	12	1	0	0	2	1	0	1	0	3	5	No target	
Number of klebsiella cases	135	3	2	25	28	31	1	3	1	1	3	4	1	1	10	13	No target	
Number of bed days lost due to infection control outbreaks							40	66	83	70	136	0	0	240	206	635	<10	>30
Patient Safety Incidents																		
Number of patient safety alerts outstanding	5						5	1	0	0	0	0	0	0	0	5	Zero	
Number of falls per 1,000 bed days		6.8	7.2	6.8	7.1	6	6.6	6	5.3	6.6	5.5	6.2	6.6	6.4			<=6	
Number of falls resulting in harm (moderate/severe)	8	6	8	8	2	7	3	4	2	7	1	5	7	1			<=3	
Number of patient safety incidents – severe harm (major/death)	1	0	1	0	3	7	13	7	9	4	12	4	7	3			No target	
Medication error resulting in severe harm						0	0	0	0	0	0	0	0	0			No target	
Medication error resulting in moderate harm						1	1	3	0	2	3	1	2	1			No target	
Medication error resulting in low harm						12	10	15	10	11	11	10	21	23			No target	
Number of category 2 pressure ulcers acquired as in-patient							43	36	28	38	36	30	24	31			<=30	
Number of category 3 pressure ulcers acquired as in-patient							10	7	7	6	6	4	4	4			<=5	
Number of category 4 pressure ulcers acquired as in-patient							0	0	0	0	0	0	0	0			Zero	
Number of unstagable pressure ulcers acquired as in-patient							3		3	14	12	5	6	5			<=3	
Number of deep tissue injury pressure ulcers acquired as in-patient						6	10	14	2	8	7	2	3	8			<=5	

Trust Scorecard – Safe (2)

OVERALL SCORE

	18/19	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	19/20 Q2	19/20	Standard	Threshold
RIDDOR																		
Number of RIDDOR		1	4	1	3	3	2	2	1	3	2	1	2	1	6		SPC	
Safeguarding																		
Level 2 safeguarding adult training - e-learning package											93%	93%	94%	95%			TBC	
Number of DoLs applied for													45	36			TBC	
Total number of maternity social concerns forms completed													55	44			TBC	
Safety Thermometer																		
Safety thermometer – % of new harms		97.90%	97.30%	97.30%	97.70%	97.20%	96.20%	97.20%	98.10%	97.40%	97.90%	96.30%	97.30%	95.80%			>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%			64.00%			64.70%					>=90%	<50%
Serious Incidents																		
Number of never events reported	1	0	0	0	0	1	1	0	0	1	0	0	1	0			Zero	
Number of serious incidents reported		1	1	3	0	3	2	3	4	2	1	5	4	3			No target	
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%			>80%	
VTE Prevention																		
% of adult inpatients who have received a VTE risk assessment	93.20%	95.40%	90.70%	96.60%	94.20%	94.80%	95.40%	88.60%	95.80%	96.70%	92.90%	91.60%	95.90%	91.80%	93.80%	93.60%	>95%	

Trust Scorecard – Effective (1)

OVERALL SCORE

	18/19	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	19/20 Q2	19/20	Standard	Threshold
Dementia Screening																		
% of patients who have been screened for dementia (within 72 hours)	1.9%	2.6%	3.3%	1.9%	0.8%	0.6%	0.4%	0.3%	67.0%	66.0%	85.0%	63.0%	62.0%				>=90%	<70%
% of patients who have scored positively on dementia screening tool that then received a dementia diagnostic assessment (within 72 hours)	27.9%	22.2%	26.3%	40.0%	0.0%	33.3%	100.0%	50.0%	0.0%	0.0%	N/A	50.0%	0.0%				>=90%	<70%
% of patients who have received a dementia diagnostic assessment with positive or inconclusive results that were then referred for further diagnostic advice/FU (within 72 hours)	2.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	N/A	N/A	50.0%	N/A				>=90%	<70%
Maternity																		
% C-section rate (planned and emergency)	26.78%					29.71%	28.93%	30.20%	29.19%	32.49%	25.61%	27.99%	25.97%	26.57%	28.83%	28.40%	<=27%	>=30%
% emergency C-section rate	14.13%					16.11%	16.31%	16.73%	15.78%	17.42%	14.02%	16.04%	13.70%	15.77%	15.84%	15.78%	No target	
% of women booked by 12 weeks gestation	89.80%	90.90%	89.60%	89.80%	90.50%	91.50%	89.70%	88.00%	87.90%	89.00%	85.30%	89.60%	91.80%	92.20%	87.70%	89.10%	>90%	
% of women that have an induced labour	29.19%					31.17%	29.13%	27.96%	28.99%	28.38%	26.83%	29.66%	29.04%	29.59%	28.31%	28.69%	<=30%	>33%
% of women smoking at delivery	11.21%	12.18%	12.28%	7.79%	13.05%	10.46%	12.06%	11.22%	11.83%	9.78%	10.16%	9.14%	10.22%	13.63%	9.68%	10.96%	<=14.5%	
% stillbirths as percentage of all pregnancies > 24 weeks	0.26%					0.21%	0.39%	0.00%	0.00%	0.38%	0.20%	0.19%	0.20%	0.43%	0.26%	0.22%	<0.52%	
Mortality																		
Summary hospital mortality indicator (SHMI) – national data	104.7		104.7			104.7	105.4	106.9	107.3							107.3	Dr Foster	
Hospital standardised mortality ratio (HSMR)	94.5	99.1	97.7	97.2	95.2	94.5	96.5	96.8	100.1	98.6	98					98	Dr Foster	
Hospital standardised mortality ratio (HSMR) – weekend	96.8	101.4	99.3	101.3	97.2	96.8	96.9	96.4	97.6	97.9	100.5					100.5	Dr Foster	
Number of inpatient deaths						168	165	159	166	125	124	143	143	152	392	1,177	No target	
Number of deaths of patients with a learning disability						2	4	1	1	2	2	0	0	0	4	10	No target	
Readmissions																		
Emergency re-admissions within 30 days following an elective or emergency spell	6.70%	6.00%	6.90%	6.50%	6.60%	6.30%	7.30%	7.10%	6.50%	6.40%	7.50%	7.20%	6.70%		7.00%	7.00%	<8.25%	>8.75%
Research																		
Research accruals	1,621	96	84	71	81	91	115	119	134	123	103	76	121	101	301		No target	

Trust Scorecard – Effective (2)

OVERALL SCORE

	18/19	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	19/20 Q2	19/20	Standard	Threshold
Stroke Care																		
Stroke care: percentage of patients receiving brain imaging within 1 hour	36.90%	26.60%	31.90%	37.10%	32.70%	22.40%	52.10%	55.30%	43.80%	53.50%	50.60%	48.60%	52.50%	39.40%	51.10%	49.60%	>=50%	<45%
Stroke care: percentage of patients spending 90%+ time on stroke unit	90.80%	87.70%	91.90%	88.70%	84.10%	87.70%	85.70%	96.30%	87.10%	80.90%	98.80%	87.90%	84.50%		88.80%	88.60%	>=80%	<70%
% of patients admitted directly to the stroke unit in 4 hours						51.70%	68.10%	62.70%	62.00%	67.90%	68.40%	62.00%	64.90%	41.40%	66.20%	62.40%	>=80%	<72%
% patients receiving a swallow screen within 4 hours of arrival						70.70%	52.10%	59.20%	63.80%	66.30%	64.90%	69.40%	70.00%	66.20%	66.80%	64.10%	>=90%	<80%
Trauma & Orthopaedics																		
% of fracture neck of femur patients treated within 36 hours	76.00%	70.10%	75.00%	83.90%	85.60%	77.80%	77.00%	81.80%	82.20%	67.10%	46.60%	66.70%	39.60%	56.10%	58.90%	64.20%	>=90%	<80%
% fractured neck of femur patients meeting best practice criteria						77.78%	77.78%	81.82%	80.49%	65.70%	45.21%	66.70%	37.90%	56.06%	57.80%	63.16%	>=65%	<55%

Trust Scorecard – Caring (1)

OVERALL SCORE

	18/19	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	19/20 Q2	19/20	Standard	Threshold
Friends & Family Test																		
Inpatients % positive	91.2%	90.9%	91.5%	91.9%	89.2%	91.5%	89.1%	90.8%	91.6%	90.7%	91.1%	91.5%	90.6%	91.8%	91.1%	90.8%	>=96%	<93%
ED % positive	83.1%	82.7%	81.0%	82.7%	82.8%	82.7%	82.7%	81.9%	85.3%	79.8%	83.3%	82.3%	82.9%	87.9%	81.9%	82.8%	>=84%	<81%
Maternity % positive	96.7%	98.2%	100.0%	100.0%	93.5%	97.5%	96.6%	97.0%	87.1%	96.2%	100.0%	96.9%	100.0%	0.0%	97.9%	96.4%	>=97%	<94%
Outpatients % positive	92.6%	92.5%	92.9%	93.4%	92.5%	93.1%	92.8%	93.2%	92.5%	92.8%	93.2%	92.7%	92.8%	93.8%	92.9%	92.9%	>=94%	<91%
Total % positive	91.2%	91.2%	90.9%	91.9%	90.7%	91.4%	90.6%	91.1%	91.4%	90.7%	91.3%	91.0%	91.1%	92.8%	91.0%	91.1%	>=93%	<90%
Inpatient Questions (Real time)																		
How much information about your condition or treatment or care has been given to you?							71.57%	77.35%	79.55%	79.67%	83.69%	77.40%	83.00%	83.00%		81.00%	>=90%	
Are you involved as much as you want to be in decisions about your care and treatment?						89.66%	94.06%	89.44%	89.65%	90.61%	95.03%	89.66%	93.00%	91.00%		92.00%	>=90%	
Do you feel that you are treated with respect and dignity?						99.32%	93.07%	97.16%	94.26%	96.09%	98.58%	99.32%	98.00%	100.00%		98.00%	>=90%	
Do you feel well looked after by staff treating or caring for you?							96.97%	97.71%	95.37%	98.33%	97.16%	99.31%	99.00%	98.00%		99.00%	>=90%	
Do you get enough help from staff to eat your meals?							95.96%	98.86%	95.93%	97.20%	97.17%	100.00%	100.00%	90.00%		94.00%	>=90%	
In your opinion, how clean is your room or the area that you receive treatment in?							96.88%	95.93%	95.81%	96.45%	96.40%	90.97%	100.00%	98.00%		99.00%	>=90%	
Do you get enough help from staff to wash or keep yourself clean?							96.97%	98.29%	94.74%	98.87%	97.86%	99.32%	100.00%	85.00%		97.00%	>=90%	
MSA																		
Number of breaches of mixed sex accommodation	68	2	6	2	1	3	4	11	18	16	11	9	0	0	36	69	<=10	>=20

Trust Scorecard – Responsive (1)

OVERALL SCORE

	18/19	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	19/20 Q2	19/20	Standard	Threshold
Cancer																		
Cancer – urgent referrals seen in under 2 weeks from GP	90.00%	90.40%	94.30%	92.00%	93.90%	95.20%	87.50%	86.70%	89.50%	92.70%	86.00%	96.50%	94.60%	94.60%	91.70%	91.50%	>=93%	<90%
2 week wait breast symptomatic referrals	95.80%	94.60%	97.70%	95.50%	97.00%	95.60%	96.90%	97.30%	99.00%	96.30%	98.40%	99.30%	98.10%	96.10%	97.80%	97.60%	>=93%	<90%
Cancer – 31 day diagnosis to treatment (first treatments)	94.60%	93.20%	94.20%	92.90%	91.60%	92.10%	92.10%	92.00%	93.80%	92.60%	92.30%	91.00%	98.00%	92.50%	91.70%	92.90%	>=96%	<94%
Cancer – 31 day diagnosis to treatment (subsequent – drug)	99.90%	100%	100%	100%	100%	100%	100%	97.50%	100%	100%	100%	100%	100%	100%	100%	99.50%	>=98%	<96%
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	95.30%	96.80%	92.90%	93.20%	96.60%	96.60%	91.10%	89.10%	96.20%	89.60%	89.80%	97.60%	100.00%	97.70%	92.50%	93.90%	>=94%	<92%
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	99.30%	98.70%	98.60%	100%	98.90%	98.70%	96.40%	97.90%	98.80%	100%	84.80%	80.80%	98.80%	95.20%	89.10%	94.50%	>=94%	<92%
Cancer 62 day referral to treatment (urgent GP referral)	74.80%	78.70%	74.90%	76.80%	66.20%	77.40%	80.10%	71.80%	68.20%	72.70%	75.40%	71.00%	78.00%	61.80%	73.10%	73.50%	>=85%	<80%
Cancer 62 day referral to treatment (screenings)	96.50%	93.80%	100.00%	94.10%	96.40%	100%	100%	96.60%	85.20%	85.20%	100%	100%	96.30%	96.80%	95.30%	94.90%	>=90%	<85%
Cancer 62 day referral to treatment (upgrades)	68.90%	58.80%	70.00%	71.40%	60.00%	77.30%	36.40%	44.40%	63.20%	91.70%	75.00%	66.70%	61.50%	100%	87.50%	66.30%	>=90%	<85%
Number of patients waiting over 104 days with a TCI date	141	13	8	8	8	14	20	15	20	18	13	9	15	12	40	122	Zero	
Number of patients waiting over 104 days without a TCI date	347	37	27	42	37	25	19	30	21	37	32	28	36	22	97	225	<=24	
Diagnostics																		
% waiting for diagnostics 6 week wait and over (15 key tests)	0.45%	0.35%	0.20%	0.67%	0.21%	0.45%	0.54%	0.67%	1.08%	0.76%	0.84%	0.72%	0.66%	1.06%	0.72%	1.06%	<=1%	>2%
The number of planned / surveillance endoscopy patients waiting at month end	726	680	686	639	600	726	835	872	966	770	714	756	756	763	756	763	<=600	
Discharge																		
Number of patients delayed at the end of each month	37	40	34	29	24	43	45	39	18	43	41	35	44	32	35	32	<=38	
Patient discharge summaries sent to GP within 24 hours	50.60%	49.20%	47.30%	51.90%	49.70%	51.10%	56.60%	54.60%	53.20%	57.90%	55.80%	56.50%	58.10%		56.80%	56.10%	>=88%	<75%

Trust Scorecard – Responsive (2)

OVERALL SCORE

	18/19	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	19/20 Q2	19/20	Standard	Threshold
Emergency Department																		
ED: % total time in department – under 4 hours (type 1)	89.60%	91.59%	87.55%	84.46%	86.08%	87.13%	86.01%	87.99%	86.80%	88.53%	88.16%	84.03%	80.58%	76.24%	86.91%	84.62%	>=95%	<90%
ED: % total time in department – under 4 hours (types 1 & 3)	92.78%	93.98%	91.29%	89.02%	90.21%	91.00%	90.39%	91.70%	91.05%	92.20%	92.01%	89.13%	86.36%	83.41%	91.11%	89.41%	>=95%	<90%
ED: % total time in department – under 4 hours CGH	96.40%	96.94%	95.47%	93.70%	95.50%	96.10%	94.66%	96.04%	96.40%	95.44%	96.20%	92.68%	95.54%	90.92%	94.77%	94.53%	>=95%	<90%
ED: % total time in department – under 4 hours GRH	86.20%	89.06%	83.82%	80.10%	81.60%	82.80%	81.89%	84.16%	82.77%	85.09%	84.25%	79.90%	73.72%	69.25%	83.08%	79.17%	>=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	87.40%	89.60%	85.40%	85.20%	83.60%	78.40%	75.80%	78.30%	77.30%	71.30%	75.70%	71.40%	68.40%	66.50%	72.80%	73.10%	>=95%	<92%
ED: % of time to start of treatment – under 60 minutes	33.50%	34.50%	32.10%	34.90%	32.40%	32.60%	32.00%	35.90%	37.20%	30.30%	31.20%	29.90%	28.30%	26.60%	29.90%	31.20%	>=90%	<87%
% of ambulance handovers that are over 30 minutes						7.90%	1.66%	1.28%	1.01%	1.25%	1.93%	2.48%	3.48%	2.80%	1.89%	1.95%	<=2.96%	
% of ambulance handovers that are over 60 minutes						0.10%	0.00%	0.00%	0.00%	0.00%	0.00%	0.02%	0.07%	0.02%	0.02%	0.02%	<=1%	>2%
Operational Efficiency																		
Cancelled operations re-admitted within 28 days							72.09%	64.29%	41.67%	96.30%	90.48%	95.12%	91.18%	64.71%	94.38%	77.07%	>=95%	
Urgent cancelled operations							0	0	0	0	0	2	3	0	2	5	No target	
Number of patients stable for discharge	73	76	69	74	72	77	86	77	63	79	88	88	90	87	85	82	<=70	
% of bed days lost due to delays							4.74%	3.78%	2.24%	3.42%	4.26%	4.51%	3.71%	3.28%	4.51%	3.28%	<=3.5%	>4%
Number of stranded patients with a length of stay of greater than 7 days	384	382	374	399	412	397	389	391	370	371	360	371	380	406	367	380	<=380	
Average length of stay (spell)	5.05	5.14	4.83	5.14	5.35	5	5.03	5.31	4.82	4.84	4.75	4.85	4.81	4.93	4.81	4.92	<=5.06	
Length of stay for general and acute non-elective (occupied bed days) spells	5.66	5.77	5.29	5.7	6.07	5.67	5.53	5.94	5.38	5.45	5.25	5.38	5.35	5.59	5.36	5.47	<=5.65	
Length of stay for general and acute elective spells (occupied bed days)	2.71	2.84	2.89	2.59	2.67	2.65	2.78	2.68	2.55	2.56	2.69	2.53	2.74	2.56	2.59	2.64	<=3.4	>4.5
% day cases of all electives						84.60%	80.00%	86.28%	85.92%	85.91%	86.04%	86.71%	86.31%	85.54%	86.22%	85.36%	>80%	<70%
Intra-session theatre utilisation rate						84.70%	87.80%	88.49%	85.50%	87.40%	87.60%	87.70%	88.20%	88.00%	87.60%	88.00%	>85%	<70%

Trust Scorecard – Responsive (3)

OVERALL SCORE

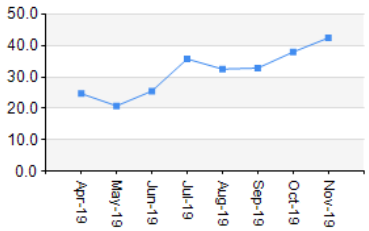
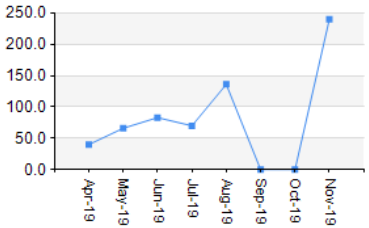
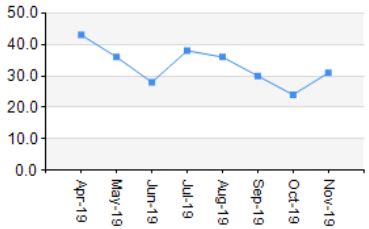
	18/19	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	19/20 Q2	19/20	Standard	Threshold
Outpatient																		
Outpatient new to follow up ratio's						1.93	1.92	1.91	1.9	1.88	1.91	1.79	1.74	1.8	1.86	1.85	<=1.9	
Did not attend (DNA) rates						6.40%	6.80%	6.80%	6.80%	7.00%	6.90%	7.30%	6.80%	6.80%	7.00%	6.90%	<=7.6%	>10%
RTT																		
Referral to treatment ongoing pathways under 18 weeks (%)						79.75%	79.46%	80.63%	81.11%	81.80%	81.41%	81.38%	81.33%	80.18%	81.38%	80.18%	>=92%	
Referral to treatment ongoing pathways 35+ Weeks (number)						2,352	2,163	2,149	1,953	1,772	1,703	1,699	1,650	1,793	1,699	1,793	No target	
Referral to treatment ongoing pathways 40+ Weeks (number)						1,860	1,699	1,748	1,626	1,437	1,378	1,390	1,312	1,269	1,390	1,269	No target	
Referral to treatment ongoing pathways over 52 weeks (number)	95	105	97	89	97	95	93	91	90	78	77	78	62	46	78	46	Zero	
SUS																		
Percentage of records submitted nationally with valid GP code	100%	100%	100%	100%	100%	100%	100%	99.90%	100%	100%	100%	100%				100%	>=99%	
Percentage of records submitted nationally with valid NHS number	99.80%	99.80%	99.80%	99.80%	99.80%	99.80%	99.90%	99.40%	99.80%	99.80%	99.80%	99.80%				99.70%	>=99%	

Trust Scorecard – Well Led (1)

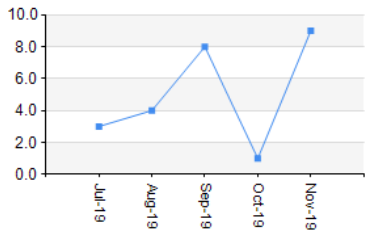
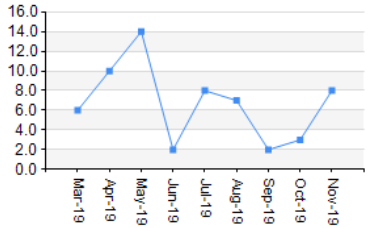
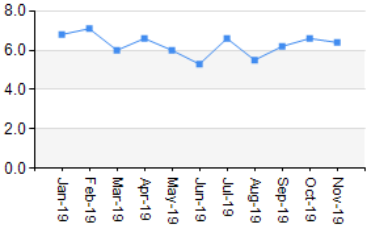
OVERALL SCORE

	18/19	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	19/20 Q2	19/20	Standard	Threshold
Appraisal and Mandatory Training																		
Trust total % overall appraisal completion	79%	79%	79%	79%	79%	81%	80%	81%	82%	83%	81%	79%	80%	82%		81%	>=90%	<70%
Trust total % mandatory training compliance	89%	91%	91%	89%	89%	91%	91%	91%	92%	92%	92%	91%	91%	92%		92%	>=90%	<70%
Finance																		
Total PayBill Spend		29.03	29.7	29.4	29.9	33.3	31.8	30.8	30.9	30.7	31.7	30.9	31.5	31.3				
YTD Performance against Financial Recovery Plan		0.4	0.04	-3	-6.6	-14.1	0.2	0.3	0.6	0.5	0.5	0.6	0.7	0.6				
Cost Improvement Year to Date Variance		2,013	1,593	0	-1,784	-3,378	0	0.8	1.3	1.7	2	2.1	1.3	1.3				
NHSI Financial Risk Rating		4	4	3	4	4	4	3	3	3	3	3	3	3				
Capital service		4	4	4	4	4	4	4	4	4	4	4	4	4				
Liquidity		4	4	4	4	4	4	4	4	4	4	4	4	4				
Agency – Performance Against NHSI Set Agency Ceiling		3	3	3	3	3	3	3	4	3	3	3	3	3				
Safe Nurse Staffing																		
Overall % of nursing shifts filled with substantive staff							96.55%	96.40%	95.10%	97.40%	95.40%	96.40%	98.40%	99.40%	96.38%	96.90%	>=75%	<70%
% registered nurse day							97.90%	97.90%	96.60%	98.70%	96.50%	97.40%	99.40%	100.7%	97.54%	98.10%	>=90%	<80%
% unregistered care staff day							97.00%	99.20%	99.40%	101.0%	99.40%	98.60%	101.4%	104.2%	99.67%	100.0%	>=90%	<80%
% registered nurse night							94.10%	93.50%	92.40%	94.80%	93.30%	94.50%	96.40%	97.10%	94.23%	94.50%	>=90%	<80%
% unregistered care staff night							100.3%	99.40%	104.8%	105.7%	105.3%	106.7%	108.6%	115.5%	105.9%	105.7%	>=90%	<80%
Care hours per patient day RN						6.2	4.61	4.6	4.7	4.8	4.7	4.7	4.7	4.8	4.7	4.7	>=5	
Care hours per patient day HCA						3.2	2.8	2.9	3	3	3	2.9	3	3	3	2.9	>=3	
Care hours per patient day total	7.1	7.1	7.3	7.3	7.2	8.1	7.4	7.5	7.7	7.8	7.6	7.6	7.7	7.8	7.7	7.7	>=8	
Vacancy and WTE																		
% total vacancy rate							9.03%	10.02%	9.54%	8.65%	8.60%	7.20%	7.00%	7.20%			<=11.5%	>13%
% vacancy rate for doctors							8.07%	8.86%	8.53%	8.20%	0.53%	2.70%	2.25%	2.30%			<=5%	>5.5%
% vacancy rate for registered nurses							12.09%	9.52%	9.42%	8.65%	8.65%	8.07%	8.22%	8.25%			<=5%	>5.5%
Staff in post FTE							6181.16	6150.11	6148.56	6171.97	6226.64	6350.1	6358.09	6358.79			No target	
Vacancy FTE							610	683	650	652.42	500	492.55	478.95	480			No target	
Starters FTE							65.5	52.8	45.2	66.66	60.55	147.7	72.72	51.61			No target	
Leavers FTE							55.14	37.5	57.4	44.69	46.75	84.63	40.81	47.31			No target	
Workforce Expenditure and Efficiency																		
% turnover	11.80%	11.60%	11.70%	11.70%	11.90%	12.20%	11.80%	11.60%	11.60%	11.80%	11.10%	11.90%	11.60%	11.70%			<=11%	>15%
% turnover rate for nursing	10.99%						1.09%	10.93%	10.87%	10.99%	10.77%	11.40%	11.09%	11.00%			<=11%	>15%
% sickness rate	3.90%	3.90%	3.90%	3.90%	3.90%	3.90%	3.90%	3.40%	3.80%	3.80%	3.90%	3.90%	3.90%	4.00%			<=3.5%	>4%

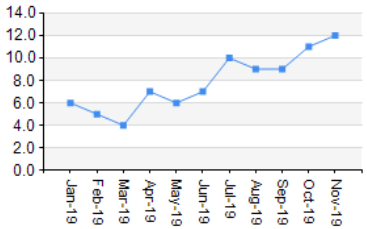
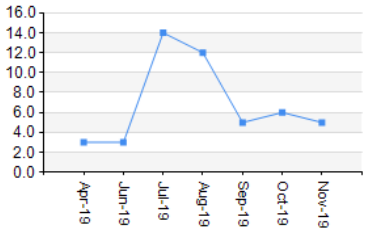
Exception Reports – Safe (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Clostridium difficile – infection rate per 100,000 bed days **Standard: <30.2**		There were 3 cases of hospital onset-healthcare associated cases and 9 community-onset healthcare associated case during November. The three hospital-onset cases have been reviewed with the clinical teams. They were associated with poor cleaning and antimicrobial prescribing issues.	**Associate Chief Nurse and Deputy Director of Infection Prevention and Control**
Number of bed days lost due to infection control outbreaks **Standard: <10**		Due to outbreaks Norovirus affecting wards across both hospitals ward closures were undertaken as a control measure.	**Associate Chief Nurse and Deputy Director of Infection Prevention and Control**
Number of category 2 pressure ulcers acquired as in-patient **Standard: <=30**		During November 2019 there were 31 hospital acquired category 2 pressure ulcers. Hospital acquired category 2 pressure ulcers are reviewed at the weekly preventing harm hub. Issues raised at the Hub include missed opportunities to complete risk assessment documentation, timely provision of equipment and robustness of pressure relieving measures. The Hub provides rapid feedback on the high impact actions required, the ward team are tasked to produce evidence of an improvement that is taken through the divisional pressure ulcer groups. Medicine and Surgery have plans to respond and reduce pressure ulcers.	**Deputy Nursing Director & Divisional Nursing Director - Surgery**

