Gloucestershire Hospitals
NHS Foundation Trust

PUBLIC BOARD AGENDA

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

Date/Time: Thursday 13 February 2020 at 12:30

Location: Lecture Hall, Redwood Education Centre, GRH

	Agenda Item	Lead	Purpose	Time	Paper
	Welcome and Apologies (DL)	Chair		12:30	
1.	Declarations of Interest	Chair		12:31	
2.	Patient Story	Suzi Cro	Information	12:32	
3.	Minutes of the Previous Meeting	Chair	Approval	13:00	YES
4.	Matters Arising	Chair	Approval	13:05	YES
5.	Chief Executive's Report	Emma Wood	Information	13:10	YES
6.	Trust Risk Register	Emma Wood	Assurance	13:20	YES
	QUALITY AND PERFORMANCE				
7.	Assurance Report of the Chair of the Quality and Performance Committee	Alison Moon	Assurance	13:30	YES
8.	Quality and Performance Report	Rachael de Caux Steve Hams Mark Pietroni	Assurance	13:35	YES
	BREAK			13:45	
	FINANCE AND DIGITAL				
9.	Assurance Report of the Chair of the Finance and Digital Committee	Rob Graves	Assurance	13:55	YES
10.	Finance Report	Karen Johnson	Assurance	14:00	YES
11.	Digital Report	Mark Hutchinson	Assurance	14:10	YES
12.	Digital Strategy	Mark Hutchinson	Approval	14:15	YES
	ESTATES AND FACILITIES				
13.	Assurance Report of the Chair of the Estates & Facilities Committee	Mike Napier	Assurance	14:20	YES

	AUDIT AND ASSURANCE				
14.	Assurance Report of the Chair of the Audit & Assurance Committee	Claire Feehily	Assurance	14:25	YES
	ADDITIONAL PAPERS				
15.	Modern Slavery Statement	Sim Foreman	Approval	14:30	YES
16.	Quarterly guardian report on safer working hours for doctors and dentists in training	Mark Pietroni	Assurance	14:35	YES
	QUESTIONS				
17.	A period of ten minutes will be available for Governors to ask questions.			14:45	
18.	A period of ten minutes will be available for members of staff to ask questions.			14:55	
19.	A period of ten minutes will be available for members of the public to ask questions submitted in accordance with the Board's procedure.			15:05	
	STANDING ITEMS				
20.	New Risks Identified	Chair		15:15	
21.	Items for the Next Meeting	Chair		15:17	
22.	Any Other Business	Chair		15:20	
CLOSE				15:25	

Date of the next meeting: Thursday 12 March 2020 in the Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital

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

Claire Feehily
Rob Graves
Balvinder Heran
Alison Moon
Mike Napier
Elaine Warwicker

Executive Directors

Deborah Lee, Chief Executive
Emma Wood, Director of People and Deputy Chief Executive
Rachael de Caux, Chief Operating Officer
Steve Hams, Director of Quality and Chief Nurse
Mark Hutchinson, Chief Digital and Information

Associate Non-Executive Directors

Marie-Annick Gournet

Bilal Lala

Karen Johnson, Director of Finance

Simon Lanceley, Director of Strategy & Transformation

Mark Pietroni, Director of Safety and Medical Director

Gloucestershire Hospitals
NHS Foundation Trust

MINUTES OF THE MEETING OF THE TRUST BOARD HELD IN THE LECTURE HALL, REDWOOD EDUCATION CENTRE, GLOUCESTERSHIRE ROYAL HOSPITAL, GLOUCESTER ON THURSDAY 9 JANUARY 2020 AT 13:00

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
Rachael De Caux	RDC	Chief Operating Officer
Claire Feehily	CF	Non-Executive Director
Rob Graves	RG	Non-Executive Director and Deputy Chair
Steve Hams	SH	Director of Quality and Chief Nurse
Balvinder Heran	BH	Non-Executive Director
Mark Hutchinson	MH	Chief Digital and Information Officer
Karen Johnson	KJ	Director of Finance
Simon Lanceley	SL	Director of Strategy and Transformation
Mike Napier	MN	Non-Executive Director
Mark Pietroni	MP	Director of Safety and Medical Director
Elaine Warwicker	EWa	Non-Executive Director
Emma Wood	EW	Director of People and Organisational Development & Deputy Chief Executive Officer

IN ATTENDANCE:

Suzie Cro	SC	Deputy Director of Quality (Item 02/20)
Marie-Annick Gournet	MAG	Associate Non-Executive Director
Sim Foreman	SF	Trust Secretary
Katie Parker-Roberts	KPR	Head of Quality (Item 02/20)
Bilal Lala	BL	Associate Non-Executive Director
Craig MacFarlane	CM	Head of Communications
Merleen Watson	MW	Patient Story (Item 02/20)
Paul Watson	PW	Patient Story (Item 02/20)
Jo Underwood	JU	Centres of Excellence Programme Director (Item 12/20)

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
Julia Preston	JP	Staff Governor
Alan Thomas	AT	Public Governor, Cheltenham and Lead Governor

One further member of staff and one member of the public attended.

APOLOGIES:

Alison Moon	AM	Non-Executive Director

PL was suffering from loss of voice and RG chaired the meeting. RG welcomed everyone and apologies were NOTED from AM.

ACTION

01/20 DECLARATIONS OF INTEREST

There were none.

02/20 PATIENT STORY

SC, KPR, MW and PW joined the meeting for this item.

SC introduced MW and PW with their hearing dog, Grace. MW was the Trust's first Quality Improvement volunteer and shared her patient story which covered hearing impairment in medical settings and the development of the hearing loss pathway. MW advised hearing impairment was a hidden disability affecting one in six people and provided examples of issues encountered within inpatient units including, a lack of awareness of hearing loops in some areas and difficulties in relation to scanning and ophthalmology (where darkness or isolation affect the ability to lip read).

Discussion and questions following the presentation highlighted that the Trust was encouraging people to wear their glasses and hearing aids in theatre as part of the consent process and had committed to providing hearing loops in key building and rooms. MP affirmed that it was common to meet people with hearing impairments and that bedside signs were helpful for both staff and patients. DL stated that the patient story had shown simple and straight forward things could improve the patient experience and asked MW, through her volunteering, to continue to help the Trust understand what made it difficult to do better and what changes would deliver the greatest magnitude.

MW demonstrated the role that Grace plays in supporting her in her day to day activities.

It was agreed that, through the usual three month feedback report, further information on the QI work would be shared.

RG thanked MW and PW for sharing their experience and for agreeing to get involved in the Quality Academy.

03/20 MINUTES OF THE PREVIOUS MEETING

RESOLVED: The minutes of the meeting held on Thursday 19 December 2019 were APPROVED as a true and accurate record for signature by the Chair.

04/20 MATTERS ARISING

Updates were provided on the following matters arising:

253/1 – Learning from Deaths Quarterly Report – MP updated that a meeting would take place the following week involving the relevant leads from each organisation. The work would complete in March 2020. **CLOSED**.

254/19 – Quality Indicators – SH confirmed that the work was on track to be completed in February and in response to a question from the Board. AT advised he was content with the timescale and discussions to date.

RESOLVED: The Board APPROVED the closed items.

05/20 CHIEF EXECUTIVE'S REPORT

DL presented the report and summarised that the start of 2020 had been operationally challenging but the leadership team were noted to be maintaining their focus on balancing safety and risk, whilst ensuring we retain a significant focus on the wellbeing of staff. DL said she had been heartened by all colleagues "pulling together" and the amount of positive feedback received from patients about care on the Acute Medical Unit (AMU) and Acute Medical Initial Assessment Unit (AMIA). The nature of patient and family feedback had reinforced the importance of communication and attention to the small things e.g. refreshments. DL highlighted one great example of compassionate care where a junior doctor had accompanied a patient to their care home in a taxi after their shift to ensure they were not admitted to hospital.

The Trust continues to make considerable positive progress in relation to the Electronic Patient Record (EPR) and is now actively preparing for deployment in Cheltenham General Hospital (CGH) on 12 February and next phase which includes electronic observations ("e-obs") and electronic ordering and receipting of diagnostic tests and results; these two developments will bring significant safety contributions and other benefits and whilst the roll-out to date had been primarily nurse-led, these deployments will bring the medical staff and others into focus.

A second climate change event had taken place on 20 December 2019 and received very positive feedback again. Of note, the Board's declaration of a *climate emergency* was especially welcome. EWa had been appointed at the lead Non-Executive Director (NED) for climate change and had addressed the delegates to positive acclaim.

Following the pre-election pause, the system was regaining momentum in relation to Fit For the Future (FFtF) with the next major event being the Citizens' Jury in the week commencing 20 January 2020. 18 jurors had now been recruited and Trust staff would be involved in presenting information to the Jury. DL said she was encouraged by the enthusiasm for involvement in this event and believed it would contribute positively to the engagement insights by allowing this group to immerse themselves in considerable detail, in a way that wasn't typically possible.

CF stated she was also heartened by performance in the Emergency Departments (ED) and other areas and asked, given the unprecedented levels and types of demand, whether the Executive felt that the winter plan had been "the right one". DL confirmed that whilst no formal review or lessons learned had taken place, no new plans had been developed to cope with demand, as had been seen in previous years suggesting the plan was comprehensive in the first instance. RDC supported this and highlighted plans had been modelled on a range of scenarios and likely challenges i.e. influenza and norovirus occurring at the same time and this had happened. With regard to system working, RDC felt that there were good relations in the main with partners who had been responsive to requests for escalation. MP said he believed that the Winter Plan was the strongest and most realistic throughout his time in Gloucestershire, flagging that nothing had been done that was not in the plan and it had delivered higher safety. SH explained that there had been investment in additional leadership throughout the year and this was showing positive benefits in AMU, AMIA and onward care.

PL asked how the Board could be assured on efforts to maintain patient

experience at busy times, particularly regarding use of dignity screens etc. when patients are cared for in corridors. SH advised this was through the visibility of himself and other nurse leaders going to wards and departments to see things in action. Mindful that it wasn't possible to be present all the time, SH advised that these visits helped to set and reinforce expectations. SH added that nurses were coming up with creative ideas to maintain and protect dignity for patients. MP advised that he was following a similar approach and in addition to the first-hand experience of working shifts, he was talking to colleagues at shift changes to hear from them.

BH commented that, in her short time on the Board, there had been a positive change to encourage people to talk and be open about issues with a culture of communication and openness becoming the "norm" albeit not without challenges.

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

06/20 TRUST RISK REGISTER

EW presented the paper and explained that the risk register was as presented at the 19 December 2019 meeting because the Trust Leadership Team (TLT) had only discussed the latest updates the previous day. DL reassured the Board that whilst the TLT discussion had covered a number of risks but there were no new risks for the Board but rather work done on actions, controls and ratings of existing risks.

RG felt it was difficult for Non-Executive Directors (NEDs) to get a true feeling of the dynamics of the risk register and asked whether risks were building up over time or moving each quarter. EW explained that the limitations within the current system prevented this level of reporting without significant administrative support, though the new version of Datix would provide this level of detail and funding for this being considered as part of the Business planning cycle.

RESOLVED: The Board NOTED the Trust Risk Register report.

QUALITY AND PERFORMANCE

07/20 QUALITY AND PERFORMANCE REPORT

SH presented the item and explained there were two versions of the report; one which the Board had been receiving and a new format based on Statistical Process Control (SPC) charts. Both would be presented for a three month period as the SPC report evolved. MP stated that SPC charts were "game-changing" and looking at trends rather than numbers was huge step forward. In response to questions from MN and RG, SH and RDC confirmed that that the SPC report was still in development but that the supporting narrative would be added as well as learning from "best in class" reports identified by NHSEI. DL confirmed that the intention was to move from an integrated performance report to develop an integrated narrative which drew out the dependencies and correlations between underlying common issues and themes.

The report showed pressure ulcers and falls as the most significant areas to focus on, however with seven dots above variation the SPC highlighted Clostridium Difficile (C.Diff) as an issue. SH confirmed that this remained a huge focus with considerable attention still be paid to

cleaning and anti-microbial prescribing but he expressed disappointment that outcomes were not improving as quickly as he had hoped. RG asked whether patients could be affected by either of these factors and SH confirmed that they were both contributory factors to C.Diff infection. DL enquired as to whether enough causal analysis was being carried out to understand those cases that could be attributed to a cleaning failure. SH confirmed that there were cases where cleaning was a component factor.

RDC updated that emergency care was extraordinarily pressurised but that Gloucestershire remained a high performing system, although there were longer waits than desired and some winter monies had been received to help address this which was being invested in extending the staffing and hours of operation of the AMIA Unit.

Planned care performance for Referral To Treatment (RTT) of 80.2% was within the agreed trajectory as was the number of 52 week waiters. The Board also noted that the Two Week Cancer Wait had been achieved for the fifth month running thanks to a relentless focus by the team resulting in a 40% drop in patients waiting 72 days with patients waiting over 104 days being the best it had been for two years (at 20 patients only).

CF recognised the success in sustaining elective care improvement and asked if this could be maintained? RDC explained that a huge focus on cancer pathway redesign, alongside “right sizing” of demand and capacity meant that increasingly performance was sustainable evidenced by the five consecutive months of Two Week Wait performance. DL advised that Gloucestershire was the only orthopaedic service undertaking routine operating in the South West, on Monday 6 January 2020 despite operational pressures.

MN asked about the 28 day diagnostic cancer pathway for the forthcoming year and whether there would be a change. RDC explained that there was now an additional new faster diagnostic standard (from April 2020) with shadow reporting in place until this was active; the key issue was that it brought very significant numbers of patients into the cohort who would need monitoring.

BH queried what had happened to improve the dementia performance from 0.3% to 67% and what more could be done. SH advised this had been a data quality issued and the improvement reflected manual audit rather than being extracted from TrakCare. SH added there was still work to be done in this area and advised that the Trust had twice been unsuccessful in recruiting to a dementia lead nurse role but he would continue to try and find a suitable candidate. Discussion took place on the support available to junior doctors to support initial screening on admission.

BH sought an update on plans to improve stroke care and MP advised there had been a significantly higher than usual number of strokes in month leading to bed pressures and this had explained the drop in performance. He believed performance would return to previous levels as activity normalised.

BH observed the inpatient questions and the Friends and Family Test (FFT) showed the importance of engagement. SH advised the FFT was changing from April 2020 and would allow the Trust to ask patients about

their entire pathway.

PL appreciated the work of staff across the Trust to deliver the performance and care to patients and noted the thanks from the Board. DL welcomed this and added that she was still receiving positive comments and messages following the message and card sent in December 2019.

RESOLVED: The Board NOTED the Quality and Performance report.

FINANCE AND DIGITAL

08/20 ASSURANCE REPORT OF THE CHAIR OF FINANCE AND DIGITAL COMMITTEE HELD ON 19 DECEMBER 2019

RG presented the report and updated on the discussions on the Strategic Site Development (SSD) Strategic Outline Case (SOC) together with an update on the Electronic Patient Record (EPR) "go live" outcome which has reinforced the strength of effort and the commitment of MH's team to the project and his leadership of it.

RG highlighted the Finance performance at Month 8 (M8) with the Trust slightly ahead of its control total and in a strong cash position. The outturn for Quarter 4 (Q4) and year-end, while challenging, now showed the Trust to be in a stronger position than previously projected. There was a strong prospect that the year-end control total would be achieved. The Committee had been assured by the quality of the dialogue and answers to questions on this matter. RG confirmed the Trust was not making inappropriate use of reserves in hitting the control total. In considering the Cost Improvement Programme situation, Q4 continued to be a significant challenge and further work was needed to maximise the achievement in order to reduce the scale of the challenge in 2020/21.

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

09/20 FINANCIAL PERFORMANCE REPORT

KJ presented the report and highlighted the Group Statement of Comprehensive Income. The M8 position showed a £600k favourable position against the budget although there had been an adverse movement in month of £161k.

The close of M9 had shown some improvement and KJ confirmed the Trust would be seeking to deliver control total as some divisions improved their Q4 forecast in Q4. The Board heard that it was important to recognise the position had been achieved with a significant number of non-recurrent CIP plans and in recurrent CIP was needed in future.

KJ stated that income was ahead of plan and year-end agreement had been reached with NHS England specialist commissioners that would maintain this position. Further to RG's earlier comment, KJ confirmed a strong cash position that would support an ambitious capital programme, however she felt that the cash position was not reflected in the payment of suppliers, which should be better and she was looking into this.

PL asked if, as an incoming Director, KJ had seen anything that caused

her concern or identified any risks that were not being addressed. KJ confirmed it was her fourth day in post but so far she had no concerns. KJ added that her initial view was that the balance sheet was healthy, there appeared to be good processes for forecasting and that divisions understood and owned their financial positions although it appeared it could sometimes be difficult to keep them on track.

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

PEOPLE AND ORGANISATIONAL DEVELOPMENT

10/20 ASSURANCE REPORT OF THE CHAIR OF THE PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE HELD ON 16 DECEMBER 2019

BH presented the report and outlined the key areas of discussion including the risk register and an update on the follow-up to the wheelchair incident.

Non-registered staff retention was noted to be improving although there were some areas where levels were lower than desired. The Integrated Care System (ICS) recruitment and retention sub-group had not met since July 2019 but the ICS workforce group continued to meet and had a new chair. Medical staffing had been revised and assurance provided this was at the right level.

The latest draft of the Engagement and Involvement Strategy had been reviewed and work would continue to develop this pending the appointment of the Associate Director of Engagement. Discussion took place on how digital solutions and approaches could enhance and support engagement.

The staff survey had identified learning opportunities from Trusts with better response rates and MAG highlighted the need to increase participation amongst Black and Minority Ethnic (BME) staff.

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

11/20 PEOPLE AND ORGANISATIONAL DEVELOPMENT REPORT

EW presented the report and updated that work continued to develop with Trust performance ahead of model hospital comparators and university hospital peers. There remained issues to be resolved; turnover had increased but vacancy levels had fallen, appraisal levels were satisfactory but required some focus and mandatory training was above target in most but not all areas.

SPC charts had been introduced where meaningful along with operational dashboard exception reports and an example for surgery was provided and well received. These would allow the Committee to look at strategic and operational performance measures and be assured on divisional performance.

PL asked how the Committee was looking at the how the Talent Pool was working? EW confirmed that work was underway to look at this and when completed, a report would be presented to the Committee to show the number of staff engaged in this and what it had achieved but

anecdotal feedback was positive.

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

12/20 FIT FOR THE FUTURE – ENGAGEMENT REPORT

Jo Underwood, Centres of Excellence Programme Director joined for this item.

SL reminded the Board of the Fit For The Future (FFtF) engagement phase that took place between August and October 2019. JU advised that the full outcomes report had been published on the One Gloucestershire website and outlined the key points.

JU advised feedback themes had included keeping CGH emergency department open, mental health care within urgent and emergency services, cross-site and cross Gloucestershire travel. There had been support for the *Centres of Excellence* vision.

CF advised that an open and engaged conversation had taken place and asked whether the feedback had shown evidence of consent and what could be taken from this to inform next steps? SL advised that it was not the purpose to seek consent but to identify ideas and any areas of concern ahead of consultation (in accordance with the advice from the Consultation Institute) so that we can demonstrate that feedback had been listened to and shaped the final proposals; he added that there was strong evidence for this including an option for CGH A&E being included in the options having not originally been included.

MAG asked how the consultees were kept informed along the way and SL and JU advised the Health Overview and Scrutiny Committee (HOSC) was a key part of this with a formal response to their comments being published. The Citizens' Jury was also a great opportunity for further learning and to understand how we describe the options for public consultation. All those who had responded on-line and in person had been asked if they would like to receive the formal feedback report. DL added that local print and radio media, alongside social media would be used to provide continual updates on key messages.

PL queried how people would be fully engaged on indirect issues affecting healthcare i.e. population growth, travel and transport etc. as the process was worked through? SL confirmed the work was across the ICS, which includes health and local authority partners, and further work would take place to identify who would lead on those areas picked up that were out of scope of FFtF. He said that travel was a major theme emerging and not particularly in relation to the proposals being shared but in relation to current services e.g. return transport following A&E attendance.

JU agreed to confirm whether the report was able to differentiate between the responses of the public and staff/colleagues. **ACTION.** **JU**

BH asked how feedback would be obtained from groups that did not engage and JU advised this would be targeted through impact/involvement leads and the team was working closely with Inclusion Gloucestershire who had facilitated a number of community engagement events as part of the programme.

RESOLVED: The Board RECEIVED the FFtF Output of Engagement Summary v2 and NOTED the full report was publically available via the One Gloucestershire website.

13/20 GOVERNOR QUESTIONS

JP asked whether data was being collected on patients on trolleys across the Trust and it was confirmed that TrakCare showed these patients as in "waiting areas" on the new system but this was not location specific. JP queried whether this should be a quality indicator and SH confirmed it was a balancing measure and included in the Emergency Department (ED) performance dashboard but more work needed to be done on hour these patients were captured on the system.

Following on from the patient story AD expressed surprise that the Trust did not have lanyard for patients with hidden disabilities. SH advised he was following up on this but also highlighted that some patients did not want "physical" labels. The lanyard didn't signal the nature of the disability and may not therefore always be helpful. DL added she was more concerned that some of the better recognised symbols were not understood by staff.

AD asked whether the Children's Centre signage could be changed to reflect Children and Young People, to recognise older children and provide some more "age appropriate" environments for young people. SH agreed to follow up with SC and advised that whilst signage could be addressed, a separate area may be more difficult but he was aware that this issue was being actively considered by the Division. **ACTION.** **SC**

DL observed that other areas used Children and Young People as the description and that where the typical offer of care in the unit might not work for teenagers, the team would seek to provide individualised care in a side room where possible. She also added that the small number of young people admitted to hospital made a dedicated ward difficult unlike areas like Bristol where as a regional cancer centre, this was more viable. She summarised by saying that there was more they could and should do to respect the needs and preference of older children and young adults.

AD queried the availability of porters on patient transfers, particularly in radiology. SH updated that work was underway to target specific porter resources within the radiology budget. DL added that a pilot within Gloucestershire Managed Services (GMS) had shown zoning of porters had improved services in some areas, but radiology would be monitored by the Executive through contract performance as this was still flagged as an issue.

AD queried the continued issues related to C.Diff? SH updated on work to improve cleaning and prescribing of alternate anti-microbial to reduce the number of cases.

AT observed that the patient story had highlighted the importance of little things making a big difference. He also commented on increased activity levels impacting on parking issues and DL advised that GMS were leading on the transport strategy and this would be presented to governors when ready.

AT welcomed the SPC charts and supported the request for a dynamic risk register.

AT queried the link between the Engagement and Involvement Strategy and People and OD Committee. SL explained it related to the "Involved People" strategic objective and EW added that whilst the strategy could stand alone, it did need oversight from a board committee.

With regard to the FFtF presentation, AT asked if any form of weighting had been applied to the themes emerging. SL confirmed this was the first cut of the report and as such detailed analysis had yet to be undertaken, however, the engagement insights would be used to assess the different options emerging against different criteria which had also been tested through the engagement work.

AT asked that the Trust consider men of working age in good health as a group to target within engagement as they could easily be missed but potentially become users of the service in later life.

14/20 STAFF QUESTIONS

There were none.

15/20 PUBLIC QUESTIONS

There were none.

16/20 NEW RISKS IDENTIFIED

There were none.

17/20 ITEMS FOR THE NEXT MEETING

There were none.

18/20 ANY OTHER BUSINESS

There were no items of any other business.

The meeting closed at 15:35.

DATE AND TIME OF THE NEXT MEETING

The next meeting of the main board will take place at 12:30 on Thursday 13 February 2020 in the Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital.

Signed as a true and accurate record:

Chair
13 February 2020

Gloucestershire Hospitals
NHS Foundation Trust

MAIN BOARD (PUBLIC) – MATTERS ARISING

Minute	Action	Owner	Target Date	Update	Status
9 JANUARY 2020					
12/20	**Fit For the Future – Engagement Report:** Confirm whether the report was able to differentiate between the responses of the public and staff/colleagues.	JU	February 2020	The only element of the report where staff views could be differentiated from general public is the online Fit for the Future survey responses, which are detailed in full in Appendix 5a. Of 984 people who responded, 117 identified themselves as a 'Health and Social Care Professional'. No further data-categories (e.g. organisation or profession) were collected.	**CLOSED**
13/20	**Governor Questions:** Follow up whether the Children's Centre signage could be changed to reflect Children and Young People.	SC	February 2020	SC has consulted with the Division's Paediatric Matron and this will be costed and approval will be sought for the spend from W&C Divisional Board.	**CLOSED**
19 DECEMBER 2019					
254/19	**Quality Strategy:** Attention to be given to selection process for Governors' Quality Indicators.	SH	February 2020	December 2019 update confirmed work on track and Alan Thomas confirmed he was content with timescale and discussions. February 2020 - Governors' Quality Group looking at this on Monday 10 February. Formal decision to be made at Council of Governors on 18 February.	**PENDING**

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD - FEBRUARY 2020

REPORT OF THE CHIEF EXECUTIVE

1. The Trust

1.1 Despite relatively mild weather, operational pressures remain considerable. However, levels of influenza circulating in the community have declined considerably and reflect a more positive picture than the same time last year; similarly, the impact of norovirus has also reduced. Although waiting time performance is considerably poorer than last year, the Trust and wider system's position remains strong relative to regional and national performance; at the end of quarter 3, the Trust was the top performing Type 1 A&E in the South West and *One Gloucestershire* performed in the upper third of systems nationally. Despite this, the experience of our patients and the ambitions of our staff fall short of what we aspire to and work continues to support improvement in waiting times alongside ensuring safe, compassionate care at all times.

1.2 Along with all NHS organisations, the Trust is working very closely with system partners and Public Health England to ensure that we are prepared for the potential implications arising from the Novel Coronavirus outbreak in China, and the subsequent confirmation of two cases in the U.K. The Trust has tried and tested emergency preparedness plans for such occasions and has established a local response team to oversee planning. Recent national guidance requires the Trust to have established coronavirus assessment areas called *Coronavirus Priority Assessment Pods*, remote from A&E departments, no later than 7 February and this has been achieved. To date, patients presenting with symptoms that fit the criteria, have been very few in number and whilst a serious issue, the risk to our local population remains low with travel to infected parts of China remaining the common feature of those cases outside of China.

1.3 Following on from the very successful first phase roll-out of our Electronic Patient Record (EPR), we are now poised to go-live in our Cheltenham wards; this phase will benefit from learning through the GRH phase and has the additional benefit of enabling our "expert" GRH nursing staff to assist their CGH peers. The initial benefits for staff and patients continue to be reported and, such has been the success of phase one, we have decided to bring forward the roll out of the electronic observations (e-obs). The e-obs development is especially exciting given the considerable benefit to patient safety that will flow from this element of the EPR, including enhanced oversight of those patients most at risk of sudden deterioration.

1.4 The Board and wider leadership team is devoting considerable time developing the Trust's culture or, as recently described by leadership guru Michael West, "the way we do things around hear (when nobody is looking)". The Board spent an incredibly valuable morning working with Michael on our developing values and behaviours framework and subsequently spent a morning with national leaders Yvonne Coghill and Habib Navqi looking at the issue of inclusion, and specifically the experience of black and minority ethnic staff (BME). The insights shared and explored demonstrate a number of positive features of our culture and approach to inclusion (especially when compared to other NHS Trusts), however it also shone a light on the irrefutable fact that BME staff report a less positive employment experience than their white colleagues in our Trust (through the optic of the national staff survey) as is the case in the majority of NHS Trusts.

1.5 This year is the *International Year of the Nurse and Midwife*. Given the size and contribution of this workforce, it's set to be an amazing year packed with activities and

celebrations which reflect all that is great about these two professions. Given the Government's commitment to increase the number of nurses this is fantastic timing. Steve Hams and colleagues will shortly publish our own local timetable of events and are working to ensure that our developing *Pathways To Excellence* programme makes the most of this special year with respect to aligning activities and seizing opportunities.

1.6 It's hard to believe that our 2020 Staff Hub has been operating since May 2019. The first six months of the Hub's activities has recently been evaluated, and very positively so. The final report will be published later in February but headlines include support to 452 colleagues which is 5.5% of our workforce. 76% of contacts were from the individual seeking support but very encouragingly, a further 18% were from line managers seeking advice and guidance to help them to support staff in their teams to better manage health and wellbeing concerns. As impressive, is the degree of access to the Hub's website and online resources with 13,454 hits since its launch. One statistic that is most certain worthy of reflection and further examination is the gender bias of those accessing the confidential counselling service; 93% of those who contacted the service were female and whilst we have considerable bias to female employees, the evidence shows that males are as susceptible to mental health issues as their female colleagues and certain groups more so. The Hub team will be considering whether the nature of our offer is fully accessible to and delivered in ways that enable our male colleagues to seek help when it's needed. The full report will be published after the 17th February People Committee has reviewed it in full.

1.7 The often unsung heroes, our porters, were acknowledged recently when they were presented with an award from the High Sheriff of Gloucestershire, Charles Berkeley. The award was given in recognition of their 'great and valuable services to the community'. As part of the award the High Sheriff had a tour of GRH to see the team in action which culminated in tea, cake and a chance to find out more about the challenges and opportunities that being a porter presents to team members on a daily basis. A similar visit to CGH is planned. Click here to see the full article on our website.

1.8 Finally, it is with huge regret that I announce the resignation of Simon Lanceley, Director of Strategy and Transformation. Simon joined the Trust just over two years ago and has made a huge contribution during his tenure, not least through his leadership of the Trust's strategic capital programme and his pivotal contribution to *One Gloucestershire's Fit For The Future Programme*. Simon has worked in a number of sectors as well has health and has decided it's time to expand his horizons once again. I wish him every success; recruitment for his successor has commenced noting he leaves "big shoes" to fill.

2. The System

2.1 It has been a very busy period in respect of the *One Gloucestershire Fit For The Future* programme with both Citizens' Jury and Solutions Appraisal workshop taking place. Both events provided invaluable opportunities for clinicians, other healthcare professionals and lay people to come together and immerse themselves in the detail underpinning our vision for the future of healthcare in the County. Both events have evaluated very positively with those that took part, as well as those who came along to observe the sessions. The outputs from both these sessions will inform the final proposals which the member organisations of the *One Gloucestershire* Integrated Care System will take forward to public consultation.

2.2 In January, I reported that the system intended to submit a deficit financial plan for the coming year 2020/21. Following further work between partners and NHS Improvement, the system has now been able to develop a balanced plan which has been submitted to NHSI. Delivery of the plan is predicated on a number of significant variables and associated planning assumptions including delivery of 2.6% reduction in the Trust's cost base and 100% achievement of the £13.1m Financial Restructuring Fund (FRF) available to the system. Differently to last year, 50% of this funding is now

reliant upon delivery of the system financial plan and the balance linked to delivery of the Trust plan. In respect of the non-financial aspects of the plan, this remains as previously described with the exception of the trajectory for achieving the national *Continuity of Carer* standard which we have now submitted as a compliant trajectory reflecting 51% of pregnant women, and their partners, being cared for within this model by 2024.

Deborah Lee
Chief Executive Officer

6 February 2020

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – 13 FEBRUARY 2020
Lecture Hall, Redwood, GRH commencing at 12:30

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 most serious risks within the organisation, alongside assurance that the Executive is actively managing those risks so far as is reasonably possible.

Key issues to note

- The Trust Risk Register is provided in appendix 1. Risks are assessed in relation to the potential consequence and likelihood of a risk materialising and scored against eight domains: safety, quality, statutory, workforce, finance, business, reputational and environmental impacts.

- Divisions are required to submit a monthly report indicating any changes to existing high-scoring risks already on the Trust Risk Register and/or any specialty or divisional risks where a change in the risk has increased the score to 12+ for safety or 15+ for all other domains. These risks are first referred to the Directors of Operations Group before being reviewed by the Trust Leadership Team (TLT) for consideration and, if accepted, inclusion on the Trust Risk Register.

- At the Trust Leadership Team (TLT) meeting on 8 January 2020, 7 divisional risks were reviewed due to increased risk scores and were accepted onto the Trust Risk Register. As the TLT meeting occurred the day before January's Board meeting there was insufficient time for a risk paper to be circulated and reviewed by the Board. The risks added to the Trust Risk Register in January are therefore included in this report. .

- Whilst an additional risk was presented to TLT in February, the evidence behind the scoring was challenged; no further additions were made in February and there are no matters to escalate to the Board.

- Of the risks already on the Trust Risk Register in January and February, there was no increase or decrease in the previously evaluated risk scores and no risks were closed during this period.

Risks reviewed by TLT in January

C3084P&OD The risk of inadequate quality and safety management owing to frequent (daily) reliance on outdated electronic systems currently used for data and information recording, storage, reporting, analysis and assurance. Outdated quality and governance systems include those currently used for Policy, Safety, Incidents, Risks, Alerts, Audits, Inspections, Claims, Complaints, Radiation, Compliance etc. across the Trust at all levels.