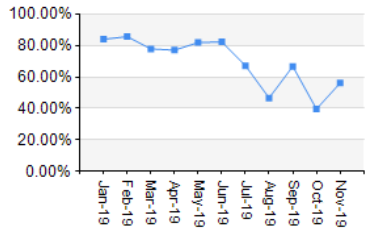
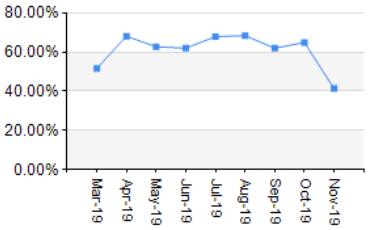
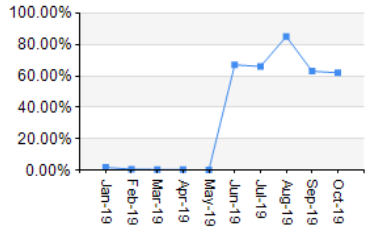
Exception Reports – Safe (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of community-onset healthcare-associated Clostridioides difficile cases per month **Standard: <=5**		There were 3 cases of hospital onset-healthcare associated cases and 9 community-onset healthcare associated case during November. The three hospital-onset cases have been reviewed with the clinical teams. They were associated with poor cleaning and antimicrobial prescribing issues.	**Associate Chief Nurse and Deputy Director of Infection Prevention and Control**
Number of deep tissue injury pressure ulcers acquired as in-patient **Standard: <=5**		During November 2019 there were 8 hospital acquired deep tissue injury pressure ulcers. Hospital acquired deep tissue injury pressure ulcers are reviewed at the weekly preventing harm hub. Issues raised at the Hub include missed opportunities to complete risk assessment documentation, timely provision of equipment and robustness of pressure relieving measures. The Hub provides rapid feedback on the high impact actions required, the ward team are tasked to produce evidence of an improvement that is taken through the divisional pressure ulcer groups. Medicine and Surgery have plans to respond and reduce pressure ulcers.	**Deputy Nursing Director & Divisional Nursing Director - Surgery**
Number of falls per 1,000 bed days **Standard: <=6**		The 12-month rolling average falls with harm per 1000 beddays is 5.5, November 2019 was above average with 6.4 cases.	**Director of Safety**

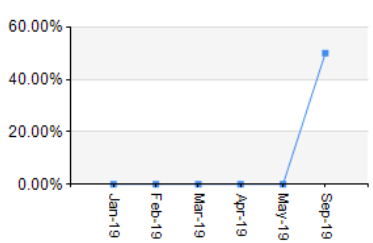
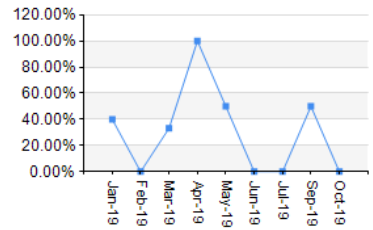
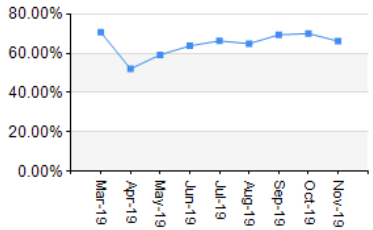
Exception Reports – Safe (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of trust apportioned Clostridium difficile cases per month **Standard: 2019/20: 114**		There were 3 cases of hospital onset-healthcare associated cases and 9 community-onset healthcare associated case during November. The three hospital-onset cases have been reviewed with the clinical teams. They were associated with poor cleaning and antimicrobial prescribing issues.	**Associate Chief Nurse and Deputy Director of Infection Prevention and Control**
Number of unstagable pressure ulcers acquired as in-patient **Standard: <=3**		During November 2019 there were 5 hospital acquired unstageable pressure ulcers. Hospital acquired unstageable pressure ulcers are reviewed at the weekly preventing harm hub. Issues raised at the Hub include missed opportunities to complete risk assessment documentation, timely provision of equipment and robustness of pressure relieving measures. The Hub provides rapid feedback on the high impact actions required, the ward team are tasked to produce evidence of an improvement that is taken through the divisional pressure ulcer groups. Medicine and Surgery have plans to respond and reduce pressure ulcers.	**Deputy Nursing Director & Divisional Nursing Director - Surgery**

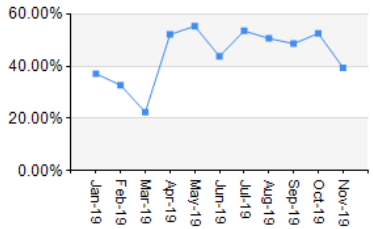
Exception Reports – Effective (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of fracture neck of femur patients treated within 36 hours **Standard: >=90%**		The implementation of the escalation plan for Trauma is being reviewed through the T&F group. This has been refreshed and will be chaired by the DCOO - this is in place for the 13/12. An interim escalation policy has been agreed with additional lists being provided. A ringfenced #NOF bed (as per our operational approach to Stroke) has been proposed to be reinstated within the site processes.	**Director of Operations - Surgery**
% of patients admitted directly to the stroke unit in 4 hours **Standard: >=80%**		29 patients met the target of being admitted directly to the stroke unit within 4 hours; 41 patients did not meet this target (this is a deterioration of 23.5% on the previous month). The majority of patients breached due to lack of stroke beds due to increased pressure for inpatient beds across GRH. 5 patients also had an unclear diagnosis (presentation reason was "confusion" / "vertigo" which was only then confirmed as a stroke due to testing later on in the pathway.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
% of patients who have been screened for dementia (within 72 hours) **Standard: >=90%**		Trac as the long term solution remains unresolved. Data collection methodology change from June 2019 onwards: 20 sets of notes are audited every month and reported retrospectively in the QPR. There continues to be unresolved issues regarding Trak. The Trust is committed to dementia tier 1 and 2 training which is currently being reviewed through the Dementia steering group. There is now Dementia Friends training provided across the organisation to both clinical and non clinical staff. With the launch of EPR patients on wards are being identified with cognitive impairment.	**Deputy Chief Nurse**

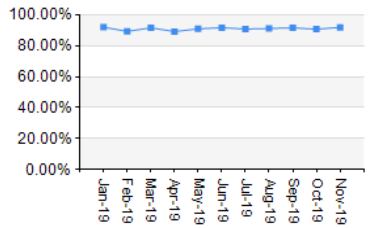
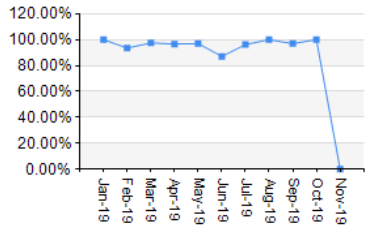
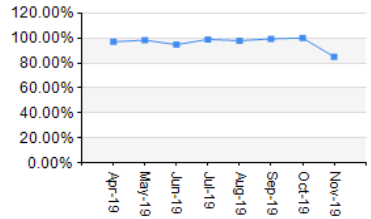
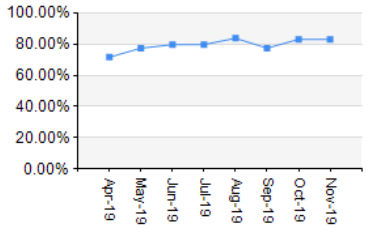
Exception Reports – Effective (2)

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)		TRAC as the long term solution remains unresolved. Data collection methodology change from June 2019 onwards: 20 sets of notes will be audited every month and reported retrospectively in the QPR. There continues to be unresolved issues with Trak. The Medical director is supporting through junior doctor engagement.	**Deputy Chief Nurse**
% of patients who have scored positively on dementia screening tool that then received a dementia diagnostic assessment (within 72 hours) **Standard: >=90%**		TRAC as the long term solution remains unresolved. Data collection methodology change from June 2019 onwards: 20 sets of notes will be audited every month and reported retrospectively in the QPR. The Trust continues to focus on dementia screening. There is a delirium screening tool being developed, which will also support dementia screening.	**Deputy Chief Nurse**
% patients receiving a swallow screen within 4 hours of arrival **Standard: >=90%**		47 patients received a swallow screen within 4 hours; 24 patients did not meet this target (this is a deterioration of 3.8% on the previous month). 18/24 breaches were due to organisational reasons (non-strokes on the stroke unit leading to the patient being held on AMU or because inital presentation led to delayed diagnosis of Stroke) and in 6 cases the patient was not medically well enough for the swallow screen to take place. 95% of patients did receive a swallow screen within 72 hours (1 did not due to being too poorly)	**Director of Unscheduled Care and Deputy Chief Operating Officer**

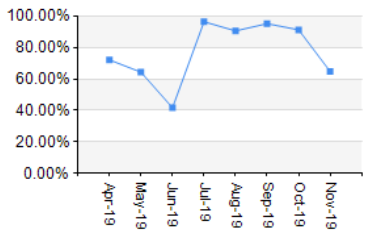
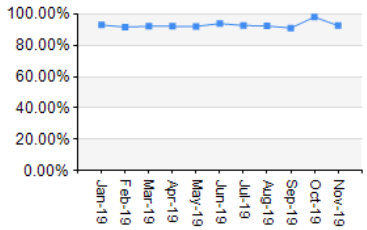
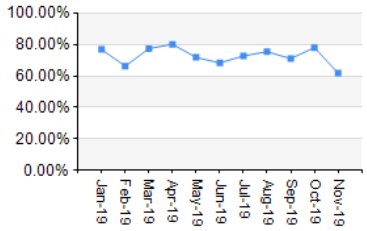
Exception Reports – Effective (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Stroke care: percentage of patients receiving brain imaging within 1 hour **Standard: >=50%**		28 patients met the target of receiving CT head scan within 60 minutes of arrival in ED; 43 patients did not meet this target (this is a deterioration of 13.1% on the previous month). 27/43 patients breached due to late notification to Stroke Specialist Nurse team / out of hours for Stroke Specialist Nurse Team cover. 14/43 patients attended with an unclear diagnosis (including unwitnessed falls, diabetic episode, vertigo) that led to a late diagnosis of Stroke and therefore delay to CT scan request. The remaining patients breached due to either being an inpatient when stroke occurred or delays to CT scan referral due to volume of patients in ED at the time of attendance.	**Director of Unscheduled Care and Deputy Chief Operating Officer**

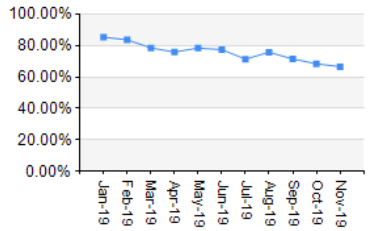
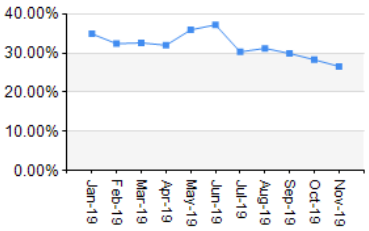
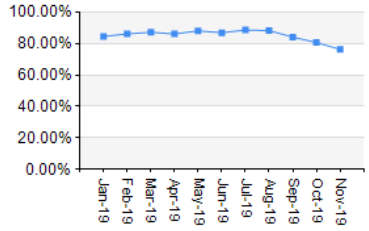
Exception Reports – Caring (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Inpatients % positive **Standard: >=96%**		Response rates are significantly lower than previous months due to the SMS element of the survey being deactivated as we change contracts with FFT providers. FFT postcards were available as normal and results will be transcribed by our new provider in December.	**Deputy Director of Quality**
Maternity % positive **Standard: >=97%**		Response rates are significantly lower than previous months due to the SMS element of the survey being deactivated as we change contracts with FFT providers. FFT postcards were available as normal and results will be transcribed by our new provider in December.	**Deputy Director of Quality**
Do you get enough help from staff to wash or keep yourself clean? **Standard: >=90%**		6/39 patients surveyed did not get enough help to wash. All 6 negative responses were on Medical Wards (4 from AMU). Results to be fed back to wards for further details.	**Head of Patient Experience Improvement**
How much information about your condition or treatment or care has been given to you? **Standard: >=90%**		24/140 patients surveys did not get enough information. The majority of these (18) were on Medical wards in Gloucester. Results to be fed back to wards for further details.	**Head of Patient Experience Improvement**

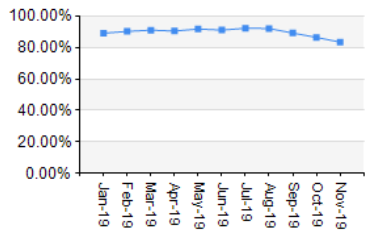
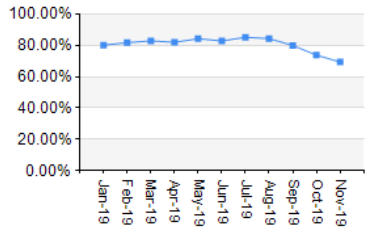
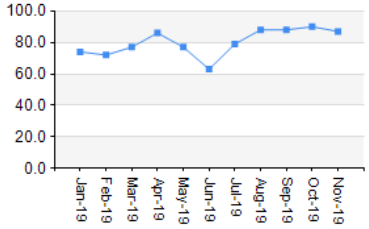
Exception Reports – Responsive (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Cancelled operations re-admitted within 28 days **Standard: >=95%**		Metric only recently agreed and validation by respective services not fully undertaken in month. However, initial review of November would suggest a higher number of genuine breaches. The reasons preventing re-admission within 28 days were varied but included patient unavailability/choice; consultant sickness; lack of list capacity due to prioritising cancer and 52ww patients.	**Deputy Chief Operating Officer**
Cancer – 31 day diagnosis to treatment (first treatments) **Standard: >=96%**		Performance - 92.5% (213 tx 16 breaches) Target - 96% National performance - 95.5% 10 - Uro 2 skin 2 LGI 1 H&N 1 Haem Unvalidated data	**Director of Planned Care and Deputy Chief Operating Officer**
Cancer 62 day referral to treatment (urgent GP referral) **Standard: >=85%**		Performance - 61.6% Target - 85% National performance - 76.9% Unvalidated data Uro 30.5 Skin 3.5 Upper GI 2.5 Lower GI - 2.5 Gynae - 2	**Director of Planned Care and Deputy Chief Operating Officer**

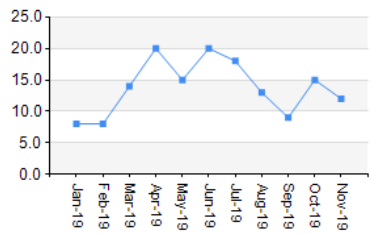
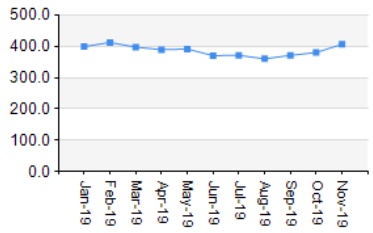
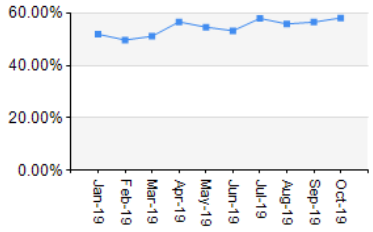
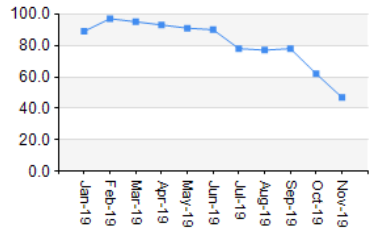
Exception Reports – Responsive (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % of time to initial assessment – under 15 minutes **Standard: >=95%**		Performance has declined marginally compared with the previous month. A business case in currently being written which includes the increase in triage nurses.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % of time to start of treatment – under 60 minutes **Standard: >=90%**		The National Quality Indicator for this metric is a 'mean consistently within 60 minutes'. Though there has been a deterioration in performance since October (-1.7%), this reflects good performance in the face of attendances.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % total time in department – under 4 hours (type 1) **Standard: >=95%**		Total time in department has increased this month because of poor bed flow. This has been due to a combination of infection control issues causing bed closures and the number of attendances increasing by 5.4% from October.	**Director of Unscheduled Care and Deputy Chief Operating Officer**

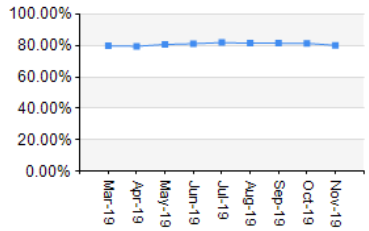
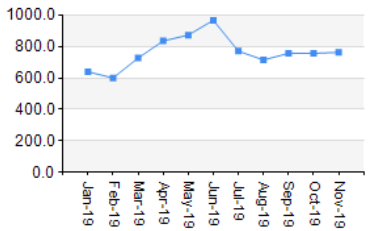
Exception Reports – Responsive (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % total time in department – under 4 hours (types 1 & 3) **Standard: >=95%**		Total time in department has increased this month because of poor bed flow. This has been due to a combination of infection control issues causing bed closures and the number of attendances increasing by 5.4% from October.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % total time in department – under 4 hours GRH **Standard: >=95%**		Total time in department has increased this month because of poor bed flow. This has been due to a combination of infection control issues causing bed closures and the number of attendances increasing by 5.4% from October.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
Number of patients stable for discharge **Standard: <=70**		Attendances and admissions have been exceptionally high and numbers of patients with complex needs are corresponding to those numbers. The Trust has been faced with ward closures across both hospitals due to D&V which have hindered the ability to discharge and indeed transfer to community beds. Discharge 2 Assess beds have been hard to sources, and there have been periods where Community Hospitals have been at full capacity.Internal incidents have been called over the last month due to poor flow, with all actions taken to support a return. A number of our complex discharges remain with Adult Social Care awaiting assessment, and there have been pockets when the Onward Care Team have experiences staffing issues either due to sickness of annual leave. Needless to say, all avenues to hasten processes have been utilised including streamlining the working processes of the Onward Care Team.	**Director of Unscheduled Care and Deputy Chief Operating Officer**

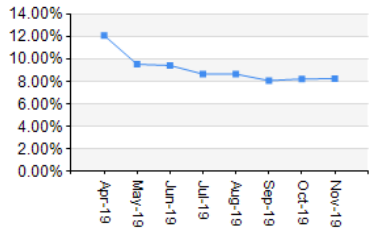
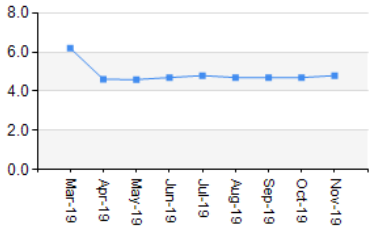
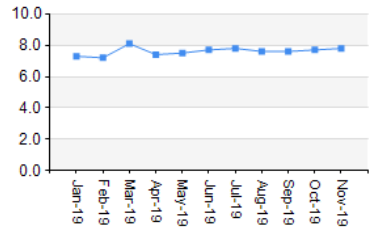
Exception Reports – Responsive (4)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of patients waiting over 104 days with a TCI date **Standard: Zero**		Row Labels — Count of MRN Gynaecological — 1 Urological (excl. testicular) — 1 Haematological (excl. acute leukaemia) — 1 Grand Total — 3	**Director of Planned Care and Deputy Chief Operating Officer**
Number of stranded patients with a length of stay of greater than 7 days **Standard: <=380**		LOS group in place and supported by system partners aligned to the winter plan.	**Deputy Chief Operating Officer**
Patient discharge summaries sent to GP within 24 hours **Standard: >=88%**		Performance remains poor, although more engagement since highlighting quality alerts to SDs to emphasize the issue. Some areas of improvement one speciality to 90%, and one to 75% from low 60%.	**Medical Director**
Referral to treatment ongoing pathways over 52 weeks (number) **Standard: Zero**		Performance is above the trajectory set with NHS I and commissioners. Work to address performance through operational actions and validation continues. Further details are provided within the planned care exception report.	**Deputy Chief Operating Officer**

Exception Reports – Responsive (5)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Referral to treatment ongoing pathways under 18 weeks (%) **Standard: >=92%**		Performance is above the trajectory set with NHS I and commissioners. Work to address performance through operational actions and validation continues. Further details are provided within the planned care exception report.	**Deputy Chief Operating Officer**
The number of planned / surveillance endoscopy patients waiting at month end **Standard: <=600**		Decrease on last month's position by 7 patients. There has been a slight increase in the number of patients waiting past recall due to increased pressures in month on the 2ww colorectal straight to test pathway and 6ww diagnostic pathway. Patients are being prioritised in order of clinical urgency and then longest waiting. The specialty are still in the process of clinically validating the waiting list and it is anticipated this will further reduce the backlog through discharging back to GP.	**Medical Director**

Exception Reports – Well Led (1)

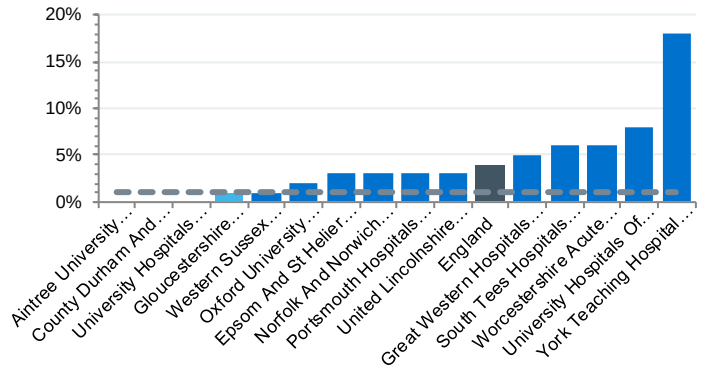
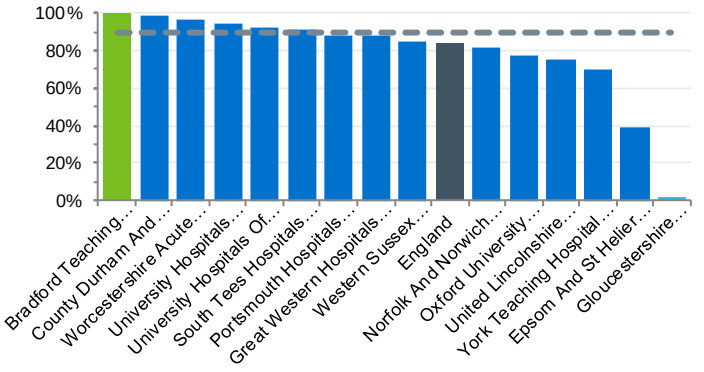
Metric Name & Standard	Trend Chart	Exception Notes	Owner
% vacancy rate for registered nurses **Standard: <=5%**		RGN vacancies (this now includes ODPs) have reduced in month from 10.02 to 8.25%. September and October saw an increase in new starters and efforts continue to improve staff retention, with particular focus from our Nurse recruitment and retention lead on actions as part of the NHSI/E retention collaborative programme.	**Director of Human Resources and Operational Development**
Care hours per patient day RN **Standard: >=5**		Since the last report several recruitment events have taken place. The Lead Nurse for Attraction, Recruitment and Retention has worked across the organisation in disseminating a short retention survey, the results are currently being collated. The draft retention plan has been submitted to NHSI collaborative. Communications are supporting the LN with developing a media plan.	**Director of Nursing and Midwifery**
Care hours per patient day total **Standard: >=8**		As well as recruitment events for substantive staff, there has also been recruitment events for temporary staffing. The DQDNs with the Matrons continue to ensure that safe staffing is in place across the divisions.	**Director of Nursing and Midwifery**

Benchmarking (1)

Gloucestershire Hospitals NHS Foundation Trust

Standard **England** **Other providers**
GHT **Best in class***

*Where there is more than one top performing provider, the first in alphabetical order is reported here

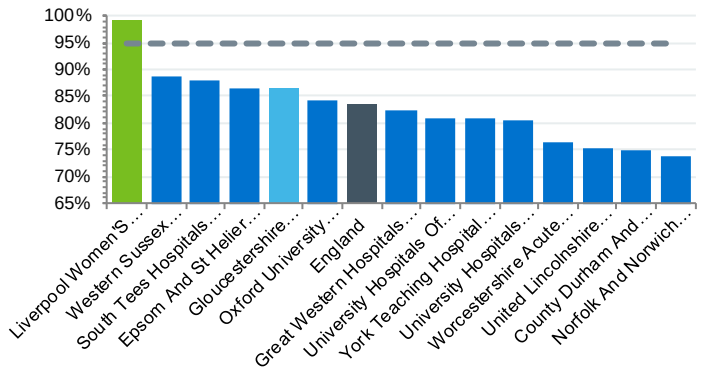
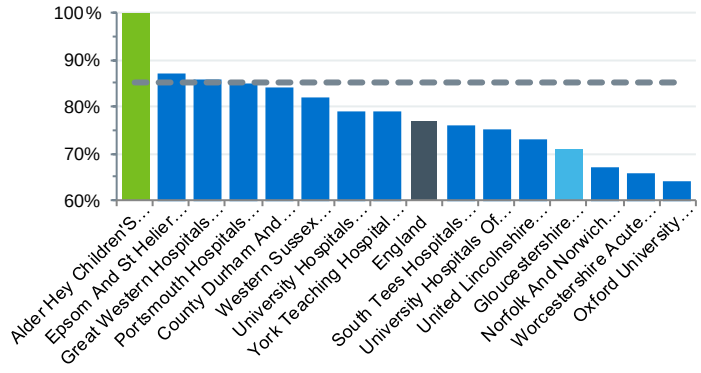
Metric	Period	Peer Group	Rank	Quartile
Diagnostics	September-19		63 / 170	2nd
Dementia	September-19		131 / 131	4th

Benchmarking (2)

Gloucestershire Hospitals NHS Foundation Trust

Standard **England** **Other providers**
GHT **Best in class***

*Where there is more than one top performing provider, the first in alphabetical order is reported here

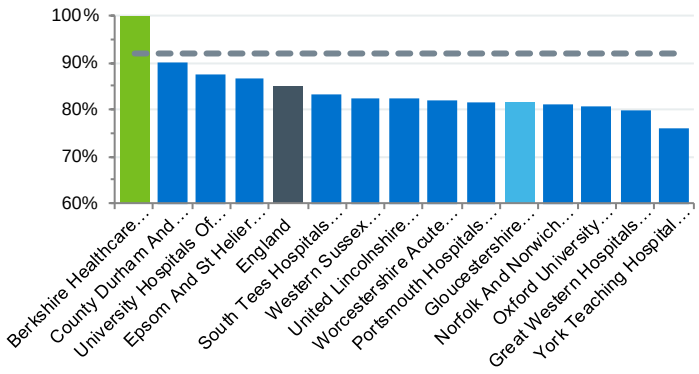
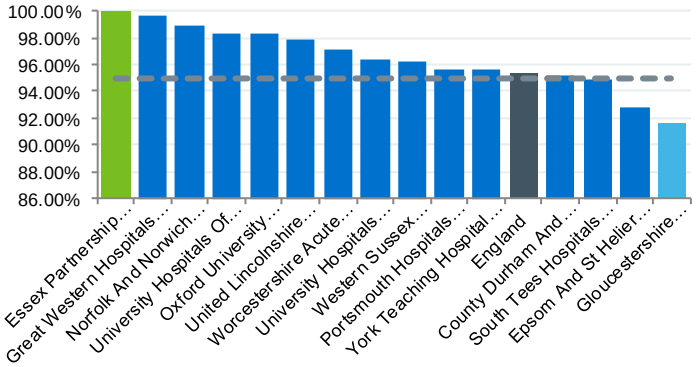
Metric	Period	Peer Group	Rank	Quartile
ED 4 Hour (Type 1 & Type 3)	October-19		39 / 119	2nd
Cancer 62 Days GP Referrals	September-19		111 / 144	4th

Benchmarking (3)

Gloucestershire Hospitals NHS Foundation Trust

Standard **England** **Other providers**
GHT **Best in class***

*Where there is more than one top performing provider, the first in alphabetical order is reported here

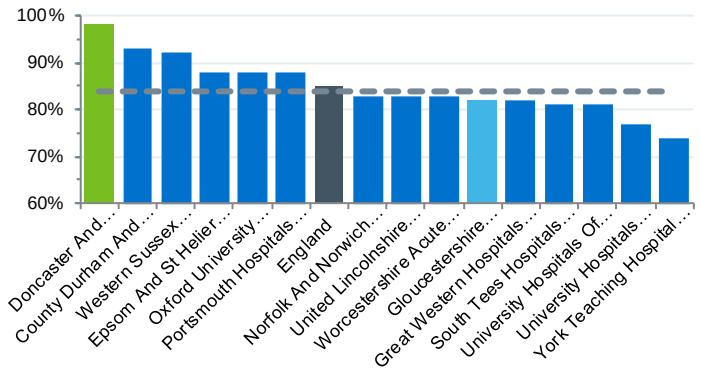
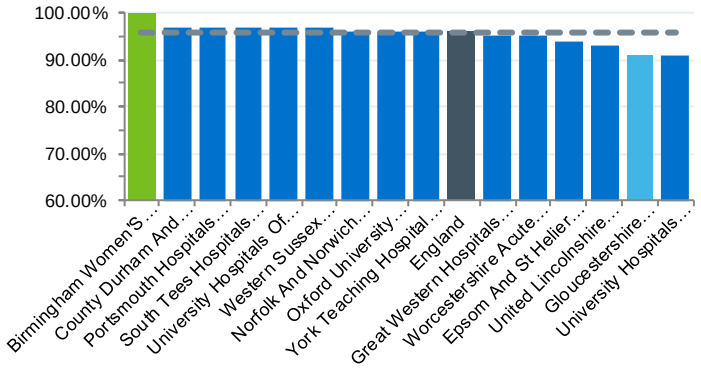
Metric	Period	Peer Group	Rank	Quartile
RTT	September-19		135 / 166	4th
VTE (published quarterly)	September-19		131 / 149	4th

Benchmarking (4)

Gloucestershire Hospitals NHS Foundation Trust

Standard **England** **Other providers**
GHT **Best in class***

*Where there is more than one top performing provider, the first in alphabetical order is reported here

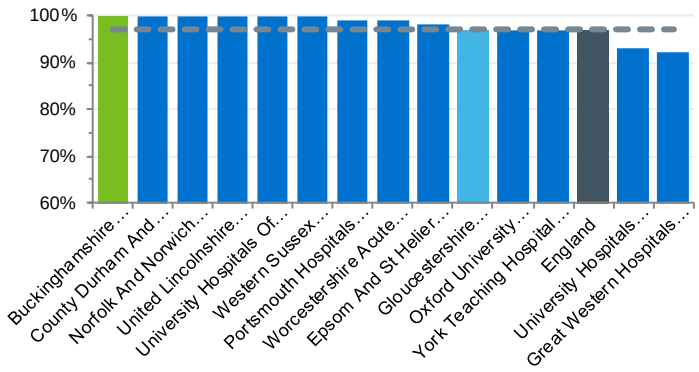
Metric	Period	Peer Group	Rank	Quartile
FFT - ED (percentage recommended)	September-19		96 / 131	3rd
FFT - Inpatient (percentage recommended)	September-19		133 / 145	4th

Benchmarking (5)

Gloucestershire Hospitals NHS Foundation Trust

Standard **England** **Other providers**
GHT **Best in class***

*Where there is more than one top performing provider, the first in alphabetical order is reported here

Metric	Period	Peer Group	Rank	Quartile
FFT - Maternity (Q2 birth touchpoint - percentage recommended)	September-19		64 / 119	3rd

Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report Statistical Process Control Reporting

Reporting period November 2019

Presented at December 2019 Q&P and January 2020 Trust Board

Contents

Gloucestershire Hospitals NHS Foundation Trust

Guidance

Gloucestershire Hospitals
NHS Foundation Trust

Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

How to interpret variation results:

- Variation results show the trends in performance over time
- Trends either show **special cause variation** or **common cause variation**
- **Special cause variation: Orange icons** indicate **concerning** special cause variation requiring action
- **Special cause variation: Blue icons** indicate where there appears to be **improvements**
- **Common cause variation: Grey icons** indicate **no significant change**

How to interpret assurance results:

- Assurance results show whether a target is likely to be achieved, and is based on trends in achieving the target over time
- **Blue icons** indicate that you would expect to **consistently achieve a target**
- **Orange icons** indicate that you would expect to **consistently miss a target**
- **Grey icons** indicate that **sometimes the target will be achieved and sometimes it will be missed**

Source: NHSI Making Data Count

SPC Summary Dashboard

Gloucestershire Hospitals NHS Foundation Trust

The following dashboard shows the results of the SPC analysis for lead metrics in the QPR and other metrics in the QPR which have been RAG rated as red this month. RAG rating is against national standards. The SPC charts are shown in the subsequent slides. SPC analysis can only be carried out on metrics with more than 10 continuous months of data. Note that data is subject to change.

	Target & Assurance		Latest Peformance & Variance			Lower Limit	Mean	Upper Limit
Safe - Lead Indicators								
Number of trust apportioned Clostridium difficile cases per month	9/10	?	Nov-19	12	H	3.7	6.0	8.3
Safety thermometer – % of new harms	>96%	?	Nov-19	95.8%		96.5%	97.5%	99.5%
Safe - Non-Lead - Red RAG Rated Indicators								
Number of falls per 1,000 bed days	<=6	?	Nov-19	6.4	L	5	6.8	8.6
Effective - Lead Indicators								
Hospital standardised mortality ratio (HSMR)	Dr Foster	N/A	Aug-19	98		93.0	96.9	100.8
Hospital standardised mortality ratio (HSMR) – weekend	Dr Foster	N/A	Aug-19	100.5		93.9	98.2	102.5
Emergency re-admissions within 30 days following an elective or emergency spell	<8.25%	P	Oct-19	6.70%		5.7%	6.9%	8.1%
Effective - Non-Lead - Red RAG Rated Indicators								
Stroke care: percentage of patients receiving brain imaging within 1 hour	>=50%	?	Nov-19	39.4%		21.1%	41.8%	62.5%
% of fracture neck of femur patients treated within 36 hours	>=90%	?	Nov-19	56.06%		45.6%	72.3%	99.0%
Caring - Lead Indicators								
ED % positive	>=84%	?	Nov-19	87.9%	H	78.7%	82.9%	87.1%
Maternity % positive	>=97%	?	Nov-19	0.0%	L	56.4%	91.6%	126.8%
Outpatients % positive	>=94%	?	Nov-19	93.8%		91.3%	92.7%	94.1%
Number of breaches of mixed sex accommodation	<=10	?	Nov-19	0		-5.7	7.2	20.1
Caring - Non-Lead - Red RAG Rated Indicators								
Inpatients % positive	>=96%	F	Nov-19	92%		88.3%	91.0%	93.7%

Key

Assurance

- P – Consistenly hit target
- ? – Hit and miss target subject to random
- F – Consistenly fail target

Variation

- H/L – Special Cause Concerning variation
- (no icon) – Common Cause
- H/L – Special Cause Improving variation

Process Limits

- **Lower Limit**: 99% of data should fall between the lower and upper limit
- **Mean**: Average performance over the baseline period
- **Upper Limit**: 99% of data should fall between the lower and upper limit

SPC Summary Dashboard

Gloucestershire Hospitals NHS Foundation Trust

	Target & Assurance	Latest Peformance & Variance		Lower Limit	Mean	Upper Limit
Responsive - Lead Indicators						
Cancer 62 day referral to treatment (urgent GP referral)	>=85%	Nov-19	61.80%	59.9%	74.3%	88.7%
Cancer 62 day referral to treatment (screenings)	>=90%	Nov-19	96.80%	83.2%	95.8%	108.4%
Cancer 62 day referral to treatment (upgrades)	>=90%	Nov-19	100%	23.6%	71.7%	119.8%
% waiting for diagnostics 6 week wait and over (15 key tests)	<=1%	Nov-19	1.06%	-0.3%	0.6%	1.5%
ED: % total time in department – under 4 hours (type 1)	>=95%	Nov-19	76.24%	82.9%	88.2%	93.5%
ED: % total time in department – under 4 hours (types 1 & 3)	>=95%	Nov-19	83.41%	88.0%	91.5%	95.0%
Responsive - Non-Lead - Red RAG Rated Indicators						
Cancer – 31 day diagnosis to treatment (first treatments)	>=96%	Nov-19	92.50%	91.2%	94.2%	97.2%
Number of patients waiting over 104 days with a TCI date	Zero	Nov-19	12	-1.2	12.9	27
The number of planned / surveillance endoscopy patients waiting at month end	<=600	Nov-19	763	402.6	585.9	769.2
Patient discharge summaries sent to GP within 24 hours	>=88%	Oct-19	58.10%	46.4%	52.3%	58.2%
ED: % total time in department – under 4 hours GRH	>=95%	Nov-19	69.25%	77.1%	84.4%	91.7%
ED: % of time to initial assessment – under 15 minutes	>=95%	Nov-19	66.50%	76.3%	82.8%	89.3%
ED: % of time to start of treatment – under 60 minutes	>=90%	Nov-19	26.60%	26.0%	33.1%	26.0%
Number of patients stable for discharge	<=70	Nov-19	87	61.7	75.6	89.5
Number of stranded patients with a length of stay of greater than 7 days	<=380	Nov-19	406	346.3	386.6	426.9
Well Led - Lead Indicators						
Trust total % overall appraisal completion	>=90%	Nov-19	82%	76.2%	79.3%	82.4%
Trust total % mandatory training compliance	>=90%	Nov-19	92%	88.6%	90.3%	92.0%
% sickness rate	<=3.5%	Nov-19	4%	3.6%	3.8%	4.0%
Well Led - Non-Lead - Red RAG Rated Indicators						
Care hours per patient day total	>=8	Nov-19	7.8	6.7	7.4	8.1

Key

Assurance

- Consistenly hit target
- Hit and miss target subject to random
- Consistenly fail target

Variation

- Special Cause Concerning variation
- Common Cause
- Special Cause Improving variation

Process Limits

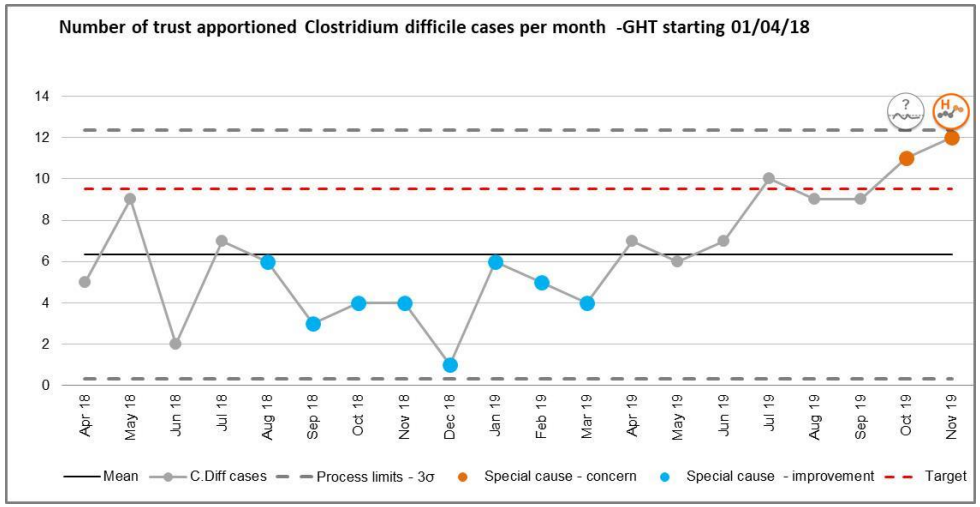
Lower Limit
99% of data should fall between the lower and upper limit

Mean
Average performance over the baseline period

Upper Limit
99% of data should fall between the lower and upper limit

SPC Charts (1)

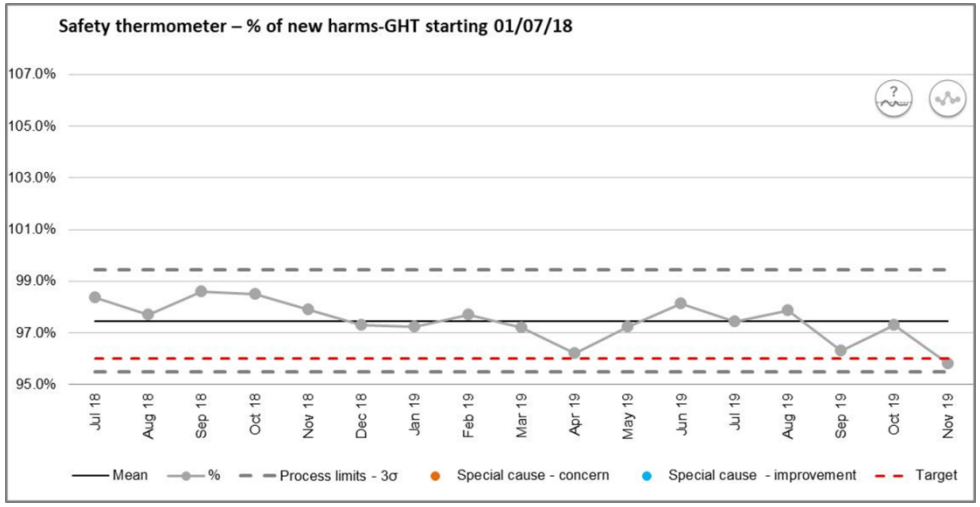
Gloucestershire Hospitals
NHS Foundation Trust



Data observations

This type of chart (SPC) allows you to identify statistically significant changes in data. The dotted lines (process limits) represent the expected range for data points if variation is within expected limits - this is, normal. You can apply a number of rules to identify when the process is not in control - that is, special cause variation.

Shift	When more than 7 sequential points fall above or below the mean this is unusual and may indicate a significant change in process. This process is not in control. There is a run of points below the mean.
2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing.

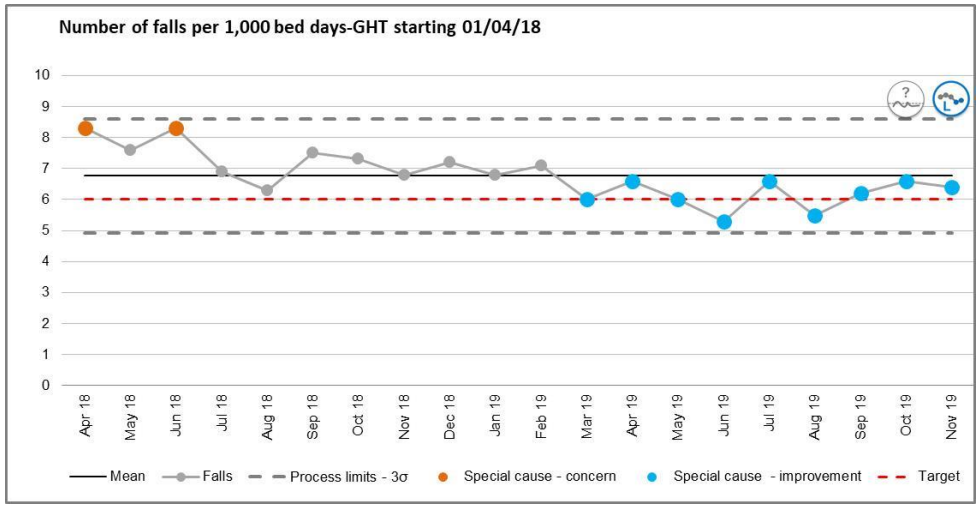


Data observations

Common cause variation

SPC Charts (2)

Gloucestershire Hospitals
NHS Foundation Trust



Data observations

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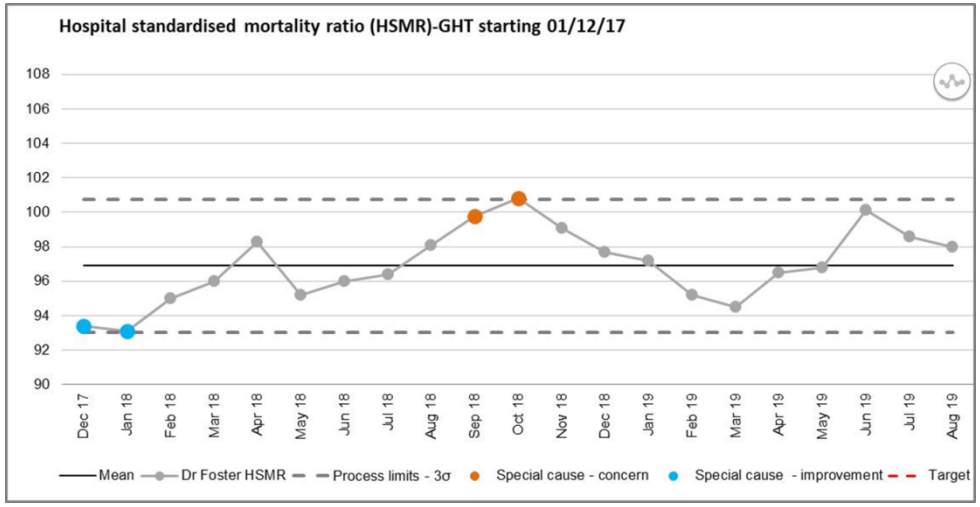
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing.
2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing.



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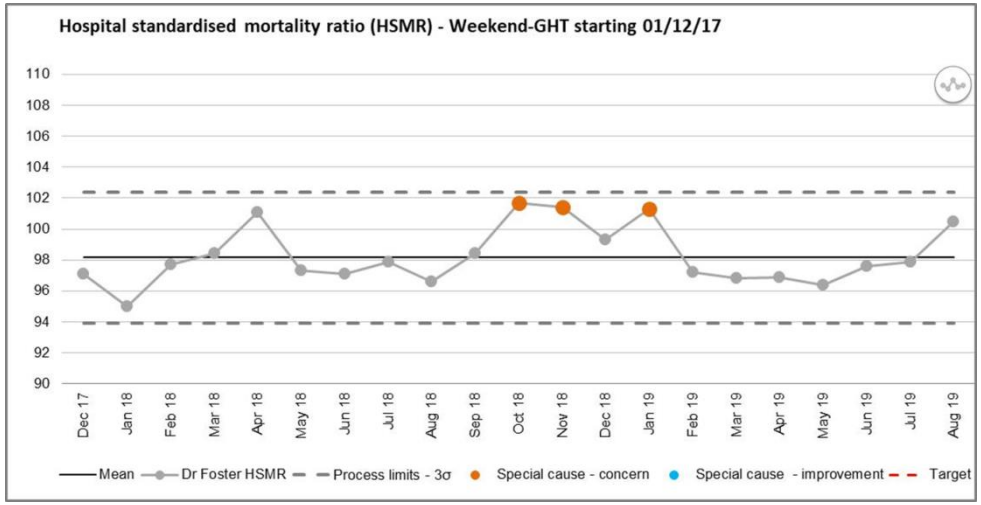
SPC Charts (3)

Gloucestershire Hospitals
NHS Foundation Trust



Data observations

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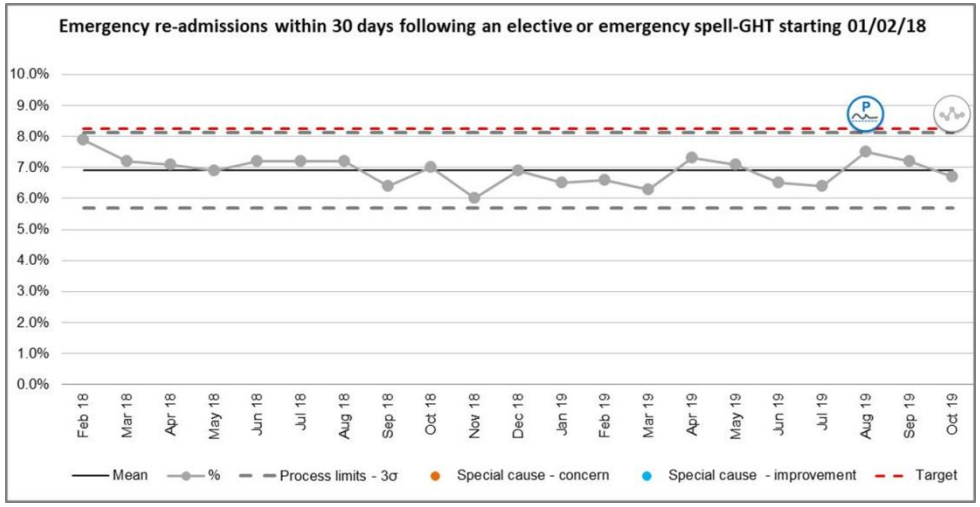
2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing.

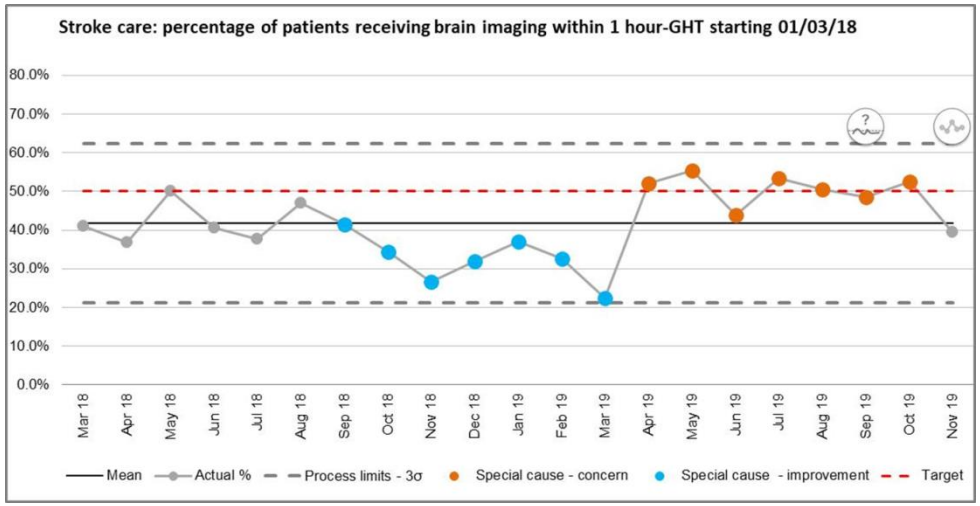


Data observations

Common cause variation

SPC Charts (4)

Gloucestershire Hospitals
NHS Foundation Trust



Data observations

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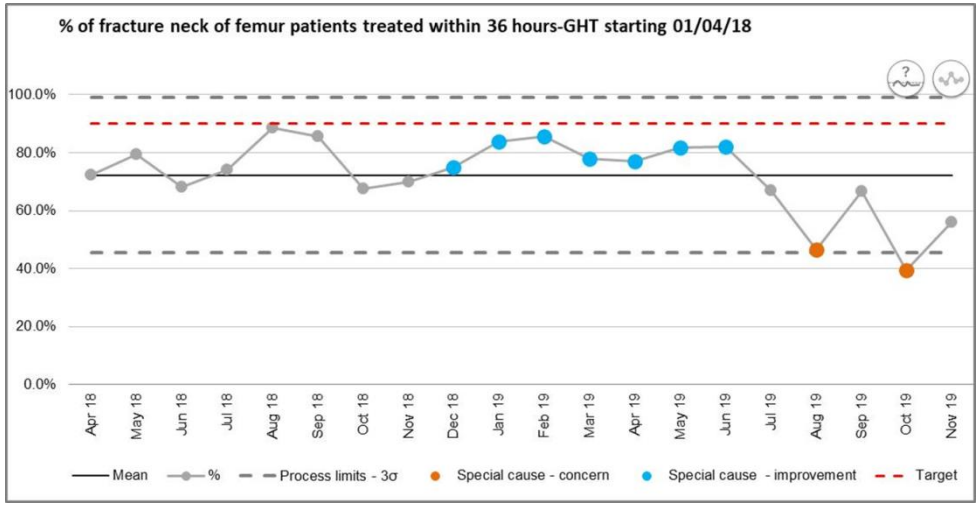

Data observations

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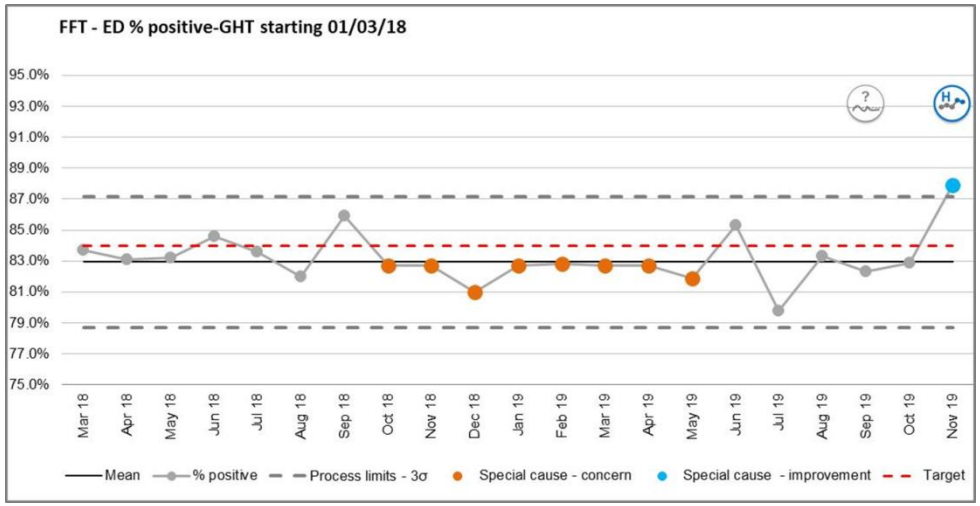
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing.