Scoring C3 x L5 = 15 for Quality

Operational lead: Lee Troake; Executive lead: Emma Wood

Key Controls (summary)	• Risk Managers monitoring the system daily • Risk Managers manually following up overdue risks, partially completed risks, uncontrolled risks and overdue actions • Risk Assessments, inspections and audits held by local departments • Risk Management Framework in place • Risk management policy in place • SharePoint used to manage policies and other documents	Mitigation plans	• Placed on intolerable risk register (complete) • Prepare a business case for upgrade / replacement of DATIX (in progress) • Referred to IMT Leads • Arrange demonstration of DATIX Cloud and Ulysis to assess market options • Explore whether GHT IT services can resolve any functionality issues
Linked risks	None	Highest Scoring Impact	Quality C3 x L5 = 15

D&S2517Path - The risk of non-compliance with statutory requirements to the control of the ambient air temperature in the Pathology Laboratories. The air temperature of the laboratory and storage areas are a key part of the laboratory environment, with most analysers and reagents needing a stable and controlled temperature range of 20-25^{o}C. Failure to comply could lead to equipment and sample failure, the suspension of pathology laboratory services at GHT and the loss of UKAS accreditation / income to GHT.

The temperature regularly exceeds the 25^{o}C upper limit; particularly during the summer months.

Scoring C4 x L4 = 16 for Statutory

Operational lead: Jonathan Lewis; Executive Lead: Rachael De Caux

Key Controls (summary)	• Air conditioning installed in some laboratory (although not still not adequate) • Desktop and floor-standing fans used where possible (cannot be used near sensitive equipment) • Quality control procedures for lab analysis • Temperature monitoring systems to alert staff • Temperature alarm for body store • Contingency plan is to transfer work to another laboratory in the event of total loss of service at GHT, such as to North Bristol	Mitigation plans	• Survey report commissioned • Business case submitted for additional air conditioning and chiller units including quotes for the work • Added to Intolerable Risk Register for funding consideration
Linked risks	D&S2937Path D&S3103Path	Highest Scoring Impact	Statutory Scoring C4 x L4 = 16

D&S3103Path - The risk of total shutdown of the Chem. Pathology Laboratory service on the GRH site due to ambient temperatures exceeding the operating temperature window of the instrumentation.

Scoring C4 x L4 = 16 for Statutory

Operational lead: Linford Rees, Executive Lead: Rachael De Caux

Key Controls (summary)	• Air conditioning installed in some laboratory (although not still not adequate) • Desktop and floor-standing fans used where possible (cannot be used near sensitive equipment) • Quality control procedures for lab analysis • Temperature monitoring systems to alert staff • Temperature alarm for body store • Contingency plan is to transfer work to another laboratory in the event of total loss of service at GHT, such as to North Bristol	Mitigation plans	• Survey report commissioned • Business case submitted for additional air conditioning and chiller units including quotes for the work • Added to Intolerable Risk Register for funding consideration
Linked risks	D&S2937Path D&S3103Path	Highest Scoring Impact	Statutory Scoring C4 x L4 = 16

S2917CC- The risk of patient and staff harm and loss of life as a result of an inability to horizontally evacuate patients from critical care in the event of a fire or other emergency.

Scoring C5 x L1 = 5 for Safety

Operational lead: Rebecca Offord; Executive Lead: Rachael De Caux

Key Controls (summary)	• Presence of fire escape staircase and routes • Fire exit signage • Fire extinguisher present / maintained • Fire risk assessment • Fire assembly points • Fire detection and alarm system • Hover-jack to aid evacuation of level 3 patients • Fire extinguisher training for staff • Local fire service pre-determined attendance response for hospital	Mitigation plans	• 20 slide sheets provided • Simulated evacuation to evaluate the Hover-jack and slide sheets as effective option / provide training – action plan / lessons learned • Observation and input from Fire Safety Team • GMS review of option for creating adequate fire escape facilities • Oxygen cylinder holders on order
Linked risks	C2719COO	Highest Scoring Impact	Safety C5 x L1 = 5

C2970COOEFD- Risk of harm or injury to staff and public due to dilapidation and/or structural failure of external elevations of Centre Block and to Hazelton Ward Ceiling – resulting in loose, blown or spalled render/masonry in external & internal areas.

Scoring C5 x L1 = 5 for Safety

Operational lead: Akin Makinde; Executive Lead: Rachael De Caux

Key Controls (summary)	• Snapshot' visual survey undertaken from ground level to establish the scope of the loose, blown or spalled render and masonry to the external elevations of the building & any loose material removed	Mitigation plans	• Refurbish the roof outside and make safe • To undertake a comprehensive structural survey of the external elevations of Centre Block to identify all areas requiring repair or

	• Heras fencing has been put up to isolate persons from the areas of immediate concern • Areas of concern being monitored		replacement and to undertake those works • Planning permission for investigatory works
Linked risks	GMS1968Est	Highest Scoring Impact	Safety C5 x L1 = 5

C2989COOEFD - Risk to patient, staff and public safety due to fragility of single glazed windows. Risk of person falling / breaking through a higher storey window pane and sustaining serious, life threatening or fatal injuries. Serious injury from contact with broken glass / shattered windows. Glass shards may also be used as a weapon against staff, other patients or visitors. Risk of distress to other patients / visitors and staff if person falls.

Scoring C5 x L1 = 5 for safety

Operational lead: Akin Makinde; Executive lead: Rachael De Caux

Key Controls (summary)	• Wards assessed to establish which accommodate higher risk patients. Windows in these wards have a protective film to prevent shards of glass fragmenting if window is broken • Vulnerable patients are assessed and controls in place to minimise patient contact with windows/glass • Window restrictors are fitted to all windows above ground floor and are maintained on an annual PPM schedule by GMS • Window Restrictor Policy reviewed on a three yearly basis or as required • If a window is broken or damaged it is replaced with toughened glass which complies with current legislative requirements	Mitigation plans	• Review confirms upgrade of 100 windows in the Tower Block required • Exploration of cost approx. £30,000 per ward • Funding and refurbishment options to be explored
Linked risks	GMS2030Est	Highest Scoring Impact	Safety C5 x L1 = 5

C1850NSafe - Risk to the safety of adolescents aged 12-18yrs, presenting with significant mental health issues and self-harming behaviour. Patients require assessment and a place of safety in an appropriate mental health setting but when this is not available are admitted to GHT despite they do not require medical care.

Scoring C3 x L4 = 12 for Safety

Operational lead: Vivien Mortimer; Executive lead: Steve Hams

Key Controls (summary)	• The paediatric environment has been risk assessed and adjusted to make the area safer for self-harming patients with agreed protocols • Additional staff including RMN's are employed via an agency during	Mitigation plans	• Develop Intensive Intervention programme • Escalation of risk to Mental Health County Partnership

	admission periods to support the care and supervision of these patients • CQC\commissioners have been made formally aware of the risk issues • Individual cases are escalated to relevant services for support		
Linked risks	WC62Paed	Highest Scoring Impact	Safety C 3x L4 = 12

Conclusions

Assurance is provided that the Trust is actively seeking to eliminate or reduce the risks identified to as low a level as reasonably practicable.

Implications and Future Action Required

Pursue the mitigating actions outlined for each risk and seek continuous improvement to the risk management processes.

Recommendations
To agree the addition of the seven risks onto the Trust Risk Register as outlined in the report.
Impact Upon Strategic Objectives
Good risk management supports delivery of a wide range of objectives relating to safety, high quality care and good governance.
Impact Upon Corporate Risks
The Trust Risk Register is included in the report.
Regulatory and/or Legal Implications
Risks with potential regulatory implications are outlined in the report.
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	**X**	For Information	

Date the paper was presented to previous Committees and/or Trust Leadership Team (TLT)							
Audit & Assurance Committee	**Finance & Digital Committee**	**Estates & Facilities Committee**	**People & OD Committee**	**Quality & Performance Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
						8 January 2020 And 5 February 2020	Directors Operational Group 18 December 2019/ 22 January 2020

Outcome of discussion when presented to previous Committees/TLT
TLT recommends the Board endorses the above changes to the Trust Risk Register.

Ref	Inherent Risk	Controls in place	Action / Mitigation	Division	Highest Scoring Domain	Score	Executive Lead title	Title of Strategic Group	Title of Operational Group	If other, please specify name of Operational Group	Title of Assurance Committee / Board	Date Risk to be reviewed by	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		Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Finance	C5xL4=20	Director of Finance	Finance and Digital Committee, Turnaround Implementation Board	Other	Finance and Digital Committee	Finance and Digital Committee, Trust Leadership Team	30/01/2020	Johnson, Karen
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	Medical	Quality	C4xL5=20	Director of Quality / Chief Nurse	Divisional Board - Medical, Emergency Care Delivery Group	Emergency Care Operational Group		Emergency Care Board, Trust Leadership Team	01/06/2020	Blake, Anna
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 8. Creation of a health and wellbeing hub aimed at reducing absence and reliance on costly temporary solutions	Corporate, Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Finance	C4xL4=16	Chief Nurse	Finance and Digital Committee, People and OD Delivery Group, Workforce Review Group	Agency Programme Board		Finance and Digital Committee, People and OD Committee, Trust Leadership Team, Workforce Committee	30/01/2020	Murrell, Mel
		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	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										

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.	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	To produce a suitable set of IRMER procedures and SOPs	Corporate, Diagnostics and Specialties, Medical, Surgical	Statutory	C4xL4=16	Medical director	Divisional Board - Corporate / DOG, People and OD Delivery Group, Quality Delivery Group, Trust Health and Safety Committee	Radiation Safety Committee		People and OD Committee, Quality and Performance Committee, Trust Leadership Team	11/03/2020	Dix, Tony
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 RTT standard is not being met and re-reporting took place in March 2019 (February data). RTT trajectory and Waiting list size (NHS I agreed) is being met by the Trust. The long waiting patients (52s)are on a continued downward trajectory and this is the area of main concern 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. Picking practice report developed by BI and theatres operations, reviewed with 2 specialities (Jan 2020) and issued to all service lines (Jan 2020) to	1.RTT and TrakCare plans monitored through the delivery and assurance structures	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Statutory	C4xL4=16	Chief Operating Officer	Divisional Board - Corporate / DOG, Planned Care Delivery Group	Clinical Systems Safety Group		Quality and Performance Committee, Trust Leadership Team	29/02/2020	Taylor-Drewe, Felicity
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	Surgical	Workforce	C4xL4=16	Medical Director	Divisional Board - Surgery, People and OD Delivery Group			People and OD Committee, Trust Leadership Team	30/12/2019	Turner, Bernie
	The risk of non-compliance with statutory requirements to the control of	A• Air conditioning installed in some laboratory (although not still not adequate)											

D&S2517Path	statutory requirements to the control of the ambient air temperature in the Pathology Laboratories. The air temperature of the laboratory and storage areas are a key part of the laboratory environment, with most analysers and reagents needing a stable and controlled temperature range of 20-25oC. Failure to comply could lead to equipment and sample failure, the suspension of pathology laboratory services at GHT and the loss of UKAS accreditation / income to GHT.	adequate) • Desktop and floor-standing fans used where possible (cannot be used near sensitive equipment) • Quality control procedures for lab analysis • Temperature monitoring systems to alert staff • Temperature alarm for body store • Contingency plan is to transfer work to another laboratory in the event of total loss of service at GHT, such as to North Bristol	• Survey report commissioned • Business case submitted for additional air conditioning and chiller units including quotes for the work • Added to Intolerable Risk Register for funding consideration	Diagnostics and Specialties	Statutory	C4xL4=16	Chief Executive Officer	Divisional Board - D & S	Pathology Management Board			19/03/2020	Lewis, Jonathan
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	1. Prioritisation of capital managed through the intolerable risks process for 2019/20 Ongoing escalation to NHSI and system	Corporate, Gloucestershire Managed Services	Environmental	C4xL4=16	Chief Operating officer	Divisional Board - Corporate / DOG	GMS Health and Safety Committee		GMS Board, Trust Leadership Team	31/01/2020	Makinde, Akin
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	Review, Assess and enact agreed future actions/controls	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Quality	C4xL4=16	Chief Operating Officer	Estates and Facilities Contract Management Group, Infection Control Committee	Other	Opened by Strategic Group	Quality and Performance Committee, Trust Leadership Team	31/12/2020	Makinde, Akin
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	Task and Finish group in situ to review all possible mitigations, meeting weekly Fit for the Future engagement process re emergency general surgery	Surgical	Quality	C4xL4=16	Medical Director	Divisional Board - Surgery, Theatre Transformation and Collaboration Board	Theatres Utilisation Group		Trust Leadership Team	30/12/2019	Turner, Bernie
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	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	C4xL4=16	Director of Quality and Chief Nurse	Divisional Board - Corporate / DOG, Infection Control Committee	Decontamination Group		Quality and Performance Committee, Trust Leadership Team	31/03/2020	Bradley, Craig

D&S3103Path	The risk of total shutdown of the Chem Path laboratory service on the GRH site due to ambient temperatures exceeding the operating temperature window of the instrumentation.	• Air conditioning installed in some laboratory (although not still not adequate) • Desktop and floor-standing fans used where possible (cannot be used near sensitive equipment) • Quality control procedures for lab analysis • Temperature monitoring systems to alert staff • Temperature alarm for body store • Contingency plan is to transfer work to another laboratory in the event of total loss of service at GHT, such as to North Bristol	• Survey report commissioned • Business case submitted for additional air conditioning and chiller units including quotes for the work • Added to Intolerable Risk Register for funding consideration	Diagnostics and Specialties	Quality	C4xL4=16	Cheif Operating Officer	Divisional Board - D & S	Pathology Management Board			19/03/2020	Rees, Linford
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	Surgical	Workforce	C5xL3=15	Medical Director	Divisional Board - Corporate / DOG, Divisional Board - Surgery, Education and Learning Development Strategy Group (ELD)	Medical Education Board		Trust Leadership Team	30/12/2019	Turner, Bernie
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	Surgical	Quality	C3xL5=15	Director of Safety and Medical Director	Divisional Board - Surgery, People and OD Delivery Group	Clinical Safety Effectiveness and Improvement Group		People and OD Committee, Trust Leadership Team	30/12/2019	Turner, Bernie
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	Surgical	Quality	C3xL5=15	Medical Director	Divisional Board - Corporate / DOG, Divisional Board - Surgery			Trust Leadership Team	30/12/2019	Turner, Bernie
		1. Speciality specific review administratively of patients (i.e. clearance of duplicates) (administrative validation) 2. Speciality specific clinical review of patients (clinical validation) 3. Utilisation of existing capacity to	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										

C1798COO	The risk of delayed follow up care due outpatient capacity constraints all specialities. (ENT; Rheumatology & Ophthalmology) Risk to both quality of care through patient experience impact(15)and safety risk associated with delays to treatment(4).	support long waiting follow up patients 4.Weekly review at Check and Challenge meeting with each service line, with specific focus on the three specialties 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 (PCDG December 2019) 9. Review of % over breach report with validated administratively and clinically the values 10. Agreement with three specialities for chronological 2017 clearance by March 2020, with then a plan for the remaining years / chronological % over breach - Each speciality to formulate plan and to self-determine trajectory.	3. Additional provision for capacity in key specialiities to support f/u clearance of backlog	Medical, Surgical	Quality	C3xL5=15	Chief Operating Officer	Divisional Board - Corporate / DOG, Planned Care Delivery Group, Quality Delivery Group	Trak Operational Group		Planned Care Board, Trust Leadership Team	31/01/2020	Taylor-Drewe, Felicity
C3084P&OD	The risk of inadequate quality and safety management owing to frequent (daily) reliance on outdated electronic systems currently used for data and information recording, storage, reporting, analysis and assurance. Outdated quality and governance systems include those currently used for Policy, Safety, Incidents, Risks, Alerts, Audits, Inspections, Claims, Complaints, Radiation, Compliance etc. across the	Risk Managers monitoring the system daily Risk Managers manually following up overdue risks, partially completed risks, uncontrolled risks and overdue actions Risk Assessments, inspections and audits held by local departments Risk Management Framework in place Risk management policy in place SharePoint used to manage policies and other documents	• Placed on intolerable risk register (complete) • Prepare a business case for upgrade / replacement of DATIX (in progress) • Referred to IMT Leads • Arrange demonstration of DATIX Cloud and Ulysis to assess market options • Explore whether GHT IT	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Quality	C3xL5=15	Director of People and OD	Divisional Board - Corporate / DOG, Finance and Digital Committee, Risk Management Group	Quality and Safety Systems Group		Finance and Digital Committee, People and OD Committee, Trust Leadership Team	30/03/2020	Troake, Lee
C2989COOEFD	The risk of patient, staff, public safety due to fragility of single glazed windows. Risk of person falling from window and sustaining serious injury or life threatening injuries. Serious injury from contact with broken glass / shattered windows. Glass shards may be used as a weapon against staff, other patients or visitors. Risk of distress to other patients / visitors and staff if person falls	• Wards assessed to establish which accommodate higher risk patients. Windows in these wards have a protective film to prevent shards of glass fragmenting if window is broken • Vulnerable patients are assessed and controls in place to minimise patient contact with windows/glass • Window restrictors are fitted to all windows above ground floor and are maintained on an annual PPM schedule by GMS • Window Restrictor Policy reviewed on a three yearly basis or as required • If a window is broken or damaged it is replaced with toughened glass which complies with current legislative requirements	• Review confirms upgrade of 100 windows in the Tower Block required • Exploration of cost approx. £30,000 per ward • Funding and refurbishment options to be explored	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Environmental	C2xL5=10	Chief Operating Officer	Divisional Board - Corporate / DOG, Estates and Facilities Committee, Trust Health and Safety Committee	GMS Health and Safety Committee		GMS Board, Trust Leadership Team	31/01/2020	Makinde, Akin
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	Monthly Audits of NEWS2. Assessing completeness, accuracy and evidence of escalation. Feeding back to ward teams Development of an Improvement Programme	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	C4xL3=12	Director of Quality and Chief Nurse	Divisional Board - Corporate / DOG, Quality Delivery Group	Resuscitation and Deteriorating Patient Group		Quality and Performance Committee, Trust Leadership Team	31/07/2020	King, Ben
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	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	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	C4xL3=12	Chief Nurse/ Quality Lead	Divisional Board - Corporate / DOG, Infection Control Committee, Quality Delivery Group	Other	Falls and Pressure Ulcers Group	Quality and Performance Committee, Trust Leadership Team	31/01/2020	Bradley, Craig
C1850NSafe	The risk of safety to adolescents 12-18 presenting with significant mental health issues and self harming behaviour who require assessment and	1. The paediatric environment has been risk assessed and adjusted to make the area safer for self harming patients with agreed protocols.	Develop Intensive Intervention programme Escalation of risk to Mental Health County Partnership	Medical, Surgical, Women's and Children's	Safety	C3xL4=12	Director of Quality and Chief Nurse	Safeguarding Adults Strategy Board, Safeguarding Adults and Children Committee, Safeguarding Children Strategic	Safeguarding Adults Operational Group, Safeguarding Children Operational Group / Board, Safeguarding Operation Group			01/04/2020	Mortimore, Vivien
M2268Emer	The risk of patient deterioration (Safety) due to lack of capacity leading to ED overcrowding with patients in the	RGN and HCA now identified on every shift to have responsibility for patients in the ambulance assessment corridor.	Complete CQC action plan Compliance with 90% recovery plan	Medical	Safety	C3xL4=12	Director of Quality and Chief Nurse	Divisional Board - Medical, Trust Health and Safety Committee	Resuscitation and Deteriorating Patient Group		Trust Leadership Team	29/03/2020	Cairns, Tiffany
		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 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										

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.	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	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	Medical, Surgical	Safety	C3xL4=12	Director of Quality and Chief Nurse	Divisional Board - Corporate / DOG, People and OD Delivery Group, Quality Delivery Group, Recruitment Strategy Group	Recruitment Strategy Group, Vacancy Control Panel		People and OD Committee, Quality and Performance Committee, Trust Leadership Team	28/02/2020	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 TVN team to audit and validate waterlow scores on Prescott ward	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	C3xL4=12	Director of Quality and Chief Nurse	Divisional Board - Corporate / DOG, Quality Delivery Group	Clinical Safety Effectiveness and Improvement Group		Trust Leadership Team	31/01/2020	Bradley, Craig
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.	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	Corporate, Gloucestershire Managed Services	Safety	C5xL1=5	Chief Operating officer	Divisional Board - Corporate / DOG, Estates and Facilities Committee, Trust Health and Safety Committee	GMS Health and Safety Committee		Executive Management Team, GMS Board, Trust Board, Trust Leadership Team	18/02/2020	Minett, Rachel
C2970COOEFD	Risk of harm or injury to staff and public due to dilapidation and/or structural failure of external elevations of Centre Block and Hazelton Ward Ceiling – resulting in loose, blown or spalled render/masonry to external & internal areas.	1) Snapshot' visual survey undertaken from ground level to establish the scope of the loose, blown or spalled render and masonry to the external elevations of the building & any loose material removed (frequency TBC); 2) Heras fencing has been put up to isolate persons from the areas of immediate concern; 3) Areas of concern being monitored (frequency TBC). (All Controls to be reviewed and	Refurbish the roof outside and make safe To undertake a comprehensive structural survey of the external elevations of Centre Block to identify all areas requiring repair or replacement and to undertake those works Planning permission for investigatory works	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical	Safety	C5xL1=5	Chief Operating Officer	Divisional Board - Corporate / DOG, Estates and Facilities Committee, Trust Health and Safety Committee			GMS Board, Trust Board, Trust Leadership Team	31/01/2020	Makinde, Akin
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	Corporate, Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	C5xL1=5	Chief Operating O fficer	Divisional Board - Corporate / DOG, Estates and Facilities Committee, Trust Health and Safety Committee	GMS Health and Safety Committee		GMS Board, Trust Board, Trust Leadership Team	31/03/2020	McGirr, Alison

S2917CC	The risk of patient and staff harm and loss of life as a result of an inability to horizontally evacuate patients from critical care	• Presence of fire escape staircase and routes • Fire exit signage • Fire extinguisher present / maintained • Fire risk assessment • Fire assembly points • Fire detection and alarm system • Hover-jack to aid evacuation of level 3 patients • Fire extinguisher training for staff • Local fire service pre-determined attendance response for hospital	• 20 slide sheets provided • Simulated evacuation to evaluate the Hover-jack and slide sheets as effective option / provide training – action plan / lessons learned • Observation and input from Fire Safety Team • GMS review of option for creating adequate fire escape facilities • Oxygen cylinder holders on order	Gloucestershire Managed Services, Surgical	Safety	C5xL1=5	Chief Operating Officer	Divisional Board - Surgery				15/06/2020	Offord, Rebecca

REPORT TO MAIN BOARD – January 2020

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

This report describes the business conducted at the Quality and Performance Committee on 18th 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
Opthalmology briefing	Summary of background to ophthalmology position and current status regarding follow up cohort. • Historic issues with long waits, CCG led quality review shared with the Committee. • Two new Consultants employed with primary task to reduce waiting times. • Progress in backward Trajectory of performance shared. • Potential for transformation approach to follow ups, part of outpatient programme.	Was it acknowledged by clinical body that review of frequency/ follow up regime was needed, how are we assured of changing practice? Focus on demand and supply balance needed for a future report. Are we confident that targeted clinical reviews are taking place? Does the corporate risk register entry covering several specialties risk of delays need review and splitting out? Should we do audit three monthly of new patients and follow up pathway prescribed? Are there other specialties which were not making	Assured that those clinicians who had completed the validation exercise reported that change and reform is beneficial. Monitoring of this work stream is through Outpatient Transformation Group Assurance given that targeting clinical harm reviews are ongoing, but would recommend the results for ophthalmology coming to Quality and Performance Committee Assurance given that it would through planned care delivery group and report from Trust Leadership Team.	Need to ensure cross referencing to Finance and Digital Committee which receives reports from Outpatient Transformation Group Follow up detailed paper to February Quality and Performance Committee to include responses to questions and detailed forward trajectories

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
		progress which merit a specific risk with mitigations? If there had not been a CCG led review, would we be getting the level of assurance needed?		
Learning From Deaths	Report showing governance systems in place for reviewing deaths and demonstrate compliance with national guidance on Learning From Deaths in the reporting period. • All deaths were recorded by bereavement team and reviewed by Trust Medical Examiners. • Family feedback considered with positive and negative comments, all shared for learning. • Feedback on performance shared with Hospital Mortality Group. • Challenges in timeliness and efficiency.	Current position on HSMR and SHMI questioned Against standard of review to be undertaken (10% in each division) Care of the Elderly well below that, what is the plan to improve? Governance route of LeDeR learning to come through Quality and Performance Committee after safeguarding group, when will this happen as has not occurred yet?	Understanding of detail and differences in indicators evident and work ongoing to ensure routine data analysis and deep dives can be undertaken. System developing well, areas of continued focus and improvement known. Clear exec ownership.	Request for HSMR/SHMI to be included in future reports Future reports to consider questions raised.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Serious Incidents	Report giving assurance on learning from serious incidents and meeting contractual standards. Position on Never events and serious incidents noted Complaint rates per division now split as % of activity.	Within the 72 hour reports, two reported with no immediate action identified.is this correct? Did any Divisions cause more concern than others?	Assurance given on process used and feedback at the time although not noted down Differing concerns within each Divisions known and monitored	This section of report to include all immediate action taken for future incidents. Use of SPC for future reports requested.
Pathway to Excellence® Programme	Update on current position with Pathway to Excellence® programme and support from the NHS Improvement Team. Focus on positive practice environment and interdisciplinary working Pathway to Excellence® Programme Lead (Eve Olivant) and Project Officer (Emma McDonald) now in place. Update on the development of the Gloucestershire Nursing and Midwifery Professional Council	At what point will the Committee see the delivery plan? Are we clear about expected outcomes for both patients and nursing/midwifery colleagues?	Progress against the key performance indicators will be through Quality and Performance Committee in due course.	Follow up report in March 2020

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Patient experience report	Quarterly report providing assurance on patient experience risks, data and insights. • FFT static, work ongoing to embed new changes to the test over coming months in line with NHS Improvement requirements. • Data not accessible to teams and specialties an issue, new analyst appointed. • Cancer experience results show improvement in some areas and deterioration in others. • New cancer lead nurse now in post to provide leadership and focus. • Recognised emerging valuable contribution being delivered through engagement with local communities.	Report welcomed, but felt too much reliance on FFT and not a systematic approach to real time feedback and improvement. What is stopping us from getting real time feedback and regular data close to real time for service lines? Do Divisions own their data and do they all have patient experience 'staff'. Future reports to include the 'so what' aspects of patient experience. To what extent do we understand the reasons behind the differential patient experience between the 'Royal' and the 'General'?	Clarity of responsibilities within Divisions on 'ownership' of patient experience.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Quality and performance reports	**Quality** Trust wide work continues to improve pressure ulcer and fall rates, each Division shares priority surveillance areas, now aligned with Divisional executive review process **Maternity** Focused report on key performance indicators and a general update on maternity services. • MBRRACE report showing good outcomes, robust process in place for any baby born unexpectedly with poor outcome, stillbirth or child deaths. • C section rate 29%, not a national outlier • Post-partum haemorrhage rates have been high, detailed work ongoing. • Shortfalls in staffing identified	Issues raised within Medicine did not reference staffing being an issue, was this correct? Concern raised with radiotherapy and CT availability and reliability. GP referrals down 28% in month and 16% year to date, what is the reason?	Much focus on workforce and staffing levels and known area of risk. Three new CT scanners awarded from national funding which should resolve concerns. Linked to MSK pathway and triage of referrals	Service line growth review to feedback to January committee

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	through the Birth Rate + review are being proactively managed by the midwifery leadership team. • Continuity of Carer (CoC) is a key are of focus for both the organisation and the Local Maternity System. The Trust is committed to delivering CoC model which will see outcome improvements for women, babies and colleagues. • Additional funding required to support full implementation with ongoing conversations between the Trust and the CCG to find a solution. Participation in Health Safety Investigation Bureau investigations	Trajectory for achievement is ambitious. Noted key CoC performance at 10.3%, sought assurance that all efforts were being made to agree funding between the Trust and CCG. Recognised that CoC is a large workforce transformation plan, what plans are in place to ensure midwives are supported to deliver a revised delivery model? With HSIB investigation timeline slower, are there missed opportunities internally for learning and interventions?	Raised at ICS Board as system issue as needs additional funding to achieve. Trust completes 72 hour reviews and identifies any learning to be implemented	Potential targeting of CoC on a risk based approach, further updates at committee each month.
	Planned care RTT at 80.3% unvalidated, stable and within agreed trajectory. 52 week waits halved from April to 45	What is confidence level to achieve zero by April 2020 Should more detail in all specialties with backlogs be	Aim still to achieve although carries risk particularly in GI specialty Review at planned care delivery group	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
		included in report		
	Cancer 2 week wait at 94.6% for November, consistently delivering over several months. 104 days patients waiting down to 22, lowest position for over 18 months. Improvements noted in prostate pathway and urology processes and practices.	What will successful infoflex update look like? Why was there a need for an executive deep dive in urology? How do we keep testing what we do with 'fresh eyes?'	AS move to national 28 day reporting, easier for informing patients and also to track and inform those who do not have cancer through an auditable trail. Number of factors including change in clinical team and links with diagnostics, will be positive to complete. Assured that the Trust will always look externally at best practice and different ways of working	Individual specialties of concern to be highlighted in future reports
	Emergency Trust position for November 76.2%, system 83.4% against backdrop of increased GP referrals, walk ins and ambulance conveyances. Bed base affected by norovirus (approx. 50 beds closed). Increased attendance not mirrored with admissions. Outliers and length of stay had increased	If attendance up bit not converting to admissions, could the assessment and treatment be done elsewhere and not in acute trust? Need to understand minors performance better	Close working with Gloucestershire Health and Care colleagues, CCG led piece of work to review place of assessments	

ICS update, monies available to system to support improvements to patient pathway including GP front door, AMIA extended hours, Discharge to assess capacity, primary care cynapsis rollout.

Alison Moon
Chair of Quality and Performance Committee

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD – February 2020

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

This report describes the business conducted at the Quality and Performance Committee held 29 January 2020, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Safeguarding six monthly update	Further update on the 'think family' approach in developing the combined adult and child safeguarding hub. Liberty Protection Safeguards briefing and implications for the Trust. New standards due to be published in June for Autumn implementation. The Trust is engaging with system partners to ensure there is a joined up approach across Gloucestershire. Application of the mental Capacity Act is an area of continued focus.	What are the LPS risks and challenges for us? Compliance with Mental Capacity Act requires further improvement, how can we be assured that all relevant patients are assessed and supported appropriately?	Resource issues being worked through with system partners. Timing tight. However, training on mental capacity act most important with regular audits/teaching and learning.	Quality and Performance Committee has asked to be kept up to date with progress in between 6 monthly updates on safeguarding.
	Update on learning themes from Serious Case Reviews.	One theme picked up was to encourage 'professional curiosity' how will this be done?	Held within the training sessions, professional standards and wider values work in Trust.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
			Interim named nurse will help to promote this. QI silver project being undertaken by ED consultant.	
		Out of county children placed in county, how do we know they are known in the Trust?	Safeguarding partners across system understand how many children and where placed.	
GIRFT	Briefing paper from Lead Consultant and service manager describing the process within the trust, working with specialties. Executive review has been undertaken in each of the 11 services that have had a GIRFT review. Five priority areas in each speciality to maximise achievement of improvement. Clear timescales within each often GIRFT reviews for improvements.	How does GIRFT outcome data resonate with other data and knowledge of specialties? Once we deliver to GIRFT standards, what is the next aspirational point we would wish to aim for? How do we share our successes with other organisations so that there is wider learning throughout the NHS?	There have been no surprises in any specialties, challenges known and included on Divisional risk registers where appropriate.	
	Working closely with national and regional teams. Exemplar areas within trust identified, e.g. ophthalmology and non medical injectors, and T and	What is happening with fractured neck of femur mortality data deteriorating?	Historic data, performance on small numbers did deteriorate but is within normal parameters now. The early warning system in place alerted the trust to	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	O for split sites for elective and trauma work. Areas to be monitored also known	We see other data describing an issue within diabetes, is this joined up?	this before being told externally. Diabetes an area of planned investment, no harm events noted. New lead nurse in place to develop the service.	
Continuity of Carers	CoC project plan shared and approved on behalf of the Board. Trust committed to the model, evidence that it improves outcomes for women and babies. Behind in delivery/implementation when compared with other Local Maternity Systems (LMS). Gloucestershire LMS have now submitted a compliant trajectory of delivery for milestones in March 2020 and 2021. Some external funding from the CCG has been agreed, further opportunities for workforce transformation are being developed through the Divisional Leadership Team.	What areas of plan concern you the most in delivering? Is there a need for targeting efforts for greatest gains? What are the workforce implications for such a large scale change? Is it possible to recruit additional midwives?	Practice development midwife employed to focus on CoC. Mobilisation of the workforce to work differently main area to ensure success. Previous LTP submission indicated we would not achieve this standard, latest submission has stated we will.	
Radiation Safety	Report on radiation safety		Clear and strong	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
update	governance arrangements in light of previous concerns raised by the Care Quality Commission.		governance arrangements set out; patient focussed reporting into Q and P committee, staff focussed reporting into P and OD committee.	
	Medical Director led group with clear reporting lines.			
	Plans in place and waiting re inspection at beginning of February, good engagement in all Divisions.			
Quality Delivery Group	Detailed report of discussions and areas of work covered by QDG. Update on CQC must dos within QDG remit	So much detail included in report, could be hard to see assurance Noted electronic observations coming forward from July to March, how is this possible as when this challenge was raised re forward implementation previously, this was not. Is the nursing generic risk on register describing well enough the issues? Discharge summaries plan noted to be ambitious, is it achievable?	New divisional reporting will ensure easier lens for assurance and bring key themes to attention. Due to very positive implementation and clinical engagement already with ePR, this enables earlier timeline, could not have been predicted. Discharge summary completion is improving when observed through the SPC variation. ePR will address most of the issues with discharge	Review of nursing risk wording prior to next meeting Executives to review

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
			summaries, until then, cultural change needed	
Planned Care Delivery Group	RTT within agreed trajectory and stable 52 week wait patients reducing Recovery plans remain in place Risk based approach to patients who wait, benchmarking against best practice. Initial numbers high, reduce when validated. Escalation system good from primary care, clinical harm reviews.		Improvements noted and assurance on detailed plans in place to achieve.	Future reports to include total numbers of patients waiting with trend over last period and plans for reduction Follow up report to committee in April with status on embedding of harm reviews across divisions
Cancer Delivery Group	2Week Wait performance 96.9%, achieved 4 months in row for first time since 2013 Significant reduction in over 104 day patients 62day 70.4% Patient experience work stream started and shared, new lead cancer nurse in post Positive update on pathway work	What does patient experience work include? In light of cancer institute ambitions, where does our performance place us?	Pt experiences throughout the pathway with regular touch time during the journey Performance supports ambitions, more improvement expected in Q1 20/21	Detail on out of county performance for future reporting

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Emergency Care Delivery Group	Decrease in 4 hour performance in trust and across system, reflected regionally and nationally. Winter business case approved and will help overcrowding in ED. Additional staffing recruited Acute initial assessment unit service expansion. considerable numbers of patients seen and treated without need for admission	What are the risks and mitigations with the increased numbers of and distribution of specialty outliers? Triage time increasing due to increasing acuity, how are we reviewing acuity for this and next winter? How do we know in busy times that patients being cared for in escalation areas receive the monitoring and care they need? Noting an ambulance handover spike in December	Clear standard operating procedures in place. Processes reviewed ongoing basis, strict implementation Named medical teams for each clinical area. Will review wording, acuity issues not the main area of increase, mostly rise in GP referrals and pts who walk in. There has not been an increase in the conversion rate although higher attendances. Named staff responsible on each shift for patients in escalation areas. SHINE checklist noted to drop during really busy time in December at GRH, working with staff to ensure it is consistently applied with further compliance checks over the next two months.	New dashboard will be presented to February Quality and Performance Committee.
Corporate Risk Register	Oversight of key and emerging risks			
	Four new risks added to risk register	Two risks to be removed as still going through governance route		
		Risk of poor quality data	New opportunities to	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		with outdated electronic system for managing alerts, policies, claims, why is this now a risk when it has been in place for some time?	review existing systems and new personnel in post bringing a new lens Business case in production to support.	
		Risk of safety to adolescents 12-18 presenting with mental health issues noted, what assurance is there on the plans in place?	Relates to Tier 4 CAMHS service availability which is commissioned by regional specialist commissioning services.	Needs rewording to clarify the issues and detailed mitigations in place
		Is the risk describing ED separate for GRH and CGH, day and night?	No, the risks are different at both sites, not a 'bedded' area in CGH overnight. Appear well sighted on specific risks in each site.	
Serious Incident Report	Two new never events (NE) in reporting period 72 hour reports included for new SI's	Good to see all immediate actions, is it usual to have a gap of 17 days from incident to immediate action planned? No action plans closed	Both noted and undergoing investigations. Due to one NE, MHRA informed to share circumstances more widely and encourage learning. Not usual, specific circumstances, assurances given that other actions progressing and not dependent on the one described. Most action plans almost complete when assessed	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		this month; does that mean a delay in assurance of learning?	at SERG, so on track, waiting for final actions to complete closure of plan.	

ICS update - system working on outpatient transformation, development and roll out of Cynapsis for GPs and Optometrists, Cancer alliance now has new Chair and opportunities for applying for funding.

New patient safety group developing across ICS.

Noted the most recent CQC quarterly engagement meeting and feedback from the critical care leadership focus group which was positive.

Alison Moon
Chair of Quality and Performance Committee
3rd February 2020

TRUST BOARD – 13 FEBRUARY 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 December 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.

Quality Summits

Preventing Harm

Hospital Acquired Pressure Ulcers (HAPU) and Falls (with injurious harm)

- The driver diagrams for these 2 improvement areas are completed and are with the Divisional Directors of Quality and Nursing for comment.
- The Electronic Patient Record (EPR) digital system was launched at GRH is now capturing HAPU and 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 as process measures will be included in the plan.
- 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.
- 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.

Red indicators

Caesarean section rates

The emergency C-Sections are below target this month, but the elective numbers have increased slightly. The service are continually reviewing elective sections, to ascertain if all are necessary for clinical reasons. The service are in the process of developing information evenings, which will provide women with unbiased advice on vaginal births following caesarean sections. The audit has now been completed and will be presented to the Divisional TRI. If any trends are identified, an action plan will be developed.

Never event

There was one never event reported and this is undergoing investigation.

Friends and family Test results ED

This indicator is stable as there has been no real change over the year. The national question is not really suitable for ED patients. We are developing our new platform for FFT and will be moving to the new national question in April 2020 when more useful data will be collated.

Performance

During December 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 December 2019, the trust performance against the 4hr A&E standard was 72.91% including system performance was 81.18%. A separate winter plan has been developed and shared with system partners.

In respect of RTT, we are reporting 80.03% for December 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 96.9% (un-validated) for December. In additional all tumour sites met the target in December. Indications are that performance for January 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 December was 70.4% (un-validated). November performance is

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>

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 has commenced in December as planned 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)**
✓						
Outcome of discussion when presented to previous Committees						
The Committee NOTED the report.						

Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report

Reporting period December 2019

Presented at January 2020 Q&P and February 2020 Trust Board

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Gloucestershire Hospitals NHS Foundation Trust

Delivery of agreed action plans remains critical to restore operational performance to the expected levels. During December 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 December was 72.91% against the STP trajectory at 85.99% against a backdrop of significant attendances. The system did not meet the delivery of 90% for the system in December, at 81.18%.

The Trust has met the diagnostics standard for December at 0.94%.

The Trust has met the standard for 2 week wait cancer at 96.9% in December, 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	159	127			
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	3	11			
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%	81.18%			
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%	72.91%			
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%	80.29%	80.57%			
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	45	39			
% 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%	0.94%			
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	87.50%	86.70%	89.50%	92.70%	86.00%	96.50%	94.60%	94.60%	96.90%			
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%	96.00%	97.30%			
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	92.10%	92.00%	93.80%	92.60%	92.30%	91.00%	98.00%	92.20%	93.80%			
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%	97.50%	100.00%	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%	97.90%	98.80%	100.00%	84.80%	80.80%	98.80%	93.80%	97.50%			
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	91.10%	89.10%	96.20%	89.60%	89.80%	97.60%	100.00%	100.00%	91.40%			
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%	85.20%	100.00%	100.00%	96.30%	96.70%	94.90%			
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	36.40%	44.40%	63.20%	91.70%	75.00%	66.70%	61.50%	83.30%	83.30%			
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	80.10%	71.80%	68.20%	72.70%	75.40%	71.00%	78.00%	63.80%	67.90%			

Summary Scorecard

Gloucestershire Hospitals NHS Foundation Trust

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

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

Safe

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

Effective

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

Caring

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

Responsive

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

Well Led

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

Demand and Activity

Gloucestershire Hospitals NHS Foundation Trust

The table below shows monthly activity for key areas. The columns to the right show the percentage change in activity from:

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

Measure	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	% change from previous year Monthly (Dec)	YTD
GP referrals	11,965	14,521	13,202	14,044	13,094	13,415	12,709	12,061	10,302	10,429	11,836	13,356	11,169	-6.65%	-12.61%
OP attendances	11,084	14,083	12,474	13,525	12,663	13,025	13,063	13,856	11,850	13,534	14,545	13,661	10,823	-2.35%	-1.69%
Day cases	5,833	6,167	5,995	6,318	5,815	6,520	6,198	6,955	6,348	6,276	7,142	6,578	6,228	6.77%	6.59%
All electives	6,837	7,124	6,955	7,465	7,255	7,556	7,213	8,096	7,378	7,238	8,275	7,690	7,155	4.65%	5.71%
ED attendances	12,639	12,962	11,701	13,245	12,949	13,618	13,072	14,066	13,267	13,240	13,329	13,066	13,287	5.13%	6.31%
Non electives	5,081	5,132	3,085	4,900	4,696	4,861	4,586	4,802	4,698	4,833	5,083	4,837	5,052	-0.57%	0.46%

Trust Scorecard – Safe (1)

OVERALL SCORE

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

	18/19	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	19/20 Q3	19/20	Standard	Threshold
Infection Control																		
Number of trust apportioned MRSA bacteraemia	1	0	0	0	1	0	1	0	0	0	1	0	0	0	0	2	Zero	
MRSA bacteraemia – infection rate per 100,000 bed days							3.5				3.6					0.8	Zero	
Number of trust apportioned Clostridium difficile cases per month	56	1	6	5	4	7	6	7	10	9	9	11	12	7	30	79	2019/20: 114	
Number of hospital-onset healthcare-associated Clostridioides difficile cases per month									7	6	1	10	3	5	18	41	<=5	
Number of community-onset healthcare-associated Clostridioides difficile cases per month									3	4	8	1	9	2	12	38	<=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	24.4	34.9	30.7	<30.2	
Number of MSSA bacteraemia cases	164	2	25	30	31	0	1	1	4	1	2	2	1	2	5	14	<=8	
MSSA – infection rate per 100,000 bed days					31		3.5	3.6	14.3	3.6	7.3	6.9	3.5	7	5.8	5.5	<=12.7	
Number of ecoli cases	295	3	39	41	44	5	4	5	1	4	3	2	5	9	16	38	No target	
Number of pseudomona cases	59	0	11	12	12	1	0	0	2	1	0	1	0	0	1	5	No target	
Number of klebsiella cases	135	2	25	28	31	1	3	1	1	3	4	1	1	1	3	14	No target	
Number of bed days lost due to infection control outbreaks						40	66	83	70	136	0	0	240	276	516	1,151	<10	>30
Patient Safety Incidents																		
Number of patient safety alerts outstanding	5					5	1	0	0	0	0	0	0	0	0	5	Zero	
Number of falls per 1,000 bed days		7.2	6.8	7.1	6	6.6	6	5.3	6.6	5.5	6.2	6.6	6.4	6.7			<=6	
Number of falls resulting in harm (moderate/severe)	8	8	8	2	7	3	4	2	7	1	5	7	1	4			<=3	
Number of patient safety incidents – severe harm (major/death)	1	1	0	3	7	13	7	9	4	12	4	7	3	3			No target	
Medication error resulting in severe harm					0	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	1			No target	
Medication error resulting in low harm					12	10	15	10	11	11	10	21	23	7			No target	
Number of category 2 pressure ulcers acquired as in-patient						43	36	28	38	36	30	24	31	29			<=30	
Number of category 3 pressure ulcers acquired as in-patient						10	7	7	6	6	4	4	4	2			<=5	

Trust Scorecard – Safe (2)

OVERALL SCORE

	18/19	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	19/20 Q3	19/20	Standard	Threshold
Patient Safety Incidents																		
Number of category 4 pressure ulcers acquired as in-patient						0	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	2			<=3	
Number of deep tissue injury pressure ulcers acquired as in-patient					6	10	14	2	8	7	2	3	8	3			<=5	
RIDDOR																		
Number of RIDDOR		4	1	3	3	2	2	1	3	2	1	2	1	2	8	39	SPC	
Safeguarding																		
Level 2 safeguarding adult training - e-learning package										93.00%	93.00%	94.00%	95.00%				TBC	
Number of DoLs applied for												45	36	50			TBC	
Total number of maternity social concerns forms completed												55	44	53			TBC	
Safety Thermometer																		
Safety thermometer – % of new harms		97.30%	97.30%	97.70%	97.20%	96.20%	97.20%	98.10%	97.40%	97.90%	96.30%	97.30%	95.80%	97.90%			>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%			71.00%			>=90%	<50%
Serious Incidents																		
Number of never events reported	1	0	0	0	1	1	0	0	1	0	0	1	0	1			Zero	
Number of serious incidents reported		1	3	0	3	2	3	4	2	1	5	4	3	1			No target	
Serious incidents – 72 hour report completed within contract timescale		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	99.00%			>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%	90.70%	96.60%	94.20%	94.80%	95.40%	88.60%	95.80%	96.70%	92.90%	91.60%	95.90%	91.80%	92.60%	93.50%	93.50%	>95%	

Trust Scorecard – Effective (1)

OVERALL SCORE

	18/19	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	19/20 Q3	19/20	Standard	Threshold
Dementia Screening																		
% of patients who have been screened for dementia (within 72 hours)	1.90%	3.30%	1.90%	0.80%	0.60%	0.40%	0.30%	67.00%	66.00%	85.00%	63.00%	62.00%	50.00%				>=90%	<70%
% of patients who have scored positively on dementia screening tool that then received a dementia diagnostic assessment (within 72 hours)	27.90%	26.30%	40.00%	0.00%	33.30%	100%	50.00%	0.00%	0.00%	N/A	50.00%	0.00%	0.00%				>=90%	<70%
% of patients who have received a dementia diagnostic assessment with positive or inconclusive results that were then referred for further diagnostic advice/FU (within 72 hours)	2.80%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	N/A	N/A	N/A	50.00%	N/A	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%	31.30%	27.82%	28.39%	<=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%	13.48%	14.27%	15.76%	No target	
% of women booked by 12 weeks gestation	89.80%	89.60%	89.80%	90.50%	91.50%	89.70%	88.00%	87.90%	89.00%	85.30%	89.60%	91.80%	92.20%	91.90%	92.00%	89.00%	>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%	30.00%	29.45%	28.66%	<=30%	>33%
% of women smoking at delivery	11.21%	12.28%	7.79%	13.05%	10.46%	12.06%	11.22%	11.83%	9.78%	10.16%	9.14%	10.22%	13.63%	11.52%	11.72%	10.95%	<=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%	0.43%	0.35%	0.22%	<0.52%	
Mortality																		
Summary hospital mortality indicator (SHMI) – national data	1.0462				1.0462	1.0533	1.0689	1.0731	1.0804							1.0804	NHS Digital	
Hospital standardised mortality ratio	94.5	97.7	97.2	95.2	94.5	96.5	96.8	100.1	98.6	98	97.6					97.6	Dr Foster	
Hospital standardised mortality ratio (HSMR) – weekend	96.8	99.3	101.3	97.2	96.8	96.9	96.4	97.6	97.9	100.5	101.6					101.6	Dr Foster	
Number of inpatient deaths					168	165	159	166	125	124	143	144	152	211	507	1,389	No target	
Number of deaths of patients with a learning disability					2	4	1	1	2	2	0	0	0	1	1	11	No target	
Readmissions																		
Emergency re-admissions within 30 days following an elective or emergency spell	6.70%	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	84	71	81	91	115	119	134	123	103	76	121	101	73	288		No target	

Trust Scorecard – Effective (2)

OVERALL SCORE

	18/19	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	19/20 Q3	19/20	Standard	Threshold
Stroke Care																		
Stroke care: percentage of patients receiving brain imaging within 1 hour	36.90%	31.90%	37.10%	32.70%	22.40%	52.10%	55.30%	43.80%	53.50%	50.60%	48.60%	52.50%	39.40%	49.60%	47.40%	49.60%	>=50%	<45%
Stroke care: percentage of patients spending 90%+ time on stroke unit	90.80%	91.90%	88.70%	84.10%	87.70%	85.70%	96.30%	87.10%	80.90%	98.80%	87.90%	84.50%	73.60%			86.50%	>=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%	62.40%	56.70%	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%	64.10%	66.80%	64.10%	>=90%	<80%
Trauma & Orthopaedics																		
% of fracture neck of femur patients treated within 36 hours	76.00%	75.00%	83.90%	85.60%	77.80%	77.00%	81.80%	82.20%	67.10%	46.60%	66.70%	39.60%	56.10%	58.30%	52.00%	63.40%	>=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%	58.30%	51.50%	62.50%	>=65%	<55%

Trust Scorecard – Caring (1)

OVERALL SCORE

	18/19	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	19/20 Q3	19/20	Standard	Threshold
Friends & Family Test																		
Inpatients % positive	91.20%	91.50%	91.90%	89.20%	91.50%	89.10%	90.80%	91.60%	90.70%	91.10%	91.50%	90.60%	91.80%	90.20%	90.80%	90.80%	>=96%	<93%
ED % positive	83.10%	81.00%	82.70%	82.80%	82.70%	82.70%	81.90%	85.30%	79.80%	83.30%	82.30%	82.90%	87.90%	78.90%	82.50%	82.50%	>=84%	<81%
Maternity % positive	96.70%	100%	100%	93.50%	97.50%	96.60%	97.00%	87.10%	96.20%	100%	96.90%	100%	0.00%	100%	100%	97.00%	>=97%	<94%
Outpatients % positive	92.60%	92.90%	93.40%	92.50%	93.10%	92.80%	93.20%	92.50%	92.80%	93.20%	92.70%	92.80%	93.80%	93.20%	93.20%	92.90%	>=94%	<91%
Total % positive	91.20%	90.90%	91.90%	90.70%	91.40%	90.60%	91.10%	91.40%	90.70%	91.30%	91.00%	91.10%	92.80%	91.30%	91.50%	91.10%	>=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%	74.00%	80.00%	79.00%	>=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%	88.00%	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%	97.00%	99.00%	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%	98.00%	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%	100%	90.00%	63.00%	81.00%	89.00%	>=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%	98.00%	99.00%	99.00%	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%	85.00%	96.00%	90.00%	96.00%	>=90%	
MSA																		
Number of breaches of mixed sex accommodation	68	6	2	1	3	4	11	18	16	11	9	0	0	2	2	71	<=10	>=20

Trust Scorecard – Responsive (1)

OVERALL SCORE

	18/19	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	19/20 Q3	19/20	Standard	Threshold
Cancer																		
Cancer – urgent referrals seen in under 2 weeks from GP	90.00%	94.30%	92.00%	93.90%	95.20%	87.50%	86.70%	89.50%	92.70%	86.00%	96.50%	94.60%	94.60%	96.90%	95.30%	91.90%	>=93%	<90%
2 week wait breast symptomatic referrals	95.80%	97.70%	95.50%	97.00%	95.60%	96.90%	97.30%	99.00%	96.30%	98.40%	99.30%	98.10%	96.00%	97.30%	97.10%	97.40%	>=93%	<90%
Cancer – 31 day diagnosis to treatment (first treatments)	94.60%	94.20%	92.90%	91.60%	92.10%	92.10%	92.00%	93.80%	92.60%	92.30%	91.00%	98.00%	92.20%	93.80%	94.40%	93.00%	>=96%	<94%
Cancer – 31 day diagnosis to treatment (subsequent – drug)	99.90%	100%	100%	100%	100%	100%	97.50%	100%	100%	100%	100%	100%	100%	100%	100%	99.60%	>=98%	<96%
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	95.30%	92.90%	93.20%	96.60%	96.60%	91.10%	89.10%	96.20%	89.60%	89.80%	97.60%	100%	100%	91.40%	97.50%	94.00%	>=94%	<92%
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	99.30%	98.60%	100%	98.90%	98.70%	96.40%	97.90%	98.80%	100%	84.80%	80.80%	98.80%	93.80%	97.50%	97.30%	94.40%	>=94%	<92%
Cancer 62 day referral to treatment (urgent GP referral)	74.80%	74.90%	76.80%	66.20%	77.40%	80.10%	71.80%	68.20%	72.70%	75.40%	71.00%	78.00%	63.80%	67.90%	71.20%	72.50%	>=85%	<80%
Cancer 62 day referral to treatment (screenings)	96.50%	100%	94.10%	96.40%	100%	100%	96.60%	85.20%	85.20%	100%	100%	96.30%	96.70%	94.90%	95.50%	94.70%	>=90%	<85%
Cancer 62 day referral to treatment (upgrades)	68.90%	70.00%	71.40%	60.00%	77.30%	36.40%	44.40%	63.20%	91.70%	75.00%	66.70%	61.50%	83.30%	83.30%	82.50%	69.60%	>=90%	<85%
Number of patients waiting over 104 days with a TCI date	141	8	8	8	14	20	15	20	18	13	9	15	12	6		128	Zero	
Number of patients waiting over 104 days without a TCI date	347	27	42	37	25	19	30	21	37	32	28	36	22	25		250	<=24	
Diagnostics																		
% waiting for diagnostics 6 week wait and over (15 key tests)	0.45%	0.20%	0.67%	0.21%	0.45%	0.54%	0.67%	1.08%	0.76%	0.84%	0.72%	0.66%	1.06%	0.94%	0.94%	0.94%	<=1%	>2%
The number of planned / surveillance endoscopy patients waiting at month end	726	686	639	600	726	835	872	966	770	714	756	756	763	835	835	835	<=600	
Discharge																		
Number of patients delayed at the end of each month	37	34	29	24	43	45	39	18	43	41	35	44	32	22	22	22	<=38	
Patient discharge summaries sent to GP within 24 hours	50.60%	47.30%	51.80%	49.60%	51.00%	56.60%	54.60%	53.20%	57.90%	55.70%	56.50%	58.00%	56.30%			56.10%	>=88%	<75%

Trust Scorecard – Responsive (2)

OVERALL SCORE

	18/19	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	19/20 Q3	19/20	Standard	Threshold
Emergency Department																		
ED: % total time in department – under 4 hours (type 1)	89.60%	87.55%	84.46%	86.08%	87.13%	86.01%	87.99%	86.80%	88.53%	88.16%	84.03%	80.58%	76.24%	72.91%	76.58%	83.47%	>=95%	<90%
ED: % total time in department – under 4 hours (types 1 & 3)	92.78%	91.29%	89.02%	90.21%	91.00%	90.39%	91.70%	91.05%	92.20%	92.01%	89.13%	86.36%	83.41%	81.18%	83.65%	88.61%	>=95%	<90%
ED: % total time in department – under 4 hours CGH	96.40%	95.47%	93.70%	95.50%	96.10%	94.66%	96.04%	96.40%	95.44%	96.20%	92.68%	95.54%	90.92%	88.74%	91.73%	94.07%	>=95%	<90%
ED: % total time in department – under 4 hours GRH	86.20%	83.82%	80.10%	81.60%	82.80%	81.89%	84.16%	82.77%	85.09%	84.25%	79.90%	73.72%	69.25%	65.20%	69.39%	78.47%	>=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	1	1	1	Zero	
ED: % of time to initial assessment – under 15 minutes	87.40%	85.40%	85.20%	83.60%	78.40%	75.80%	78.30%	77.30%	71.30%	75.70%	71.40%	68.40%	66.50%	64.30%	66.40%	72.10%	>=95%	<92%
ED: % of time to start of treatment – under 60 minutes	33.50%	32.10%	34.90%	32.40%	32.60%	32.00%	35.90%	37.20%	30.30%	31.20%	29.90%	28.30%	26.60%	26.00%	27.00%	30.60%	>=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%	3.71%	2.81%	3.33%	2.16%	<=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%	0.07%	0.24%	0.13%	0.05%	<=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%	80.00%	80.99%	78.37%	>=95%	
Urgent cancelled operations						0	0	0	0	0	2	3	0	1	4	6	No target	
Number of patients stable for discharge	73	69	74	72	77	86	77	63	79	88	88	90	87	81	86	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%	2.77%	2.77%	2.77%	<=3.5%	>4%
Number of stranded patients with a length of stay of greater than 7 days	384	374	399	412	397	389	391	370	371	360	371	380	406	403	396	382	<=380	
Average length of stay (spell)	5.05	4.83	5.14	5.35	5	5.03	5.31	4.82	4.84	4.75	4.85	4.81	4.91	5.23	4.98	4.95	<=5.06	
Length of stay for general and acute non-elective (occupied bed days) spells	5.66	5.29	5.7	6.07	5.67	5.53	5.94	5.38	5.45	5.25	5.38	5.35	5.57	5.79	5.57	5.52	<=5.65	
Length of stay for general and acute elective spells (occupied bed days)	2.71	2.89	2.59	2.67	2.65	2.78	2.68	2.55	2.56	2.69	2.53	2.74	2.54	2.79	2.69	2.65	<=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%	87.04%	86.30%	85.55%	>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%	87.40%	87.90%	87.90%	>85%	<70%

Trust Scorecard – Responsive (3)

OVERALL SCORE

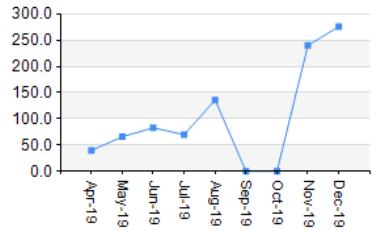
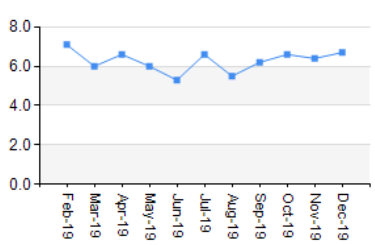
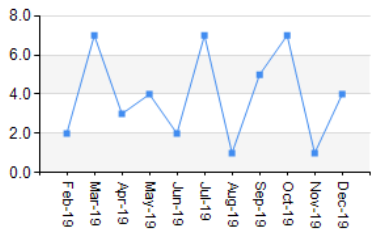
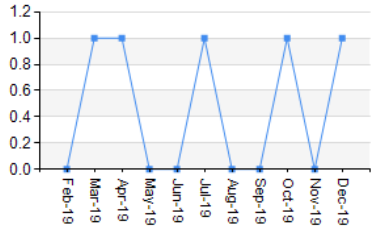
	18/19	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	19/20 Q3	19/20	Standard	Threshold
Outpatient																		
Outpatient new to follow up ratio's					1.93	1.92	1.91	1.91	1.88	1.91	1.8	1.74	1.8	1.85	1.8	1.86	<=1.9	
Did not attend (DNA) rates					6.40%	6.80%	6.80%	6.80%	7.00%	6.90%	7.20%	6.80%	6.80%	7.00%	6.90%	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%	80.29%	80.57%	80.57%	80.57%	>=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	1,792	1,790	1,790	1,790	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	824	1,263	1,263	1,263	No target	
Referral to treatment ongoing pathways over 52 weeks (number)	95	97	89	97	95	93	91	90	78	77	78	62	45	39	39	39	Zero	
SUS																		
Percentage of records submitted nationally with valid GP code	100%	100%	100%	100%	100%	100%	99.90%	100%	100%	100%	99.80%	99.80%	99.80%			99.90%	>=99%	
Percentage of records submitted nationally with valid NHS number	99.80%	99.80%	99.80%	99.80%	99.80%	99.90%	99.40%	99.80%	99.80%	99.80%	99.80%	99.80%	99.90%			99.80%	>=99%	

Trust Scorecard – Well Led (1)

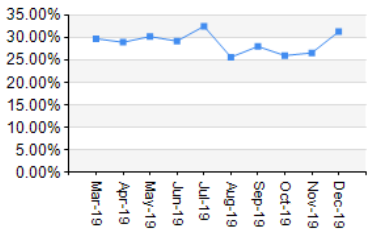
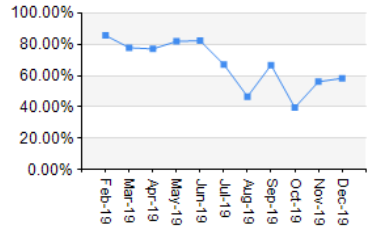
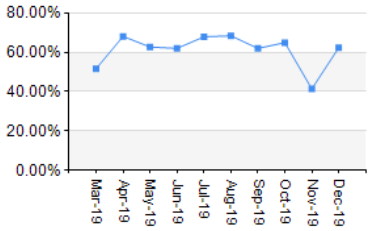
OVERALL SCORE

	18/19	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	19/20 Q3	19/20	Standard	Threshold
Appraisal and Mandatory Training																		
Trust total % overall appraisal completion	79.00%	79.00%	79.00%	79.00%	81.00%	80.00%	81.00%	82.00%	83.00%	81.00%	79.00%	80.00%	82.00%	82.00%	82.00%	82.00%	>=90%	<70%
Trust total % mandatory training compliance	89%	91%	89%	89%	91%	91%	91%	92%	92%	92%	91%	91%	92%	92%	92%	92%	>=90%	<70%
Finance																		
Total PayBill Spend		29.7	29.4	29.9	33.3	31.8	30.8	30.9	30.7	31.7	30.9	31.5	31.3	31.4				
YTD Performance against Financial Recovery Plan		0.04	-3	-6.6	-14.1	0.2	0.3	0.6	0.5	0.5	0.6	0.7	0.6	0.4				
Cost Improvement Year to Date Variance		1,593	0	-1,784	-3,378	0	1	1	2	2	2	1	1	-2				
NHSI Financial Risk Rating		4	3	4	4	4	3	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	4	3	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%	98.30%	98.69%	97.00%	>=75%	<70%
% registered nurse day						97.90%	97.90%	96.60%	98.70%	96.50%	97.40%	99.40%	100.7%	98.70%	99.58%	98.20%	>=90%	<80%
% unregistered care staff day						97.00%	99.20%	99.40%	101%	99.40%	98.60%	101.4%	104.2%	98.60%	101.3%	99.90%	>=90%	<80%
% registered nurse night						94.10%	93.50%	92.40%	94.80%	93.30%	94.50%	96.40%	97.10%	97.50%	97.03%	94.90%	>=90%	<80%
% unregistered care staff night						100.3%	99.40%	104.8%	105.7%	105.3%	106.7%	108.6%	115.5%	105.4%	109.6%	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	4.9	4.8	4.7	>=5	
Care hours per patient day HCA					3.2	2.8	2.9	3	3	3	2.9	3	3	3	3	3	>=3	
Care hours per patient day total	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	7.9	7.8	7.7	>=8	
Vacancy and WTE																		
% total vacancy rate						9.03%	10.02%	9.54%	8.65%	8.60%	7.20%	7.00%	6.95%	7.00%			<=11.5%	>13%
% vacancy rate for doctors						8.07%	8.86%	8.53%	8.20%	0.53%	2.70%	2.25%	2.80%	2.80%			<=5%	>5.5%
% vacancy rate for registered nurses						12.09%	9.52%	9.42%	8.65%	8.65%	8.07%	8.22%	8.30%	8.30%			<=5%	>5.5%
Staff in post FTE						6181.16	6150.11	6148.56	6171.97	6226.64	6350.1	6358.09	6354.32	6355			No target	
Vacancy FTE						610	683	650	652.42	500	492.55	478.95	474.24	475			No target	
Starters FTE						65.5	52.8	45.2	66.66	60.55	147.7	72.72	51.61	69.42			No target	
Leavers FTE						55.14	37.5	57.4	44.69	46.75	84.63	40.81	47.02	49.37			No target	
Workforce Expenditure and Efficiency																		
% turnover	11.80%	11.70%	11.70%	11.90%	12.20%	11.80%	11.60%	11.60%	11.80%	11.10%	11.90%	11.60%	11.70%	11.80%			<=11%	>15%
% turnover rate for nursing	10.99%					1.09%	10.93%	10.87%	10.99%	10.77%	11.40%	11.09%	10.75%	10.75%			<=11%	>15%
% sickness rate	3.90%	3.90%	3.90%	3.90%	3.90%	3.90%	3.40%	3.80%	3.80%	3.90%	3.90%	3.90%	3.90%	4.00%			<=3.5%	>4%

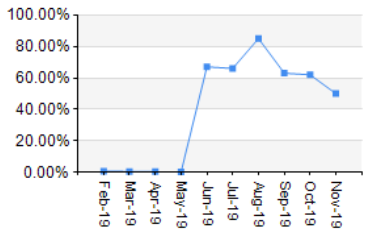
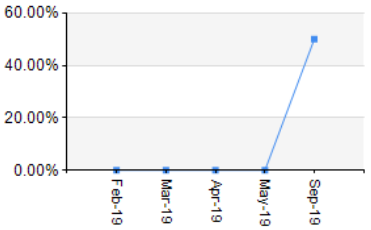
Exception Reports – Safe (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of bed days lost due to infection control outbreaks **Standard: <10**		During December 2019 the trust experienced increased levels of Norovirus across both sites. Several wards were closed to bring about control in affected areas. We implemented a restricted visiting policy during this time.	**Associate Chief Nurse and Deputy Director of Infection Prevention and Control**
Number of falls per 1,000 bed days **Standard: <=6**		The incidence of falls per 1000 bed days continues to perform below the annual average. We have both a trustwide improvement programme and a series of quality improvement initiatives to address performance.	**Director of Safety**
Number of falls resulting in harm (moderate/severe) **Standard: <=3**		The incidence of harm from falls despite falling has remained static. We have a number if initiatives and a trustwide improvement programme to address performance.	**Director of Safety**
Number of never events reported **Standard: Zero**		The Never Event will be investigated following the normal SI route, immediate local action has been identified.	**Director of Safety**