SPC Charts (5)

Gloucestershire Hospitals
NHS Foundation Trust



Data observations

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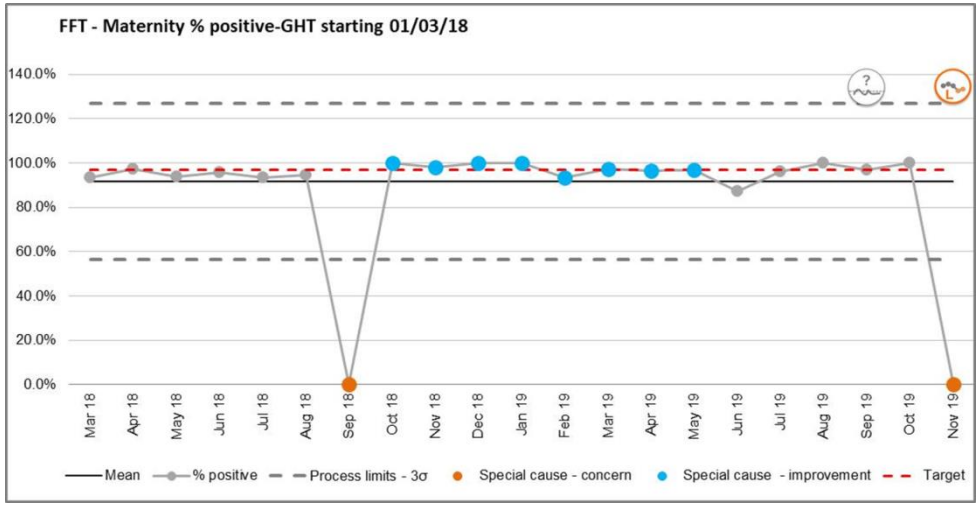

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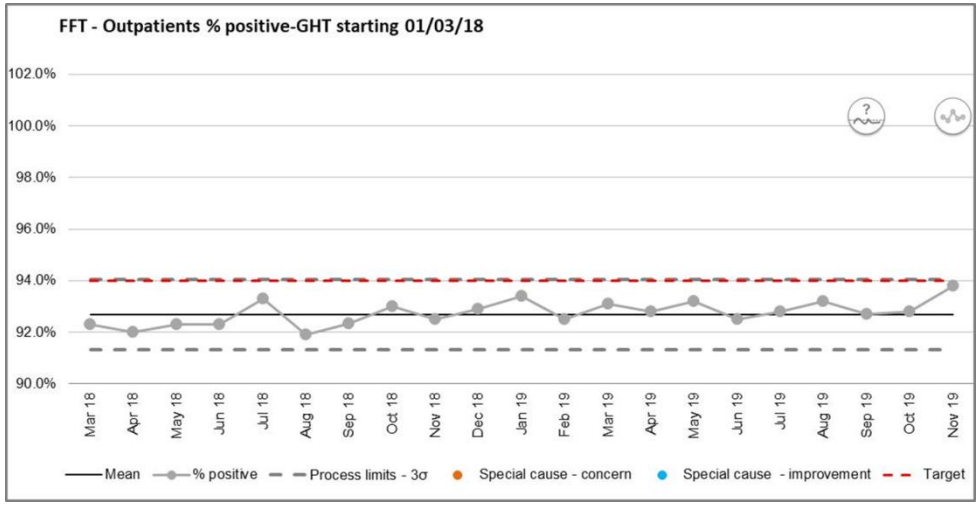
Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 2 data points below the line.
Shift	When more than 7 sequential points fall above or below the mean this is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above the mean.

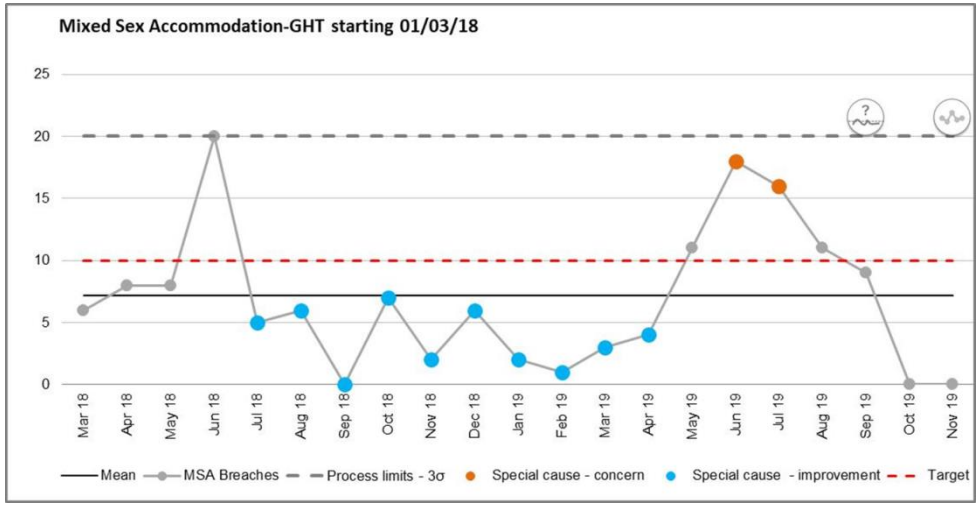
SPC Charts (6)

Gloucestershire Hospitals
NHS Foundation Trust



Data observations

Common cause variation



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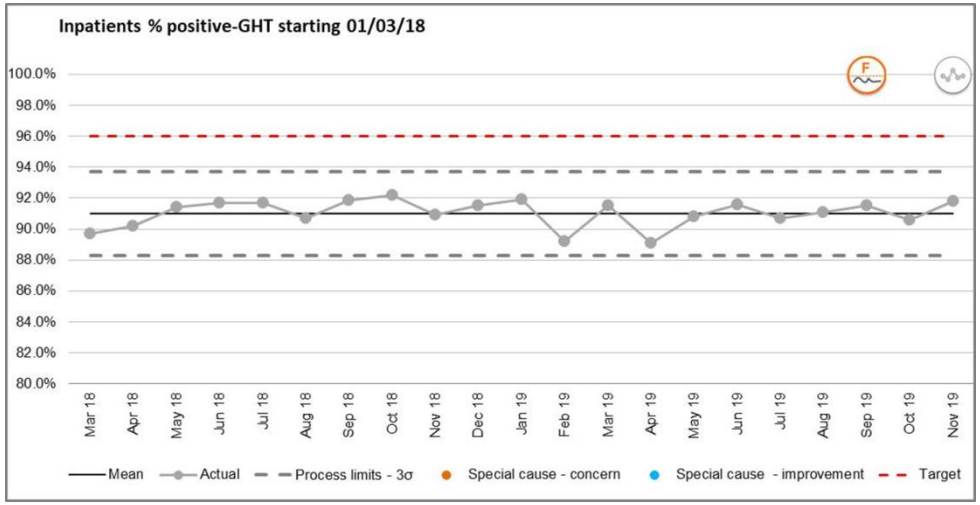
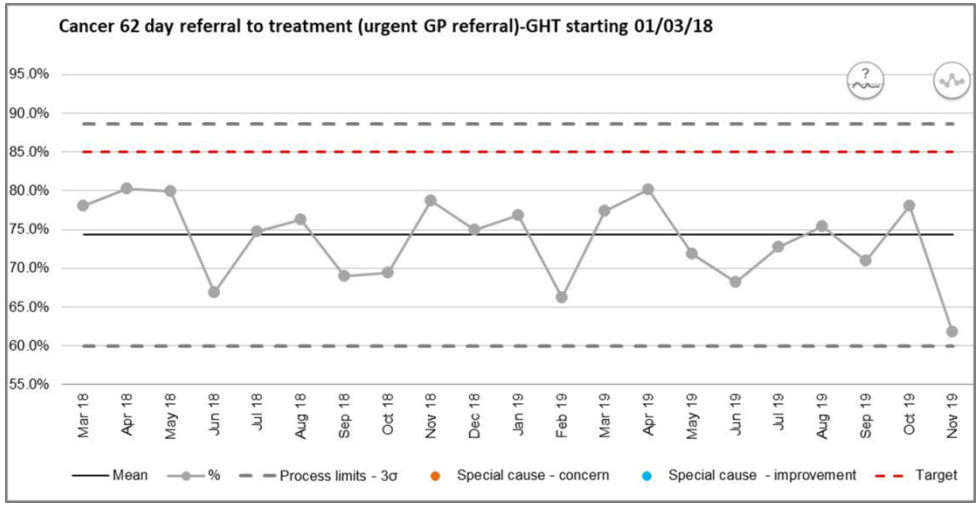
SPC Charts (7)

Gloucestershire Hospitals
NHS Foundation Trust



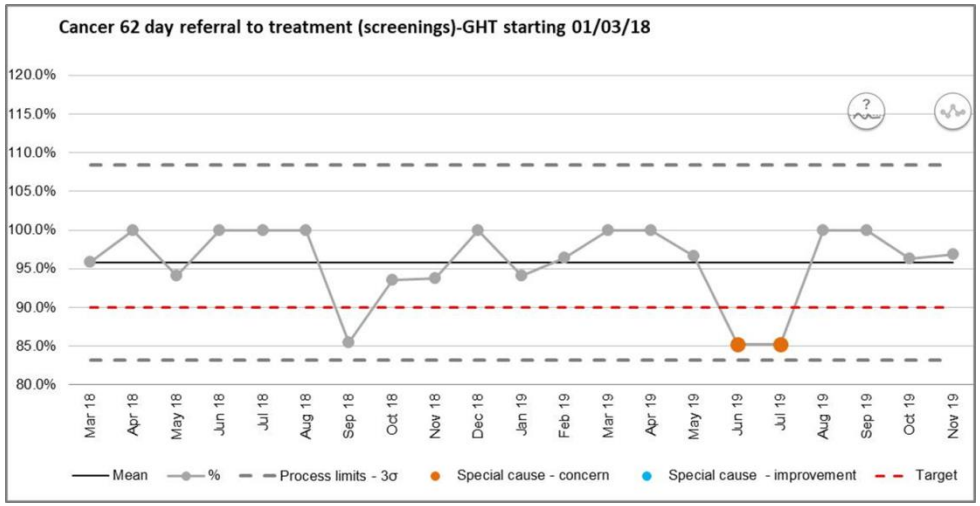
Data observations
Common cause variation



Data observations
Common cause variation

SPC Charts (8)

Gloucestershire Hospitals
NHS Foundation Trust



Data observations

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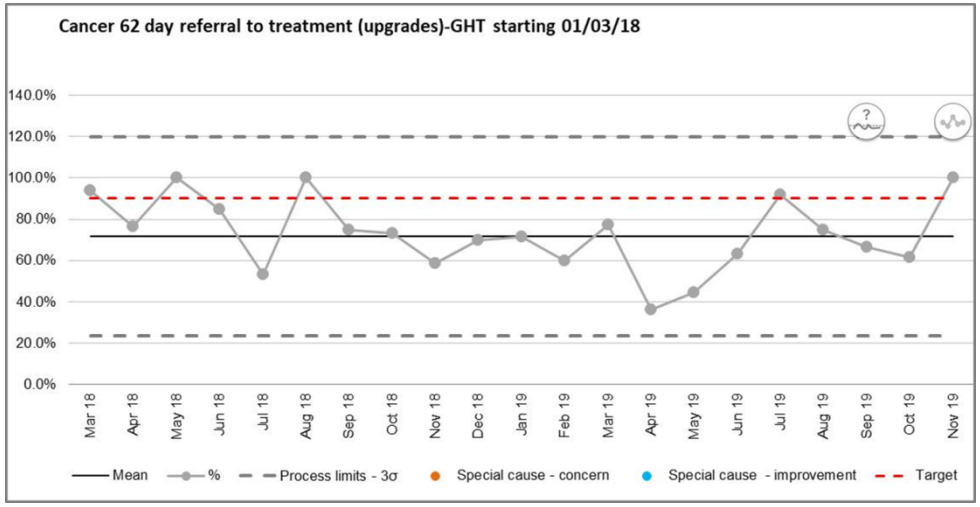
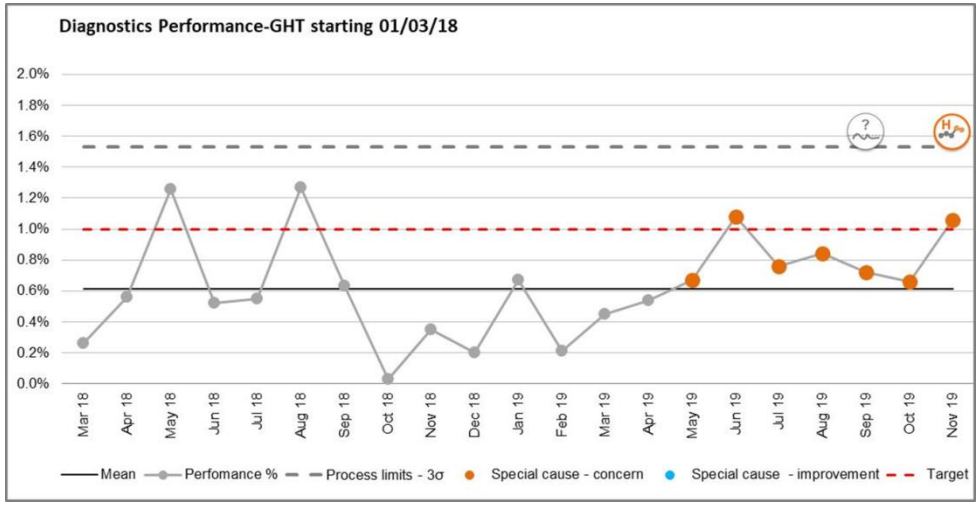


Data observations

Common cause variation

SPC Charts (9)

Gloucestershire Hospitals
NHS Foundation Trust



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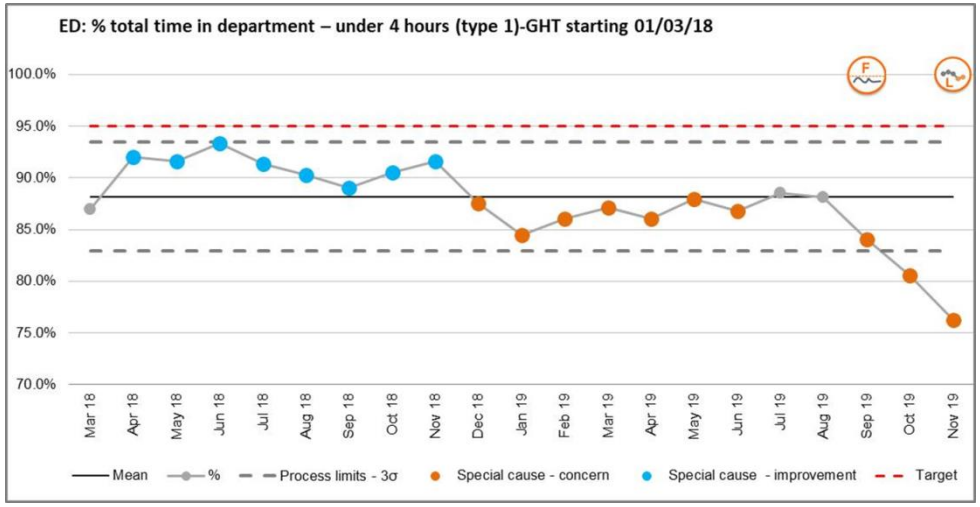

Data observations

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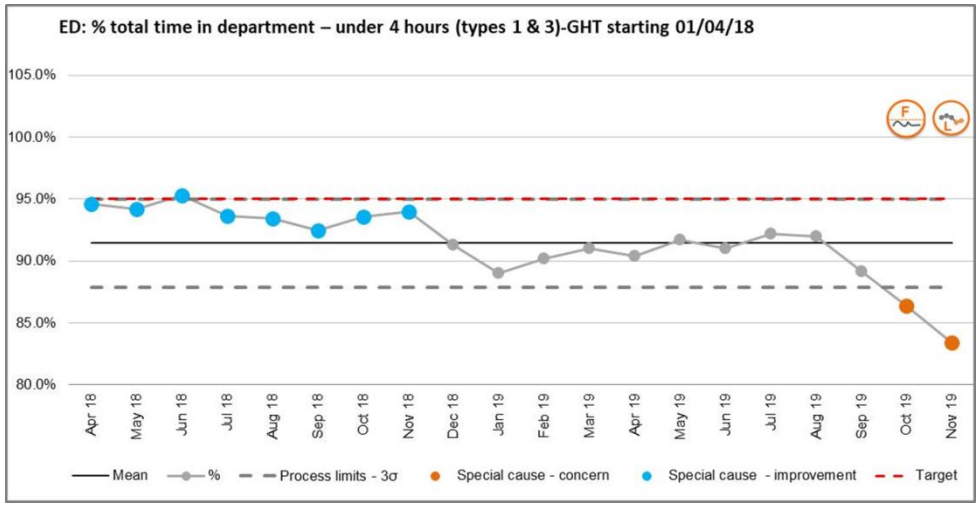
Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 2 data points below the line.
Shift	When more than 7 sequential points fall above or below the mean this is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing.
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing.

SPC Charts (10)

Gloucestershire Hospitals NHS Foundation Trust



Data observations

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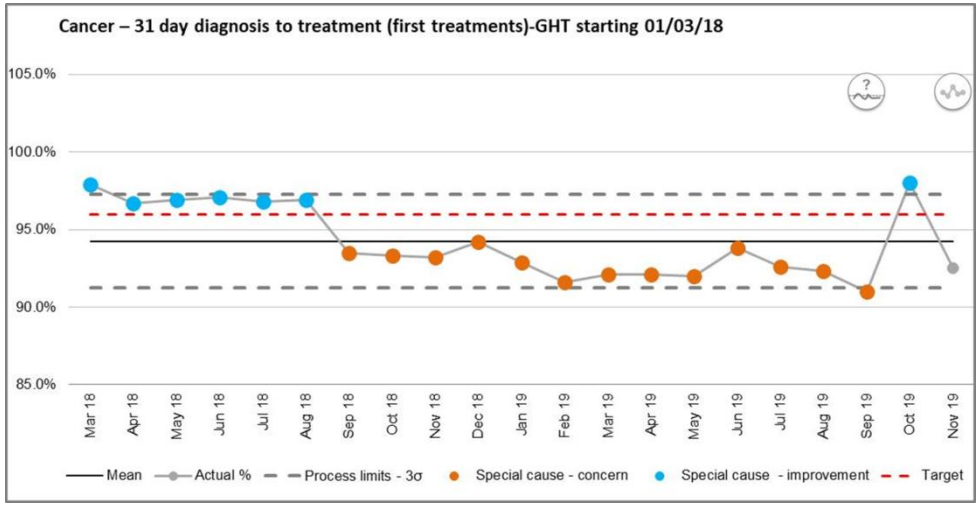
Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 1 data point which is above the line. There are 2 data points below the line.
Shift	When more than 7 sequential points fall above or below the mean this is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above the mean.
2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing.
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing.



Data observations

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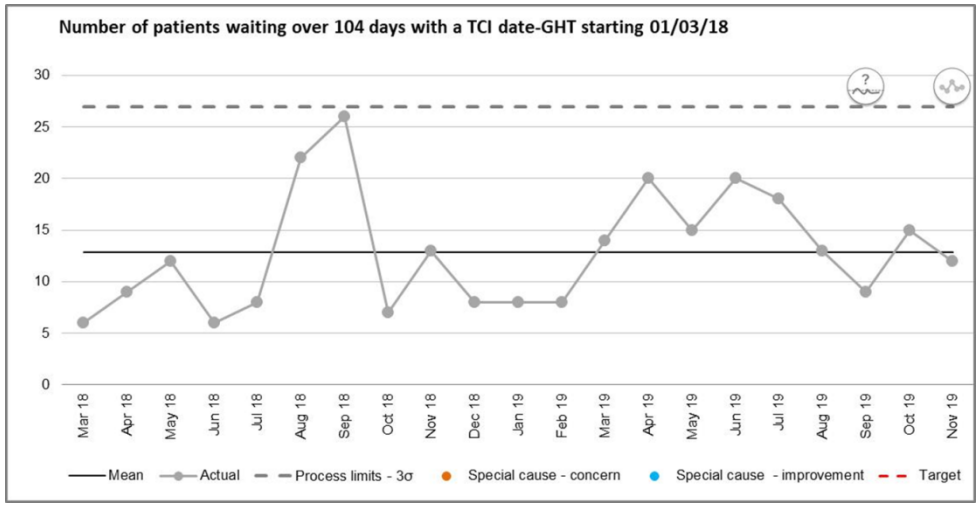
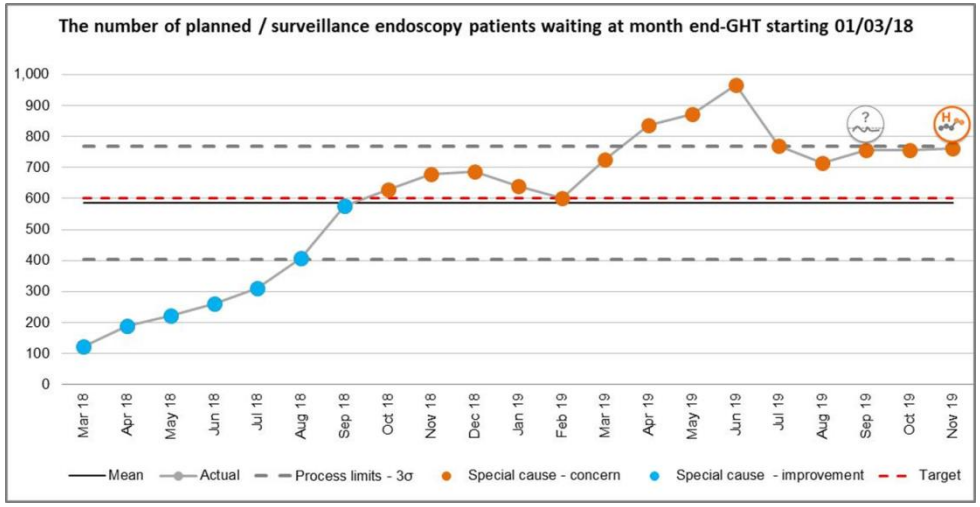
Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 2 data points which are above the line. There is 1 data point which is below the line.
Shift	When more than 7 sequential points fall above or below the mean this is unusual and may indicate a significant change in process. This process is not in control. There is a run of points below the mean.
2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing.
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing.

SPC Charts (11)

Gloucestershire Hospitals
NHS Foundation Trust





Data observations

Common cause variation

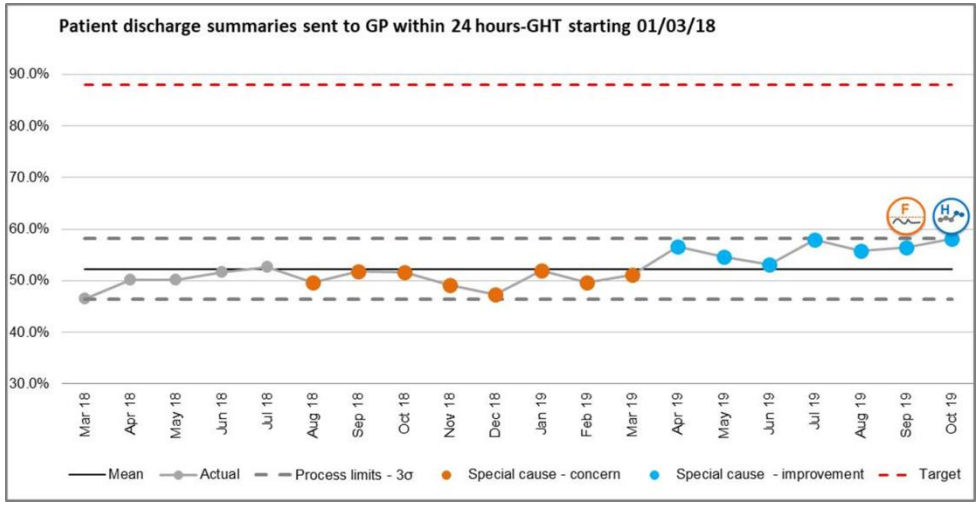
Data observations

This type of chart (SPC) allows you to identify statistically significant changes in data. The dotted lines (process limits) represent the expected range for data points if variation is within expected limits - this is, normal. You can apply a number of rules to identify when the process is not in control - that is, special cause variation.

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 4 data points which are above the line. There is 5 data points below the line.
Shift	When more than 7 sequential points fall above or below the mean this is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points.
2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing.
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing.

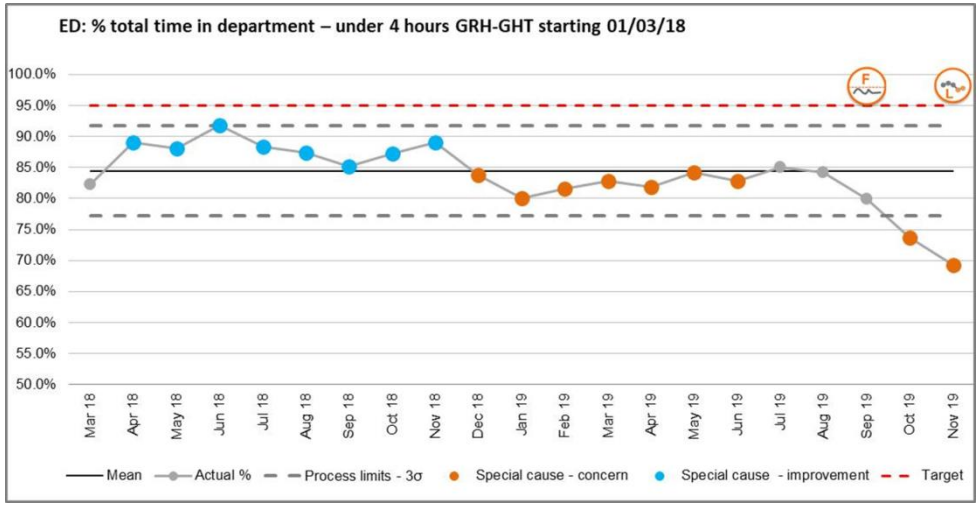
SPC Charts (12)

Gloucestershire Hospitals
NHS Foundation Trust



Data observations

This type of chart (SPC) allows you to identify statistically significant changes in data. The dotted lines (process limits) represent the expected range for data points if variation is within expected limits - this is, normal. You can apply a number of rules to identify when the process is not in control - that is, special cause variation.	
Shift	When more than 7 sequential points fall above or below the mean this is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing.