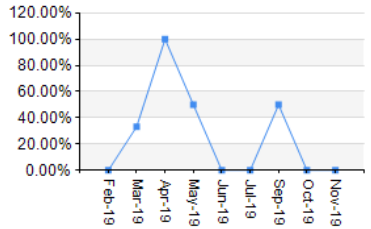
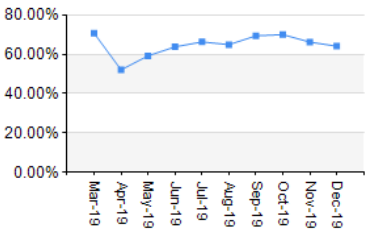
Exception Reports – Effective (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% C-section rate (planned and emergency) **Standard: <=27%**		The emergency C-Sections are below target this month, but the elective numbers have increased slightly. The service are continually reviewing elective sections, to ascertain if all are necessary for clinical reasons. The service are in the process of developing information evenings, which will provide women with unbiased advice on vaginal births following caesarean sections. The audit has now been completed and will be presented to the Divisional TRI. If any trends are identified, an action plan will be developed.	**Divisional Chief Nurse and Director of Midwifery**
% of fracture neck of femur patients treated within 36 hours **Standard: >=90%**		Action plan in place but increase in trauma have resulted in cancellations of elective list provision. Escalation policy from T&O service line in place. Trauma Task and Finish group now chaired by Deputy COO. Plan, Do, Study, Act (PDSA) cycles. For example extended theatre lists for 2 weeks. Issues with radiology capacity remain and the team are looking to review lists to support this. In addition we are supporting through site management the ring-fencing of a #NOF bed daily.	**Director of Operations - Surgery**
% of patients admitted directly to the stroke unit in 4 hours **Standard: >=80%**		Improvement of 21% on November performance (41.40%). 40 patients breached the target in the month of December. Of these 40: 5 patients were an inpatient already when the stroke presented (3 at CGH) and experienced a delayed transfer. 21 patients were delayed due to lack of beds - non-Strokes on the Stroke ward due to increased demand for medical beds at GRH during this period. 14 patients were delayed due to an unclear diagnosis which led to them initially being admitted to AMU for further tests.	**Director of Unscheduled Care and Deputy Chief Operating Officer**

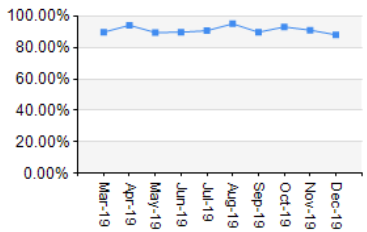
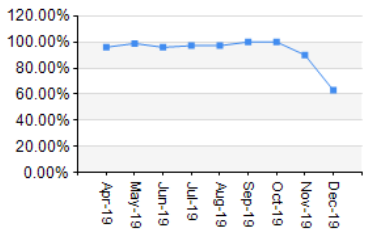
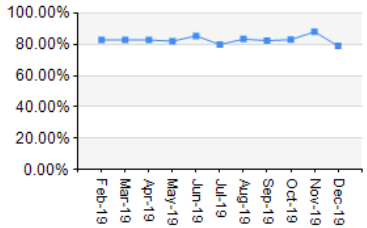
Exception Reports – Effective (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of patients who have been screened for dementia (within 72 hours) **Standard: >=90%**		Dementia assessments are recorded in 2 different parts of the ED admission documentation. • AMT 4 is recorded in the neurological section of the paperwork. The case finding question and (AMT and 4 AT) are located the medical clerking section. • If clerking doctors use the AMT 4 section on the clerking documentation they generally do not complete the full assessment or case finding question in the clerking notes. • If the patient appeared alert and independent assessments are generally not completed. • No Dementia assessments were documented in the following 72 hours for those not assessed in ED short term action to remind on call teams to complete assessments,longer term documentation / patient assessments are being reviewed.	**Deputy Chief Nurse**
% of patients who have received a dementia diagnostic assessment with positive or inconclusive results that were then referred for further diagnostic advice/FU (within 72 hours) **Standard: >=90%**		Dementia assessments are recorded in 2 different parts of the ED admission documentation. • AMT 4 is recorded in the neurological section of the paperwork. The case finding question and (AMT and 4 AT) are located the medical clerking section. • If clerking doctors use the AMT 4 section on the clerking documentation they generally do not complete the full assessment or case finding question in the clerking notes. • If the patient appeared alert and independent assessments are generally not completed. • No Dementia assessments were documented in the following 72 hours for those not assessed in ED short term action to remind on call teams to complete assessments,longer term documentation / patient assessments are being reviewed.	**Deputy Chief Nurse**

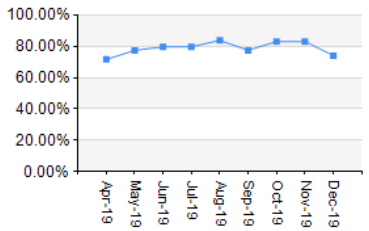
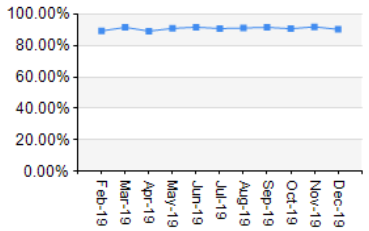
Exception Reports – Effective (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of patients who have scored positively on dementia screening tool that then received a dementia diagnostic assessment (within 72 hours) **Standard: >=90%**		Dementia assessments are recorded in 2 different parts of the ED admission documentation. • AMT 4 is recorded in the neurological section of the paperwork. The case finding question and (AMT and 4 AT) are located the medical clerking section. • If clerking doctors use the AMT 4 section on the clerking documentation they generally do not complete the full assessment or case finding question in the clerking notes. • If the patient appeared alert and independent assessments are generally not completed. • No Dementia assessments were documented in the following 72 hours for those not assessed in ED short term action to remind on call teams to complete assessments,longer term documentation / patient assessments are being reviewed.	**Deputy Chief Nurse**
% patients receiving a swallow screen within 4 hours of arrival **Standard: >=90%**		Deterioration of 2.1% on November performance (66.20%). 23 patients breached the target in the month of December. Of those 23: 3 patients were an inpatient in CGH when stroke presented and were delayed in transfer over to GRH due to lack of bed capacity. 9 patients were delayed in receiving a bed on the Stroke Unit and therefore had a delayed swallow screening. 11 patients had an unclear diagnosis on initial presentation (vertigo, ?TIA, headaches) and therefore were a late diagnosis. Knock on impact were delays to each of the onward pathway elements as a result.	**Director of Unscheduled Care and Deputy Chief Operating Officer**

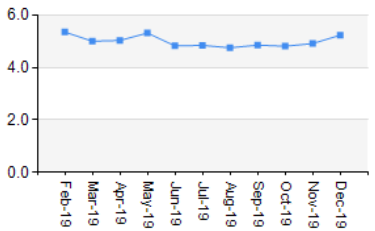
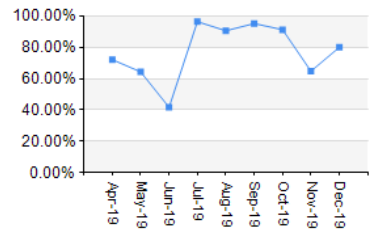
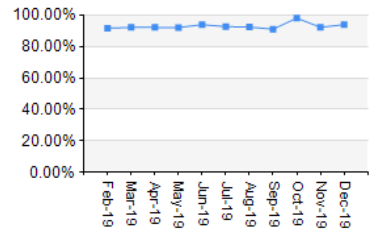
Exception Reports – Caring (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Are you involved as much as you want to be in decisions about your care and treatment? **Standard: >=90%**		17/144 patients surveyed said they weren't involved enough – in particular Ward 8b, Ryeworth, and 6A were flagged as areas where this was raised. This has been shared with the matrons for looking into, and the patient experience improvement team will be supporting them with any improvement work.	**Head of Patient Experience Improvement**
Do you get enough help from staff to eat your meals? **Standard: >=90%**		7/19 respondents who said they wanted help with their meals said they did not get the help they wanted. This was spread equally across 4A, 6A, AMU, Avening, Guiting, Knightsbridge, and Ryeworth. The numbers are lower as the majority of respondents said they do not need help eating their meals (the average number of respondents across the questions is approximately 145). This feedback has been shared with matrons.	**Head of Patient Experience Improvement**
ED % positive **Standard: >=84%**		We have moved to a new provider for FFT and we are working to bring in the new requirements for reporting which will start in April 2020. There has been no real change in this indicator over the last year.	**Deputy Director of Quality**

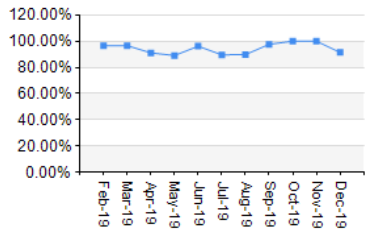
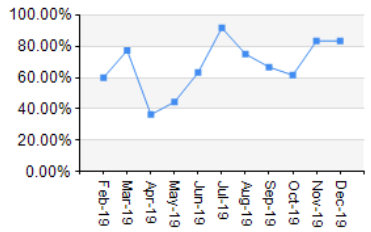
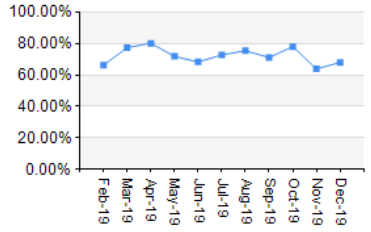
Exception Reports – Caring (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
How much information about your condition or treatment or care has been given to you? **Standard: >=90%**		38/146 patients surveyed said they did not have the right amount of information given to them – in particular Ward 8b, Ryeworth, and 6A were flagged as areas where this was raised. This has been shared with the matrons for looking into, and the patient experience improvement team will be supporting them with any improvement work.	**Head of Patient Experience Improvement**
Inpatients % positive **Standard: >=96%**		There has been no real change to the performance of this indicator for a year. The insight data produced has limited usability. The new question and our tailored follow up questions commence in April 2020.	**Deputy Director of Quality**

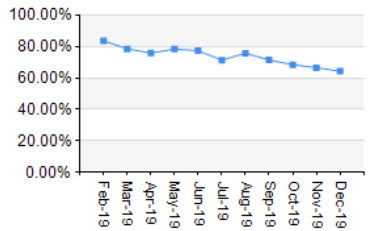
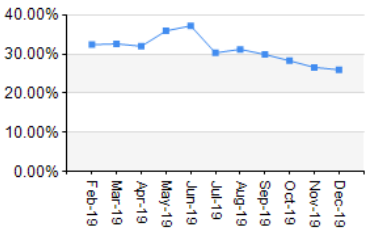
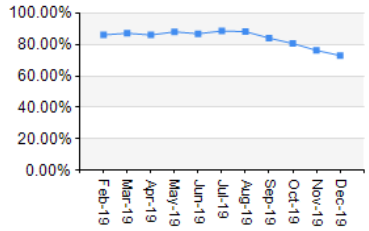
Exception Reports – Responsive (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Average length of stay (spell) **Standard: <=5.06**		increase in ALOS - Trust wide driven through the patient flow programme. For Surgical teams through ERAS work.	**Deputy Chief Operating Officer**
Cancelled operations re-admitted within 28 days **Standard: >=95%**		Services are now routinely reviewing cancellations. However given the pressures on both cancer and 52ww breaches significant challenges exist regarding capacity, resulting in limited ability to re-book within the timeframes. Other breaches occurred during December for a multitude of reasons, including equipment failure and lack of interpreting services.	**Deputy Chief Operating Officer**
Cancer – 31 day diagnosis to treatment (first treatments) **Standard: >=96%**		Performance - 93.8% Target - 96% 194 tx 12 breaches LGI 5 Gynae 2 Skin 2 Uro 2	**Director of Planned Care and Deputy Chief Operating Officer**

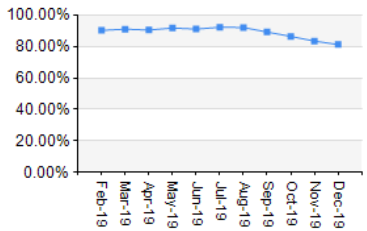
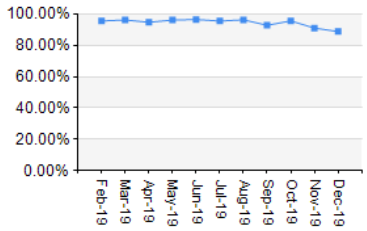
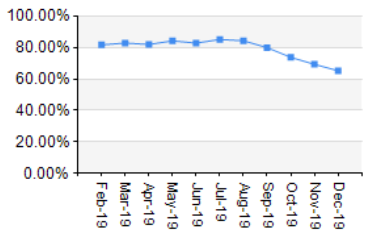
Exception Reports – Responsive (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Cancer – 31 day diagnosis to treatment (subsequent – surgery) **Standard: >=94%**		Performance - 91.4% Target 94% 35 tx 3 breaches Gynae 1 LGI 1 SKin 1	**Director of Planned Care and Deputy Chief Operating Officer**
Cancer 62 day referral to treatment (upgrades) **Standard: >=90%**		Performance 83.3% Target - N/A 6 treatments 1 breach Gynae 1	**Director of Planned Care and Deputy Chief Operating Officer**
Cancer 62 day referral to treatment (urgent GP referral) **Standard: >=85%**		Performance - 67.9% Target 85% 123 tx 39.5 breaches Uro 16.5 LGI 8 Haem 5 Skin 4 Gynae 3 Lung 2	**Director of Planned Care and Deputy Chief Operating Officer**

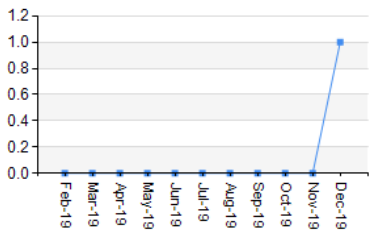
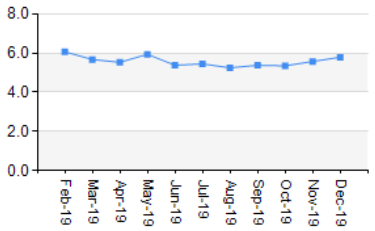
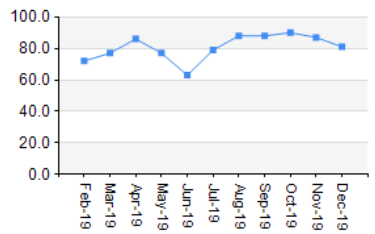
Exception Reports – Responsive (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % of time to initial assessment – under 15 minutes **Standard: >=95%**		For ambulance patients - Performance has improved marginally compared with the previous month. Increase triage capacity is included in the Winter Summit roll out which commences in January 2020. For walk in patients - Maintaining walk-in triage remains challenging due to patient numbers, space and the number of trained staff available to triage. Increased triage capacity is also included in the Winter Summit roll out which commences in January 2020	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % of time to start of treatment – under 60 minutes **Standard: >=90%**		This metric has decreased marginally in month. Average time to see a Doctor has increased this month which reflects the challenges seen in both departments throughout the month	**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 due to overcrowding. This has been due to a combination of infection control issues causing bed closures and poor flow throughout the hospitals	**Director of Unscheduled Care and Deputy Chief Operating Officer**

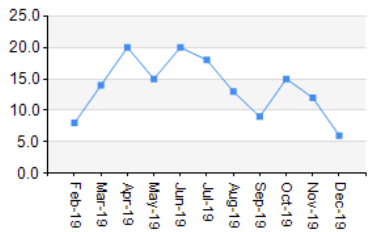
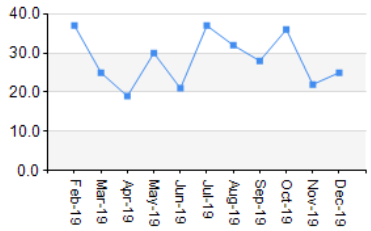
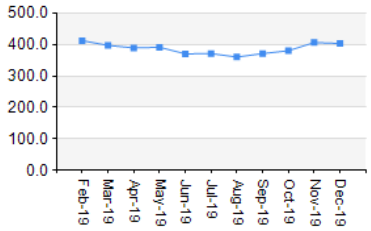
Exception Reports – Responsive (4)

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 due to overcrowding. This has been due to a combination of infection control issues causing bed closures and poor flow throughout the hospitals	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % total time in department – under 4 hours CGH **Standard: >=95%**		Total time in department has increased this month due to overcrowding. This has been due to a combination of infection control issues causing bed closures and poor flow throughout the hospitals	**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 due to overcrowding. This has been due to a combination of infection control issues causing bed closures and poor flow throughout the hospitals	**Director of Unscheduled Care and Deputy Chief Operating Officer**

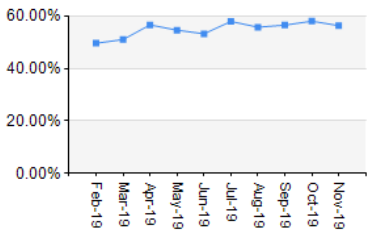
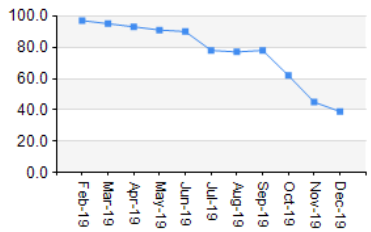
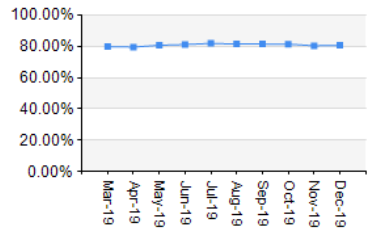
Exception Reports – Responsive (5)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission) **Standard: Zero**		There was one 12 hour trolley wait in December. This was on an extremely busy Saturday with a quick succession of patients awaiting beds, all with a 12 hour breach time around the same time. The team were unable to locate the patient on the tracking screen when a bed was allocated indicating that the patient had already left the department. Within minutes the patient reappeared on the tracking screen and a bed was allocated immediately. However in accordance with strict technical guidance, this was a 12 hour breach by 18 minutes.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
Length of stay for general and acute non-elective (occupied bed days) spells **Standard: <=5.65**		The impact of medical outliers has increased the LOS on non-elective wards. Winter pressures impacted average LOS in December.	**Deputy Chief Operating Officer**
Number of patients stable for discharge **Standard: <=70**		Activity has remained high, including numbers of people admitted with complex needs, this has impacted the numbers of people in hospital waiting for Adult Social Care assessments. The Trust continue to be faced with ward closures across both hospitals due to D&V and flu 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.	**Director of Unscheduled Care and Deputy Chief Operating Officer**

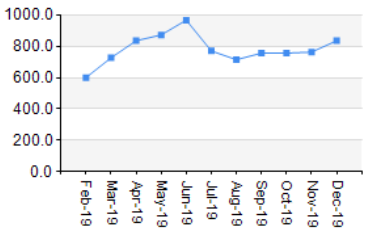
Exception Reports – Responsive (6)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of patients waiting over 104 days with a TCI date **Standard: Zero**		Specialties Urological 4 Breast 1 Lung 1 Grand Total 6	**Director of Planned Care and Deputy Chief Operating Officer**
Number of patients waiting over 104 days without a TCI date **Standard: <=24**		Specialties Urological 12 Lower GI 3 Skin 1 Upper GI 1 Gynaecological 1 Other 1 Grand Total 19	**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**		There continues to be a whole system approach and this month the DDQN have emailed all their areas regarding the importance of accurate EDDs. The 21 day reviews continuing, it is evident that the social services resource remains insufficient for the workload.	**Deputy Chief Operating Officer**

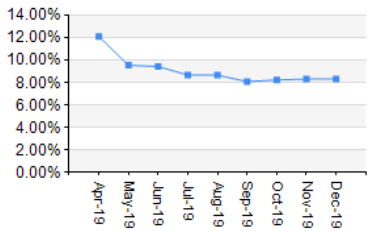
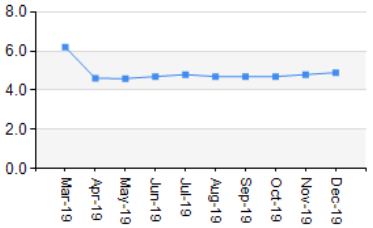
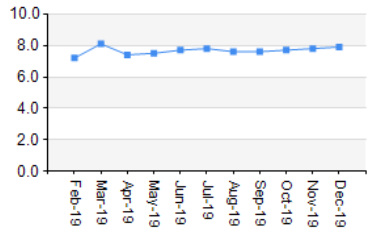
Exception Reports – Responsive (7)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Patient discharge summaries sent to GP within 24 hours **Standard: >=88%**		The issue continues to be highlighted to specialities and is now being reported at the divisional Executive reviews.	**Medical Director**
Referral to treatment ongoing pathways over 52 weeks (number) **Standard: Zero**		December position was at 39 patients over 52 weeks. This is a reduction on previous months and is in line with the trajectory agreed within NHS I. The Trust is working to reduce the longest waiting patients.	**Deputy Chief Operating Officer**
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**

Exception Reports – Responsive (8)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
The number of planned / surveillance endoscopy patients waiting at month end **Standard: <=600**		The backlog has grown by 72 patients compared to the previous month.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. Further capacity has been organised January - March 2020 to clear the longest waiting patients (278) via GLANSO and 18 Weeks Support insourcing.	**Medical Director**

Exception Reports – Well Led (1)

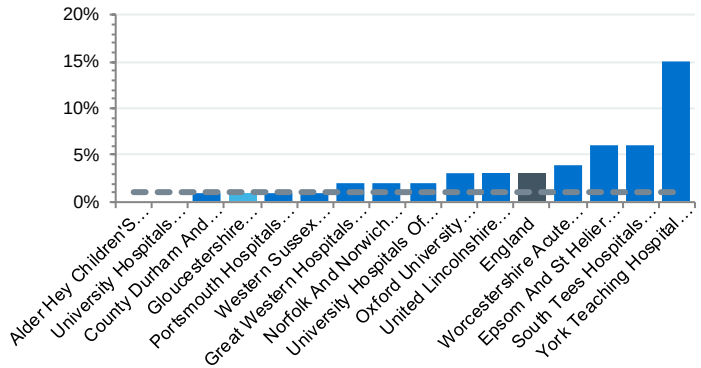
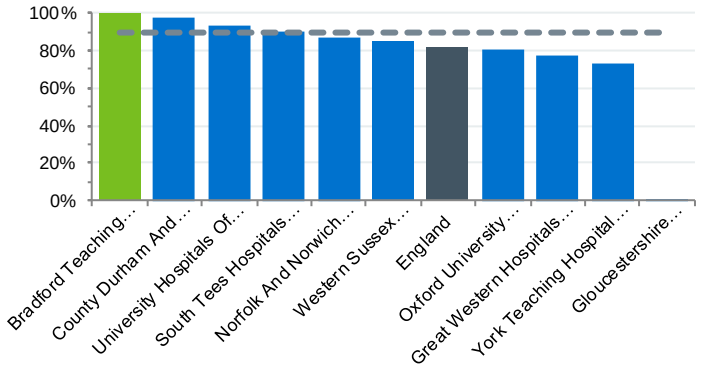
Metric Name & Standard	Trend Chart	Exception Notes	Owner
% vacancy rate for registered nurses **Standard: <=5%**		RN vacancies (this now includes ODPs) have remained stable since last month. Efforts continue to improve staff retention, with particular focus from our Nurse recruitment and retention lead on actions as part of the NHSI/E retention collaborative programme, a calendar of planned recruitment activity for the year and a new partner for International Recruitment activity.	**Director of Human Resources and Operational Development**
Care hours per patient day RN **Standard: >=5**		CHPPD is above our regional peers, however remains below the national figure.The Lead Nurse for retention, recruitment and attraction has collated the results of the trust retention survey (23% nursing staff completed). The findings demonstrate reasons for staff staying, intentions to leave and key improvement areas. These findings have informed the GHFT nurse retention plan 'Person-Centred Careers: Nursing Workstream 3 Improving Retention in Nursing' submitted to NHSI.	**Director of Nursing and Midwifery**
Care hours per patient day total **Standard: >=8**		CHPPD is above our regional peers, however remains below the national figure.The Lead Nurse for retention, recruitment and attraction has collated the results of the trust retention survey (23% nursing staff completed). The findings demonstrate reasons for staff staying, intentions to leave and key improvement areas. These findings have informed the GHFT nurse retention plan 'Person-Centred Careers: Nursing Workstream 3 Improving Retention in Nursing' submitted to NHSI.	**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

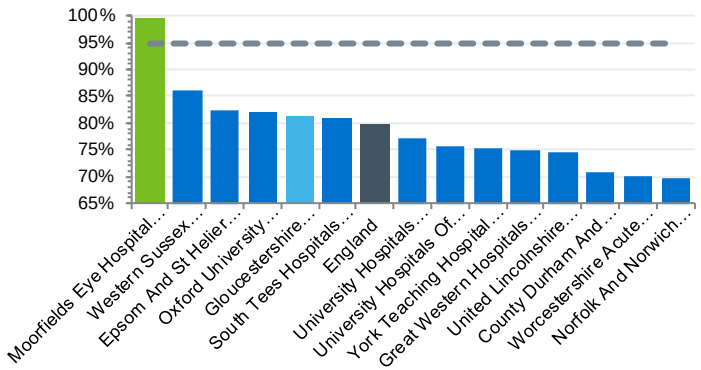
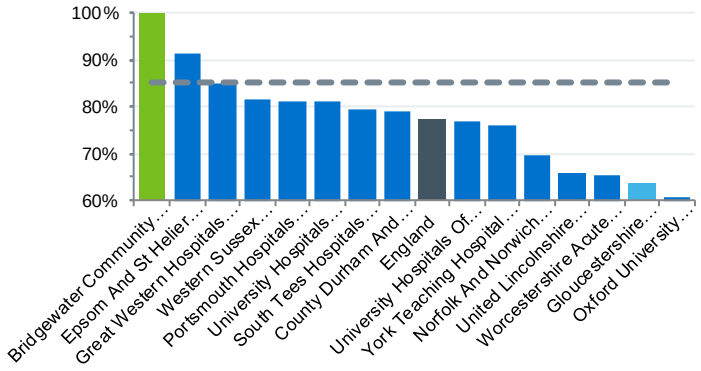
Metric	Period	Peer Group	Rank	Quartile
Diagnostics	November-19		71 / 166	2nd
Dementia	October-19		84 / 84	4th

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

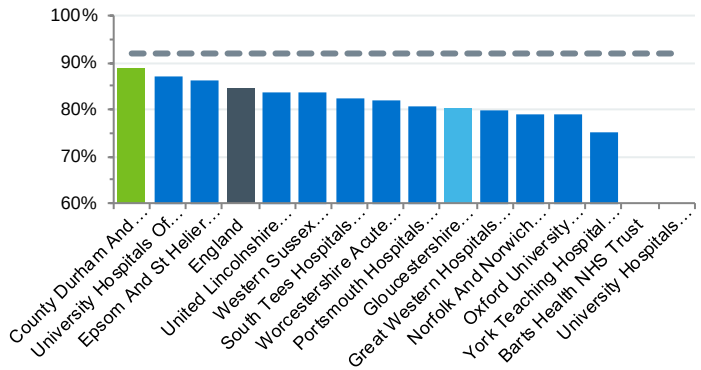
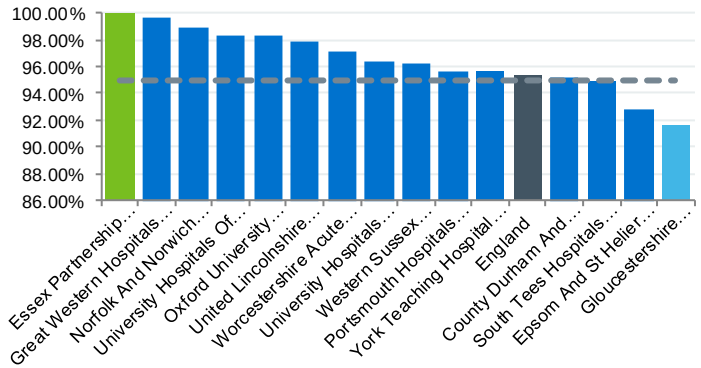
Metric	Period	Peer Group	Rank	Quartile
ED 4 Hour (Type 1 & Type 3)	December-19		49 / 119	2nd
Cancer 62 Days GP Referrals	November-19		131 / 142	4th

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

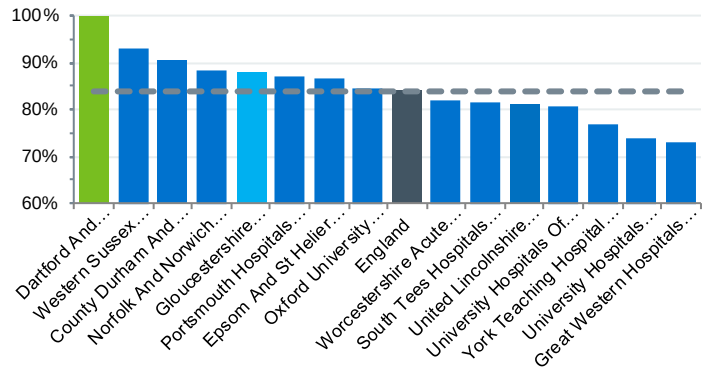
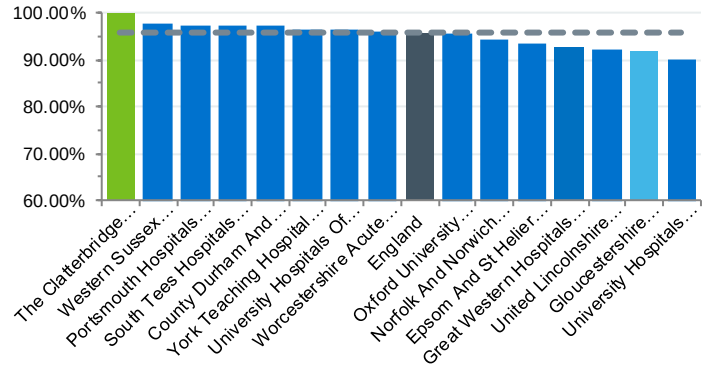
Metric	Period	Peer Group	Rank	Quartile
RTT	November-19		130 / 162	3rd
VTE (published quarterly)	September-19		131 / 149	4th

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

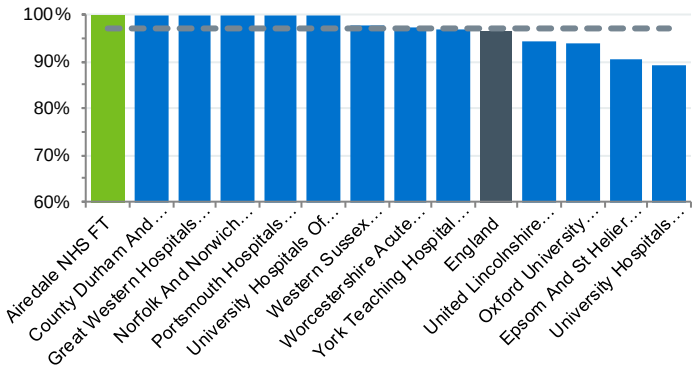
Metric	Period	Peer Group	Rank	Quartile
FFT - ED (percentage recommended)	November-19		52 / 131	2nd
FFT - Inpatient (percentage recommended)	November-19		131 / 145	4th

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)	November-19		NO DATA	NO DATA

Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report Statistical Process Control Reporting

Reporting period December 2019

Presented at January 2020 Q&P and February 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

Executive Summary

Gloucestershire Hospitals NHS Foundation Trust

Delivery of agreed action plans remains critical to restore operational performance to the expected levels. During December 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 December was 72.91% against the STP trajectory at 85.99% against a backdrop of significant attendances. The system did not meet the delivery of 90% for the system in December, at 81.18%.

The Trust has met the diagnostics standard for December at 0.94%.

The Trust has met the standard for 2 week wait cancer at 96.9% in December, 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.

Access Dashboard

Gloucestershire Hospitals NHS Foundation Trust

ACCESS	Target & Assurance		Latest Peformance & Variance		
Cancer – urgent referrals seen in under 2 weeks from GP	>=93%		Dec-19	96.90%	
2 week wait breast symptomatic referrals	>=93%		Dec-19	97.30%	
Cancer – 31 day diagnosis to treatment (first treatments)	>=96%		Dec-19	93.80%	
Cancer – 31 day diagnosis to treatment (subsequent – drug)	>=98%		Dec-19	100.00%	
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	>=94%		Dec-19	91.40%	
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	>=94%		Dec-19	97.50%	
Cancer 62 day referral to treatment (urgent GP referral)	>=85%		Dec-19	67.90%	
Cancer 62 day referral to treatment (screenings)	>=90%		Dec-19	94.90%	
Cancer 62 day referral to treatment (upgrades)	>=90%		Dec-19	83.30%	
Number of patients waiting over 104 days with a TCI date	Zero		Dec-19	6	

Key

Access | Quality | Financial | People & OD Risk Rating

Access Dashboard

Gloucestershire Hospitals NHS Foundation Trust

ACCESS	Target & Assurance		Latest Peformance & Variance		
Number of patients waiting over 104 days without a TCI date	<=24		Dec-19	25	
% waiting for diagnostics 6 week wait and over (15 key tests)	<=1%		Dec-19	0.94%	
The number of planned / surveillance endoscopy patients waiting at month end	<=600		Dec-19	835	
Stroke care: percentage of patients receiving brain imaging within 1 hour	>=50%		Dec-19	49.60%	
Stroke care: percentage of patients spending 90%+ time on stroke unit	>=80%		Nov-19	73.60%	
% of fracture neck of femur patients treated within 36 hours	>=90%		Dec-19	58.30%	
Number of patients delayed at the end of each month	<=38		Dec-19	22	
Patient discharge summaries sent to GP within 24 hours	>=88%		Nov-19	56.30%	
ED: % total time in department – under 4 hours (type 1)	>=95%		Dec-19	72.91%	
ED: % total time in department – under 4 hours (types 1 & 3)	>=95%		Dec-19	81.18%	

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

Access | Quality | Financial | People & OD Risk Rating

Access Dashboard

Gloucestershire Hospitals NHS Foundation Trust

ACCESS	Target & Assurance		Latest Peformance & Variance		
ED: % total time in department – under 4 hours CGH	>=95%	?	Dec-19	88.74%	L
ED: % total time in department – under 4 hours GRH	>=95%	F	Dec-19	65.20%	L
ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission)	Zero	F	Dec-19	1	L
ED: % of time to initial assessment – under 15 minutes	>=95%	F	Dec-19	64.30%	L
ED: % of time to start of treatment – under 60 minutes	>=90%	F	Dec-19	26.00%	L
Number of patients stable for discharge	<=70	?	Dec-19	81	
Number of stranded patients with a length of stay of greater than 7 days	<=380	?	Dec-19	403	H
Average length of stay (spell)	<=5.06	?	Dec-19	5.23	
Length of stay for general and acute non-elective (occupied bed days) spells	<=5.65	?	Dec-19	5.79	
Length of stay for general and acute elective spells (occupied bed days)	<=3.4	P	Dec-19	2.79	
Referral to treatment ongoing pathways over 52 weeks (number)	Zero	F	Dec-19	39	L

Key

Assurance

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

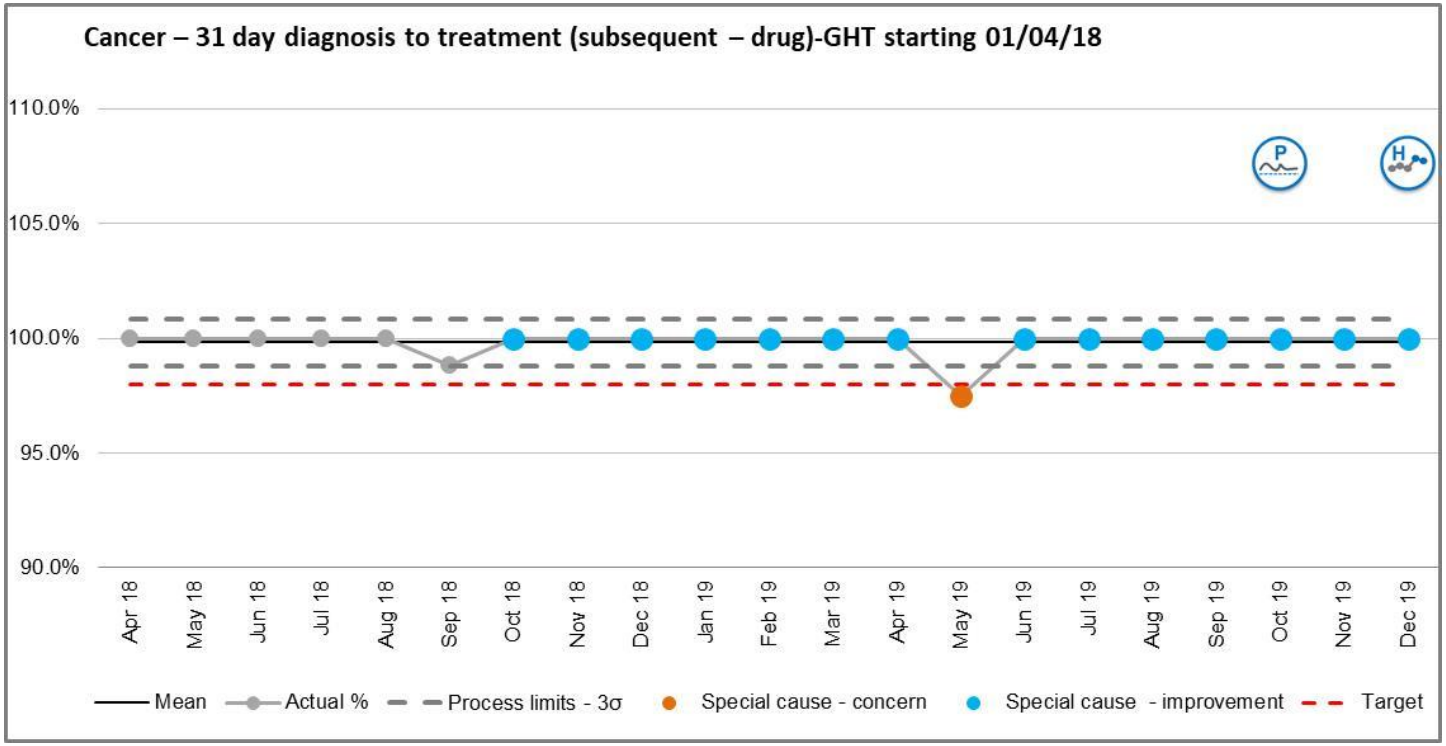
Variation

- H L – Special Cause Concerning variation
- Common Cause
- H L – Special Cause Improving variation

Access | Quality | Financial | People & OD Risk Rating

Access – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Data Observations

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(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that 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.

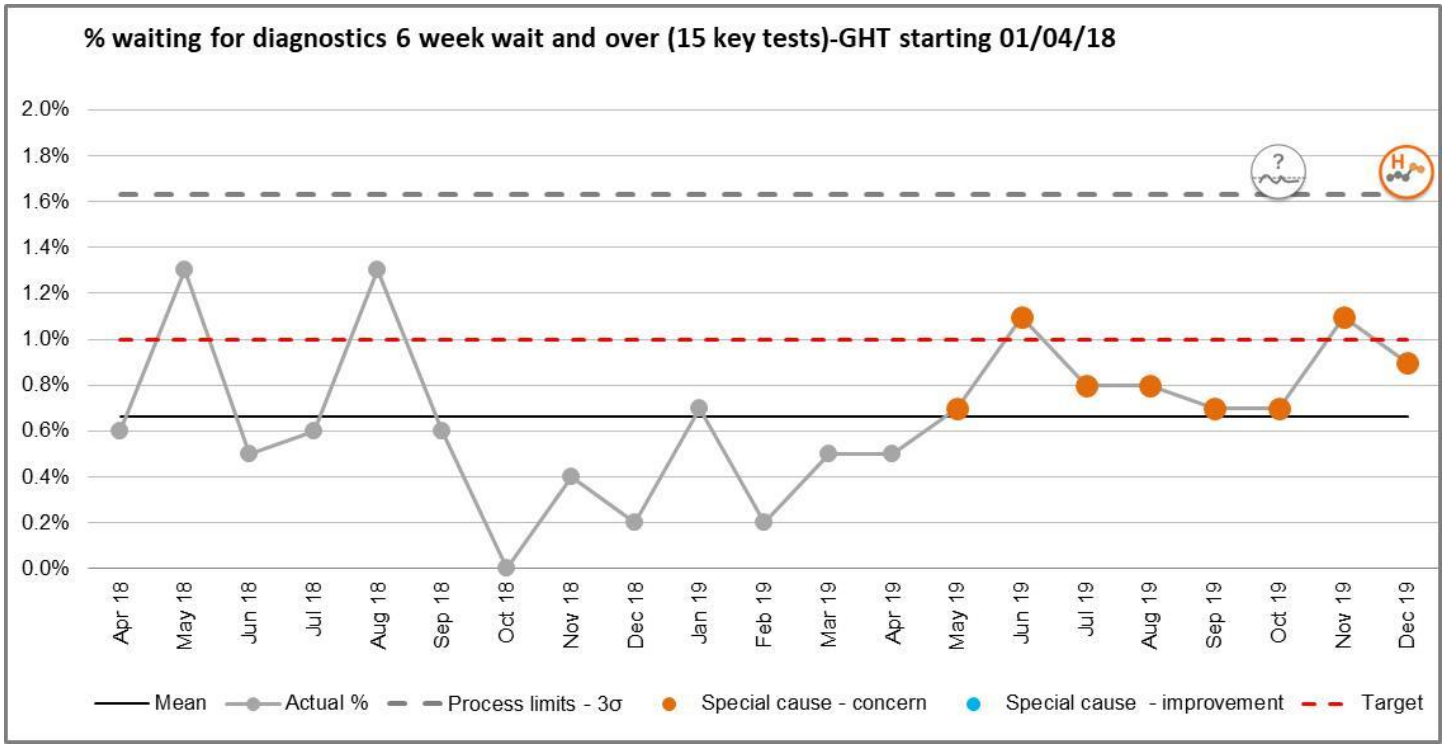
Commentary

Performance - 100%
Target 98%

- Director of Planned Care and Deputy Chief Operating Officer

Access – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



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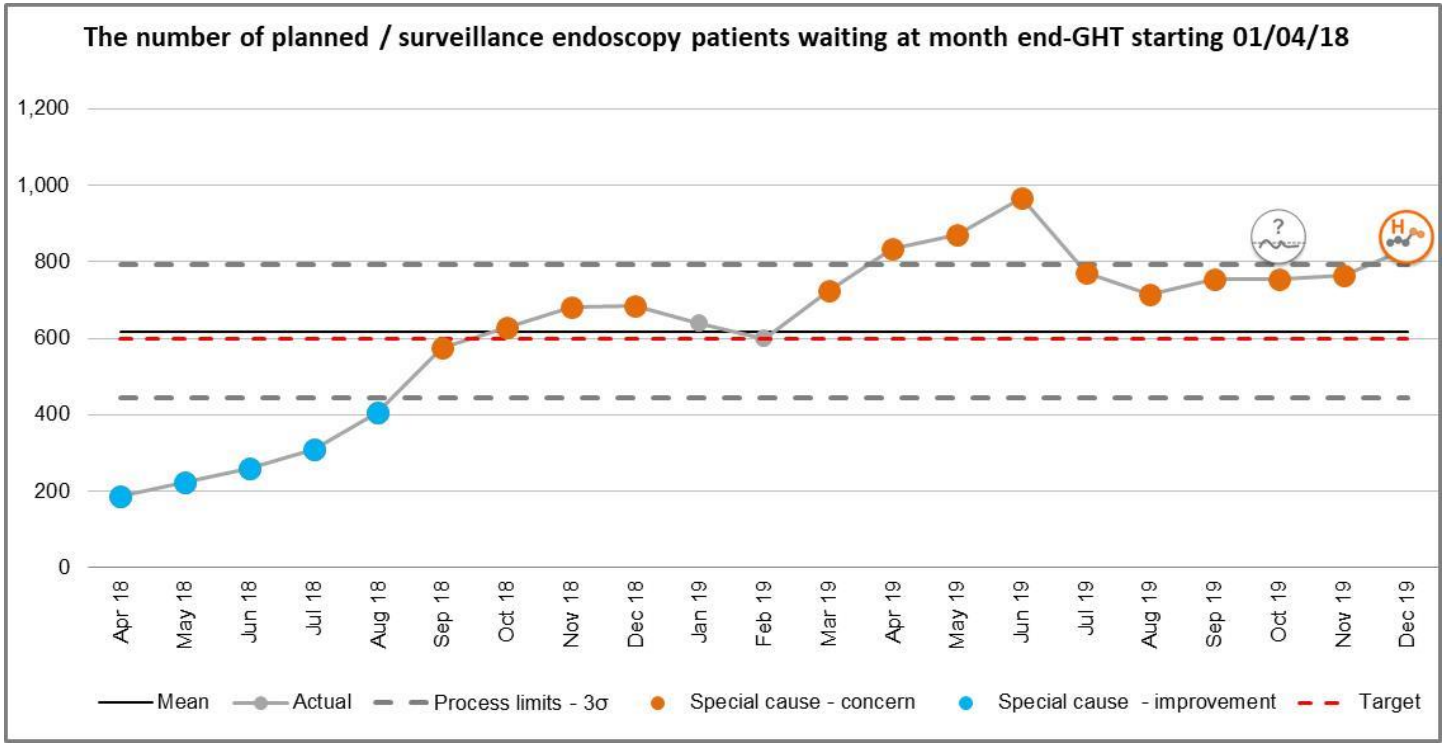
Commentary

Access – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Data Observations

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 are 5 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that 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.
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 LPL this is a warning that the process may be changing

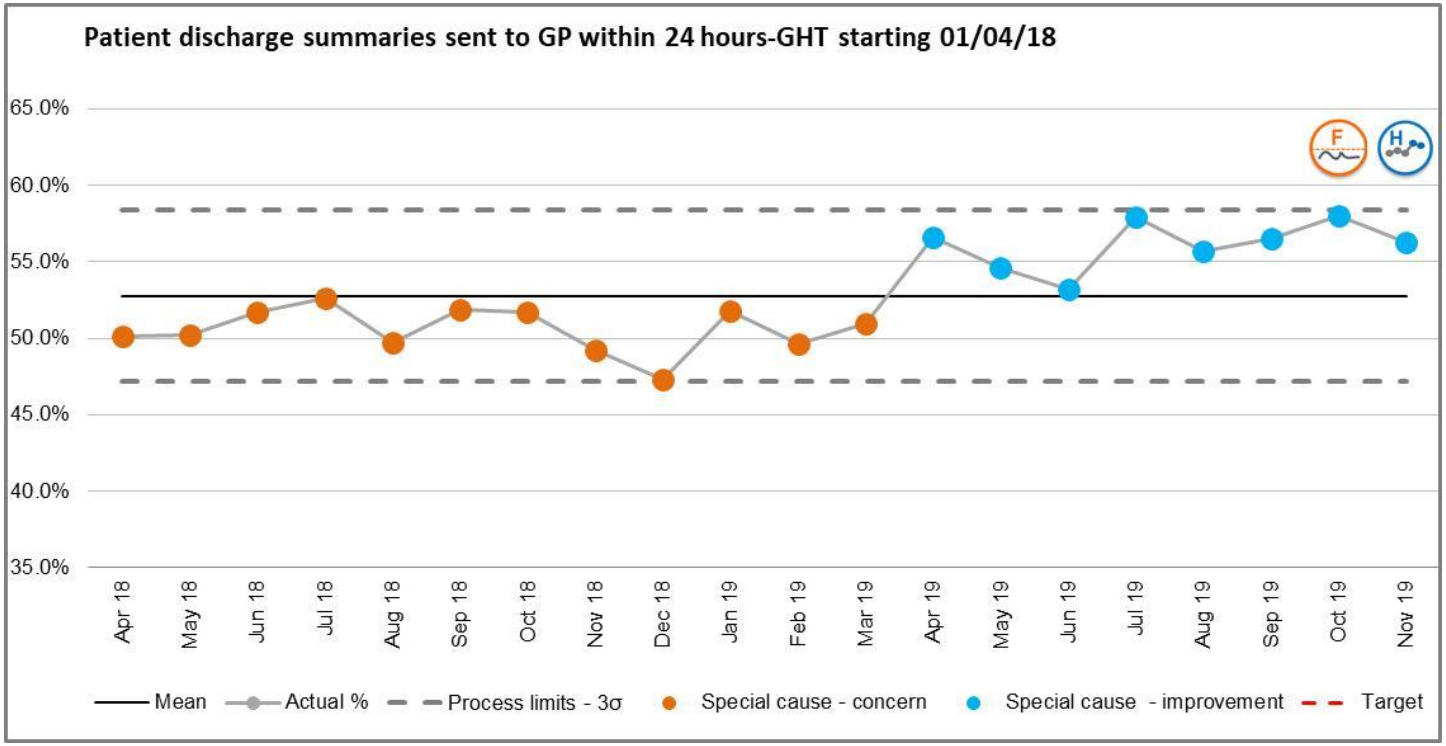
Commentary

The backlog has grown by 72 patients compared to the previous month. 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.
Further capacity has been organised January - March 2020 to clear the longest waiting patients (278) via GLANSO and 18 Weeks Support insourcing.

- Medical Director

Access – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Data Observations

Shift	When more than 7 sequential points fall above or below the mean that 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.

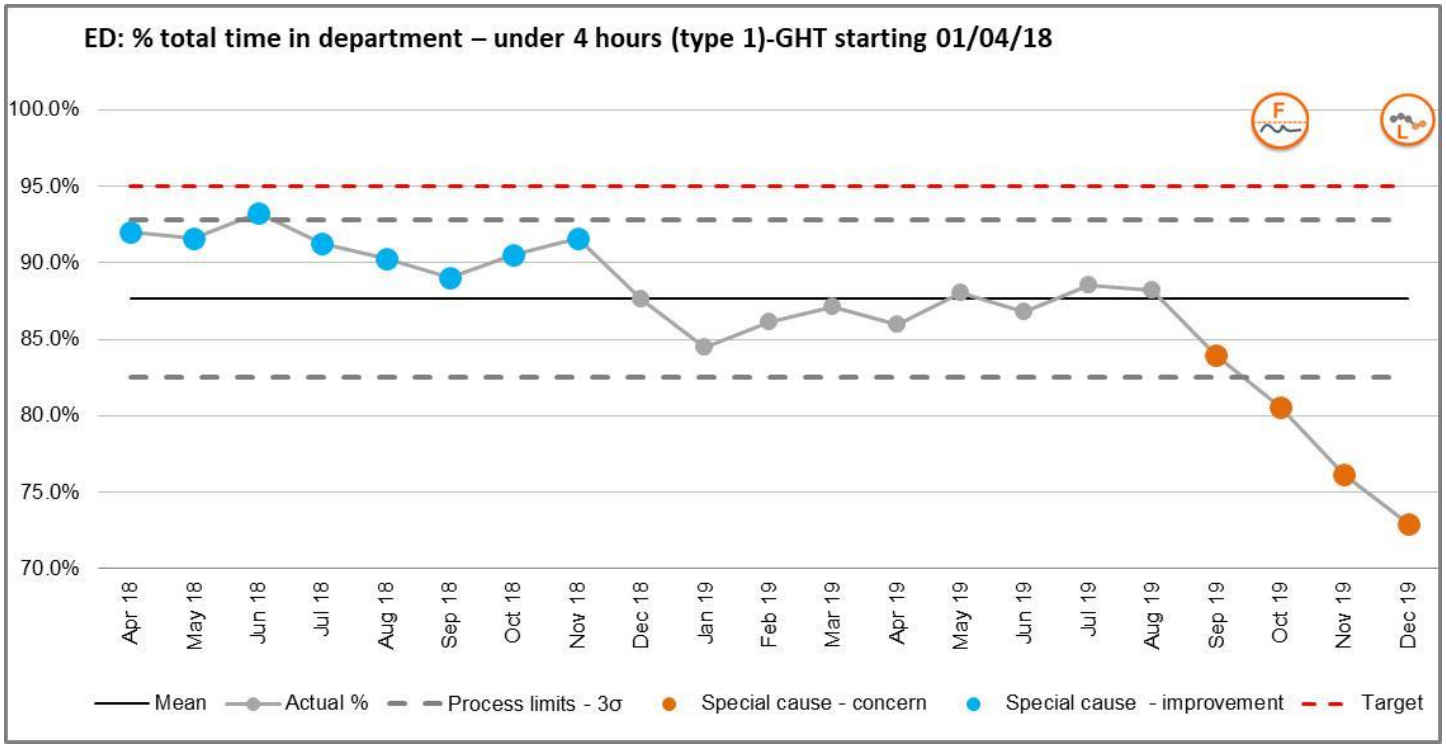
Commentary

The issue continues to be highlighted to specialities and is now being reported at the divisional Executive reviews.

- Medical Director

Access – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Total time in department has increased this month due to overcrowding. This has been due to a combination of infection control issues causing bed closures and poor flow throughout the hospitals

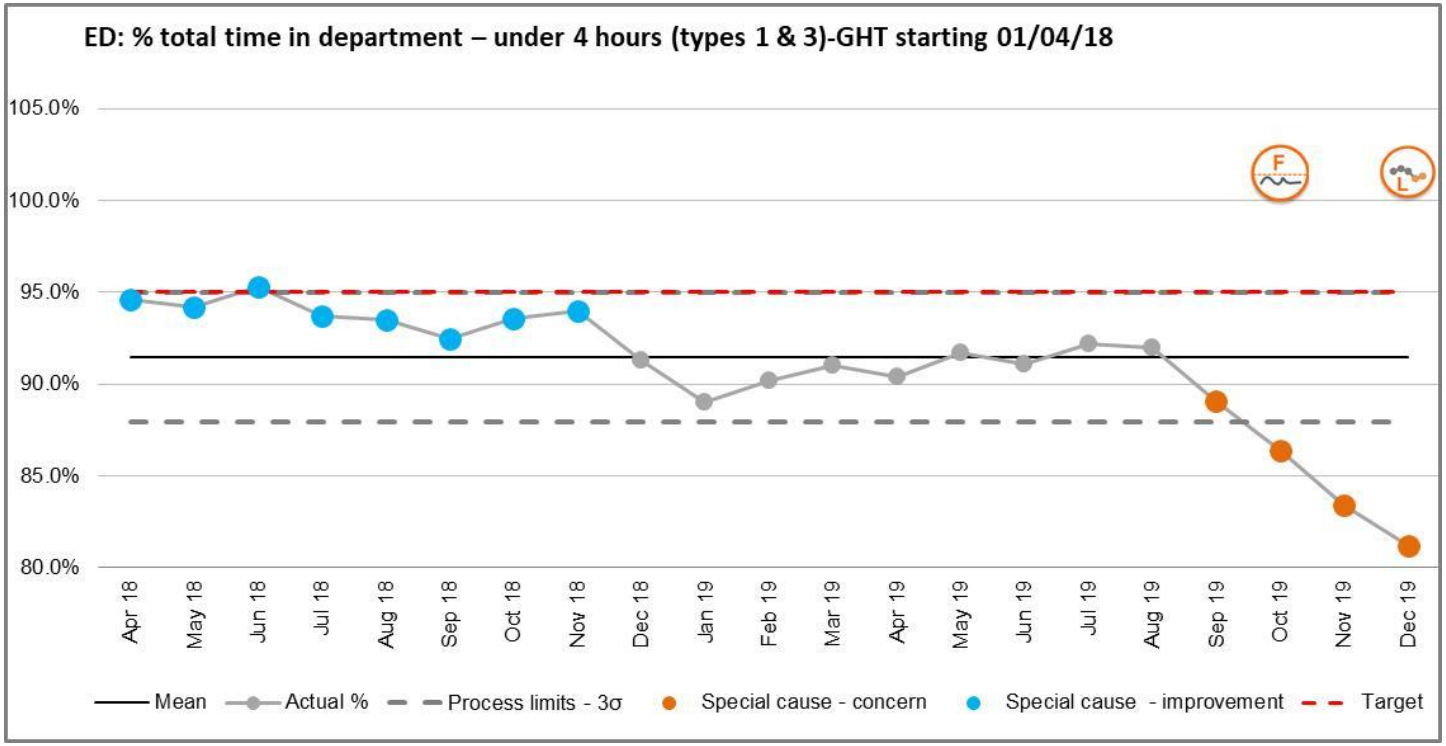
- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

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 point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that 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 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

Access – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



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- Director of Unscheduled Care and Deputy Chief Operating Officer

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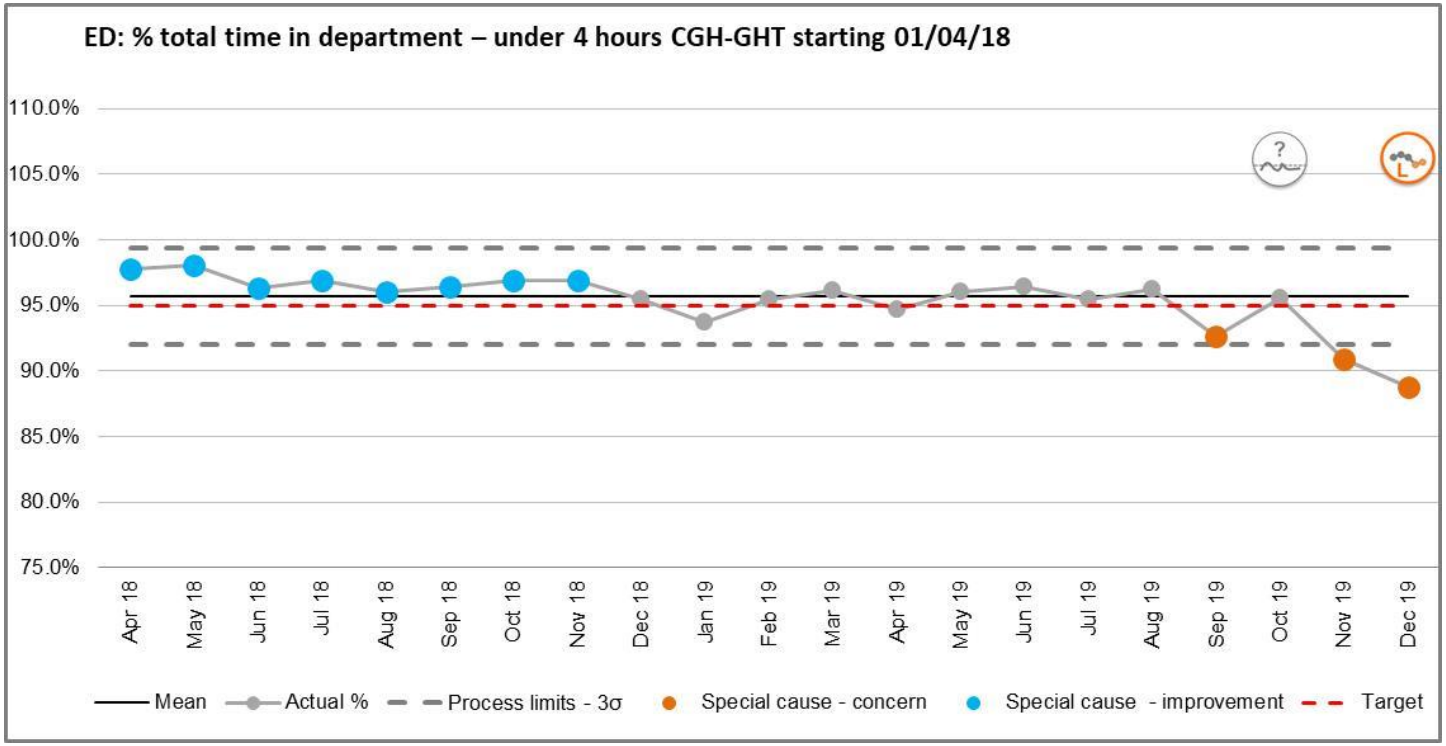
Access – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

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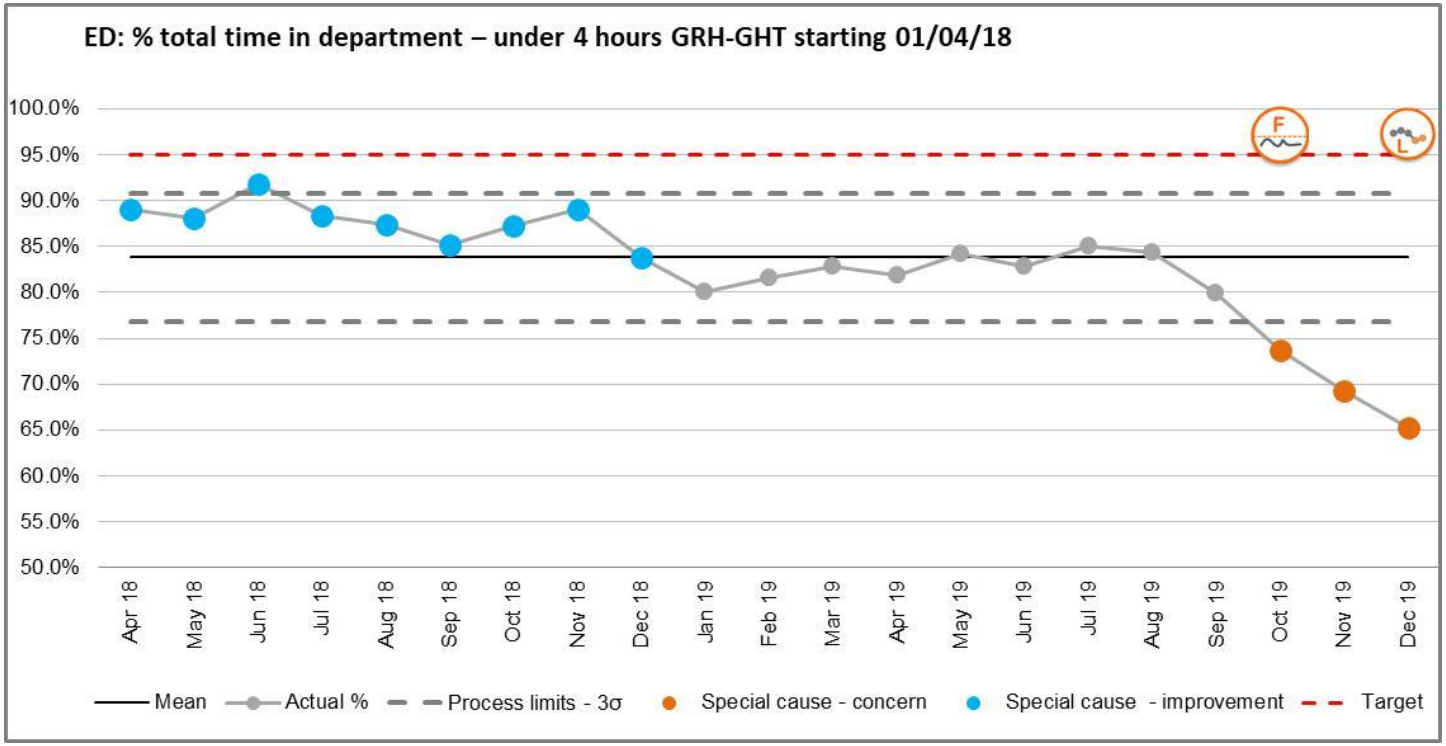
- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

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 point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that 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 LPL this is a warning that the process may be changing

Access – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

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- Director of Unscheduled Care and Deputy Chief Operating Officer

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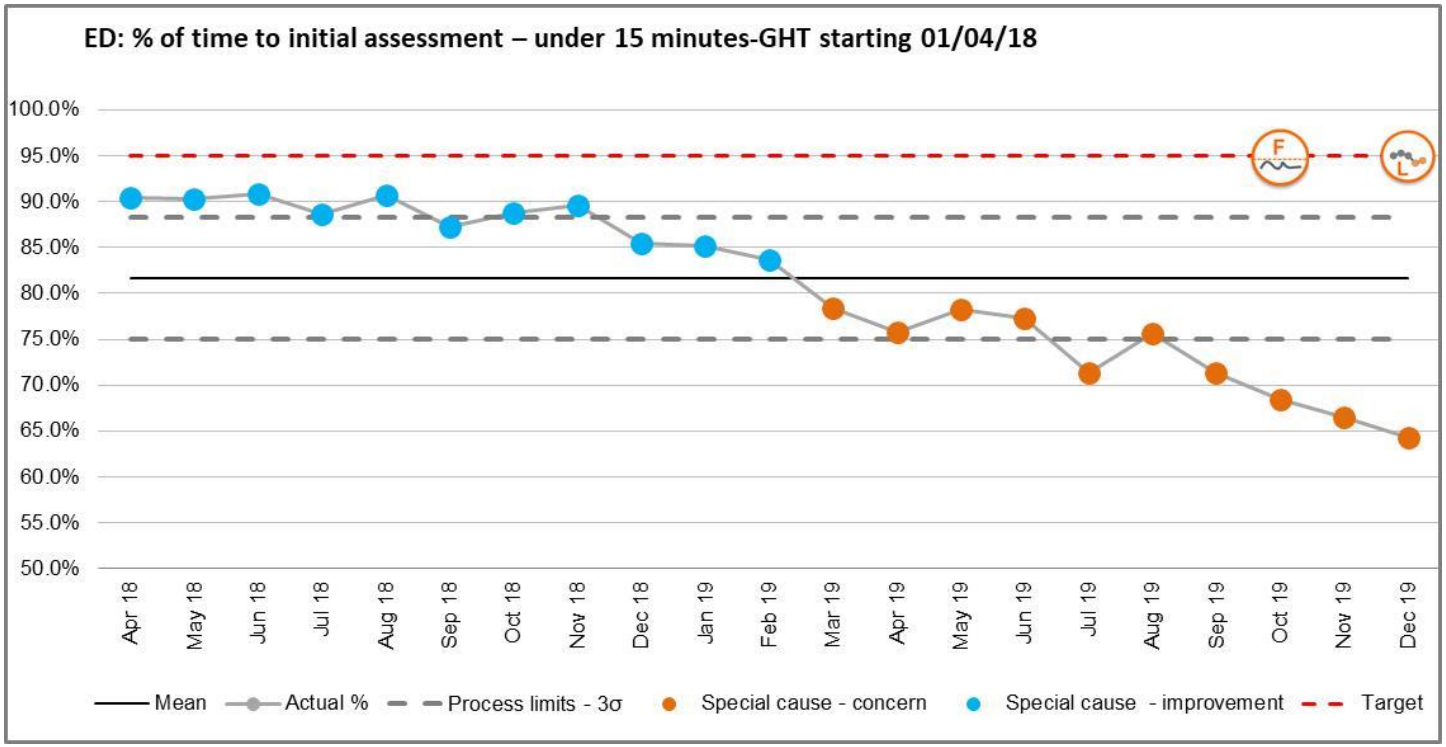
Access – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