Data observations

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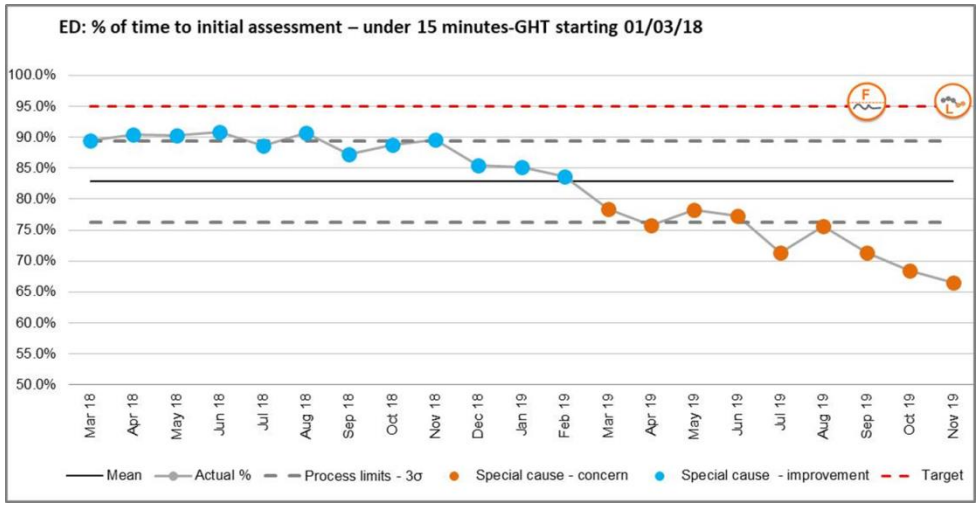
Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 1 data point which is above the line. There are 2 data points below the line.
Shift	When more than 7 sequential points fall above or below the mean this is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing.

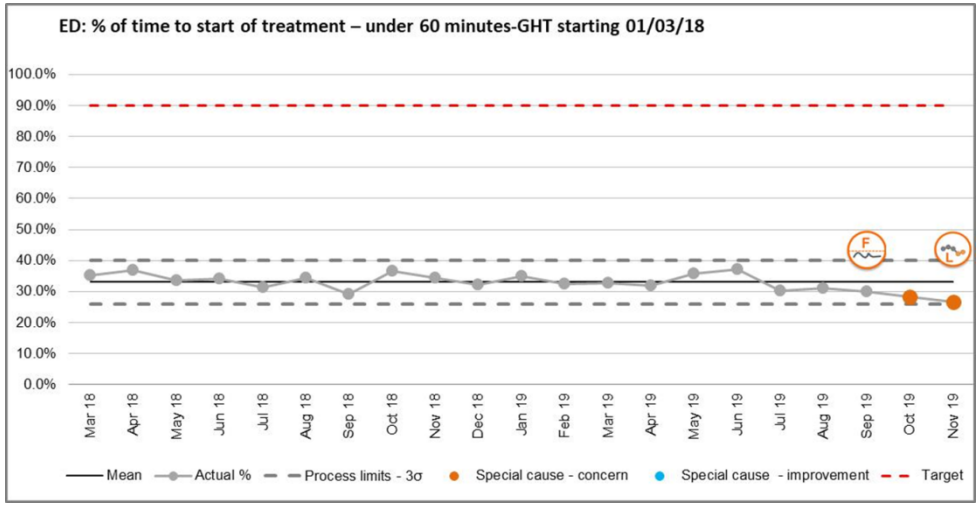
SPC Charts (13)

Gloucestershire Hospitals
NHS Foundation Trust



Data observations

This type of chart (SPC) allows you to identify statistically significant changes in data. The dotted lines (process limits) represent the expected range for data points if variation is within expected limits - this is, normal. You can apply a number of rules to identify when the process is not in control - that is, special cause variation.	
Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 6 data points which are above the line. There are 6 data points below the line.
Shift	When more than 7 sequential points fall above or below the mean this is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing.
2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing.



Data observations

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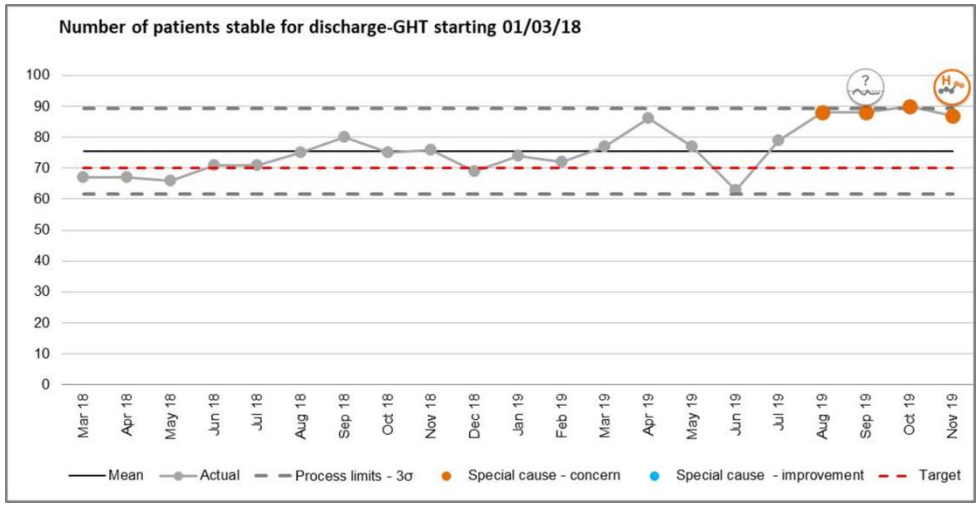
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing.

SPC Charts (14)

Gloucestershire Hospitals
NHS Foundation Trust



Data observations

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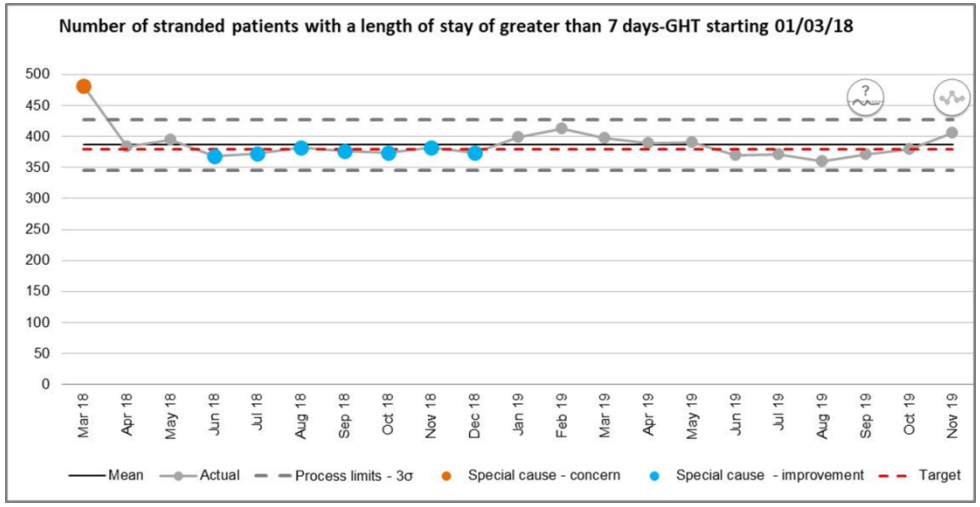
Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 1 data point which is above the line.
2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing.



Data observations

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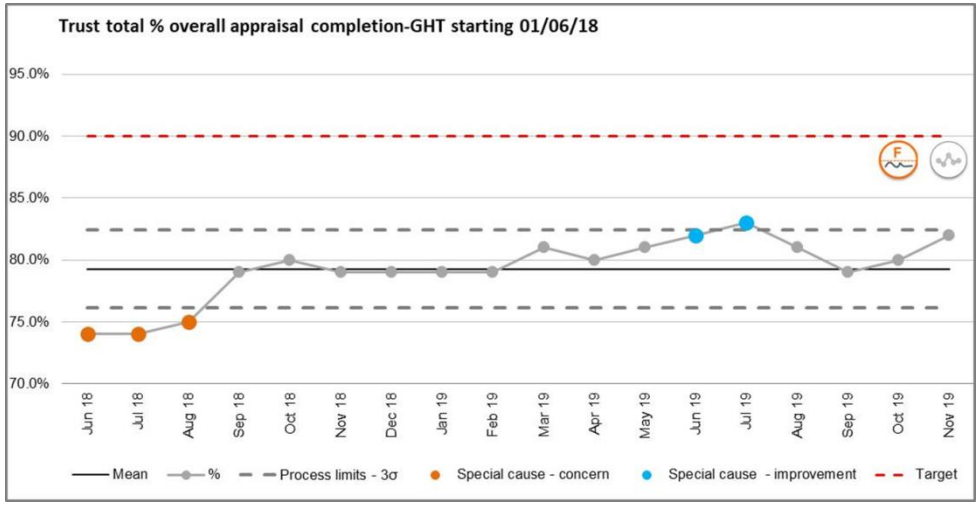
Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 1 data point which is above the line.
Shift	When more than 7 sequential points fall above or below the mean this is unusual and may indicate a significant change in process. This process is not in control. There is a run of points below the mean.

SPC Charts (15)

Gloucestershire Hospitals NHS Foundation Trust



Data observations

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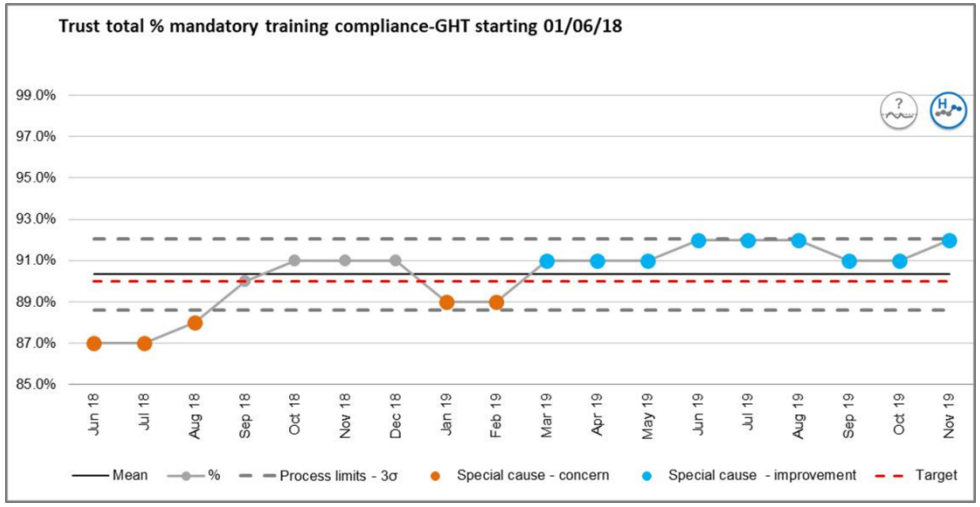
Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 1 data point which is above the line. There are 3 data points below the line.
2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing.
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing.



Data observations

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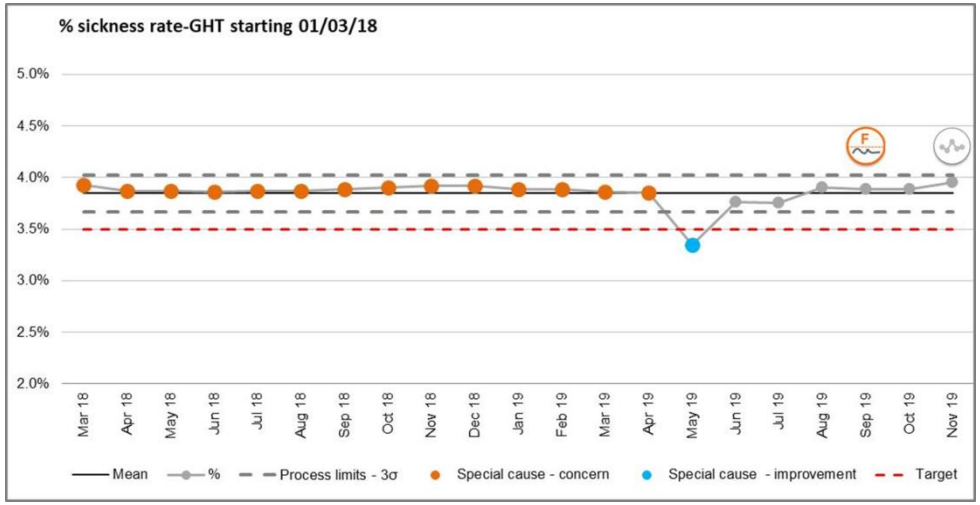
Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 3 data points below the line.
Shift	When more than 7 sequential points fall above or below the mean this is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above the mean.
2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing.
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing.

SPC Charts (16)

Gloucestershire Hospitals
NHS Foundation Trust



Data observations

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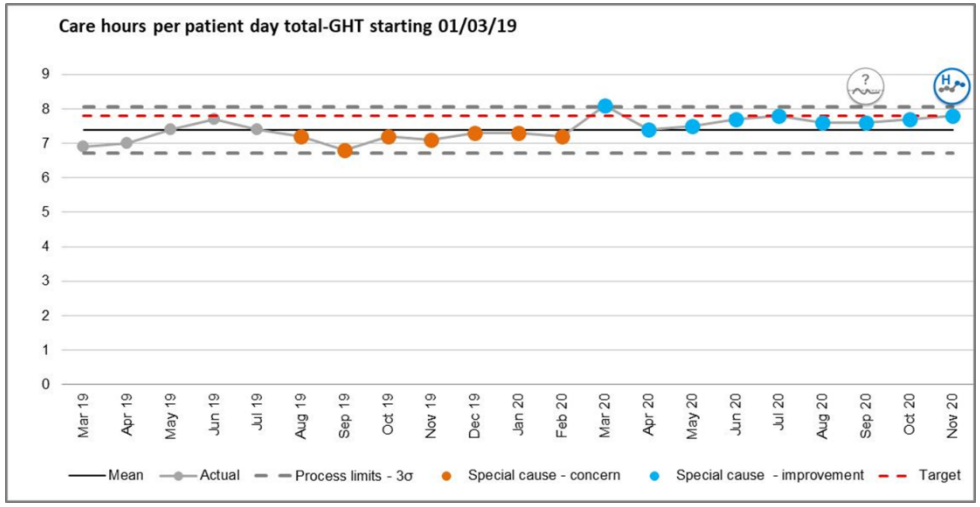
Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. Thereis 1 data point below the line.
Shift	When more than 7 sequential points fall above or below the mean this is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above the mean.



Data observations

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Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. Thereis 1 data point which is above the line.
Shift	When more than 7 sequential points fall above or below the mean this is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.

REPORT TO MAIN BOARD – JANUARY 2020

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

This report describes the business conducted at the Finance and Digital Committee held on 19 December 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
Strategic Site Development Outline Business Case	Status report provided covering: - Key financial assumptions - Benefit assessment - Capital cost summary - Finalisation actions and timeline	Extensive range of questions raised including: - Construction end date - Security of capital flow - Options to achieve the required Dermatology decant - Scope of benefits - Approach to savings analysis (micro v. macro) - Confidence levels - Robustness of risk assessment	Overall presentation, documentation and discussion provided strong assurance of the quality of the project development and analysis to date.	Further development of benefits assessment and risk analysis required
Sunrise EPR Highlight Report	Update of the programme progress focusing on the 4 December Go Live at Gloucestershire Royal Hospital	What has been the dependency on the Trakcare interface? How is the relationship with the key supplier?	TrakCare provider has been very helpful AllScripts have delivered Go Live within 5 months and have honoured requests and commitments to achieve a successful launch Overall progress is exemplary at this stage with planned implementation working and	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
			potentially patient care improvements exceeding expectations	
Digital Risk Register	Risk report update – no change since November. Discussion surrounding broader risk matters associated with digital transformation	When would it be best to take a detailed look at this Risk evolution? What is the plan to review the quantification of benefits associated with EPR	Review scheduled for January with a focus on how staff use their time	March 2020
Finance Performance Report	8 months' cumulative deficit at £7.2 million (on a Control total basis) is a £0.6 million favourable variance against plan. Key favourable variances: - Commissioner income £4.1m - Other income £2.8m Partially offset by adverse variance on pay (£1.2 m) and non-pay (£5.6m) non-pay Detailed variance analysis presented Cash balance (£19.0 million) continues to be relatively high representing cash held following loan receipts for committed	Are there increasing tensions between patient safety and winter pressures and holding Divisions to forecast? What is the analysis of the change in opening balances? Does the revised view of the 4th quarter present any challenges in terms of reserve and provision levels What comprises non-current trade and other receivables?	Division plans and analysis generally robust but challenges exist in Medical Division Expected balance sheet entries will be appropriate	Monitoring of additional work to continue and be reported to the Committee Post audit reconciliation to be shared at Committee Analysis to be provided

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	capital expenditure Balance sheet commentary Challenges and opportunities for balance of year described in detail. Projection of Quarter 3 outcome at plan with expectation for 4th quarter now closer to plan than previously estimated.			
Capital Programme Update	Update on the 19/20 capital programme with an expected outturn of £26.5 million. Significant current activity notably in enabling works, IT and Imaging	Does the expected cash position support the planned expenditure? What plans are in place to work with local MPs and Central Government to maximise funding?	Yes Ongoing meetings in place and support sought when and where considered appropriate	
Cost Improvement Programme Update	At month 8 savings of £10.4 million delivered – a £0.9 million shortfall from plan – 2nd month where target missed Year's outturn projected at £ 14.7 million delivery – a £7.7m shortfall from the plan of £22.4 million. 61% - £9 million of the total is recurrent £5.6 m plan Detailed actual and planned performance described.	Is the Trust thinking beyond a 12-month timeframe for CIP planning? Where/how are staff being encouraged to think about longer term transformative opportunities? What is the real progress with the 4/5 most significant	A 3-year timeframe is in place with clinical engagement a priority. Trial approach on Surgical Division including an "ideas week" New approaches being considered	Report results of new approach to committee in February Must be kept under review Reconciliation statement covering progress and

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	Delivery risk assessment improvement described 20/21 productivity opportunities reviewed together with increased emphasis on collaborative working at the ICS level	transformation projects described to the committee earlier in the year?		current status to be shared at the next committee
System 5 Year Plan	Verbal update on the Plan - Next submission scheduled for 10 January - Current plan currently has a significant gap - CCG in dialogue with the regulator	Is there consistency with the approach being taken on other systems? How to ensure the 3 and 5-year horizons captured and not drowned out by a one year view?	Work continuing	Board level briefing and discussion essential prior to next submission

Rob Graves
Finance & Digital Committee

TRUST BOARD – January 2020
Redwood Education Centre, Gloucestershire Royal Hospital commencing at 12:30

Report Title
Financial Performance Report – Month 8 2019/20

Sponsor and Author(s)
Author: Aidan Quinn, Director of Operational Finance (Interim) Sponsor: Karen Johnson, Director of Finance

Executive Summary

Purpose

This report provides the Trust Board with details of the financial performance for the period ended 30th November 2019.

Key issues to note

- At Month 8 the Trust is reporting a cumulative deficit of £7.2m, which is £0.6m favourable to plan.
- Commissioner income is £4.1m favourable against plan.
- Other NHS patient related income is £0.7m favourable against plan.
- Private and paying patients' income is £0.6m favourable to plan.
- Other operating income (including Hosted Services) is £1.6m favourable to plan.
- Pay expenditure is showing an adverse variance of £1.2m.
- Non-pay expenditure is showing an adverse variance of £5.6m.
- Non-operating costs are £4.6m adverse to plan (reflecting the impairment of TrakCare) – this is reversed out from a control total point of view leaving a favourable variance to the planned position.
- The closing cash position contains a high level of committed cash – relating to planned expenditure for both revenue and capital.
- The Trust is working on a number of initiatives to mitigate the outstanding financial gap to deliver its planned control total, noting the risks to delivery.

Conclusions

- The Trust Board is asked to note the contents of the report and approve the submission of control total delivery to NHSE&I in the month 9 provider return.

Implications and Future Action Required

The submission of the Trust's month 9 provider return forecasting control total delivery.

Recommendations

- The Trust Board is asked to note the contents of the report and approve the submission of control

total delivery to NHSE&I in the month 9 provider return.

Impact Upon Strategic Objectives

Delivery of the in-year financial position supports Strategic Objective 7 – "We are a Trust in financial balance, with a sustainable financial footing evidenced by our NHSI Outstanding rating for Use of Resources".

Impact Upon Corporate Risks

The following risks on the Trust Risk Register are all impacted by the in-year financial position:

- 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
- Risk that available capital is insufficient to support requirements associated with buildings maintenance, equipment renewal and backlog maintenance resulting in major operational impacts and increased costs
- Risk that the Trust does not achieve the required cost improvement resulting in failure to deliver the Financial Plan for FY20

Regulatory and/or Legal Implications

There is potential for regulatory action if the financial position is not delivered as planned in 2019/20.

Equality & Patient Impact

Whilst there are no direct implications, the financial position affects investment decisions and prioritisation of expenditure in year which may have implications on service development.

Resource Implications

Finance	**X**	Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required

For Decision		For Assurance	**X**	For Approval	**X**	For Information	

Date the paper was presented to previous Committees 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)
	19th December 2019						

Outcome of discussion when presented to previous Committees/TLT

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

Gloucestershire Hospitals NHS
NHS Foundation Trust

Report to the Trust Board

Financial Performance Report
Month Ended 30th November 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 8.

The financial position as at the end of November 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 November the Group's consolidated position shows a year to date deficit of £7.2m. This is £0.6m 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.

Statement of Comprehensive Income (Trust and GMS)

	TRUST POSITION			GMS POSITION			GROUP POSITION *		
Month 08 Cumulative Financial Position	Budget £000s	Actuals £000s	Variance £000s	Budget £000s	Actuals £000s	Variance £000s	Budget £000s	Actuals £000s	Variance £000s
SLA & Commissioning Income	321,542	325,663	4,120	0	0	0	321,542	325,663	4,120
PP, Overseas and RTA Income	3,201	3,824	622	0	0	0	3,201	3,824	622
Other Income from Patient Activities	598	1,308	709	0	0	0	598	1,308	709
Operating Income	52,612	53,857	1,245	30,666	30,882	215	55,208	56,767	1,559
Total Income	**377,954**	**384,651**	**6,697**	**30,666**	**30,882**	**215**	**380,550**	**387,561**	**7,011**
Pay	236,169	236,806	(637)	12,235	12,834	(599)	248,181	249,373	(1,192)
Non-Pay	134,494	140,355	(5,861)	16,819	16,389	429	123,466	129,039	(5,573)
Total Expenditure	**370,664**	**377,161**	**(6,498)**	**29,054**	**29,223**	**(169)**	**371,647**	**378,412**	**(6,765)**
EBITDA	**7,290**	**7,490**	**200**	**1,613**	**1,659**	**46**	**8,903**	**9,149**	**246**
EBITDA %age	**1.9%**	**1.9%**	**0.0%**	**5.3%**	**5.4%**	**0.1%**	**2.3%**	**2.4%**	**0.0%**
Non-Operating Costs	15,403	19,943	(4,540)	1,613	1,659	(46)	17,016	21,601	(4,586)
Surplus/(Deficit) with Impairments	**(8,113)**	**(12,453)**	**(4,340)**	**0**	**0**	**0**	**(8,113)**	**(12,453)**	**(4,340)**
Less Fixed Asset Impairments	0	4,918	4,918	0	0	0	0	4,918	4,918
Surplus/(Deficit) excluding Impairments	**(8,113)**	**(7,535)**	**578**	**0**	**0**	**0**	**(8,113)**	**(7,535)**	**578**
Excluding Donated Assets	295	292	(2)	0	0	0	295	292	(2)
Control Total Surplus/(Deficit)	**(7,818)**	**(7,243)**	**575**	**0**	**0**	**0**	**(7,818)**	**(7,243)**	**575**

* Group Position excludes £29.3m 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.

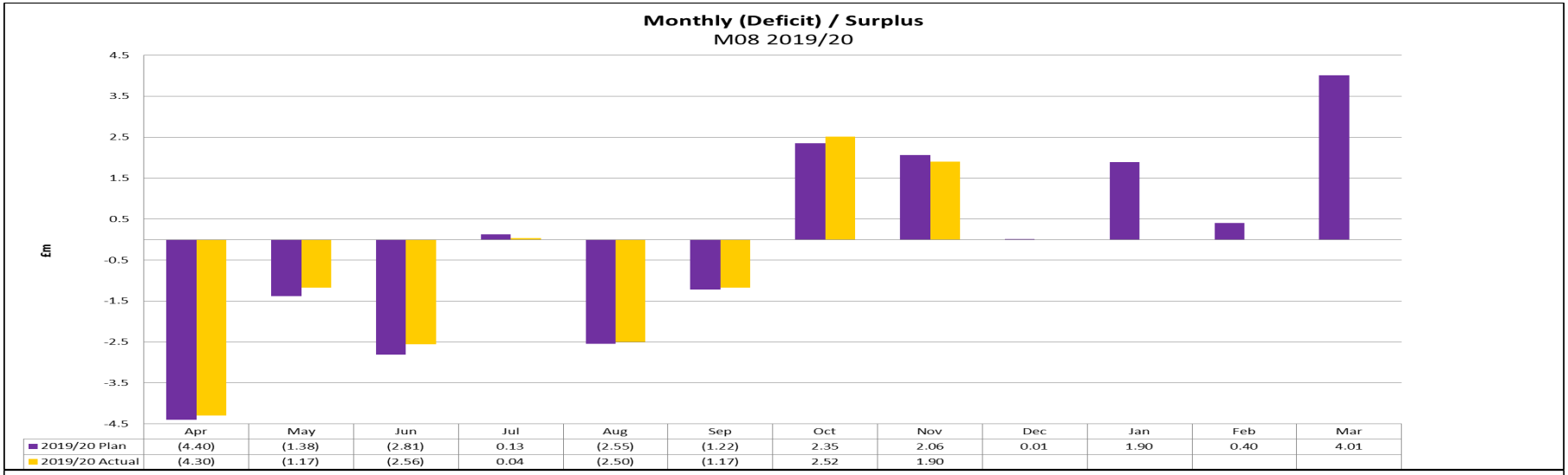
In November the Group's consolidated position shows an in month surplus of £1.9m on a control total basis, an adverse variance to plan of £0.2m.