For ambulance patients - Performance has improved marginally compared with the previous month. Increase triage capacity is included in the Winter Summit roll out which commences in January 2020.
For walk in patients - Maintaining walk-in triage remains challenging due to patient numbers, space and the number of trained staff available to triage. Increased triage capacity is also included in the Winter Summit roll out which commences in January 2020

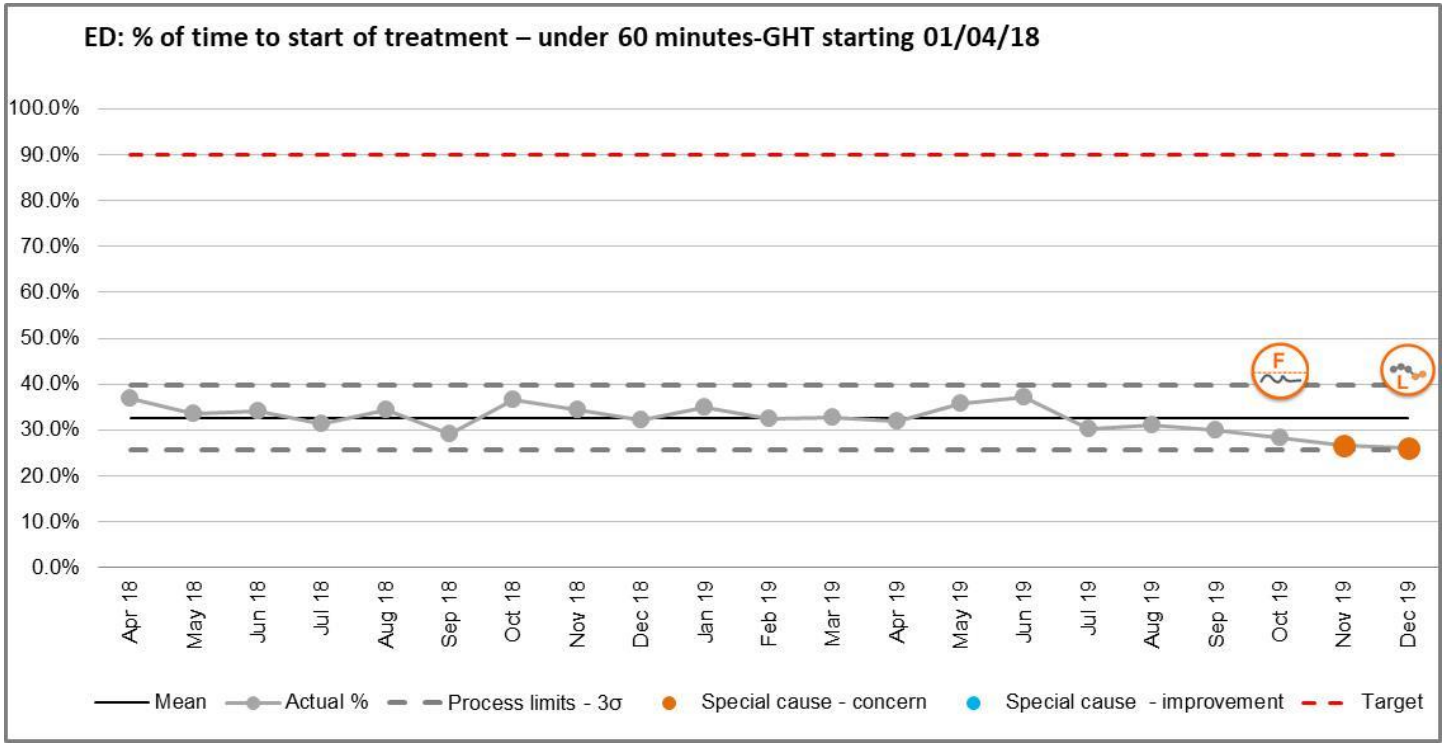
- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

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 7 data points which are above the line. There are 5 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that 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

Access – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Data Observations

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

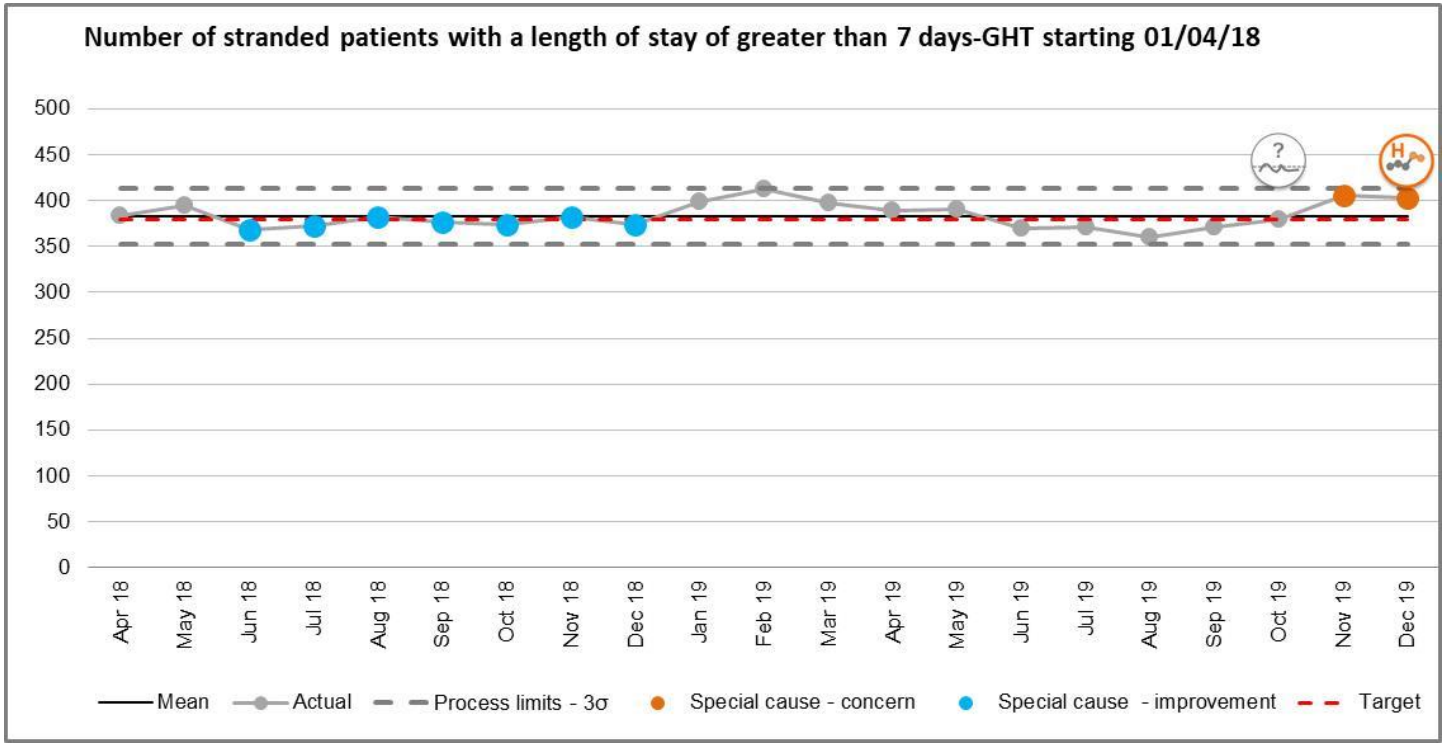
Commentary

This metric has decreased marginally in month. Average time to see a Doctor has increased this month which reflects the challenges seen in both departments throughout the month

- Director of Unscheduled Care and Deputy Chief Operating Officer

Access – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Data Observations

Shift	When more than 7 sequential points fall above or below the mean that 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

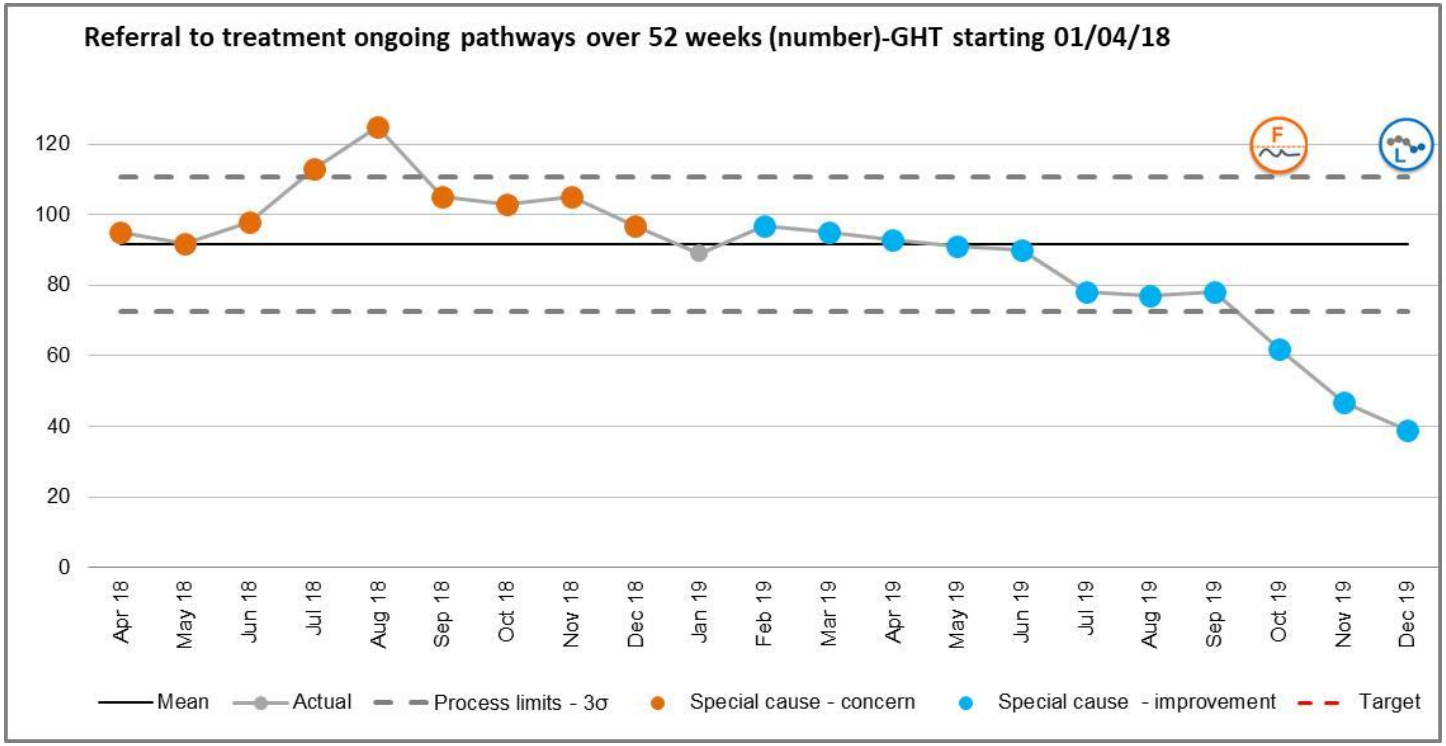
Commentary

There continues to be a whole system approach and this month the DDQN have emailed all their areas regarding the importance of accurate EDDs. The 21 day reviews continuing, it is evident that the social services resource remains insufficient for the workload.

- Deputy Chief Operating Officer

Access – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



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 are 3 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that 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 falling points
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

Commentary

December position was at 39 patients over 52 weeks. This is a reduction on previous months and is in line with the trajectory agreed within NHS I. The Trust is working to reduce the longest waiting patients.

- Deputy Chief Operating Officer

Quality Dashboard

Gloucestershire Hospitals NHS Foundation Trust

QUALITY	Target & Assurance		Latest Peformance & Variance		
FFT - Inpatients % positive	>=96%	F	Dec-19	90.2%	
FFT - ED % positive	>=84%	?	Dec-19	78.90%	
FFT - Maternity % positive	>=97%	?	Dec-19	100%	
FFT - Outpatients % positive	>=94%	F	Dec-19	93.20%	
FFT - Total % positive	>=93%	F	Dec-19	91.3%	
Number of trust apportioned Clostridium difficile cases per month	9/10	?	Dec-19	7	H
Number of falls per 1,000 bed days	<=6	?	Dec-19	6.7	L
Number of falls resulting in harm (moderate/severe)	<=3	?	Dec-19	4	
Number of patient safety incidents – severe harm (major/death)	No target		Dec-19	3	
Number of RIDDOR	No target		Dec-19	2	
Safety thermometer – % of new harms	>96%	?	Dec-19	97.9%	

Key

Assurance

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

Variation

- H — Special Cause Concerning variation
- Common Cause
- L — Special Cause Improving variation

Access | Quality | Financial | People & OD Risk Rating

Quality Dashboard

Gloucestershire Hospitals NHS Foundation Trust

QUALITY	Target & Assurance	Latest Peformance & Variance	
Number of serious incidents reported	No target	Dec-19	1
% of adult inpatients who have received a VTE risk assessment	>95%	Dec-19	92.6%
% of patients who have been screened for dementia (within 72 hours)	>=90%	Nov-19	50.00%
% of women booked by 12 weeks gestation	>90%	Dec-19	91.9%
% of women smoking at delivery	<=14.5%	Dec-19	11.52%
Hospital standardised mortality ratio (HSMR)	Dr Foster	Sep-19	97.6
Hospital standardised mortality ratio (HSMR) – weekend	Dr Foster	Sep-19	101.6
Emergency re-admissions within 30 days following an elective or emergency spell	<8.25%	Nov-19	7.0%
Percentage of records submitted nationally with valid GP code	>=99%	Nov-19	99.80%
Percentage of records submitted nationally with valid NHS number	>=99%	Nov-19	99.90%
Care hours per patient day total	>=8	Dec-19	7.9

Key

Assurance

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

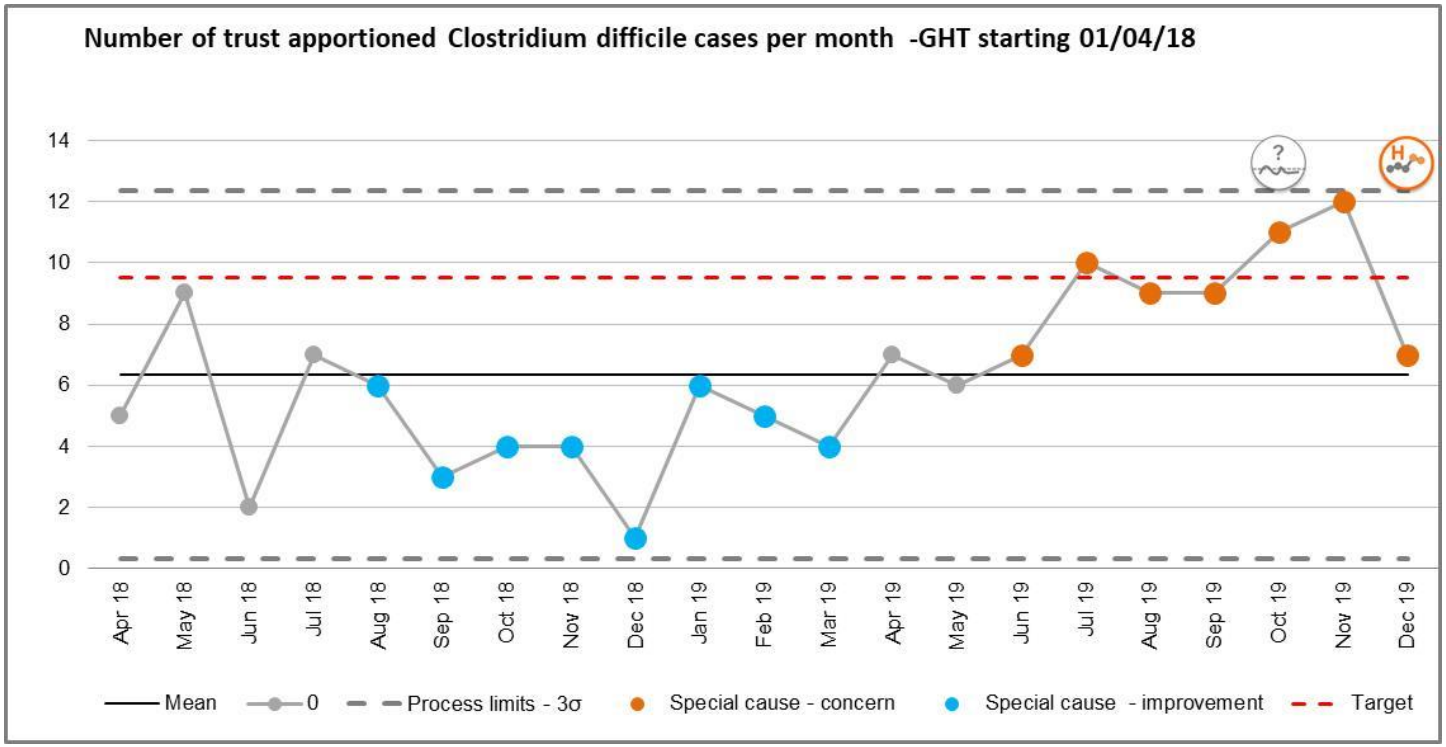
Variation

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

Access | **Quality** | Financial | People & OD Risk Rating

Quality – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



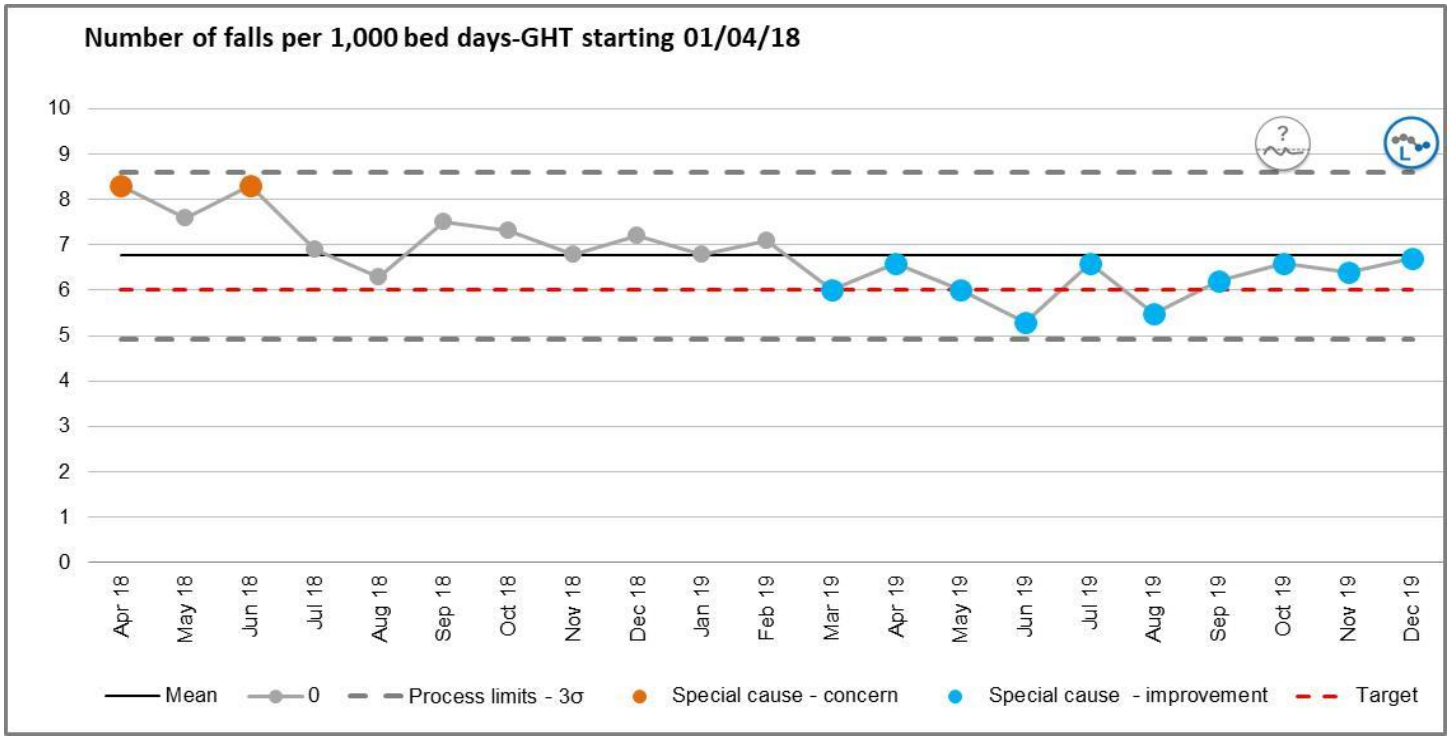
Data Observations

Shift	When more than 7 sequential points fall above or below the mean that 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

Commentary

Quality – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



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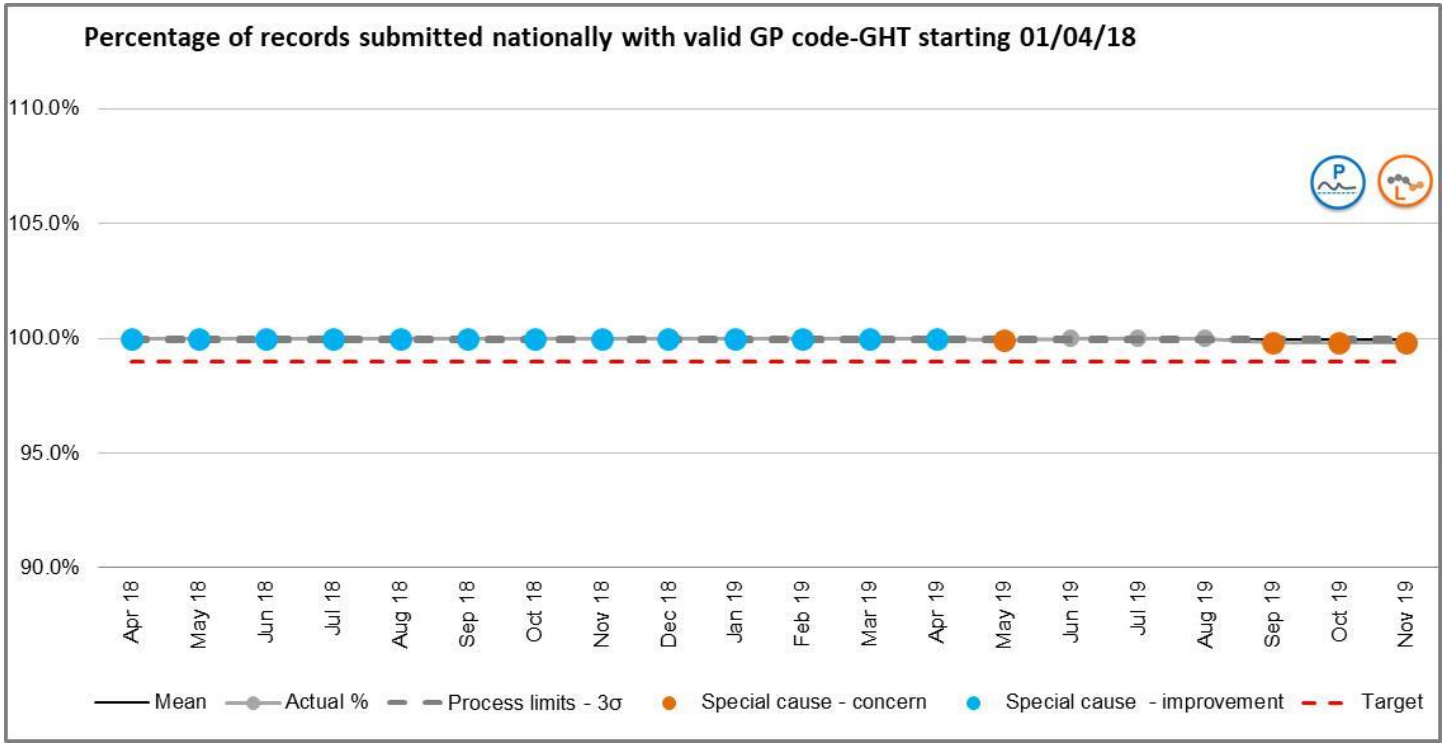
Commentary

The incidence of falls per 1000 bed days continues to perform below the annual average. We have both a trustwide improvement programme and a series of quality improvement initiatives to address performance.

- Director of Safety

Quality – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Data Observations

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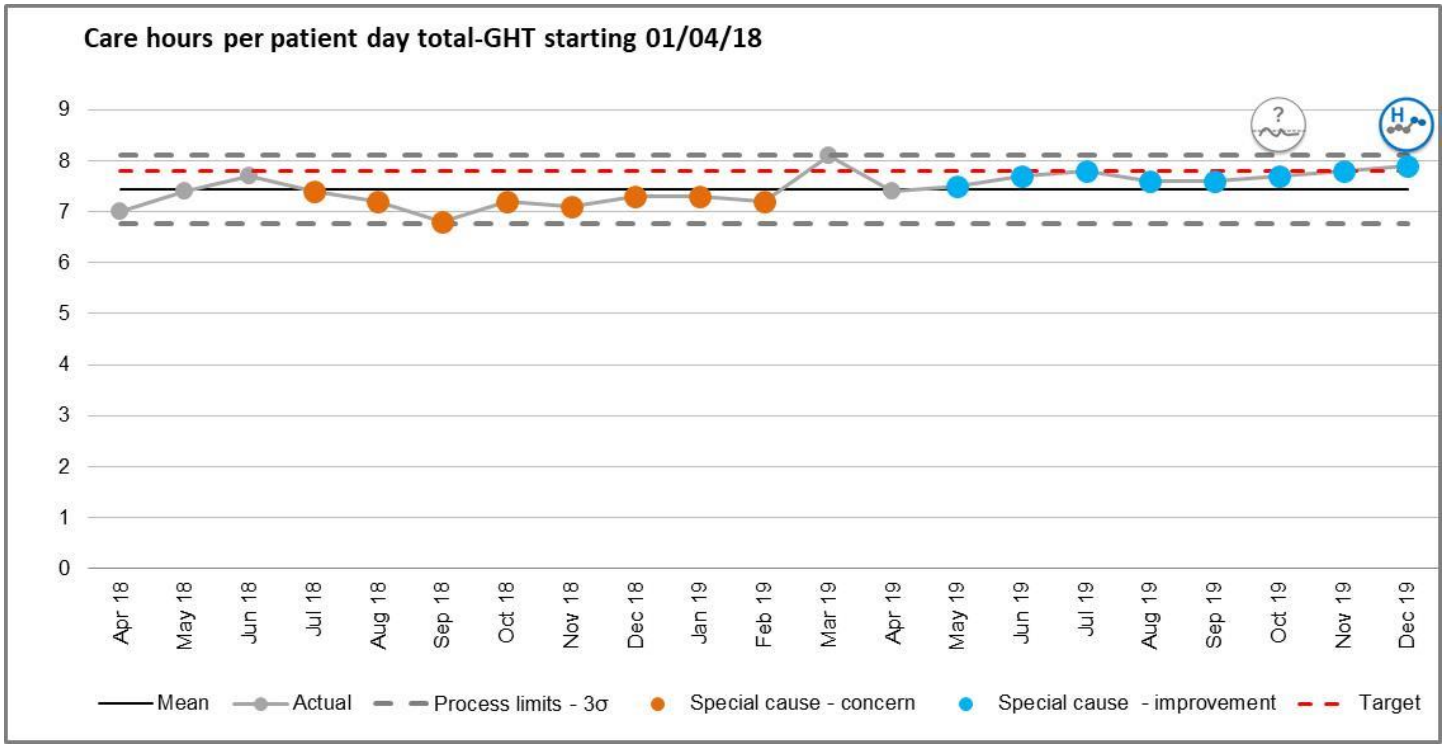
Commentary

Quality – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Data Observations

Shift	When more than 7 sequential points fall above or below the mean that 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.

Commentary

CHPPD is above our regional peers, however remains below the national figure. The Lead Nurse for retention, recruitment and attraction has collated the results of the trust retention survey (23% nursing staff completed). The findings demonstrate reasons for staff staying, intentions to leave and key improvement areas. These findings have informed the GHFT nurse retention plan 'Person-Centred Careers: Nursing Workstream 3 Improving Retention in Nursing' submitted to NHSI.