Month 08 Financial Position	Annual Budget £000s	M08 Budget £000s	M08 Actuals £000s	M08 Variance £000s	M08 Cumulative Budget £000s	M08 Cumulative Actuals £000s	M08 Cumulative Variance £000s
SLA & Commissioning Income	482,404	41,764	41,699	(66)	321,542	325,663	4,120
PP, Overseas and RTA Income	4,802	400	472	72	3,201	3,824	622
Other Income from Patient Activities	898	75	144	69	598	1,308	709
Operating Income	86,896	7,474	7,362	(112)	55,208	56,767	1,559
Total Income	**574,999**	**49,714**	**49,677**	**(36)**	**380,550**	**387,561**	**7,011**
Pay	367,900	29,935	31,265	(1,330)	248,181	249,373	(1,192)
Non-Pay	182,515	15,627	14,461	1,166	123,466	129,039	(5,573)
Total Expenditure	**550,415**	**45,563**	**45,726**	**(164)**	**371,647**	**378,412**	**(6,765)**
EBITDA	**24,584**	**4,151**	**3,951**	**(200)**	**8,903**	**9,149**	**246**
EBITDA %age	**4.3%**	**8.3%**	**8.0%**	**(0.4%)**	**2.3%**	**2.4%**	**0.0%**
Non-Operating Costs	25,526	2,127	2,088	39	17,016	21,601	(4,586)
Surplus/(Deficit) with Impairments	**(942)**	**2,024**	**1,863**	**(161)**	**(8,113)**	**(12,453)**	**(4,340)**
Less Fixed Asset Impairments	0	0	0	0	0	4,918	4,918
Surplus/(Deficit) excluding Impairments	**(942)**	**2,024**	**1,863**	**(161)**	**(8,113)**	**(7,535)**	**578**
Excluding Donated Assets	(558)	37	37	(0)	295	292	(2)
Control Total Surplus/(Deficit)	**(1,500)**	**2,061**	**1,900**	**(161)**	**(7,818)**	**(7,243)**	**575**

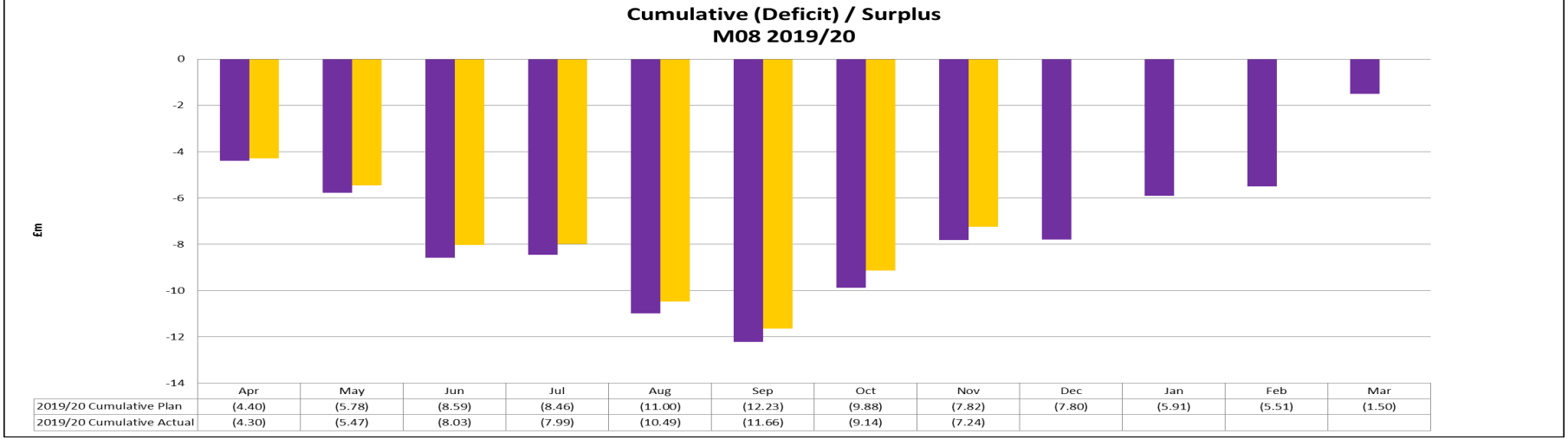
2019/20 Position Trend

Gloucestershire Hospitals NHS
NHS Foundation Trust

The tables below show the trend of plan and actual position, both by month and cumulatively at a control total level. The plan values from October show a significant improvement in run rate which is predicated on the delivery of increased CIP performance.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019/20 Plan	(4.40)	(1.38)	(2.81)	0.13	(2.55)	(1.22)	2.35	2.06	0.01	1.90	0.40	4.01
2019/20 Actual	(4.30)	(1.17)	(2.56)	0.04	(2.50)	(1.17)	2.52	1.90				



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019/20 Cumulative Plan	(4.40)	(5.78)	(8.59)	(8.46)	(11.00)	(12.23)	(9.88)	(7.82)	(7.80)	(5.91)	(5.51)	(1.50)
2019/20 Cumulative Actual	(4.30)	(5.47)	(8.03)	(7.99)	(10.49)	(11.66)	(9.14)	(7.24)				

Detailed Income & Expenditure

Gloucestershire Hospitals NHS
NHS Foundation Trust

Month 08 Financial Position	M08 Budget £000s	M08 Actuals £000s	M08 Variance £000s	M08 Cumulative Budget £000s	M08 Cumulative Actuals £000s	M08 Cumulative Variance £000s
SLA & Commissioning Income	41,764	41,699	(66)	321,542	325,663	4,120
PP, Overseas and RTA Income	400	472	72	3,201	3,824	622
Other Income from Patient Activities	75	144	69	598	1,308	709
Operating Income	7,474	7,362	(112)	55,208	56,767	1,559
Total Income	**49,714**	**49,677**	**(36)**	**380,550**	**387,561**	**7,011**
Pay						
Substantive	27,881	28,566	(685)	231,909	228,461	3,448
Bank	975	1,298	(323)	7,811	10,067	(2,256)
Agency	1,079	1,401	(322)	8,461	10,844	(2,383)
Total Pay	**29,935**	**31,265**	**(1,330)**	**248,181**	**249,373**	**(1,192)**
Non Pay						
Drugs	5,940	5,554	386	45,199	48,404	(3,205)
Clinical Supplies	3,243	3,348	(105)	25,952	26,807	(855)
Other Non-Pay	6,445	5,559	885	52,315	53,828	(1,514)
Total Non Pay	**15,627**	**14,461**	**1,166**	**123,466**	**129,039**	**(5,573)**
Total Expenditure	**45,563**	**45,726**	**(164)**	**371,647**	**378,412**	**(6,765)**
EBITDA	**4,151**	**3,951**	**(200)**	**8,903**	**9,149**	**246**
EBITDA %age	**8.3%**	**8.0%**	**(0.4%)**	**2.3%**	**2.4%**	**0.0%**
Non-Operating Costs	2,127	2,088	39	17,016	21,601	(4,586)
Surplus/(Deficit)	**2,024**	**1,863**	**(161)**	**(8,113)**	**(12,453)**	**(4,340)**
Fixed Asset Impairments	0	0	0	0	4,918	4,918
Surplus/(Deficit) after Impairments	**2,024**	**1,863**	**(161)**	**(8,113)**	**(7,535)**	**578**
Excluding Donated Assets	37	37	(0)	295	292	(2)
Surplus/(Deficit)	**2,061**	**1,900**	**(161)**	**(7,818)**	**(7,243)**	**575**

Non-Pay – expenditure is showing a year to date £5.6m overspend, reflecting overspends on pass through drugs and clinical supplies which are offset within income (£3.2m). The clinical supplies overspend of £0.9m includes the hire from Cobalt of MRI and CT Scanners (£0.3m), and tube repairs (£0.1m). The overspend on other non pay of £1.5m reflects expenditure mainly for outsourced clinical services e.g. D&S outsourced reporting (£0.2m), unidentified CIP (£0.5m) and the timing of receipt of the CNST rebate (£0.5m) for the Women & Children Division, which has now been confirmed.

SLA & Commissioning Income – is reporting an over performance of £4.1m 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 £0.6m, reflecting private Oncology patients activity in D&S.

Other Operating income – Includes additional non-commissioned income in Cytology, Microbiology and Histology £0.2m, training income of £0.4m, car parking £0.2m, and hosted services of £0.3m and R&D £0.1m; the final two being offset by expenditure.

Pay – Cumulatively there is an overspend of £1.2m, reflecting an underspend on substantive budgets (£3.4m), offset by overspends on bank (£2.3m) and agency budgets (£2.4m). The in month overspend reflects the increased CIP requirement in pay budgets.

Cost Improvement Programme

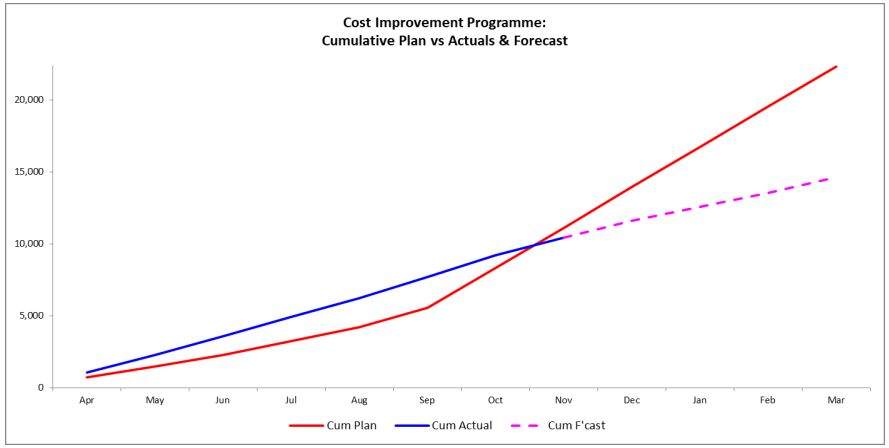
Gloucestershire Hospitals NHS
NHS Foundation Trust

1. At Month 8 the Trust has delivered £10.4m of CIP against the Year to date target of £11.1m, this is an under performance of £0.7m. Within the month, the Trust has delivered £1.2m of CIP against an in-month target of £2.8m. Within the month, this is a negative variance of £1.5m which is largely due to the profiling of 'unidentified' schemes from month 7.

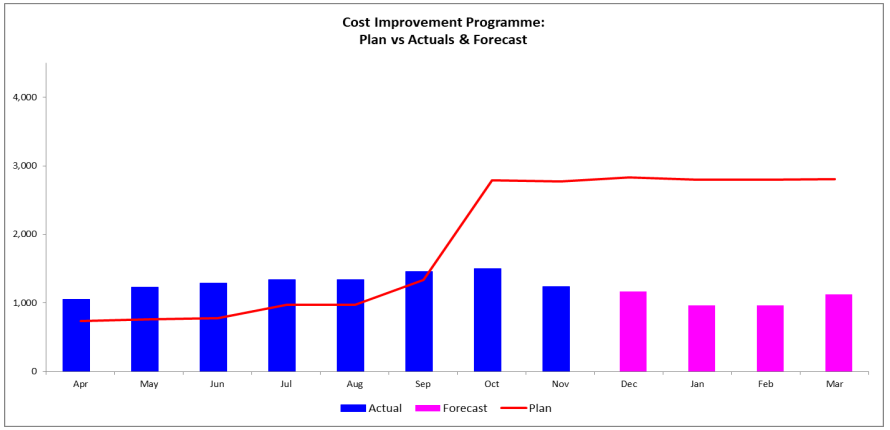
2. At Month 8, the Divisional year end forecast figures indicate delivery of £14.7m against the Trust's target of £22.4m. This has stayed relatively steady since month 5 which leaves a negative variance against target of £7.7m. The forecast outturn splits into £9m (61%) of recurrent schemes and £5.7m (39%) of non-recurrent schemes.

3. In year recovery measures to improve the forecast outturn continue. Oversight and scrutiny of the delivery of the 2019/20 Cost Improvement Programme continues through weekly deep dives.

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



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 M8 £000	B/S movements from 31st March 2019 £000
Non-Current Assests			
Intangible Assets	10,412	5,801	(4,611)
Property, Plant and Equipment	231,216	233,623	2,407
Trade and Other Receivables	5,185	4,668	(517)
Investment in GMS		0	
Total Non-Current Assets	**246,813**	**244,092**	**(2,721)**
Current Assets			
Inventories	7,571	8,239	668
Trade and Other Receivables	25,419	34,606	9,187
Cash and Cash Equivalents	7,317	19,013	11,696
Total Current Assets	**40,307**	**61,858**	**21,551**
Current Liabilities			
Trade and Other Payables	(54,315)	(69,910)	(15,595)
Other Liabilities	(5,837)	(2,890)	2,947
Borrowings	(12,527)	(11,954)	573
Provisions	(160)	(160)	0
Total Current Liabilities	**(72,839)**	**(84,914)**	**(12,075)**
Net Current Assets	**(32,532)**	**(23,056)**	**9,476**
Non-Current Liabilities			
Other Liabilities	(6,860)	(6,609)	251
Borrowings	(135,294)	(154,753)	(19,459)
Provisions	(1,434)	(1,434)	0
Total Non-Current Liabilities	**(143,588)**	**(162,796)**	**(19,208)**
Total Assets Employed	**70,693**	**58,240**	**(12,453)**
Financed by Taxpayers Equity			
Public Dividend Capital	172,676	172,676	0
Equity		0	
Reserves	23,915	23,915	0
Retained Earnings	(125,898)	(138,351)	(12,453)
Total Taxpayers' Equity	**70,693**	**58,240**	**(12,453)**

The table shows the M08 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 8 balance sheet position against the 2018/19 outturn

Current Assets

- Inventories have increased in year by £0.7m reflecting an increase in pharmacy stock.
- Cash has increased by £11.7m 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 £18.9m, reflecting working capital loan support of £12.5m and a capital loan of £10m, offset by the repayment of loans approved in prior years.

Retained Earnings

- The retained earnings reduction of £12.5m 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 November	
	Number	£'000	Number	£'000
Total Bills Paid Within period	69,697	154,959	7,837	16,910
Total Bill paid within Target	61,261	129,509	7,157	14,096
Percentage of Bills paid within target	88%	84%	91%	83%

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

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

Liabilities – Borrowings

Analysis of Borrowing	As at 30th November 2019 £000
<12 months	
Loans from ITFF	2,988
Distress Funding	6,800
Obligations under finance leases	1,598
Obligations under PFI contracts	568
Balance Outstanding	**11,954**
>12 months	
Loans from ITFF	19,958
Capital Loan	14,016
Distress Funding	99,409
Obligations under finance leases	3,785
Obligations under PFI contracts	17,585
Balance Outstanding	**154,753**
Total Balance Outstanding	**166,707**

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 £22.5m of additional in-year borrowing from the DoH, £12.5m deficit support and a £10m capital loan.

Cash flow: November

Gloucestershire Hospitals NHS
NHS Foundation Trust

Cashflow Analysis	Apr-19 £000s	May-19 £000s	Jun-19 £000s	Jul-19 £000s	Aug-19 £000s	Sep-19 £000s	Oct-19 £000s	Nov-19 £000s	Forecast Movement Dec-19 to March-20 £000s	Forecast Outturn £000s
Surplus (Deficit) from Operations	**(3,464)**	**(5,470)**	**(1,626)**	**835**	**(1,700)**	**(305)**	**3,037**	**2,668**	**4,352**	**(4,341)**
Adjust for non-cash items:										
Depreciation	1,229	1,229	1,229	1,229	1,229	1,229	1,229	1,229	**6,144**	**14,745**
Other operating non-cash	0	4,918	0	0	0	0	0	0	**(1,000)**	**3,918**
Operating Cash flows before working capital	**(2,235)**	**677**	**(397)**	**2,063**	**(471)**	**924**	**4,266**	**3,897**	**9,496**	**14,322**
Working capital movements:										
(Inc.)/dec. in inventories	113	0	298	(202)	(28)	0	(825)	0	**0**	**(644)**
(Inc.)/dec. in trade and other receivables	1,430	2,796	78	(4,472)	(2,526)	(1,033)	(1,296)	(1,182)	**(3,781)**	**(8,804)**
Inc./(dec.) in current provisions	0	0	0	0	0	0	0	0	**0**	**0**
Inc./(dec.) in trade and other payables	(2,349)	916	154	16,467	(6,712)	(161)	7,732	(1,528)	**(6,670)**	**9,377**
Inc./(dec.) in other financial liabilities	0	(1,055)	0	0	0	0	(1,761)	(131)	**3,348**	**532**
Net cash in/(out) from working capital	**(806)**	**2,657**	**530**	**11,793**	**(9,266)**	**(1,194)**	**3,850**	**(2,841)**	**(7,103)**	**461**
Capital investment:										
Capital expenditure	(1,129)	(1,629)	(1,729)	(3,125)	(1,129)	(500)	(1,807)	(4,208)	**(16,385)**	**(27,433)**
Capital receipts	0	0	0	0	0	0	0	0		**0**
Net cash in/(out) from investment	**(1,129)**	**(1,629)**	**(1,729)**	**(3,125)**	**(1,129)**	**(500)**	**(1,807)**	**(4,208)**	**(16,385)**	**(27,433)**
Funding and debt:										
PDC Received	0	0	0	0	0	0	0	0	**4,015**	**4,015**
Interest Received	17	17	17	17	17	17	16	16	**80**	**198**
Interest Paid	(124)	(294)	(114)	(259)	(196)	(1,327)	0	(291)	**(2,066)**	**(4,380)**
DH loans - received	2,442	3,368	2,887	0	10,049	3,842	0	0	**4,950**	**27,538**
DH loans - repaid	0	0	0	0	(167)	(1,317)	0	0	**(1,486)**	**(2,970)**
Finance lease capital	(488)	(488)	(488)	(488)	(488)	(488)	(488)	(488)	**(2,440)**	**(5,856)**
Interest element of Finance Leases	(12)	(12)	(12)	(12)	(12)	(12)	(13)	(13)	**(65)**	**(150)**
PFI capital element	(68)	(68)	(68)	(68)	(68)	(68)	(68)	(68)	**(349)**	**(825)**
Interest element of PFI	(38)	(38)	(38)	(38)	(38)	(38)	(38)	(38)	**(190)**	**(456)**
PDC Dividend paid						(277)			**(764)**	**(1,041)**
Net cash in/(out) from financing	**1,729**	**2,485**	**2,184**	**(848)**	**9,097**	**332**	**(591)**	**(882)**	**1,685**	**16,073**
Net cash in/(out)	**(2,441)**	**4,190**	**588**	**9,883**	**(1,769)**	**(438)**	**5,718**	**(4,034)**	**(8,273)**	**3,423**
Cash at Bank - Opening	**7,317**	**4,876**	**9,065**	**9,653**	**19,537**	**17,768**	**17,330**	**23,047**	**19,013**	**7,317**
Closing	**4,876**	**9,065**	**9,653**	**19,537**	**17,768**	**17,330**	**23,047**	**19,013**	**10,740**	**10,740**

The cash flow for November 2019 is shown in the table opposite

Cashflow Key movements:

The Cash Position – reflects the Group position. The Trust has drawn down loan support of £12.5m and a capital loan of £10m in 2019/20, and the position also reflects the receipt of Incentive PSF funds from 2018/19 of £3.3m.

The closing cash position includes £5.7m of committed cash:

Committed cash from 2018/19	£2.9m
Balanced of £10m capital loan	£1.3m
Accrued capital expenditure	£1.5m

The remaining cash balance of £13.3m represents Group working capital.

The year end forecast cash position reflects the income and expenditure forecast, and assumes full commitment of the capital programme.

Year End Income and Expenditure Forecast

The table below summarises the forecast year end income and expenditure position for the Trust. At month 8 the Trust is forecasting a control total deficit of £8.5m, a deficit to plan of £7m.

The forecast assumes the repayment to the Trust of all 52 week wait fines currently being levied by NHSE&I, and that winter capacity measures are delivered within existing forecast expenditure.

The forecast has improved from that reported to the Board in December by £2.5m. Drivers of this improvement include release of central reserves (£1.5m), D&S (£0.2m), and Corporate (£1.1m) including a transfer of £0.5m expenditure from revenue to capital. The forecast includes the additional income (£0.3m) and additional expenditure (£0.6m) for the winter summit business case.

Month 08 Forecast Outturn	FY PLAN £000s	M08 FoT £000s	Variance £000s
Total Income (Exc PSF/FRF)	**558,857**	**574,096**	**15,239**
PSF/FRF	**15,801**	**10,270**	**(5,531)**
Pay	**(367,559)**	**(375,397)**	**(7,838)**
Non Pay	**(182,515)**	**(191,597)**	**(9,082)**
EBITDA	**24,584**	**17,371**	**(7,213)**
Non Operating Costs	**(25,526)**	**(30,244)**	**(4,718)**
Surplus/(Deficit)	**(942)**	**(12,873)**	**(11,931)**
Fixed Asset Impairments	0	4,918	4,918
Surplus/(Deficit) after Impairments	**(942)**	**(7,955)**	**(7,013)**
Excluding Donated Assets	(558)	(562)	(4)
Surplus/(Deficit)	**(1,500)**	**(8,517)**	**(7,017)**

Work on financial recovery actions to mitigate the gap continues as does the ongoing review of balance sheet flexibility.

The table above reflects the assumed loss of PSF and FRF for quarter 4 of £5.5m, resulting in a total gap from control total of £7m.

Closing The Year End Income and Expenditure Gap

Gloucestershire Hospitals NHS
NHS Foundation Trust

Previously reported mitigating actions to close the gap to control total continue, with particular focus on:

- Run rate expenditure control
- Introduction of further grip and control measures, particularly around discretionary spend
- Development of Divisional opportunities resulting in additional cost reduction delivery
- Year-end outturn income agreement with commissioners

Forecast Scenarios	Downside £m	Likely £m	Upside £m
Planned Deficit (control total)	(1.50)	(1.50)	(1.50)
Forecast deficit at month 8	(8.52)	(8.52)	(8.52)
Month 8 FOT gap to control total	**(7.02)**	**(7.02)**	**(7.02)**
52 week fines imposed	(1.85)		
Gap to control total	**(8.86)**	**(7.02)**	**(7.02)**
Improvement in Forecast		0.50	1.49
Revised Gap to control total	**(8.86)**	**(6.52)**	**(5.53)**
Quarter 4 PSF and FRF funding	5.53	5.53	5.53
Outstanding financial gap	**(3.33)**	**(0.99)**	**0.00**

The table shows the forecast impact of these initiatives on the existing forecast deficit. It also takes into consideration risks and summarises downside, likely and upside year end forecast scenarios.

The outstanding financial gap values reflect the financial improvement required to secure the quarter 4 PSF and FRF funding of £5.5m

The downside forecast assumes that 52 week wait fines are imposed by NHSE&I.

The upside scenario assumes further improvement in the forecast and delivery of the Trust's control total.

The Trust continues to work to improve the forecast position and deliver the upside scenario, and it is recommended that the month 9 return to NHSE&I confirms delivery of control total.

Delivery of the upside scenario will be achieved by a combination of management actions and balance sheet flexibility.

Capital Programme

The table below summarises capital expenditure at month 8 and forecast outturn for 2019/20.

Capital Programme Expenditure Summary position at 30th November 2019

Capital Summary	Internal YTD Plan £k	YTD Spend £k	YTD Var £k	19/20 Full Year Plan £k	FOT 19/20 Spend £k	Forecast Variance £k
Health & Safety Projects	1,558	2,445	888	2,605	2,888	283
Environmental Works	208	238	29	350	391	41
Non Health & Safety Projects	90	328	238	150	334	184
Committed Schemes	277	321	44	460	498	38
Service Reconfiguration	5	0	(5)	37	37	0
Major Equipment Replacement	12	19	7	20	25	5
IM&T	6,052	6,743	691	9,883	9,883	0
MEF	1,493	1,381	(112)	2,490	2,490	0
Other Schemes	2,968	1,532	(1,436)	6,328	6,276	(52)
Contingency/Leases Capitalisation	951	0	(951)	3,678	3,678	0
Overspend/(Underspend)	**13,615**	**13,007**	**(608)**	**26,000**	**26,500**	**500**

- The Trust has also been allocated £0.5m for winter planning and this is reflected in the forecast outturn.
- Following a successful bid, the Trust has been awarded £0.7m to install energy efficient LED lighting across the two hospital sites.

Recommendations

Gloucestershire Hospitals NHS
NHS Foundation Trust

The Trust Board is asked to:

- Note the Trust is reporting a year to date actual income and expenditure deficit on a control total basis of £7.2m at November 2019. This is £0.6m favourable against plan.
- Note the actions being taken to mitigate the forecast gap to delivery of the Trust's control total, and associated forecast scenarios, with consideration of risks to delivery, and approve the submission of control total delivery to NHSE&I in the month 9 provider return.

Author: **Aidan Quinn, Director of Operational Finance (Interim)**

Presenting Director: **Karen Johnson, Director of Finance**

Date: **January 2020**

REPORT TO TRUST BOARD – December 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 16 December 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	No new risks C2997 Radiation Safety: CQC Improvement notice removed and risk will be updated accordingly C2873 Pension Risk. Annual Allowance liabilities will be paid for clinicians with 19/20 liabilities from the government.	What is the risk of colleagues reducing hours / sessions due to pension tax issues	Limited evidence of sessions being dropped. Only 8 clinicians opted out of the scheme and into the alternative contribution scheme, one of the mitigations for this risk	Do the 5 predictors of care, discussed at Board seminar, need to be added as a risk or included as a running theme for People and OD Committees?
Update on CQC/HSE	CQC notice signed off. New inspection January 2020. Radiation Safety Committee well established. Wheelchair case: A jury will be organised to hear the case. Contractual relationships with	Progress on additional Health and Safety resources? Will remedial work be done	Funding was secured earlier than the planned April 2020. Recruitment starts January 2020	Add an update on staff issues relating to the Radiation Committee meetings.

	GMS and PFI provider under review and new Health and Safety charter will be added to the contract to make responsibility clear. Tendering process for remedial work is underway.	prior to coroner case?	Immediate work concluded and procurement underway for remaining remedial works required to be completed pre any CQC follow up investigation.	
Retention and Silver QI Project Update	Non-registered nursing turnover down since June 2019 Nurse retention collaboration. • Person centred careers. • Co-design with nurses. • Insight from colleagues. Interest from NHSI in our Retention plans and innovations	Direction of travel looking good but some areas still have high turnover which need addressing. Triangulation of data shows concerns of patient experience and colleague issues, which is reviewed regularly. How does digital strategy assist in improving colleague experience?	Divisional review process and then in the Committee dashboard monitor trends and areas of concern. Digital strategy includes how we can release time to care and lead but consideration across all key areas on how digital can increase productivity, release time to care and reduce costs (to enable further investment into services) should be more prominent	Include compassionate leadership into thinking of next iteration of retention update.

ICS	Recruitment and Retention sub-group not met since July 2019; Associate Director of Resourcing will Chair from February 2020. Workforce Steering Group meets monthly and has produced the long-term plan narrative. Other updates:- • Development of healthcare programmes. • Funding for Advanced Clinical Practitioner Strategy (£76k funding received). • Refreshing apprenticeship contract. • Education subgroups restarted • Director of People and OD now Chair for SW HRD Network Group under view giving Trust wider view on National Programmes			
Board Assurance Framework	5-year workforce plans produced to support operational plans	Risk 10.3 and 10.4 to be reviewed and merged	Director of Strategy and Trust Secretary will review as part of overall BAF - Process to check that principle risk definitions are correct.	

Safer Staffing Report	July 2019 nursing acuity and dependency analysis using safe care live demonstrates an under establishment of 8 WTE nurses. Actions have been taken to night shift nurses and allocations to increase medicine. Medicine under pressure and needs focus and energy.	Is the 2-3-year profile of investment fast enough given medical workloads?	Medical Director and Director of Nursing to consider and review and report back to P&OD in early 2020	
Modern Slavery	Assurance that the Trust complies with Modern Slavery Act (2015) and procurement HR and Safeguarding mechanisms are in place. Statement endorsed for publication.		Assurance received	
Staff Survey action plan update	Update on the 2018 action plan. Last scrutinised at October Colleague and Patient Experience and Improvement Group Progress provided for divisions and Trust wide themes of Quality of appraisals, Bullying and Harassment and Health and Wellbeing.	Learning from others important, ie, what do higher preforming Trusts with greater response rates do? Concern about addressing key issue from Women's and Children on strained relationships	Analysis of how to improve response and recommendations made nationally have all been implemented. Board and Divisions often focus on Performance data: financial and delivery targets dominate softer items further – harder to show impact and	Need less detailed data and more narrative and assurance on exceptions. What is on and off track? If

		What are the barriers to successful action on staff survey plans and how do me make it more important to divisions. How to make staff survey more important to divisions	progress on softer issues. Divisional executive process is trying to stop concern on statistics to move to improved qualitative information on expenses	something hasn't started, why?
Engagement and Involvement Strategy	Latest draft provided for feedback Considered where next? Associate Director of Engagement appointment would provide an input. Definition of a stakeholder useful and strong. Need clarity on how Governors should engage the public. Clarity on differences patient experience and patient engagement, Colleague experience and colleague engagement	Peer review opportunities - ensure triangulation with Quality and People and OD Strategy A spring CQC well led will require a strategy. Dynamism of real time feedback missing plus ambition needs to show as part of business as usual as well as 'you said, we did approach'.	Some progress made but strategy still requires further work and may need external support	
Performance Dashboard	Included SPC charts to track longitudinal changes. Variation box provides additional	Appraisal rate in 80's	HRBP's supporting divisions on how to programme appraisals throughout the year.	

	detail Additional exceptional reports from divisional reviews will be provided and draft style reports received. Improving trend in vacancy rate	Granular divisional data will assist to provide information on areas of concern.		

Board note/matter for escalation

Balvinder Kaur Heran
Chair of People and OD Committee, 16 December 2019

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – 9 JANUARY 2020
LECTURE HALL, REDWOOD EDUCATION CENTRE, GRH

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

Purpose

The performance dashboard aligns to key metrics identified within the People and Organisational Development Strategy. Key performance indicators detailed within are benchmarked (where appropriate) to Model Hospital Peer rates and University Hospital/ Teaching Peer rate. The indicators include:

- Retention
- Vacancy levels
- Turnover
- Sickness
- Appraisal and Mandatory Training

The People and Organisational Development Committee are advised that there are a variety of other strategic and operational measures contained within the strategy for which performance is more appropriately measured in narrative/ more detailed report form (i.e. Bullying and Harassment, Equality, Diversity and Inclusion measures, Staff Engagement, ICS). These have been mapped accordingly in People and Organisational Development Committee Assurance Mapping profile (presented at October 2019 meeting) and feature, as part of the overarching People and OD Committee work plan.

Key issues to note

Turnover and Retention
Non Registered nursing turnover remains below 2018 levels; **Medicine Division** has the highest Turnover rate for non-registered nursing staff at 24.59%. The next highest Division is Surgery at 13.31%.
When we benchmark our Registered Nurse retention rate against Model Hospital Peers (rate **86.8%) and** University/Teaching Peer (rate **87%**) The Trust outperforms with a current retention rate of **88.56%.** An SPC chart for turnover is enclosed which demonstrates the activity within this mean rate and a reduction in Turnover since April 2019.

Sickness Absence
Trust annual sickness absence rates are **stable (3.89%)** and sit below both Model Hospital Peers (rate 4.01%) and University/Teaching Peer (rate 4.05%). An SPC chart is enclosed which demonstrates the activity within this mean rate.

Vacancy levels
Vacancy levels within Non Registered Nursing and Doctors has decreased. With medical vacancies reducing dramatically over the summer months. Staff Nurse vacancies have reduced to 11.74% or, if ODPs are included, (their funding has been transferred to Nursing & Midwifery) 7.95%, an improvement to the

national picture relating to staff nurse recruitment. Efforts continue to find innovative ways to attract and recruit Nursing staff from both domestic and international pipelines. September saw an increase in Band 5 recruitment thanks to newly qualified & overseas qualified staff.

Appraisal
Appraisal compliance has declined since July and remains an area of concern, although there was a 1% improvement for October. Divisions are challenged via the executive review process to report on specific action plans to improve compliance and their progress. We anticipate further decline in appraisal rates across clinical areas over the winter pressure period.

Mandatory Training
Compliance is achieved at **91% against a target of 90%.** Only Medicine Division remains below the target at 89%. By Staff Group, Additional Clinical Services and SAS Doctors are at 86% & 87% respectively, Training Grade Medical staff have improved by 9% to 79%. All other groups are over target. Information Governance training is highlighted as an exception due to the decline in compliance. It is recognised that the anniversary of this training requirement means some slippage may occur, however Divisions will now be challenged to focus on local improvement plans to improve and meet the required 95% target.

Divisional Exception Report

A new template has been drafted for the divisional executive review process following further review and discussion during November (Annex 2 and Annex 2a). The scorecard aligns to the newly developed accountability framework, with an additional slide to capture divisional narrative and actions relating to key measures in the People and Organisational Development Strategy. These will be added in the next iteration of the performance dashboard.

Recommendations

It is recommended the Board are assured that sufficient controls exist to monitor performance against key workforce priorities as articulated in the People and Organisational Development Strategy. Where operational improvements are required, actions are fed into the appropriate workstreams, monitored by the People and OD Delivery Group. Where Divisional exceptions are highlighted this is challenged and monitored through the Executive Review process.

Impact Upon Strategic Objectives

Reflects known pressures and priorities relating to the delivery of 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.

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

The reports proposed in Appendix 2 are designed in such a way to provide assurance that the Trust are operating in accordance with:
National reporting requirements associated with Equality, Diversity and Inclusion
Freedom to Speak Up best practice
NHSI/E requirements
Best practice and employment legislation, including the Equality Act.

Equality & Patient Impact

There is a known researched link between employee experience, stability, retention and patient experience. The People and OD Strategy promotes a culture of 'caring for those who care', who in turn will enhance the experience of our patients.

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 & Digital Committee**	**Estates & Facilities Committee**	**People & OD Committee**	**Quality & Performance Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
			17.12.2019				

Outcome of discussion when presented to previous Committees/TLT

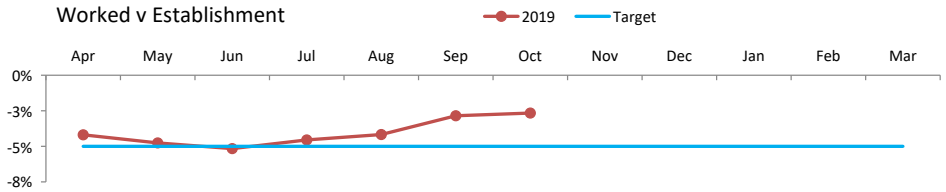
The People and OD committee noted:

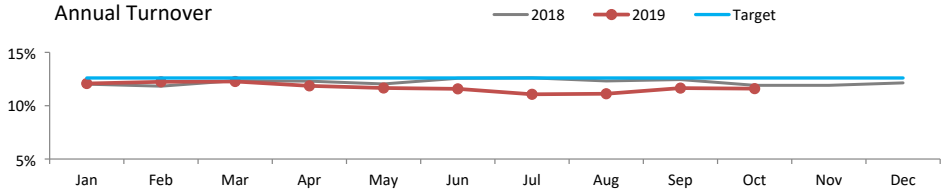
Improving trend in vacancy rates

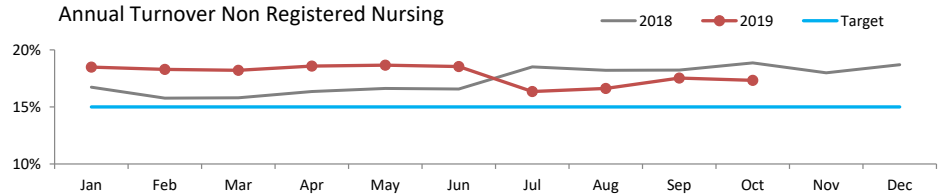
Additional exceptional reports from divisional reviews would be useful to provide greater detail on areas of concern and the draft example was agreed

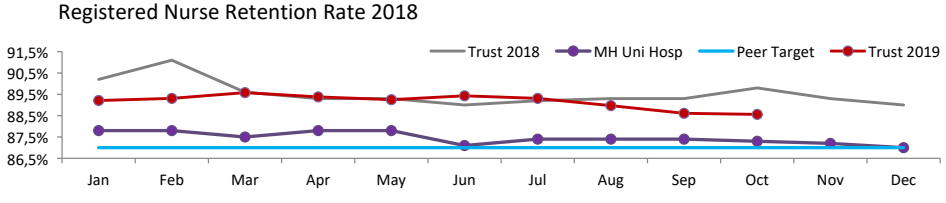
HRBP's supporting divisions on how to programme appraisals throughout the year was welcomed to improve compliance.

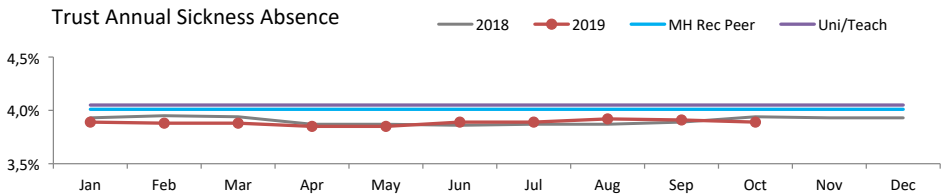
Gloucestershire Hospitals NHS Foundation Trust Oct 2019

Measure	Description	okt-18	okt-19	Trend	Variation
Worked vs Establismen t %	The difference between the establishment and worked fte as a percentage of establishment. Target in line with Monthly BI reporting. (below -5% is 'green'))	-2,60%	-2,30%		Worked fte has increased steadily since June 2019. The Add Prof Sci Tec Staff Group is the furthest from Target at -7.16%, in June the figure was -4.83%. Admin & Clerical are at -7.16% however this has reduced from 10.33% in June. In October 2018 the difference between worked & establishment was 2.6%. In 2018 this represented a shortfall of 169 fte but in 2019 despite the lower % , the figure is 181 fte (establishment is higher this year).

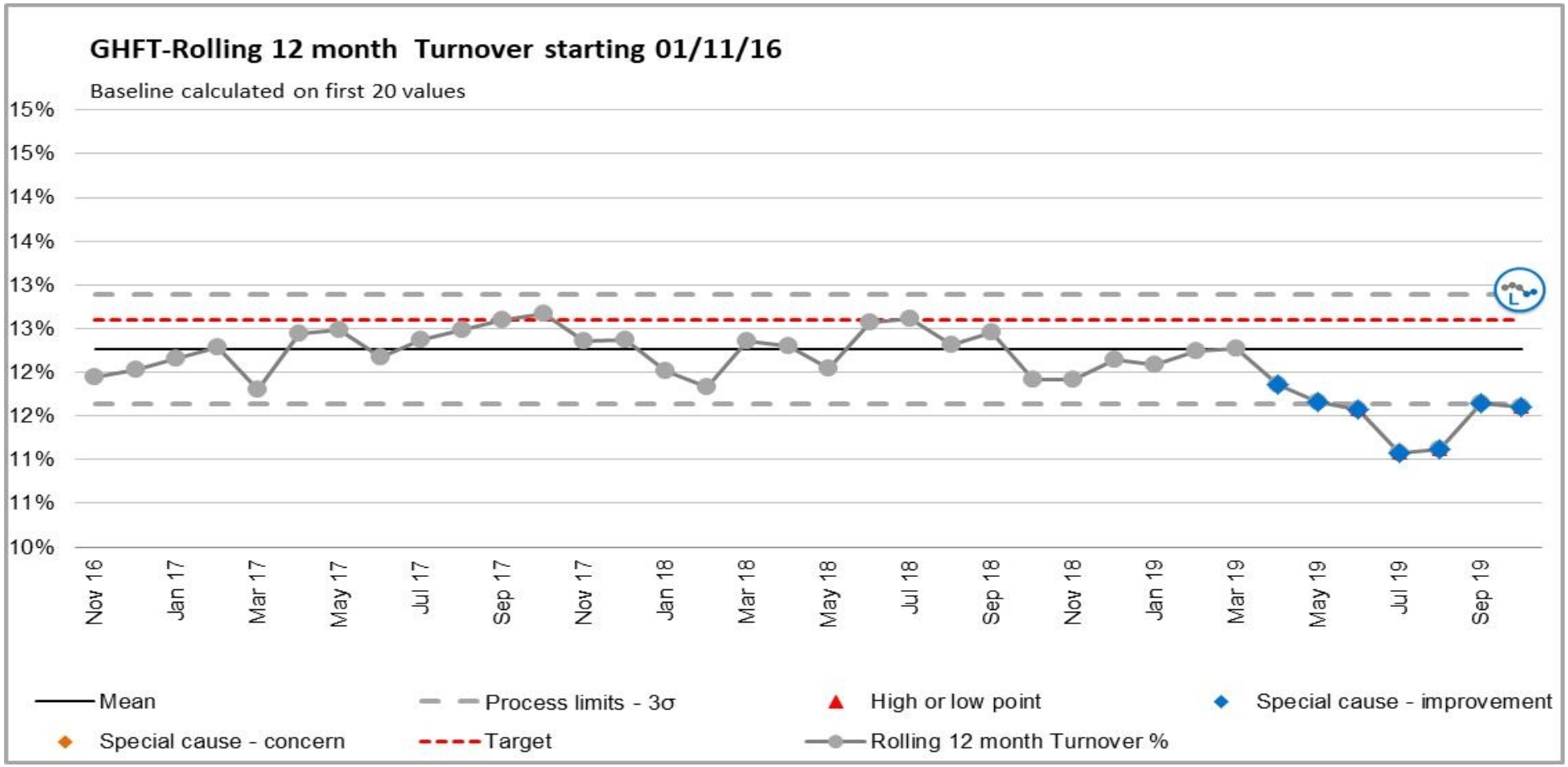
Measure	Description	okt-18	okt-19	Trend	Variation
12 Month Rolling Turnover Link to SPC chart	Turnover is the no of leavers (in fte) expressed as a % of the ave numbers (fte)over the period. It is based on permanent contracts only.Trust target 12.6% (Top quartile of Model Hospital Peer Group)	11,91%	11,60%		AHP's as a Staff Group have the highest turnover to Oct 19 at 16.32%. All other Staff Groups with the exception of Additional Clinical Services (14.54%) are below the 12.6% threshold. Medicine & Corporate Division are above the threshold, at 14.68% & 12.99% respectively. Women & Children Division have the lowest turnover (8.39%). Turnover since Mar 19 has been consistently lower than at the same period last year.

Measure	Description	okt-18	okt-19	Trend	Variation
Non- Reg Nursing 12 Month Turnover	Non - registered nursing includes HCAs, Apprentice HCAs, Trainee Nursing Assistants. Threshold 15% This figure not avail from MH.	18,86%	17,33%		Medicine Division has the highest Turnover rate for non registered nursing staff at 24.59%. The next highest Division is Surgery at 13.31%. Within Medicine , Respiratory has a TO rate of 35% (9.69 fte leavers) GOAM's rate is 25.87% (21.60 fte leavers). Turnover was slower to decrease than the overall Trust figures ,but since July 19, it is has been on average 1.5% lower.

Measure	Description	okt-18	okt-19	Trend	Variation
Nurse Retention Rate %	The percentage of nursing and health visitors that remained stable over 12 months period. Latest data from Model Hospital is Dec 18. University/Teaching Peer rate was 87%, MH recommended Peer rate 86.8% (NB excludes Midwifery)	89,61%	88,56%		Model Hospital data is calculated slightly differently to ESR, resulting in a figure approx 0.5% higher. The latest available from MH is December 18. Trust Nurse retention has reduced slightly (0.75%) since July 19 and is now lower than 2018. An analysis of nurse leavers for 2018 to 2019 shows that the monthly leaving average was 22 for 2018 & 22.7 for 2019. However the number of retirements has risen from 50 in 2018 to 70 in 2019.

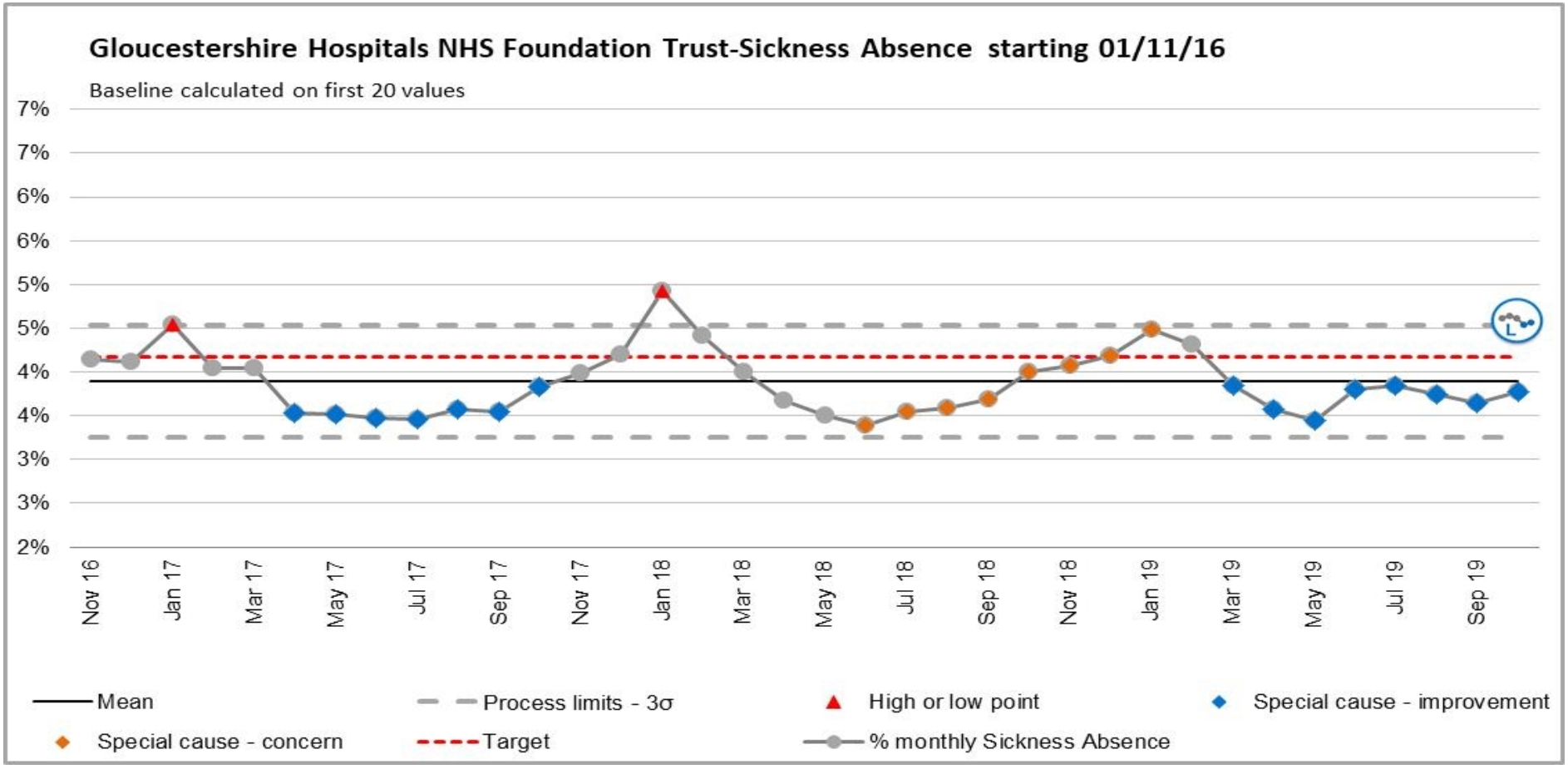
Measure	Description	okt-18	okt-19	Trend	Variation
Annual Sickness Absence % Link to SPC Chart	Sickness Absence is expressed as a percentage of fte lost /available fte. The Uni/Teaching Hospital Peer rate from MH is 4.05%. MH recommended peer rate is 4.01%	3,94%	3,89%		Trust annual sickness absence is relatively stable and there are no major changes to the 2018 figures. Corporate has the lowest annual rate at 3.69%. Diagnostics Div has the highest rate at 4.17%. By Staff Group, Nursing & Midwifery 4.34% and Additional Clinical Services (HCAs etc) 4.54% have the highest rates whilst Add Prof Sci Tech, AHPs, Health Scientists & Medical & Dental staff are below 3.5%

GHFT 12 month rolling turnover SPC chart



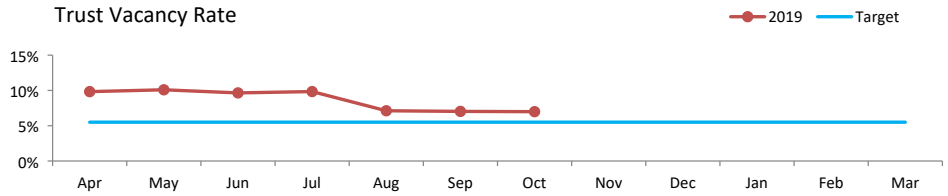
There has been a statistically significant reduction in Trust Turnover since April 2019

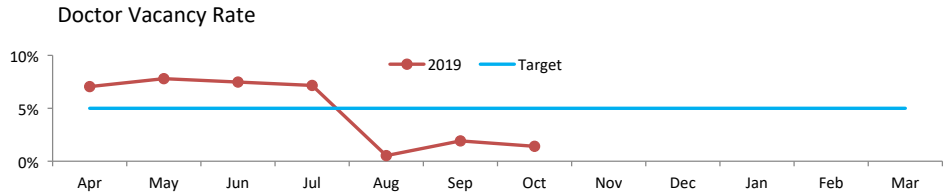
GHFT monthly sickness Absence SPC chart

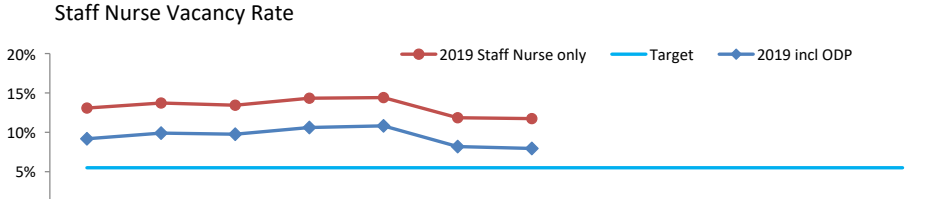


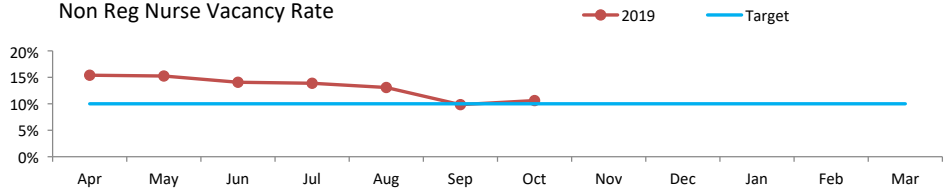
The SPC chart clearly demonstrates the seasonal variations in sickness absence rate. Although This could be illustrated equally well on a simple run chart, this report will continue with SPC charting to monitor high/low points.

Gloucestershire Hospitals NHS Foundation Trust Oct 2019

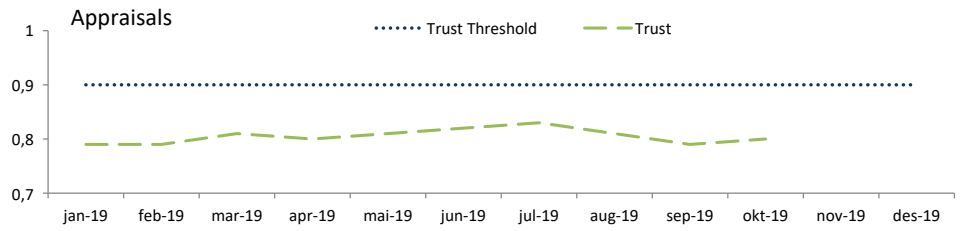
Measure	Description	okt-18	okt-19	Trend	Variation
Trust Vacancy Rate	The difference between the establishment and the staff in post as a percentage of establishment. Target revised to ...	6,70%	6,99%		August's vacancy rate at 8.75% has decreased by 0.5% since July and remains within trend for the year to date. Despite an increase of 250 fte in Oct 19 compared to Oct 18, our vacancy rate is higher due to the establishment increase in April 19. We therefore have a shortfall of 486 fte in Oct 2019 compared to a shortfall of 437 fte in Oct 18.

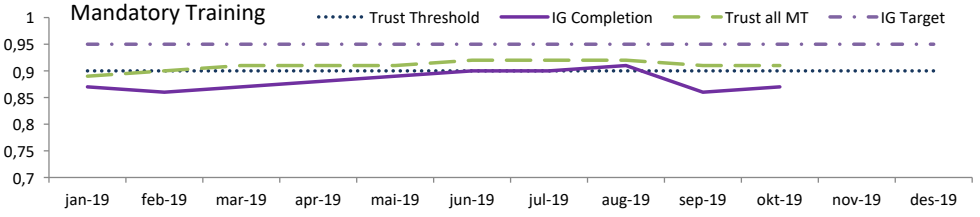
Measure	Description	okt-19	okt-19	Trend	Variation
Doctor Vacancy Rate	The difference between the establishment and the staff in post as a percentage of establishment. Target revised to ...	5,63%	1,41%		August's vacancy rate at 0.53% has decreased dramatically since July . It has only increased slightly since then. Despite an increase of 51 fte in the Medical establishment in April 19, we are now only 12.7 fte below that establishment. In October 2018, we were 48 short of establishment.

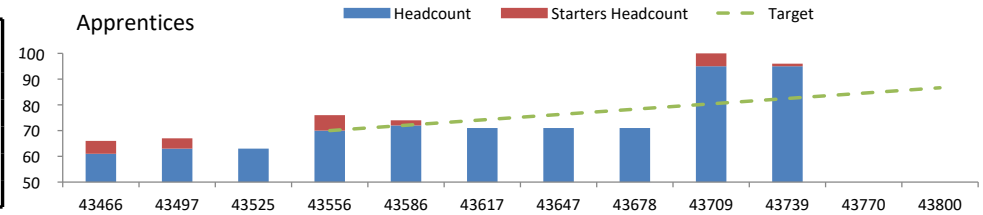
Measure	Description	okt-19	okt-19	Trend	Variation
Staff Nurse /ODP Vacancy Rate	The difference between the establishment and the staff in post as a percentage of establishment. Target revised to ...	7,60%	7,95%		October see's a continuation in the reduction of Staff nurse vacancy since August, thanks to recruitment of newly qualified and Overseas qualified nurses in September. Funding has been removed from ODP on the ledger so a calculation that includes ODP staff in the contracted nurse rates results in a figure of only 7.95% VR for Staff Nurse/ODP Band 5. This is a more accurate reflection of shortage than the Staff Nurse only figure. The Staff Nurse only line will be removed from the next report. In Oct 2019 we are 101.33 below establishment -last October the figure was 99.41.