- Director of Nursing and Midwifery

Financial Dashboard

Gloucestershire Hospitals NHS Foundation Trust

FINANCIAL	Target & Assurance	Latest Peformance & Variance		
Total PayBill Spend	No target	Dec-19	31.4	
YTD Performance against Financial Recovery Plan	No target	Dec-19	0.4	
Cost Improvement Year to Date Variance	No target	Dec-19	-2	
NHSI Financial Risk Rating	No target	Dec-19	3	
Capital Service	No target	Dec-19	4	
Liquidity	No target	Dec-19	4	
Agency - Performance Against NHSI Set Agency Ceiling	No target	Dec-19	3	
Research accruals	No target	Dec-19	73	
Number of breaches of mixed sex accommodation	<=10	Dec-19	2	

Key

Assurance

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

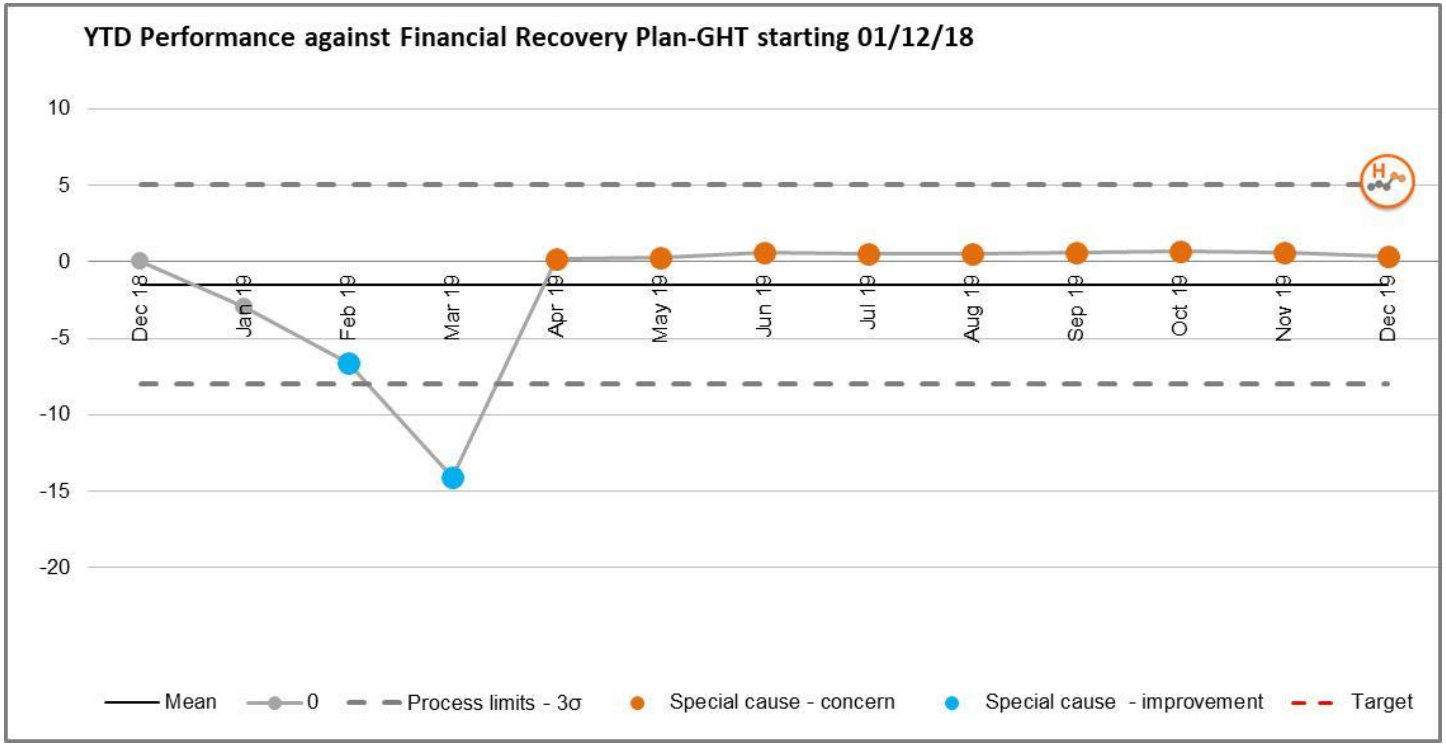
Variation

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

Access | Quality | Financial | People & OD Risk Rating

Financial – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Data Observations

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(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a sigificant change in process. This process is not in control. There is a run of points above the mean.
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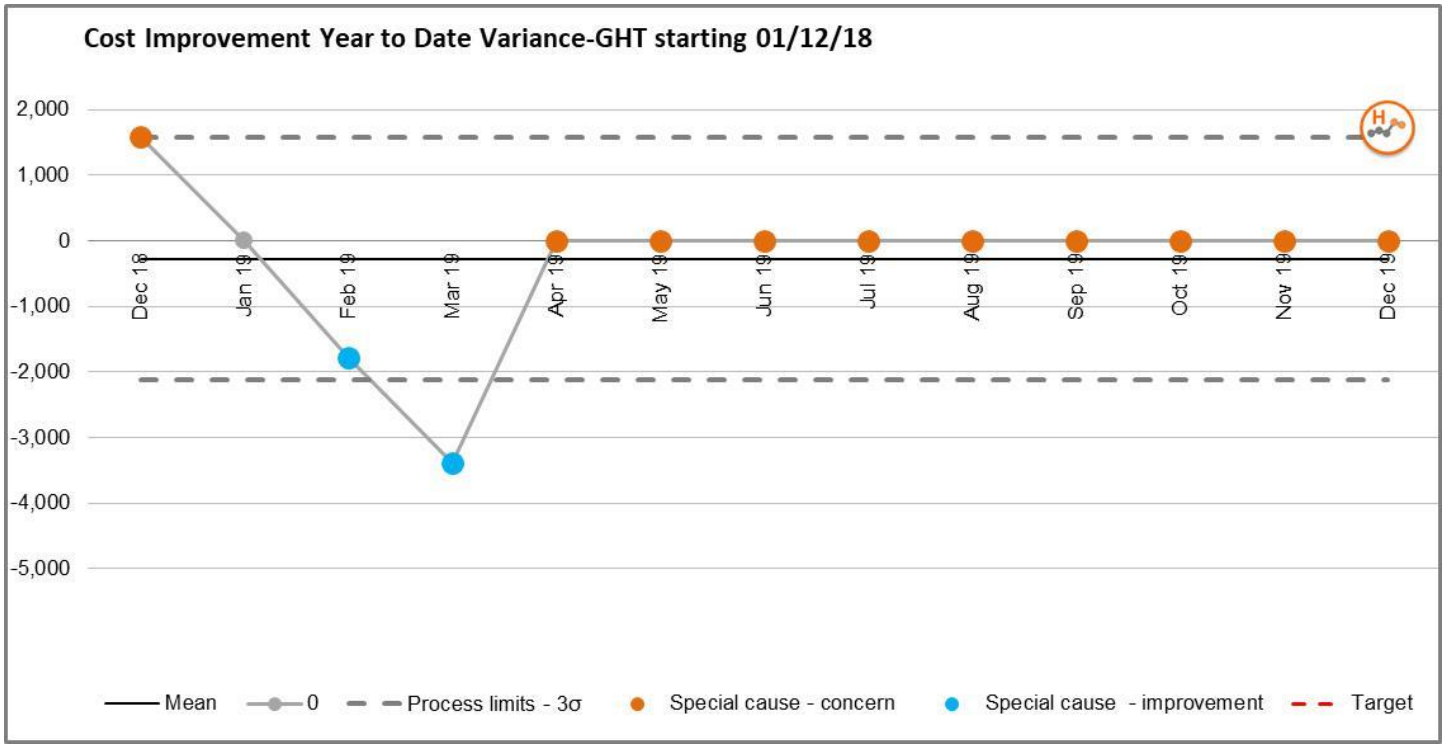
Commentary

Financial – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



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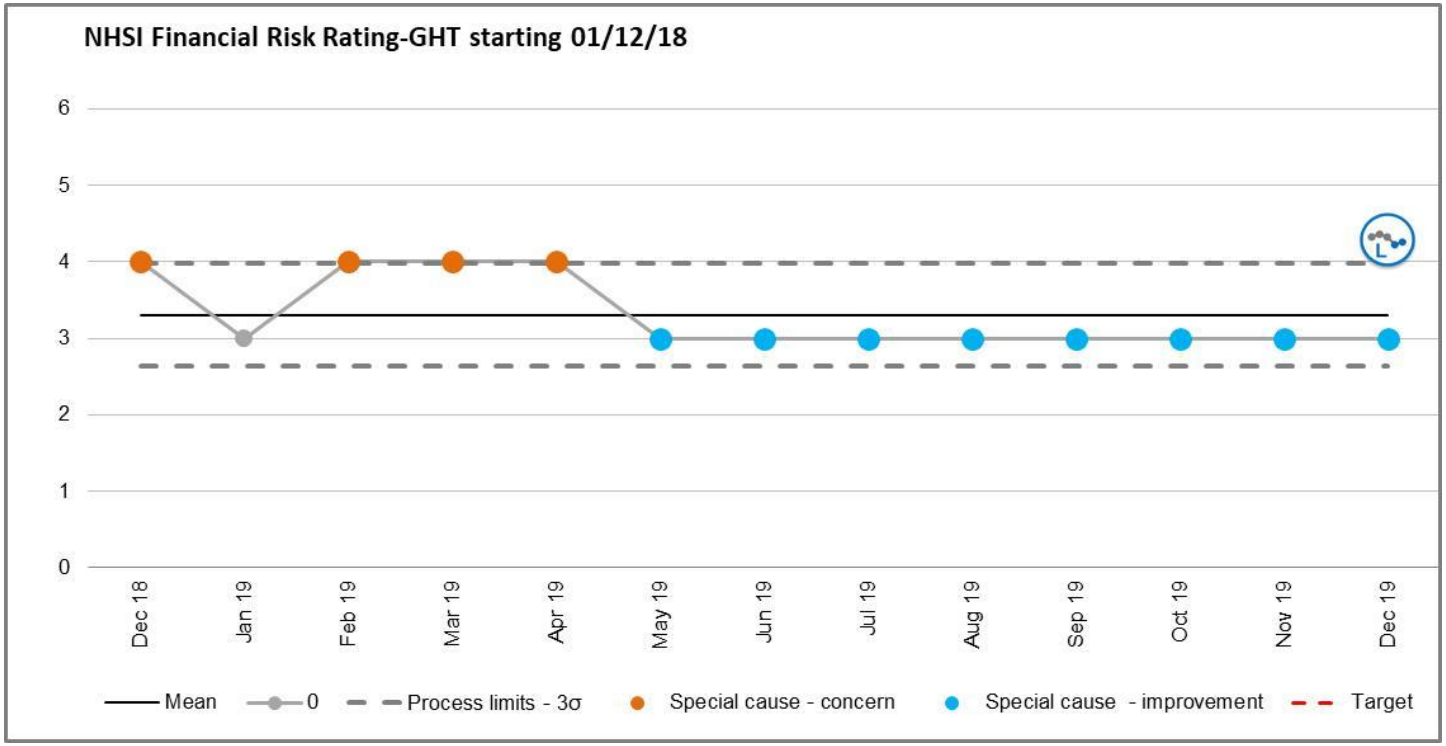
Commentary

Financial – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Data Observations

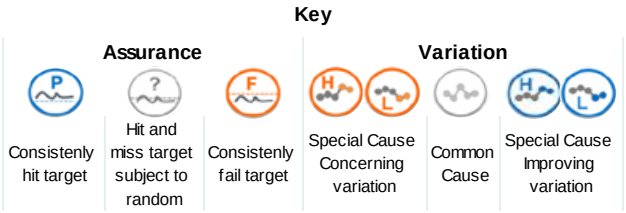
Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 4 data points which are above the line.
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a sigificant 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

Commentary

People & OD Dashboard

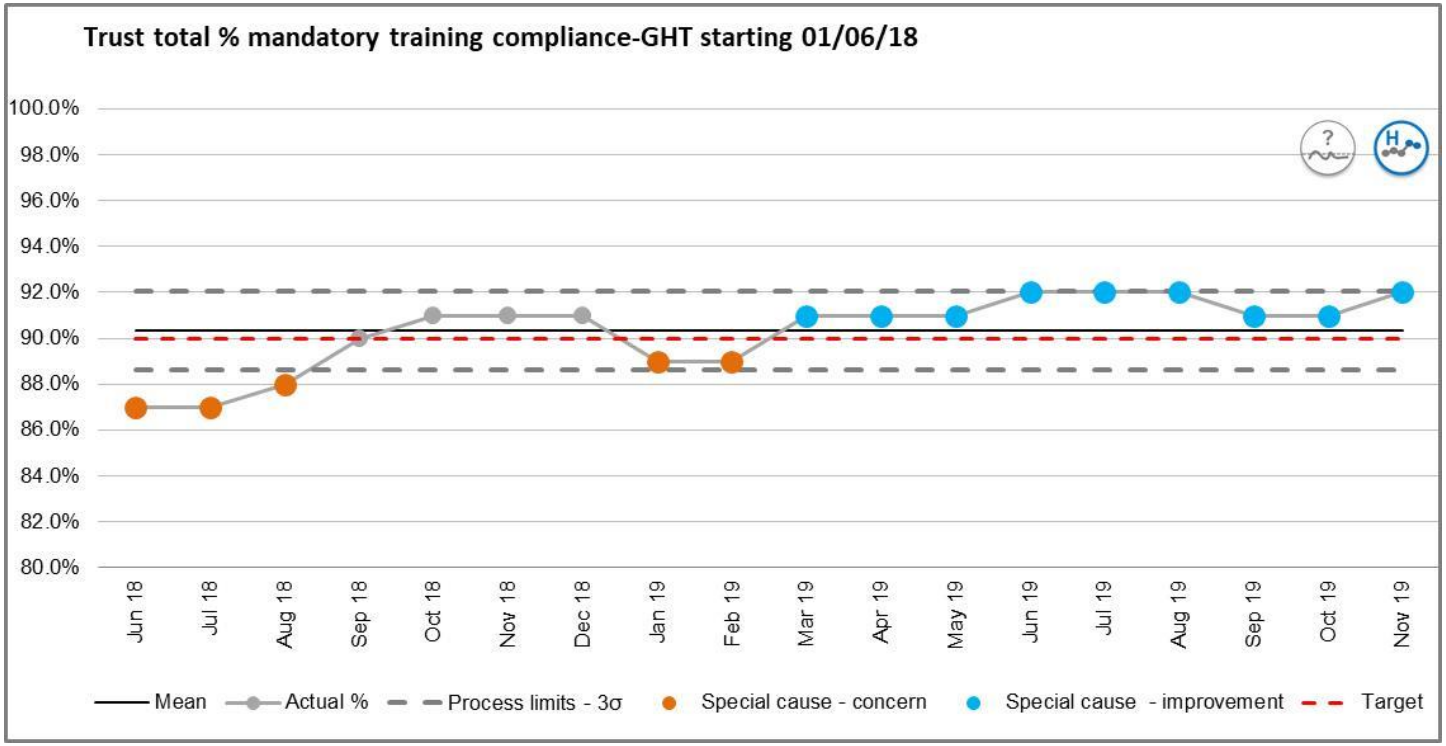
Gloucestershire Hospitals NHS Foundation Trust

PEOPLE & OD Risk Rating	Target & Assurance		Latest Peformance & Variance		
Trust total % overall appraisal completion	>=90%	F	Dec-19	82.00%	
Trust total % mandatory training compliance	>=90%	?	Dec-19	92.00%	H
% turnover	<=11%	F	Dec-19	11.80%	
% sickness rate	<=3.5%	F	Dec-19	4.00%	



People & OD – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Data Observations

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Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD – FEBRUARY 2020

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

This report describes the business conducted at the Finance and Digital Committee held on 30 January 2020, 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
Finance and Digital Committee Terms of Reference	Annual review of the document including discussion of scope and confirmation of committee membership	Is there adequate emphasis of back office systems? Could the multiple bullet points on responsibilities be rationalised?	Will be reviewed. Any modifications need to maintain the consistency of approach and format across all Board sub-committees	
Digital Care Board Project Report	Status update on all active projects: - Trakcare optimization - TCLE Pathology implementation - Document viewer - ICNet PAS & Lab - Pharmacy Stock Control	What is the confidence level in the ICNet implementation timeline? What will the links be between the Pharmacy physical stock records and the financial ledger?	Timeline considered achievable subject to remaining validation work System contains a financial reporting module	Review in February Assessment to be made of the impact of system cutover on year-end financial reporting

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Sunrise EPR Highlight Report	Review of progress to date, planned further roll-out and extension of scope to include implementation of E-Observations Particular emphasis on the opportunity presented by electronic observations which have been consistently shown to have significantly greater reliability than manual recording	What lessons from the successful Gloucester site roll-out will be incorporated in the Cheltenham roll-out? Have any examples of users taking shortcuts that invalidate broader system implementation benefits been identified? What is the planning approach to implementing the additional scope in terms of applications and departments/wards? How does the team achieve assurance that the organization IT infrastructure has the capacity to meet the demands of increased usage? What is the plan to assess benefit realisation and return on investment?	Basic approach is the same as key lessons learnt were identified in the initial Gloucester site pilot wards and then deployed site wide Buddying system to be used across sites to maximise support available Data quality of reports being analysed at granular level to assess compliance and reporting effectiveness The team is running an optimisation project to ensure appropriate extended deployment in terms of scope and timeline Investments have been made in upgraded infrastructure and increased capacity	 Findings to be included in future updates A core topic for future updates A core topic for future updates Directors and Committee chair to discuss and agree plan

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
IM & T Programme Board Update	Update of active projects: - Desktop Imaging – Windows 10 - Imprivata implementation - Next generation telephony - Windows 2003 upgrade - Fax replacement - MDT Video conferencing - PC Refresh Phase 2 - Firewall replacement - Back up solution - Email archiving - Network remediation - Phase 3 - Wi-Fi Review - DOCMAN 10 - Multi-Functional Devices	What is the programme to utilise benefits of multi-function devices? How can multi-function devices support the Trust's sustainability ambitions? What are the criteria and process for inclusion of a proposal in the IM & T programme?	Initial phase is like for like replacement to establish base for benefit realization Project assessment process described	Project to involve Director of Quality and NED as sponsors
Integrated Care System (Digital)	Update on the establishment of a digital delivery board at ICS level to ensure system wide IT governance Example of "Joining Up Your Information" project participation described	What is the quality of the system wide collaboration? Does the ICS Executive Group have aa line of sight in to digital?	Manager with experience of other systems described the high level of maturity evident in Gloucestershire Yes	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Finance Performance Report	9 months' cumulative deficit at £7.4 million (on a Control total basis) is a £0.4 million favourable variance against plan. Key favourable variances: - Commissioner income £6.0m - Other income £2.5m - Other patient related income £1.5m Partially offset by adverse variance on pay (£2.6 m) and non-pay (£7.4m) non-pay Detailed variance analysis presented Cash balance (£18.1 million) continues to be relatively high representing cash held following loan receipts for committed capital expenditure Balance sheet commentary and supplementary analysis reviewed Challenges and opportunities for balance of year described in detail with dialogue on plans to meet the year's control total.	Would activity variances be available in future analysis? What are the operational and HR implications of the demand levels within Medicine Division? How are Divisions being challenged in relation to the year-end target?	Yes An area of focus Finance teams working closely with operational management to ensure stabilisation or improvement in positions	 Additional analysis and review to be shared at next meeting

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Capital Programme Update	Update on capital project spending and key project status including information on three additional bids Current projected year's spend is £31 million reflecting a c.£5m increase from the original plan	Does the Trust have sufficient capacity to utilise the additional funds allocated?	Yes – there is sufficient flexibility to accommodate even relatively late allocations of funding	
Cost Improvement Programme Update	At month 9 savings are £11.6 million a £2.3 million shortfall form plan. Current year's projection is a shortfall of £7.7 million from plan - a delivery of £14.7million Preliminary review of the 20/21 plans and the assessment process	Can an indicator be added to show relative performance and success over time? What is the process for addressing divisions with significant shortfalls?	This is addressed directly at the point of budget setting	Report to be enhanced
Financial Planning and Budget Setting	Financial Planning and Budget setting paper reviewed and discussed	Detailed questions on the methodology, assumptions and relationship between Finance and Operational management	Assurance provided that the process would be as per prior year which was effective	Progress reports monthly
Strategic Site Development – Outline Business Case	Summary presentation of the proposal and changes incorporated from prior versions of the draft case, all supported by the full documentation Detailed discussion on numerous aspects of the proposal and	What is the methodology behind the calculation of discounted operating cost benefits? Clarification sought regarding VAT treatment in the analysis?	Question prompted by terminology which needs updating	Calculation to be validated Update schedule

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	documentation	Is the very structured approach to the document mandated? Is the proposal allocation of 1 month for project commissioning adequate? Should the narrative concerning backlog maintenance be strengthened?	Yes – documents prepared following NHSE/I guidance and in full collaboration with them Represents final phase commissioning work but some would be undertaken earlier in the programme	Narrative to be strengthened

Rob Graves
Finance & Digital Committee

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – FEBRUARY 2020
Lecture Hall, Redwood Education Centre

Report Title
Financial Performance Report **Month Ended 31st December 2019**
Sponsor and Author(s)
Author: Tony Brown, Senior Finance Advisor Sponsor: Karen Johnson, Director of Finance
Executive Summary
Purpose This report provides the Board with details of the financial performance for the period ended 31st December 2019. Key issues to note • At Month 9 the Trust is reporting a cumulative deficit of £7.4m, which is £0.4m favourable to plan. • Commissioner income is £6.0m favourable against plan. • Other NHS patient related income is £0.8m favourable against plan. • Private and paying patients' income is £0.7m favourable to plan. • Other operating income (including Hosted Services) is £2.5m favourable to plan. • Pay expenditure is showing an adverse variance of £2.6m. • Non-pay expenditure is showing an adverse variance of £7.4m. • Non-operating costs are £4.5m 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. Conclusions The Board is asked to note the contents of the report. Implications and Future Action Required The Board is asked to note the contents of the report.
Recommendations
The Board is asked to note the report.
Impact Upon Strategic Objectives
Supports Trust to deliver Strategic Objectives around financial position and sustainability
Impact Upon Corporate Risks
Risks around CIP delivery and budget management
Regulatory and/or Legal Implications
Potential for regulatory action if the financial position is not delivered as planned
Equality & Patient Impact
None

Resource Implications			
Finance	✓	Information Management & Technology	
Human Resources		Buildings	

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

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

Outcome of discussion when presented to previous Committees/TLT

Gloucestershire Hospitals NHS
NHS Foundation Trust

Report to the Trust Board

Financial Performance Report
Month Ended 31st December 2019

Director of Finance Summary

Gloucestershire Hospitals NHS
NHS Foundation Trust

Financial Performance Month 9

Month 9 position has shown a stabilisation in the financial position and the Trust has achieved quarter 3 PSF/FRF which is a significant achievement.

The Trust remains under operational pressure across the majority of areas, the largest percentage growth seen in Critical Care. Medicine and Surgery financial positions reflect these financial pressures and demand.

Forecast Outturn

The forecast position remains largely consistent with previous months. Although CIP achievement will become a material pressure during the last quarter. The Trust is as confident as it can be around achieving the year end position due to re-prioritisation of contingency to support the bottom line and the continuation of working with Divisions to improve divisional forecast outturn.

Capital

As at month 9 the capital programme has spent £15.1m which is 49% of the total budget. There is a requirement this year that all capital money should be spent otherwise it will be lost. The capital team have pulled together a detailed forecast showing a potential £3.6m under performance. The Trust is now looking at next years capital programme to see what can be brought forward from 2020/21 to ensure all 2019/20 money is spent. The three main areas will be IT, estates and divisional schemes. Schemes will be agreed by the Executive Team by the end of January to allow time to spend the money by the end of the financial year.

Balance Sheet

There are no balance sheet issues to bring to the Committee's attention

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 9.

The financial position as at the end of December 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 December the Group's consolidated position shows a year to date deficit of £7.4m. This is £0.4m favourable against plan. The position includes an impairment of £4.9m for the writing down of TrakCare expenditure incurred in previous financial years, which has no impact on the control total position. The favourable Quarter 3 position means that full receipt of the Q3 PSF/FRF funding of £4.7m (£10.3m YTD) is expected, this is reflected in the position.

Statement of Comprehensive Income (Trust and GMS)

	TRUST POSITION			GMS POSITION			GROUP POSITION *		
Month 09 Cumulative Financial Position	Budget £000s	Actuals £000s	Variance £000s	Budget £000s	Actuals £000s	Variance £000s	Budget £000s	Actuals £000s	Variance £000s
SLA & Commissioning Income	360,670	366,648	5,978	0	0	0	360,670	366,648	5,978
PP, Overseas and RTA Income	3,602	4,293	691	0	0	0	3,602	4,293	691
Other Income from Patient Activities	673	1,513	840	0	0	0	673	1,513	840
Operating Income	59,762	61,913	2,151	34,500	34,767	267	62,682	65,182	2,501
Total Income	**424,707**	**434,367**	**9,660**	**34,500**	**34,767**	**267**	**427,627**	**437,636**	**10,009**
Pay	264,613	266,671	(2,058)	13,730	14,358	(628)	278,091	280,731	(2,640)
Non-Pay	150,902	158,579	(7,677)	18,956	18,517	439	138,530	145,896	(7,366)
Total Expenditure	**415,515**	**425,249**	**(9,735)**	**32,686**	**32,875**	**(189)**	**416,621**	**426,627**	**(10,006)**
EBITDA	**9,192**	**9,117**	**(74)**	**1,814**	**1,892**	**78**	**11,006**	**11,009**	**3**
EBITDA %age	**2.2%**	**2.1%**	**(0.1%)**	**5.3%**	**5.4%**	**0.2%**	**2.6%**	**2.5%**	**(0.1%)**
Non-Operating Costs	17,328	21,739	(4,411)	1,814	1,892	(78)	19,142	23,631	(4,489)
Surplus/(Deficit) with Impairments	**(8,137)**	**(12,622)**	**(4,485)**	**0**	**0**	**0**	**(8,137)**	**(12,622)**	**(4,485)**
Less Fixed Asset Impairments	0	4,918	4,918	0	0	0	0	4,918	4,918
Surplus/(Deficit) excluding Impairments	**(8,137)**	**(7,704)**	**432**	**0**	**0**	**0**	**(8,137)**	**(7,704)**	**432**
Excluding Donated Assets	331	329	(3)	0	0	0	331	329	(3)
Control Total Surplus/(Deficit)	**(7,805)**	**(7,375)**	**430**	**0**	**0**	**0**	**(7,805)**	**(7,375)**	**430**

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.

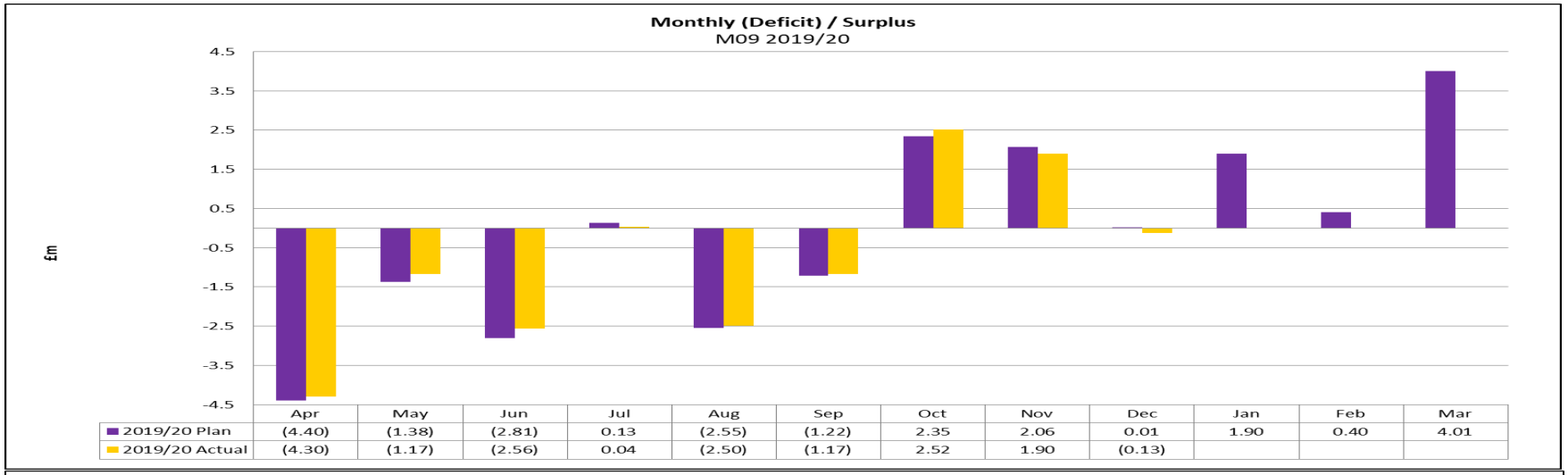
In December the Group's consolidated position shows an in month deficit of £0.13m on a control total basis, an adverse variance to plan of £0.15m.

Month 09 Financial Position	Annual Budget £000s	M09 Budget £000s	M09 Actuals £000s	M09 Variance £000s	M09 Cumulative Budget £000s	M09 Cumulative Actuals £000s	M09 Cumulative Variance £000s
SLA & Commissioning Income	482,404	39,128	40,985	1,857	360,670	366,648	5,978
PP, Overseas and RTA Income	4,802	400	469	69	3,602	4,293	691
Other Income from Patient Activities	898	75	206	131	673	1,513	840
Operating Income	86,896	7,474	8,416	942	62,682	65,182	2,501
Total Income	**574,999**	**47,077**	**50,076**	**2,999**	**427,627**	**437,636**	**10,009**
Pay	367,900	29,910	31,358	(1,448)	278,091	280,731	(2,640)
Non-Pay	182,515	15,064	16,857	(1,793)	138,530	145,896	(7,366)
Total Expenditure	**550,415**	**44,974**	**48,215**	**(3,241)**	**416,621**	**426,627**	**(10,006)**
EBITDA	**24,584**	**2,103**	**1,861**	**(242)**	**11,006**	**11,009**	**3**
EBITDA %age	**4.3%**	**4.5%**	**3.7%**	**(0.8%)**	**2.6%**	**2.5%**	**(0.1%)**
Non-Operating Costs	25,526	2,127	2,030	97	19,142	23,631	(4,489)
Surplus/(Deficit) with Impairments	**(942)**	**(24)**	**(169)**	**(145)**	**(8,137)**	**(12,622)**	**(4,485)**
Less Fixed Asset Impairments	0	0	0	0	0	4,918	4,918
Surplus/(Deficit) excluding Impairments	**(942)**	**(24)**	**(169)**	**(145)**	**(8,137)**	**(7,704)**	**432**
Excluding Donated Assets	(558)	37	37	(0)	331	329	(3)
Control Total Surplus/(Deficit)	**(1,500)**	**13**	**(132)**	**(145)**	**(7,805)**	**(7,375)**	**430**

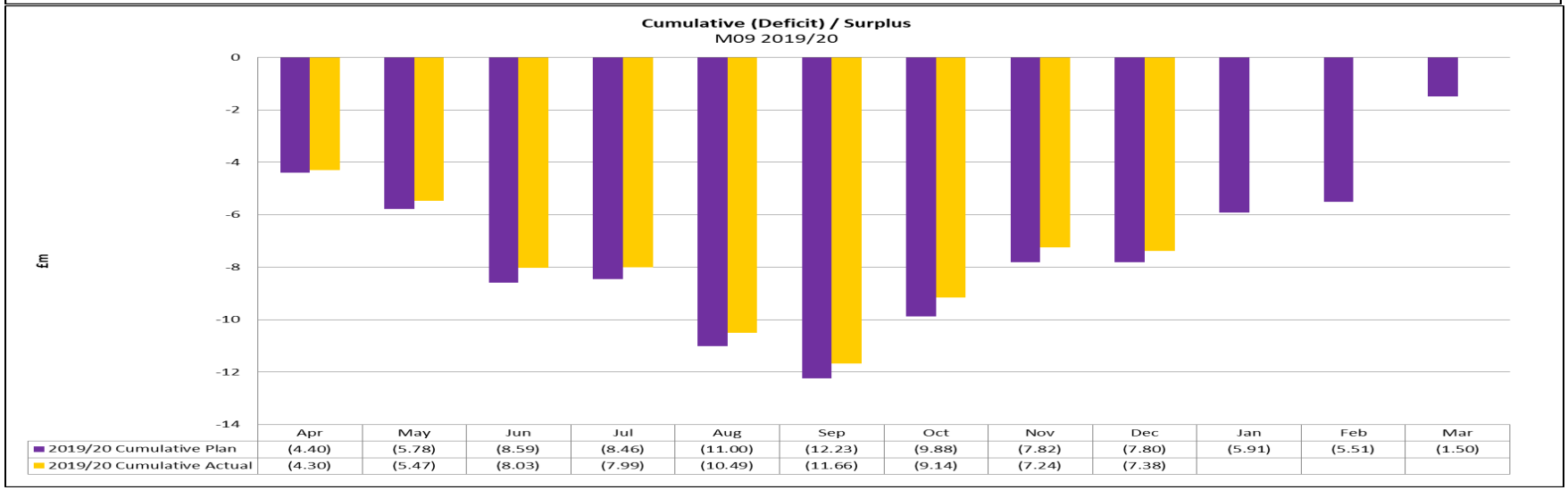
2019/20 Position Trend

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	(0.13)			



	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)	(7.38)			

Detailed Income & Expenditure

Gloucestershire Hospitals NHS
NHS Foundation Trust

Month 09 Financial Position	M09 Budget £000s	M09 Actuals £000s	M09 Variance £000s	M09 Cumulative Budget £000s	M09 Cumulative Actuals £000s	M09 Cumulative Variance £000s	Passthrough Variance £000s	Net Variance £000s
SLA & Commissioning Income	39,128	40,985	1,857	360,670	366,648	5,978	(4,089)	1,889
PP, Overseas and RTA Income	400	469	69	3,602	4,293	691		691
Other Income from Patient Activities	75	206	131	673	1,513	840		840
Operating Income	7,474	8,416	942	62,682	65,182	2,501		2,501
Total Income	**47,077**	**50,076**	**2,999**	**427,627**	**437,636**	**10,009**	**(4,089)**	**5,920**
Pay								
Substantive	27,856	28,819	(963)	259,765	257,280	2,484		2,484
Bank	976	1,321	(345)	8,787	11,389	(2,602)		(2,602)
Agency	1,079	1,218	(139)	9,539	12,062	(2,523)		(2,523)
Total Pay	**29,910**	**31,358**	**(1,448)**	**278,091**	**280,731**	**(2,640)**	**0**	**(2,640)**
Non Pay								
Drugs	5,398	6,396	(999)	50,597	54,800	(4,204)	4,416	212
Clinical Supplies	3,217	3,344	(126)	29,170	30,151	(981)	(205)	(1,186)
Other Non-Pay	6,449	7,116	(668)	58,763	60,945	(2,181)		(2,181)
Total Non Pay	**15,064**	**16,857**	**(1,793)**	**138,530**	**145,896**	**(7,366)**	**4,211**	**(3,155)**
Total Expenditure	**44,974**	**48,215**	**(3,241)**	**416,621**	**426,627**	**(10,006)**	**4,211**	**(5,795)**
EBITDA	**2,103**	**1,861**	**(242)**	**11,006**	**11,009**	**3**	**122**	**125**
EBITDA %age	**4.5%**	**3.7%**	**(0.8%)**	**2.6%**	**2.5%**	**(0.1%)**	**(3.0%)**	**(3.0%)**
Non-Operating Costs	2,127	2,030	97	19,142	23,631	(4,489)		(4,489)
Surplus/(Deficit)	**(24)**	**(169)**	**(145)**	**(8,137)**	**(12,622)**	**(4,485)**	**122**	**(4,363)**
Fixed Asset Impairments	0	0	0	0	4,918	4,918		4,918
Surplus/(Deficit) after Impairments	**(24)**	**(169)**	**(145)**	**(8,137)**	**(7,704)**	**432**	**122**	**554**
Excluding Donated Assets	37	37	(0)	331	329	(3)		(3)
Surplus/(Deficit)	**13**	**(132)**	**(145)**	**(7,805)**	**(7,375)**	**430**	**122**	**552**

Non-Pay – expenditure is showing a year to date £7.4m overspend, reflecting overspends on pass through drugs and clinical supplies which are offset within income (£4.1m). 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 £2.2m reflects expenditure mainly for outsourced clinical services (£1.1m) and unidentified CIP (£0.8m)

SLA & Commissioning Income – is reporting an over performance of £6m 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 £0.7m, reflecting private Oncology patients activity in D&S £0.4m, overseas patients in Medicine £0.1m and Surgery PP income £0.1m.