Measure	Description	okt-19	okt-19	Trend	Variation
HCA Vacancy Rate	The difference between the establishment and the staff in post as a percentage of establishment. Target revised to ...	16,82%	10,61%		October's vacancy rate at 10.61% has decreased by 3.27% since July and continues the general downward trend for the year to date (although a 0.77% rise since September). Surgery has the highest number of vacancies (43.62/12.54%) followed by Medicine (29.24/8.38%). The shortfall in HCA fte fte has reduced to 99 fte from 151 fte in October 2018, despite an increase of 37 fte in establishment.

Gloucestershire Hospitals NHS Foundation Trust Oct 2019

Measure	Description	okt-18	okt-19	Trend	Variation
Appraisals	% of Appraisals completed in previous 12 months. Excludes: Bank, staff joining Trust in the last 10 months (12 months for Medical staff) , staff on Maternity & adoption leave, suspended, external secondment, career break, Junior medcal staff.	80,00%	80,00%		Lowest Divisional Appraisal rate is Corporate with 71% completion. No Division has reached target, Women & Children is closest with 83%.

Measure	Description	okt-18	okt-19	Trend	Variation
Mandatory Training	Compliance rate is expressed as a percentage of number of completions meeting requirement /number of completions required. NHS Digital have set a national requirement to achieve a compliance target of 95% for Information Governance Training.	89,00%	91,00%		Only Medicine Division is below target at 89%. By Staff Group, Additional Clinical Services and SAS Doctors are at 86%, Training Grade Medical staff are at 70%. All other groups are over target.

Measure	Description	aug-18	okt-19	Trend	Variation
Apprentice Recruitm'n t	The number of apprentices in post including starters per month. The target is an additional 10 apprentices in each Division by Y2.	60	95		The Apprentices in this report are those employed into an Apprentice post or a current employee who has transferred into one. Excluded are those who are undertaking training funded by the Apprenticeship levy in their current role - there are a further 92 staff in this category. The number of apprentices currently with the Trust is 205.

Divisional ACCESS risk rating - scoring

NHS Gloucestershire Hospitals NHS Foundation Trust

Surgical Division- People & OD Metrics

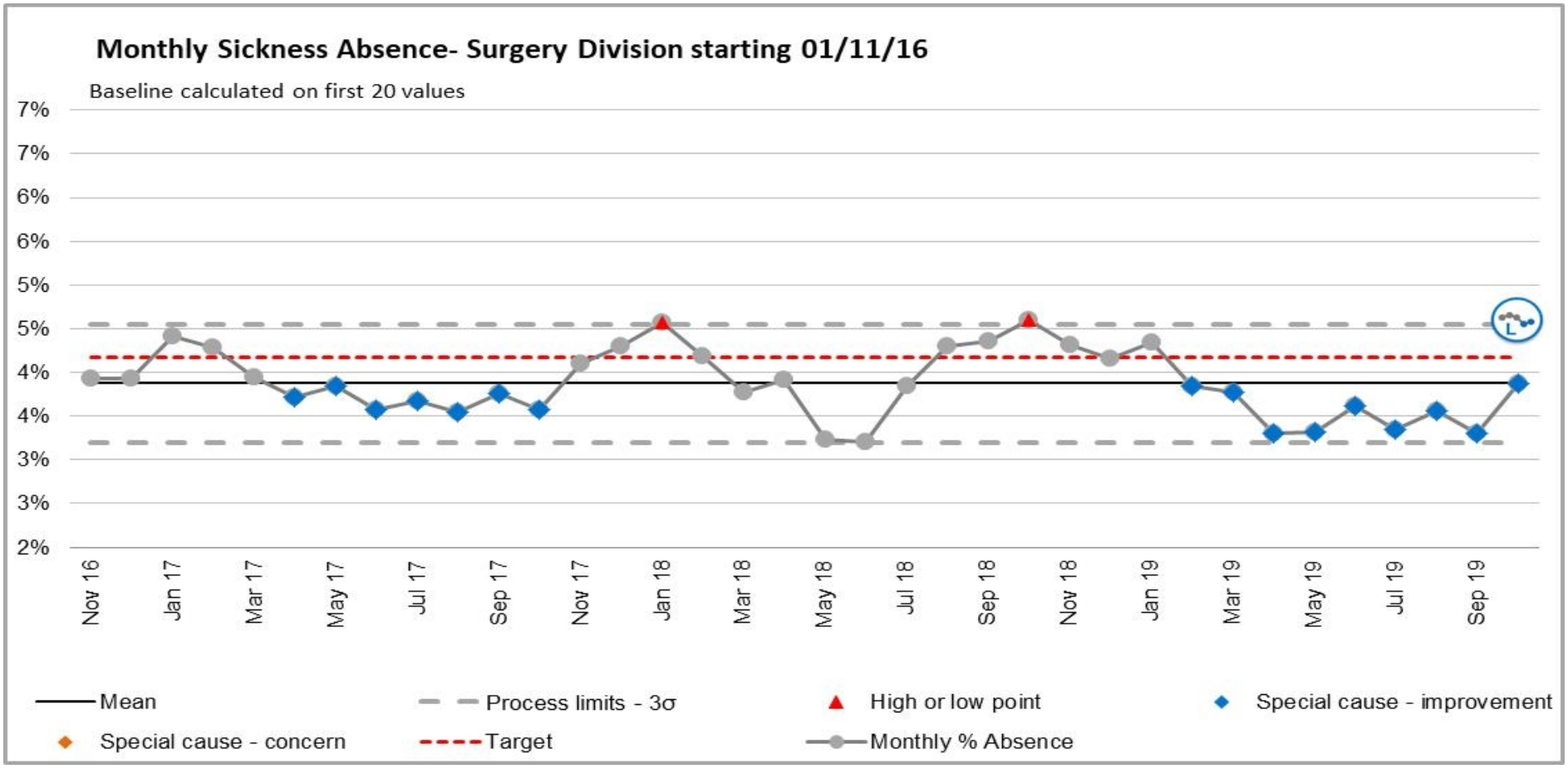
Measure	Score	Notes	Apr 2019 Target	Apr 2019 Actual	May 2019 Target	May 2019 Actual	Jun 2019 Target	Jun 2019 Actual	Jul 2019 Target	Jul 2019 Actual
12 Month Rolling Turnover % (link to SPC chart)	1	Target is top quartile of Model Hospital recommended Peer Group. Data from 'Annual Turnover from Organisation benchmarking tool, August 19' published by NHS Digital	12,60%	12,43%	12,60%	11,84%	12,60%	11,83%	12,60%	11,16%
12 month Nurse retention rate	1	Target is University/Teaching hospital Peer group rate	87,00%	85,70%	87,00%	85,60%	87,00%	85,90%	87,00%	86,00%
HCA Turnover	1	Target is Trust HCA Turnover rate minus 1% at 31 March 2019	18,12%	18,32%	18,12%	17,84%	18,12%	17,21%	18,12%	15,48%
A&C Turnover	1	Target is Trust A&C Turnover rate minus 1% at 31 March 2019	11,07%	12,84%	11,07%	11,30%	11,07%	11,41%	11,07%	10,18%
Sickness Absence % (link to SPC chart)	1	Target is average of Model Hospital recommended Peer Group. Data from 'NHS Sickness Absence Rates July 2019 Monthly tables' published by NHS Digital	4,17%	3,96%	4,17%	3,98%	4,17%	4,01%	4,17%	3,94%
Stress & Mental Health Absence proportion of time lost to si		Target is Trust rolling 12 months to 31 Mar 2019	19,80%	22,00%	19,80%	22,40%	19,80%	22,80%	19,80%	24,10%
MSK Absence Absence proportion of time lost to sickness		Target is Trust rolling 12 months to 31 Mar 2019	19,20%	22,20%	19,20%	22,80%	19,20%	23,10%	19,20%	23,00%
Appraisal Completion %	1	Targets set by Training Dept Red is below 70%	90,00%	80,00%	90,00%	81,00%	90,00%	83,00%	90,00%	86,00%
Mandatory Training Completion %	1	Targets set by Training Dept Red is below 70%	90,00%	91,00%	90,00%	91,00%	90,00%	91,00%	90,00%	92,00%
IG Mandatory Training Completion %	1	Targets set by Training Dept Red is below 95%	95,00%	90,00%	95,00%	90,00%	95,00%	90,00%	95,00%	90,00%
		Total score (failed to achieve target)		5		4		4		3

Annexe 2 – Example Exception Report part 1: Narrative

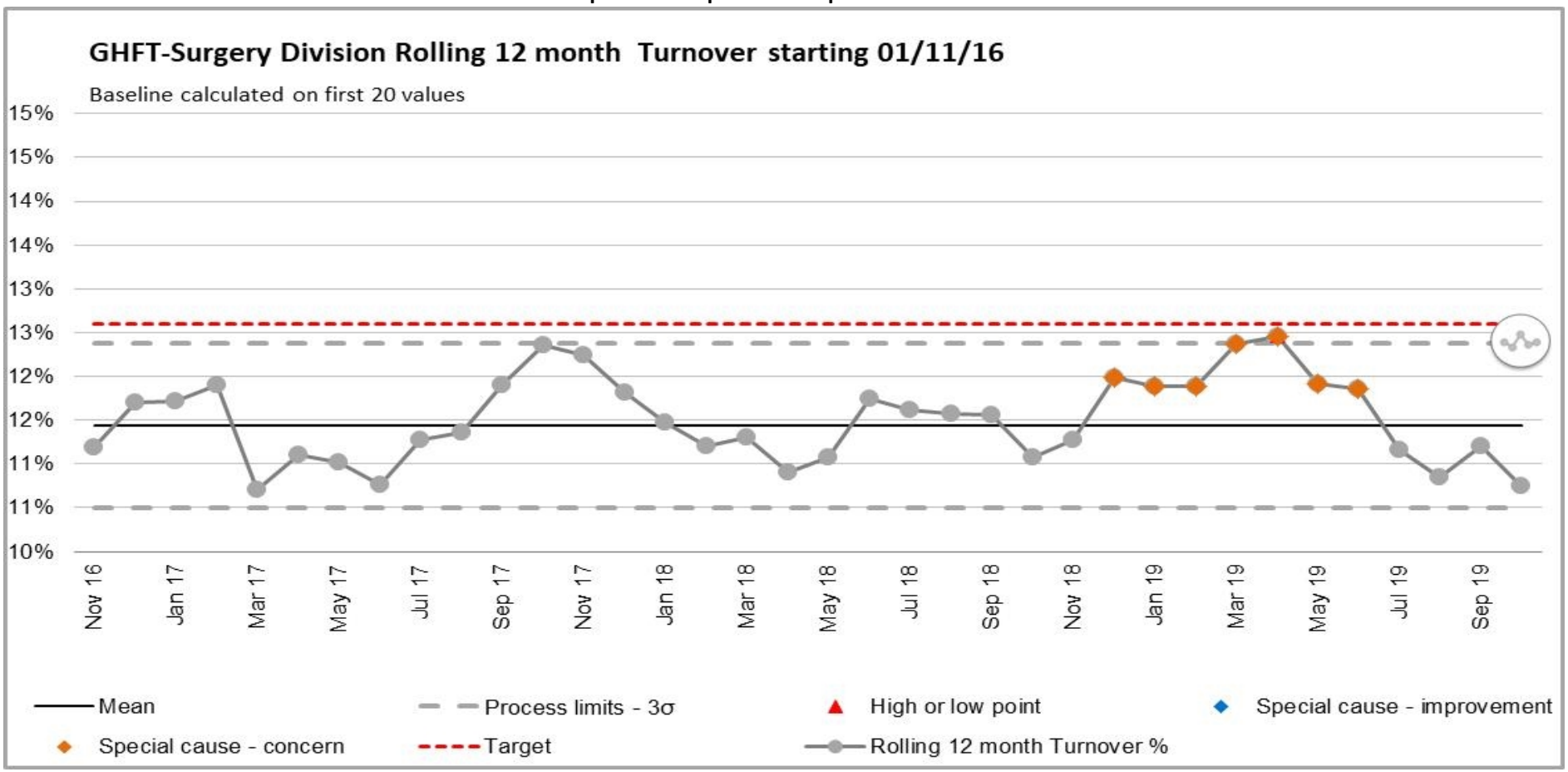
P&OD Exception Report - Surgery

Enabling Pillar: Workforce Sustainability	Divisional Narrative	Actions in Place and Progress to Note
.	*to include: outliers, hotspots, issues for escalation, context, service issues*	*what actions are being taken to resolve/ escalate*
Workforce Supply/ Vacancies / Retention	*Vacancy rates of 25% in XYZ speciality, triangulates with reported poor staff experience (staff survey) and increased turnover of X%.*	*Known development needs exist with senior leadership team - coaching intervention in place and mentoring being provided. Currently being monitored at tri to tri meetings. BP support in place to review whether R&R premium would offer a potential solution, proposal will escalate to PODDG if agreed and appropriate.*
	Turnover increased across XYZ technicians over past 6 months, reflects know capacity issues and pressure on staff	*L&OD team supporting with team intervention. Exit interview analysis highlights working patterns are of concern. Work underway to review bank and agency support/ availability*
	Exit interview trends/ themes	*actions to address*
Alternative Role Development	*X TNA's in post now to support shortages across xxxx specialty*	*no further action required at this point*
	Associate Specialist posts considered in XYZ specilialities, ACPs etc..	*opportunity out to advert w/c/ xxxxxxx*
Advanced Development Pool Membership (next update due February 2020) ?	*X members currenlty in the ADP (X Nurse, 1 admin, 1 blah blah)*	*plans to increase/ promote membership by …xyz…*
Apprenticeships	*Critical shortages across XYZ role (vac. Factor of X%)*	*role development and apprenticeship pathway included within workforce plan , 2 already in place, 2 will be recruited in Q2 20/21*
	Divisional summary: X apprenticeship learning programmes in place (include numbers on levy programmes not just those called 'apprentices')	*Plans to increase in X speciality … / or / there are no further plans to increase until Q4 to ensure all apprenties access adequate support and supervision*
Enabling Pillar: Colleague Experience	**Divisional Narrative**	**Actions in Place and Progress to Note**
Improved reporting of bullying and harassment resolution and ensure faster resolution of cases.	*case work trends/ numbers - do they triangulate with staff survey and FTSU for your division?*	*actions to support*
Reduce colleague absence specifically for Multiskeletal and mental health illnesses	*trends/ spikes worth reporting?*	*actions to support*
ER Activity	*trends/ spikes - what are the key issues, are things being resolved to timescales ?*	*actions to support*
Appraisal & Mandatory Training	*Exception - top areas of concern*	*actions to support*
Enabling Pillar: Transformation	**Divisional Narrative**	**Actions in Place and Progress to Note**
Organisational Change Update	*Highlight any key programmes impacting on workforce - summary / update*	*next steps*
Workforce Planning	*Key workforce priorities this Quarter/ year as identified in the workforce plan include X, Y, Z, Z*	*actions under review at Div Board, all actions in progress - no outliers to planto report*

Annexe 2a: Example exception report Part 2:Metrics



Annexe 2a Example Exception Report Part 2: Metrics



Gloucestershire Hospitals NHS
NHS Foundation Trust

PUBLIC MAIN BOARD – JANUARY 2020

Report Title
Fit for the Future – Outcomes of Engagement Report
Sponsor and Author(s)
Author: Jo Underwood, Centres of Excellence Programme Director Sponsor: Simon Lanceley, Director of Strategy and Transformation
Executive Summary

Purpose

To brief the Board on the outcomes of the *Fit for the Future* engagement process, using the attached summary presentation. The full outcomes report (and supporting appendices) can be found here: https://www.onegloucestershire.net/yoursay/fit-for-the-future-output-of-engagement/

Key issues to note

1. A public engagement phase was launched in August 2019 and ran until mid-October 2019
2. For *centres of excellence* we engaged with the public on the following topics (as agreed at July TLT):
    a. Overall *centres of excellence* vision
    b. General surgery
    c. Emergency and acute medicine (including emergency departments and acute medical take)
    d. Image-guided interventional surgery hub (including interventional radiology, cardiology, vascular)
    e. All of the above relating to adult services only, outpatients excluded.
3. The *Outcomes of Engagement Report* will be discussed in public at the Health Overview and Scrutiny Committee on 14 January.

Conclusions

The outcomes of the engagement process have been used by the Fit for the Future programme to develop and inform potential solutions to the issues and risks defined in the Case for Change.

Implications and Future Action Required

As above.

Recommendations

The Board is asked to:

1. Receive and note the *FFTF Output of Engagement_Summary v2* and note the full report is now in the public domain and available via the One Gloucestershire website.

Impact Upon Strategic Objectives

Delivers the 'Centres of Excellence' objective and supports delivery of 'Outstanding Care'

Impact Upon Corporate Risks

C2784 – Risk of formal challenge to service reconfiguration proposals: provided we follow advice, the PCBC and engagement process seek to mitigate risk of successful challenge to proposals.

Regulatory and/or Legal Implications

As a clinical reconfiguration programme Centres of Excellence carries a high risk of legal challenge. This is well understood and the processes set out here are designed deliberately to ensure transparency of decision making and clarity that discussions and suggestions are subject to evaluation of impact, and public engagement and consultation where required.

Equality & Patient Impact
A comprehensive *Baseline Impact Assessment* report has been prepared which sets out the current equalities baseline for each of the services in scope. It also considers important factors that should be taken into account in the development and evaluation of potential solutions, such as how people travel to hospital, and the impact of physical, mental and social circumstances on access to services. The Baseline Report does not evaluate any specific options. A multi-agency Reference Group, including several patient and public representatives, was tasked with overseeing development of this report. Following agreement the medium and shortlist of options, a Pre-Consultation Report will be produced which sets out the actual impact of any options proposed. This will form part of the solutions appraisal supporting materials pack.

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 & Digital Committee**	**Audit & Assurance Committee**	**People and OD Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
					8/01/20	
Outcome of discussion when presented to previous Committees						
Pending						

One Gloucestershire
Transforming Care, Transforming Communities

FIT FOR THE FUTURE

NHS

Output of Engagement

The FFTF Engagement sought views on the future provision of urgent and specialist hospital care in Gloucestershire.

Key Findings

A comprehensive Output of Engagement Report can be found at:
www.onegloucestershire.net

Date:
January 2020

What was the engagement about and what did we ask the public and staff to help us with?

The engagement was an opportunity to talk about :

- the ways services could be organised to get the best urgent advice, support and care across Gloucestershire
- The benefits of having two thriving specialist hospitals in future in Cheltenham and Gloucester

We said we think it's important to:

- make it easier, faster and more convenient to get advice, support and services 7 days a week
- ensure care is co-ordinated
- provide most care in or near home
- ensure high quality services in the right place: right staff, skills and equipment
- Have outstanding hospital care when you are unwell

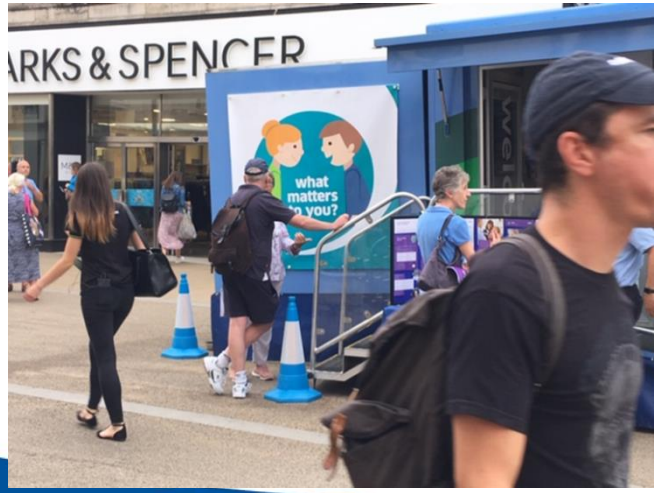
What was the engagement about and what did we ask the public and staff to help us with?

We asked the public and staff:

- **to help us to develop ideas** to support easier, faster and more convenient ways to get urgent same day advice and care wherever people live in Gloucestershire
- **what's important to them** in getting urgent (not life threatening) same day advice and care
- **to tell us what they think about** our ideas for a *'centres of excellence'* approach to providing specialist services at the two large hospital sites in the county
- **to help us with developing potential solutions** for some specialist services: Emergency and Acute Medicine, General Surgery and Image Guided Interventional Surgery
- **to consider** the new hospital for the Forest of Dean

What did we do during the public engagement and how many people got involved?

- **1230** FFTF online surveys completed
- ***1252*** *FFTF surveys (template) received from Cheltenham MP*
- **153** FoD Hospitals surveys completed
- **28** Public Drop in Events
- **12** Independently facilitated workshops
- **1** Engagement Hearing
- **13** Other events
- Staff communication and engagement
- Media advertising



- **Website** - **18,872** views of the One Gloucestershire website, incl. 4,755 views of the Fit for the Future engagement page.
- **1,800** visits to the Forest of Dean website
- **21 Facebook** posts (non- paid for activity), with a total reach of 34,406.
- 4-week paid for **Facebook** advert that linked to the engagement section on the One Gloucestershire website. This achieved a reach of **57,440** with **82** shares.
- **49 tweets**, with a total of 42,625 impressions.
- **7,000** Hardcopy engagement **booklets**

OVER 3300 local people participated in planned activities – but the focus of engagement is not about numbers it is about receiving qualitative feedback from a broad range of people

Does the feedback reflect the views of a cross-section of people in Gloucestershire?

We worked with **Inclusion Gloucestershire** to ensure the voices of people with protected characteristics were heard

We collected a range of demographic data from the FFTF survey respondents*

Age, Role, Postcode, Disability status, Carer status, Ethnicity, Religion/belief, Gender identity, Sexual orientation, whether Pregnant or recently given birth.

Respondents to the demographic survey questions broadly represent the local population profile. Exception are a high response rate from people with a Cheltenham postcode and people who identify as an unpaid carer.

All feedback received during engagement is collated, read and considered; no ‘weighting’ is applied to feedback.

**note individuals self-select to complete surveys*

What were the main feedback themes? These are some of the things people said about: Urgent Care Services in Local Areas

Cheltenham Keep A&E at CGH/ Restore 24/7 A&E at CGH

£/Funding Additional investment needed in the NHS / ensure value for money/best use of resources

111: Need improved 111 people have confidence in / directs to the most appropriate service

Accessible and timely opening hours, travel times/location essential / Services provided in a timely manner / consider the needs of population/demographic, now and into the future

Pathways and communication Ensure people know where and when to seek support / Establish simple, accessible pathways

Access to GP services Improved access to GP appointments, both urgent and routine and "out of hours" / Better use of range of healthcare professionals at GP practices

Integration & workforce More joined up way of providing care / Make the most of diversity of workforce / Ensure sufficient staff, with mix of skills deliver range of services / Staff recruitment and retention

Minor Illness and Injury Units (MIIU) Ensure MIIUs provide local, equitable access, are well-resourced (staff and equipment) with access to a range of diagnostics / Introduce MIIUs for Gloucester and Cheltenham

Quality and Equity Ensure provision is resilient; of a high quality; is fair and equitable across the county

What were the main feedback themes ? These are some of the things people said about: Emergency and acute medicine

Cheltenham Retain CGH A&E / Re-instate A&E 24.7 at CGH / CGH is a General Hospital

Centres of excellence Emergency Medicine is not a specialist service / GRH A&E won't have capacity to cope with increased demand / Some support for ED at GRH only

Quality/Equity/Sustainability Safety risk – people will have poorer outcomes / Important: Quality of care/ Outcomes/Safety/Patient experience / Not sustainable as it is, the system is going to have to change

Ensure **mental health** is considered and built into the system

Communications/pathways NHS 111 sends too many people to A&E / Better communications – public don't know where to go

Access/Population Access from the east of the County = Inequality / A&E attendance increased by poor GP access / Travel delays / Poor public transport / Car parking charges / consider population growth

Workforce / Technology Attract next generation of A&E clinicians / More joined up way of providing care / Make the most of diversity of workforce / Ensure sufficient numbers of staff, with appropriate mix of skills to deliver range of services required / Focus on staff recruitment and retention

What were the main feedback themes?

These are some of the things people said about:

General (incl. Emergency) Surgery

Cheltenham or Gloucester Retain General Surgery at CGH and GRH / Centralise General Surgery at GRH

Centres of excellence Centralising emergency general surgery enables running of a daily emergency surgical clinic / Would one hospital site have capacity for all emergency general surgery beds?

Access/Population Concern about having a site without critical care or general surgery

Image Guided Interventional Surgery (IGIS)

Cheltenham or Gloucester Establish IGIS at both CGH and GRH / at GRH only/ or at CGH only

Centres of excellence /Sustainability Why aren't we doing this already?

£Funding Cost effective to establish IGIS on one site

Access Surprise and shock at current situation (patients having to go out of county for treatment)

Workforce Attract next generation of sub-specialist surgeons to Gloucestershire

What were the main feedback themes?
These are some of the Other things people said:

- Build one hospital half way between CGH and GRH
- Charge ‘timewasters’: sports injuries, drunks and health tourists
- Car parking too expensive
- Extend hours of shuttle bus between CGH and GRH
- Join up services with social care better
- Prevention and self care a priority to manage demand
- More investment in NHS
- Staff recruitment into Gloucestershire vital
- Maximise use of digital/technology
- Concentrate on staff morale
- Sustainability: Increasing population/housebuilding
- *Centres of excellence* = Parcels for privatisation
- Reduce administration and management costs

A new hospital for the Forest of Dean - what did we ask the public and staff to help us with?

The focus of the engagement was to:

- **test and develop ideas** to support our planning for inpatient services in the new hospital;
- **find out what's important** to local people in accessing consistent urgent (not life threatening) advice, assessment and treatment;
- **gather feedback** on the range of outpatient and diagnostic services that should be provided in the new hospital;
- **understand what's important** to local people when accessing services in the new hospital.

A new hospital for the Forest of Dean: Feedback themes - These are some of the things people told us:

Numbers of beds

- Significant concerns about any reduction in beds, given the rising population and increase in elderly demographic.
- Insufficient detail regarding alternative provision for Gloucester and Cheltenham residents was provided
- The bed planning does not seem to account for people who chose to die in a community hospital.

Urgent care

- Transport/accessibility in the Forest of Dean is really difficult. Cinderford is particularly difficult to reach from the southern part of the Forest.
- GP appointments – improvements to accessibility of local GP appointments are required to support urgent/out-of-hours care.

Outpatient and Diagnostic Services

- Current range of services provided at the Dilke and Lydney hospitals should be provided in the new hospital - including therapies, follow-up appointments, children's services, screening, ophthalmology and audiology/hearing aid service.
- Some of the diagnostic services commonly mentioned include: blood tests, endoscopy and colonoscopy, screening, x-ray, and ultrasound.

Summary of key feedback and next steps

Key feedback

- *Centres of excellence:* Both positive and negative feedback about this approach to future hospital service configuration
- Quality/Equity/Sustainability
- Access
- Population growth/demographic
- £Funding
- Workforce / Technology
- Communications/pathways
- Access to GP services
- Integration
- Workforce

Over 3300 local people took part in planned activities

Over 50 events

Feedback Report published and considered

Next steps

First stage

- Consideration of Output of Engagement Report
- Citizens' Jury
- Solutions Appraisal

Second stage

- Development of business cases
- NHS England Assurance

Third stage

- Consultation (as required)
- Consideration of Output of Consultation
- Decisions