Other Operating income – Includes additional non-commissioned income in Cytology, Microbiology and Histology £0.4m, training income of £0.7m, car parking £0.2m, and hosted services of £0.4m and R&D £0.2m; the final two being offset by expenditure.

Pay – Cumulatively there is an overspend of £2.6m, reflecting an underspend on substantive budgets (£2.5m), offset by overspends on bank (£2.6m) and agency budgets (£2.5m). The in month overspend reflects the increased CIP requirement in pay budgets. Further detail on pay expenditure is provided on page 9.

Cost Improvement Programme

Gloucestershire Hospitals NHS
NHS Foundation Trust

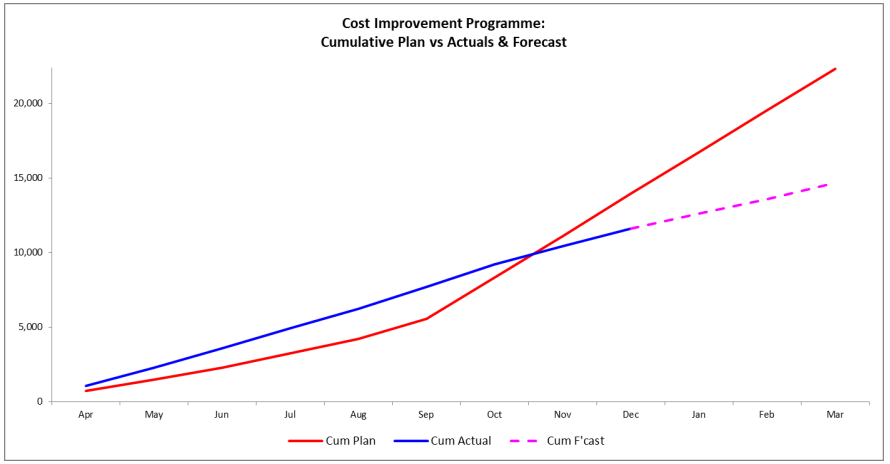
1. At Month 9 the trust has delivered £11.6m of CIP against the Year to date NHS Improvement target of £13,96m, this is an under performance of £2.3m. Within the month, the Trust has delivered £1.2m of CIP against an in-month NHSI target of £2.8m. Within the month, this is a negative variance of £1.6m which is largely due to the profiling of 'unidentified' schemes from M7.

2. At Month 9, 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 M7 which leaves a negative variance against target of £7.7m. The FOT splits into £9.6m (65%) of recurrent schemes and £5.1m (35%) of non-recurrent schemes.

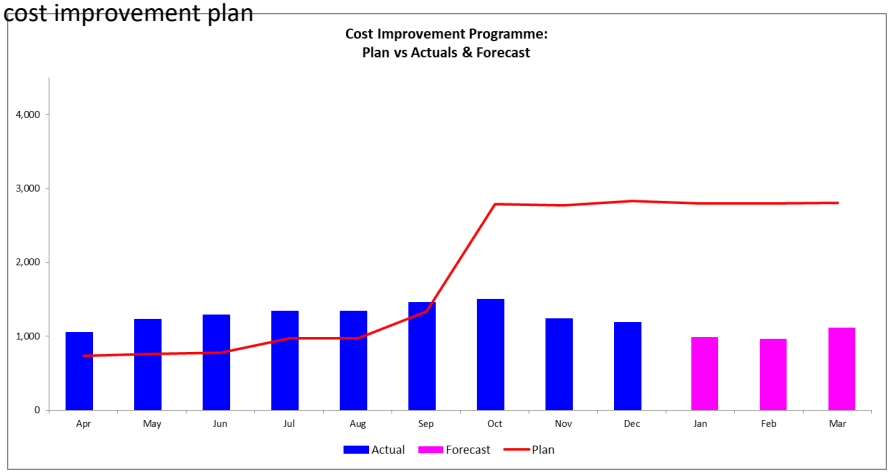
£2.5m relating to a review of Business Rates, which is very high risk, was profiled into month 12 in the Trust's CIP plan submission (for NHSI) but was never assumed within the internal CIP plan. Recent information indicates that this will not materialise in 19/20 therefore it has been removed from NHSI reporting.

3. In year recovery measures to hold/improve the FOT continue. £1.6m of improvement has been made since Month 4. Despite some deterioration in divisional forecasts the FOT has been maintained. A further £0.73m is being actively pursued. Oversight and scrutiny of the delivery of the 19/20 Cost Improvement Programme continues through weekly deep dives.

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



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



Balance Sheet (1)

Gloucestershire Hospitals NHS
NHS Foundation Trust

Trust Financial Position	Opening Balance 31st March 2019 £000	GROUP Balance as at M9 £000	B/S movements from 31st March 2019 £000
Non-Current Assests			
Intangible Assets	10,412	5,884	(4,528)
Property, Plant and Equipment	231,216	231,562	346
Trade and Other Receivables	5,185	4,672	(513)
Total Non-Current Assets	**246,813**	**242,118**	**(4,695)**
Current Assets			
Inventories	7,571	8,941	1,370
Trade and Other Receivables	25,419	32,623	7,204
Cash and Cash Equivalents	7,317	18,139	10,822
Total Current Assets	**40,307**	**59,703**	**19,396**
Current Liabilities			
Trade and Other Payables	(54,315)	(65,637)	(11,322)
Other Liabilities	(5,837)	(2,192)	3,645
Borrowings	(12,527)	(34,239)	(21,712)
Provisions	(160)	(160)	0
Total Current Liabilities	**(72,839)**	**(102,228)**	**(29,389)**
Net Current Assets	**(32,532)**	**(42,525)**	**(9,993)**
Non-Current Liabilities			
Other Liabilities	(6,860)	(6,578)	282
Borrowings	(135,294)	(133,510)	1,784
Provisions	(1,434)	(1,434)	0
Total Non-Current Liabilities	**(143,588)**	**(141,522)**	**2,066**
Total Assets Employed	**70,693**	**58,071**	**(12,622)**
Financed by Taxpayers Equity			
Public Dividend Capital	172,676	172,676	0
Reserves	23,915	23,915	0
Retained Earnings	(125,898)	(138,520)	(12,622)
Total Taxpayers' Equity	**70,693**	**58,071**	**(12,622)**

The table shows the M09 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 9 balance sheet position against the 2018/19 outturn

Current Assets

- Inventories have increased in year by £1.4m reflecting an increase in pharmacy stock.
- Cash has increased by £10.8m 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.

Current Liabilities

- The current borrowings increase reflects of additional in-year borrowing from the DoH, £12.5m deficit support and a £10m capital loan offset by repayments.

Retained Earnings

- The retained earnings reduction of £12.6m 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 December	
	Number	£'000	Number	£'000
Total Bills Paid Within period	77,246	171,959	7,549	16,999
Total Bill paid within Target	68,154	149,130	6,893	15,507
Percentage of Bills paid within target	88%	87%	91%	91%

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

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

Liabilities – Borrowings

Analysis of Borrowing	As at 31st December 2019 £000
<12 months	
Loans from ITFF	2,906
Capital Loan	829
Distress Funding	28,338
Obligations under finance leases	1,598
Obligations under PFI contracts	568
Balance Outstanding	**34,239**
>12 months	
Loans from ITFF	19,955
Capital Loan	13,613
Distress Funding	78,752
Obligations under finance leases	3,652
Obligations under PFI contracts	17,538
Balance Outstanding	**133,510**
Total Balance Outstanding	**167,749**

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.

Due to repayment dates £27.8m of borrowings have now moved to current borrowings in month.

Cash flow: December

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	Dec-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**	**5,496**	**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	1,229	**6,144**	**14,745**
Other operating non-cash	0	4,918	0	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**	**6,725**	**9,496**	**14,322**
Working capital movements:											
(Inc.)/dec. in inventories	113	0	298	(202)	(28)	0	(825)	0	(726)	**0**	**(644)**
(Inc.)/dec. in trade and other receivables	1,430	2,796	78	(4,472)	(2,526)	(1,033)	(1,296)	(1,182)	(999)	**(3,781)**	**(8,804)**
Inc./(dec.) in current provisions	0	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)	(3,664)	**(7,137)**	**8,910**
Inc./(dec.) in other financial liabilities	0	(1,055)	0	0	0	0	(1,761)	(131)	(698)	**3,348**	**532**
Net cash in/(out) from working capital	**(806)**	**2,657**	**530**	**11,793**	**(9,266)**	**(1,194)**	**3,850**	**(2,841)**	**(6,087)**	**(7,570)**	**(6)**
Capital investment:											
Capital expenditure	(1,129)	(1,629)	(1,729)	(3,125)	(1,129)	(500)	(1,807)	(4,208)	(807)	**(16,385)**	**(27,433)**
Capital receipts	0	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)**	**(807)**	**(16,385)**	**(27,433)**
Funding and debt:											
PDC Received	0	0	0	0	0	0	0	0	0	**4,015**	**4,015**
Interest Received	17	17	17	17	17	17	16	16	16	**80**	**198**
Interest Paid	(124)	(294)	(114)	(259)	(196)	(1,327)	0	(291)	(114)	**(2,066)**	**(4,380)**
DH loans - received	2,442	3,368	2,887	0	10,049	3,842	0	0	0	**4,950**	**27,538**
DH loans - repaid	0	0	0	0	(167)	(1,317)	0	0	0	**(1,486)**	**(2,970)**
Finance lease capital	(488)	(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)	(13)	**(65)**	**(150)**
PFI capital element	(68)	(68)	(68)	(68)	(68)	(68)	(68)	(68)	(68)	**(349)**	**(825)**
Interest element of PFI	(38)	(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)**	**(705)**	**1,685**	**16,073**
Net cash in/(out)	**(2,441)**	**4,190**	**588**	**9,883**	**(1,769)**	**(438)**	**5,718**	**(4,034)**	**(874)**	**(7,866)**	**2,956**
Cash at Bank - Opening	**7,317**	**4,876**	**9,065**	**9,653**	**19,537**	**17,768**	**17,330**	**23,047**	**19,013**	**18,139**	**7,317**
Closing	**4,876**	**9,065**	**9,653**	**19,537**	**17,768**	**17,330**	**23,047**	**19,013**	**18,139**	**10,273**	**10,273**

The cash flow for December 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 £2.9m of committed cash:

Committed cash from 2018/19 £2.9m

The remaining cash balance of £15.2m 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 9 the Trust continues to forecast 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 (£1.8m), and that winter capacity measures are delivered within existing forecast expenditure.

The forecast is in line with that reported to the Committee in December.

Month 09 Forecast Outturn	FY PLAN £000s	M08 FoT £000s	FoT VARIANCE £000s
Total Income	**574,658**	**586,016**	**11,358**
Pay	**(367,559)**	**(375,789)**	**(8,230)**
Non Pay	**(182,515)**	**(192,799)**	**(10,284)**
EBITDA	**24,584**	**17,428**	**(7,157)**
Non Operating Costs	**(25,526)**	**(30,275)**	**(4,749)**
Surplus/(Deficit)	**(942)**	**(12,848)**	**(11,906)**
Fixed Asset Impairments	0	4,918	4,918
Surplus/(Deficit) after Impairments	**(942)**	**(7,930)**	**(6,988)**
Excluding Donated Assets	(558)	(562)	(4)
Surplus/(Deficit)	**(1,500)**	**(8,492)**	**(6,992)**

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 9	(8.49)	(8.49)	(8.49)
Month 9 FOT gap to control total	**(6.99)**	**(6.99)**	**(6.99)**
52 week fines imposed	(1.78)		
Additional winter expenditure			
Gap to control total	**(8.77)**	**(6.99)**	**(6.99)**
Release of reserves			
Improvement in Divisional Forecasts		0.50	1.46
Revised Gap to control total	**(8.77)**	**(6.49)**	**(5.53)**
Quarter 4 PSF and FRF funding	5.53	5.53	5.53
Outstanding financial gap	**(3.24)**	**(0.96)**	**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, on this basis 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

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

Capital Programme Expenditure Summary position at 31st December 2019

Capital Summary	19/20 Full Year Plan £k	Internal YTD Plan £k	YTD Spend £k	YTD Var £k	Jan 20 £k	Feb 20 £k	Mar 20 £k	FOT 19/20 Spend £k	Forecast Variance £k
Health & Safety Projects	3,537	2,527	3,121	593	267	267	267	3,922	386
Environmental Works	350	243	254	11	51	51	51	407	57
Non Health & Safety Projects	150	105	379	274	2	2	2	385	235
Committed Schemes	460	323	370	47	43	43	43	500	40
Service Reconfiguration	37	6	2	(4)	12	12	12	37	0
Major Equipment Replacement	20	14	19	5	2	2	2	25	5
IM&T	9,883	6,941	6,872	(68)	771	771	1,469	9,883	0
MEF	2,490	1,992	1,567	(425)	87	87	87	1,827	(663)
Other Schemes	10,364	3,027	2,495	(532)	377	1,418	4,815	9,106	(1,258)
Contingency/Leases Capitalisation	3,678	1,027	0	(1,027)	257	257	757	1,272	(2,406)
Overspend/(Underspend)	**30,968**	**16,206**	**15,079**	**(1,127)**	**1,869**	**2,910**	**7,506**	**27,364**	**(3,604)**
Brought Forward Schemes									3,604
Total									**(0)**

The table summarises (at a high level) the capital plan expenditure (not cash flow) year end position. Detail information is provided in Appendix A.

During December allocations of £15.7k and £79.2k were made from the Estates and MEF contingencies respectively.

Points to note:

- NHSE/I have confirmed that the Trust will get funding for an MRI, 3 CT scanners and one mammography machine, at an average unit cost per machine. The Trust is currently in discussions with NHSE/I around securing more funding for these items and possibly funding for enabling works.
- The Trust has also been allocated £0.5m PDC for winter planning and this funding will be spent on the Clinical Decisions Unit (CDU) and telemetry. The Trust has made a further bid and has secured an additional £41k of funding.
- Following a successful bid, the Trust has been awarded £677k to install energy efficient LED lighting across the two hospital sites. The funding will need to be spent by March 2021 and will produce electricity and carbon savings as well as reducing maintenance costs.
- The significant spend in March under 'Other Schemes' reflects the purchase of the centrally funded diagnostic equipment.
- Divisions are meeting to discuss and prioritise the schemes to be brought forward from 20/21 to utilise the underspend

Recommendations

Gloucestershire Hospitals NHS
NHS Foundation Trust

The Board is asked to note:

- Note the Trust is reporting a year to date actual income and expenditure deficit on a control total basis of £7.4m at December 2019. This is £0.4m favourable to 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 endorse the submission of control total delivery to NHSE&I in the month 9 provider return.

- Author: Tony Brown, Senior Finance Advisor
- Presenting Director: Karen Johnson, Director of Finance
- Date: February 2020

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – FEBRUARY 2020
Lecture Hall, Redwood Education Centre, GRH commencing at 12:30

Report Title
Digital Update
Sponsor and Author(s)
Author: Leah Parry, Digital Transformation Lead Sponsor: Mark Hutchinson, Exec. CIO
Executive Summary
This paper details the overarching digital update for GHFT. Key issues to note There are no new areas of concern to note Implications and Future Action Required None
Recommendations
The Board is asked to note the report.
Impact Upon Strategic Objectives
The position presented identifies how the relevant strategic objectives will be achieved
Impact Upon Corporate Risks
Progression of the digital agenda will allow us to significantly reduce a number of corporate risks
Regulatory and/or Legal Implications
Progression of the digital agenda will allow the trust to provide more robust and reliable data and information to provide assurance of our care and operational delivery
Equality & Patient Impact
Progression of the Digital agenda will improve the safety and reliability of care in the most efficient and effective manner.

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 Trust Leadership Team (TLT)							
Audit & Assurance Committee	**Finance & Digital Committee**	**Estates & Facilities Committee**	**People & OD Committee**	**Quality & Performance Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
Outcome of discussion when presented to previous Committees/TLT							

February 2020

DIGITAL UPDATE

1.0 Digital Care Board Update

Total Number of Projects: 4	**Total Change since last report:** +/-0	**Number of Red Projects:** 0	**Number of Amber Projects:** 1	**Number of Green Projects:** 2	**Number of Projects Closed since last Board:** 1

Red Significant issues with the project – scope, time or budget is beyond tolerance level

Amber Issue/s having negative impact on the project performance, project is close to tolerance level

Green Project is on track

Implementation	**TrakCare Optimisation**	Weekly RTT reporting continues to be submitted with no new issues identified. A reduction in the overall number of issues have been demonstrated. The numbers have reduced in staged blocks due to the solutions having been implemented prior to testing and deployment. Moving forward, there is an intention to switch on Trak enhancements following the T2018 upgrade.	**Mar 2020**
Scoping	**Document Viewer (formally Infoflex Viewer)**	The document viewer went live as planned in readiness for the Sunrise EPR pilot go live. Project to be closed. Excellent feedback received demonstrating significant improvements to ability to care.	**Close**
Implementation	**ICNet**	Validation nearly complete with the view to delivering on time and to plan. Amber status due to previous delay in validation activities and the outstanding final validation sign off. ICNet interim solution for infection control but longer term this functionality will be delivered in Sunrise EPR.	**March 2020**
Scoping	**Pharmacy Stock Control System**	Meeting has been held with Procurement to discuss route to market. It was agreed that this is likely to be a direct award via a waiver as the solution required has limited options available. Procurement are finalising the quote from the expected supplier, to ensure the modules purchased are required.	**TBC**

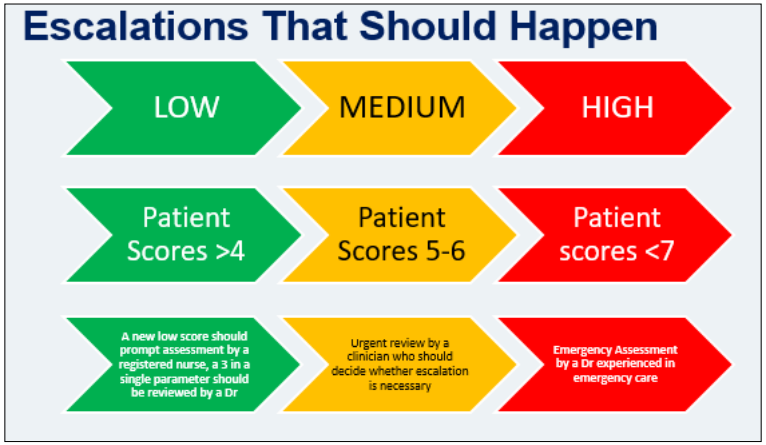
2.0 Sunrise EPR Update

1. Roll Out 1b: Cheltenham Go Live

The combined forces of the EPR programme team, nursing and estates colleagues are working collaboratively to roll out Sunrise EPR at our Cheltenham site on February 12th. Senior nurses have been highly engaged and are keen and excited to start releasing the benefits that are being described by their colleagues in Gloucester. Following the GRH roll out training has been reviewed and amended based on go live. We were able to incorporate the frequently asked questions and some of the real life experiences of staff in December. Super User huddles have continued with GRH colleagues sharing their experiences and top tips. For general training, we have now hit a site wide percentage of 80% with senior colleagues ensuring that their colleagues are ready and prepared for go live. This is an exceptional achievement. 24/7 technical and clinical support is planned for the first week of go live to ensure that our staff feel supported and able to use Sunrise EPR. Go Live support at Gloucester was able to be stood down sooner than anticipated, a testament to the trust's preparation of its staff.

2. Roll Out 2: E- Observations

Failure to recognise the deteriorating patient is a common cause of serious adverse events. Sepsis kills over 40,000 people a year and by taking observations, patients can be identified as at risk or their care escalated in a timely and prompt fashion. The use of NEWS2 to standardise the review, communication and escalation of patients was mandated in 2018.



2.1 Patient Stories

Below are three incidents that have been reported as patient incidents. When sharing these stories with colleagues all were easily recognised situations that resonated with staff as familiar situations when relying on capturing observations in a busy environment and using paper.

Patient 1

- 38 yr old male, admitted at 1.30pm generally unwell, usually fit and well
- Busy AMU department
- Nurse caring for 7 patients, HCA reviews patients, takes obs and settles patient in (2pm)
- Dr reviewed and for admission to a ward
- Senior nurse handing patient over to receiving ward
- Notices that patient has a NEWS2 of 5 (medium) at 2pm with no escalation, HCA has been busy washing patients
- Cancels Transfer, senior nurse repeats obs
- Now triggering at a 12, septic and requiring urgent review

Patient 2

- Serious incident review of an unexpected death
- Nursing staff reviewed patient in a side room and found that they had passed away, this was not expected and likely due to deterioration of an infection
- Senior staff feel that the patient would have shown some signs of deterioration
- On review of the observation chart it was documented that only an hour prior to the patient being discovered their obs were stable
- Senior management suspect that the stable obs were entered retrospectively but have no way of proving this……

Patient 3

- Patient admitted with an Exacerbation of Respiratory Disease
- Suffered a respiratory arrest and reviewed by emergency team
- Patient stabilised, but on review of the observation chart had high parameters for the last three obs recordings and on some occasions the respiratory rate was not completed
- Opportunity to escalate and be reviewed sooner clearly missed

2.2 Staff Experience

"I have been a nurse looking after a patient and identified that a HCA has not escalated obs in a timely fashion, it is frustrating and I always feel so very guilty. It is even harder when we are so busy that it's easy to see why something else gets in the way. In this particular occasion the HCA had been asked to do something by the ward manager with another poorly patient. I have also been in the situation where I have miscalculated a NEWS2 score, it's not straightforward, luckily nothing happened in this instance, but it made me wonder if I had done it before and I felt very guilty."

Band 6 Nurse, AMU

"On arrival at a crash call one day I could find the paper notes for a patient. After some hunting, it transpired that because the patients chart had not been at the bedside their obs had been neglected, somebody thought someone else was using them and therefore looking at/ reviewing the patient. I have found patients with more than one obs chart as well; this makes it difficult to see trends and spot when a patient could be rescued. NEWS2 really can catch people before its too late, but it needs to be done properly and patterns are so important."

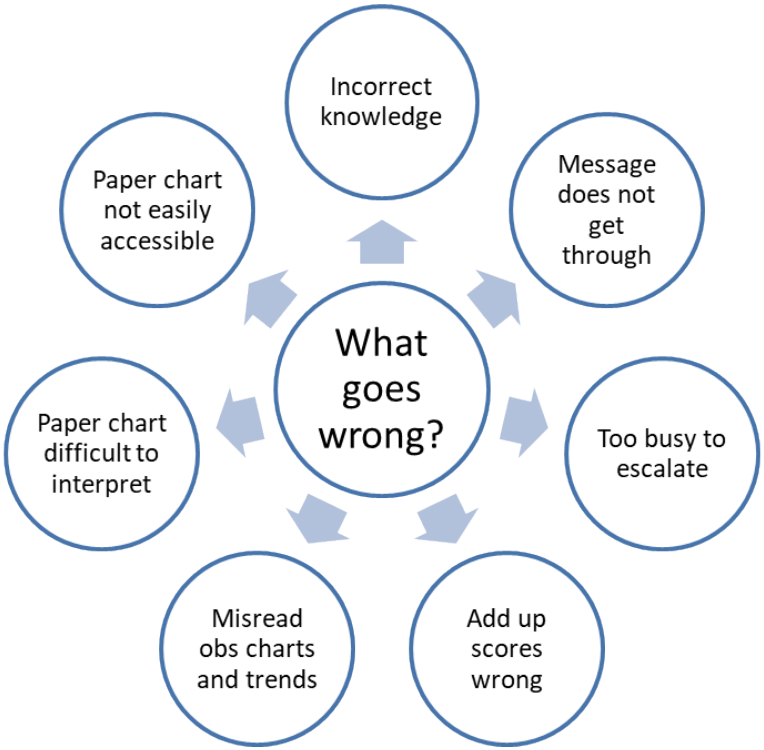
Middle grade Dr, ITU

"I can come on to the ward and be responsible for nearly 30 sick individuals. It is really hard for me to quickly identify who is the sickest and who needs to be seen first. It is not abnormal for me to get halfway through a shift and find a patient that is unwell that I should have definitely seen first. I hope that nurses and staff will point me in the direction of poorly people, but sometimes it is clear that they think I already know because I have had a handover- often I have but things can change quickly. I spend a lot of time when I am on call worrying about how all of my patients are doing, and inevitably I go home feeling like I could have done better. I hate it."

Junior Dr, Medicine

2.3 Current NEWS2 Audit

Every month the resuscitation team audit every ward and their observations. This audit shows that 1 in 5 patients have an error in the recording and calculation of their NEWS2 and in addition to this every month, approximately 35% of observations recorded are not documented as escalated appropriately. The process of recording observations is subject to error due to the high level of reliance on human beings consistently remembering to do the right thing at the right time (as described in the image below). The move towards the electronic capture and recording of observations allows us to implement rules and processes that act as a guiding hand to our colleagues, making it easy to consistently do the right thing at the right time. By making this information electronic, we are also providing the opportunity for easier and timelier access to this information to the relevant professionals.



3. Roll Out 3: Order Communications- “Requests and Resulting”

The Trust currently has a heavy reliance on paper requests and orders for patient specific tests and diagnostics. The amount of duplicate tests that are requested for a patient is a financially costly and time-consuming exercise for staff and highlights various inherent issues, including:

- Duplication of test request by different staff members
- Time delays between request reaching the lab and result reaching the service
- Difficulty reading the handwritten paper request forms
- Repeat tests on patients, reducing their satisfaction and confidence
- Reduced accountability of processing and actioning care based on results

Roll out 3 of the Sunrise EPR programme will see the trust introducing the electronic ability to request pathology and radiology requests through Sunrise EPR. These results will then be surfaced back in the patient’s record within Sunrise EPR allowing the timely response and action to be taken, improving the delivery of patient care. This workstream, led by Chief of Service Kate Hellier has now kicked off and further details will follow in the coming months**.**

3.0 IM & T Programme Board Update

This paper provides the Board with updates on projects which report to the IM&T Programme Board. This is a small subset of the projects currently underway based on those with capital spend allocation.

The current status of those projects which report to this Board are as follows:

Total Number of Projects: 31	Total Change since last report: +/- 0	Number of Red Projects: 2	Number of Amber Projects: 2	Number of Green Projects: 25	Number of Projects Closed since last Board: 2

Red	Significant issues with the project – scope, time or budget is beyond tolerance level
Amber	Issue/s having negative impact on the project performance, project is close to tolerance level
Green	Project is on track

	New key risks / escalation to Board: • One project to note is the Docman project, this project is currently being reviewed and re-scoped		
	2018/19 Capital Programme		**Status**
Implementation	**Desktop Imaging – Windows 10**	• Rollout has restarted following the go live of EPR.The project is once again in full flight with over 100 devices migrated over the past 3 weeks, 60% of the Trust is now migrated. Work will continue deploying the Windows 10 operating system across the Trust. The team continue to monitor, track and resolve issues that arise	**March 2020**
	2019/20 Capital/Improvements Programme		
Implementation	**Imprivata Implementation**	Project ahead of schedule with 5164 users enrolled. Outstanding areas are: Rheumatology, USC Wide, Breast, Pain, Upper GI, Anaesthetics. No issues expected to complete	**March 2020**
Implementation	**Next Generation Telephony**	Work is continuing on the final activities within the original scope, the aim by the end of January is for 90% handset rollout.	**June 2020**
Implementation	**Windows 2003 Upgrade**	34 Servers remaining that need to be decommissioned or migrated. The project is now focussing on micro-segmenting the bulk of the remaining servers.	**March 2020**
Implementation	**Fax Replacement**	Audits now complete, server built and ready. Final details being completed on the	**Jan 2020**

		Rightfax checklist with Infrastructure, Server and Applications teams and submitted. Request to Process Flows for a conference call to better understand telephony requirements.	
Implementation	**MDT Video Conferencing**	Project complete, closure documentation being completed, Benefits to be realised over the next month or so when monitoring of use can be gained.	**Jan 2019**
Implementation	**PC Refresh Phase 2**	Project complete, closure documentation being completed.	**Feb 2020**
Scoping	**Firewall Replacement/ HSCN Migration – Fibre replacement.**	Joint paper drafted for Countywide Exec LDR Group	**April 2019**
Implementation	**Back Up Solution**	Progress continuing on plan for completion by the end of March The project has undergone extensive planning and design activities prior to delivery. Dates are in place for configuration and installation activities, Backup hardware racked, Operating System installed and raided at CGH and GRH, Date agreed for backup environment configuration, High level design agreed for archive/tape storage. Software configuration due to take place 13/01/20	**April 2019**
Implementation	**Email Archiving**	All servers have set up and are ready, these include 4 servers, 1 x filestore server and 3 x ingestion servers. Storage requirements disks have now been specified. Trust Comms team have been engaged regarding general awareness to all users and how this can be successfully delivered, using user self-help videos received from suppliers.Next steps are to agree a pilot group and rollout out to this group.	**Mar 2020**
Implementation	**NEW - Network Remediation – Phase 3**	Project in flight, plan in place and progressing as expected. Some milestones require dates	**Sept 2020**
Scoping	**Wi-Fi Review**	Project now in implementation phase – all in scope detailed surveys for GRH and CGH completed, and filed on LIMA portal. Discovery information collation for low level design complete and provided to LIMA. Wireless controllers and ISE devices (GRH and CGH) have been racked in readiness. Routing between Cheltenham and Gloucester (10Gb link) in place for ISE, WLC & AP's. Next steps for the LLD to be signed off and pilot areas agreed. Rollout will then commence.	**May 2020**
Implementation	**DOCMAN10 Transfers of Care**	This project is reporting as red due to uncertainty in relation to the suitability of the solution. Investigation and discussions are underway to understand the scope, solution and contract obligations. Expertise in previous Docman implementation has been drafted in to provide a better insight to the solution. Discussions are expected to provide a way forward by the end of February when the project will be re-scoped and baselined.	**March 2020**
Scoping	**Multi-Functional Devices (printer**	Presentation from Banner received and some potential significant savings identified. Next steps are a PID and print policy is being drafted for submission to IM&T senior	**TBC**

	replacement)	leads. If agreement is gained to take this project forward, business buy in will be required.	

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – FEBRUARY 2020

Report Title
Digital Strategy
Sponsor and Author(s)
Author: Leah Parry, Digital Transformation Lead Sponsor: Mark Hutchinson, Chief Digital & Information Officer
Executive Summary
Purpose To share our inaugural trust wide digital strategy that will see us becoming a hospital known for its digitally enabled best care. By continuing to invest and develop our digital capabilities over the next five years, we will become a HIMSS level 6 hospital that consistently delivers and is able to demonstrate its consistently safe, reliable and effective care.
Recommendations
The Board is asked to APPROVE the Digital Strategy.
Impact Upon Strategic Objectives
Digital Future - Allow delivery of corporate strategy and the ability to truly transform care so that we can work towards the delivery of our own objectives and those that are described in the wider long term plan.
Impact Upon Corporate Risks
Improve a number of corporate risks by providing new ways of working that improve the safety and reliability of care.
Regulatory and/or Legal Implications
This strategy is part of the trust wide suite of strategies to support the delivery of the trust objectives over the next five years.
Equality & Patient Impact
The Digital strategy is a patient centric strategy that will allow the trust to deliver consistently safer, more reliable care in an effective and efficient way that enables our journey towards becoming an “outstanding” trust.

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 and/or Trust Leadership Team (TLT)

Audit & Assurance Committee	Finance & Digital Committee	Estates & Facilities Committee	People & OD Committee	Quality & Performance Committee	Remuneration Committee	Trust Leadership Team	Other (specify)
	31 October 2019					2 October 2019	Digital Care board, Directors Operational Group

Outcome of discussion when presented to previous Committees/TLT
Recommended for approval by the Board.

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Digital Strategy

Foreword

On 28 November 2018 at a keynote event in London, Secretary of State for Health and Social Care Matt Hancock laid down the requirement that all NHS organisations should have Chief Information Officers on their boards.

Reinforced by the finding of the Topol Review, the requirement for technology and information experts to sit on boards is a necessary move to ensure the art of the digital possible is not only understood by boards but also prioritised. The NHS must close the gap between where it is now and making the most of the opportunities that technology provides us.

Marking the beginning of a new digital journey, in October 2018, I was appointed by the Trust as its first Executive Chief Digital Information Officer. With the Chief Executive and the Board fully identifying the need for GHNHSFT to improve its digital maturity, the decision to include a Digital Strategy in the new strategic plan for the Trust shows clear commitment and dedication to the digital cause.

As a Trust that delivers care across a number of sites and aspires to collaborate seamlessly with partner organisations, we can no longer rely on pens and paper to manage our delivery of care. We must be able to access information about our patients quickly and easily to make accurate and informed decisions about the care we provide; we must pursue open source technologies that are interoperable and allow us to share information; we must invest in and deploy strong digital foundations that allow us to follow an accelerated path to digital excellence.

While the last year has seen a number of significant improvements in our IT provision, we simply cannot afford to stand still and not develop our digital offer. This strategy sets out how in the next five years we will become a recognised and exemplar digital hospital where people seek employment and where patients receive digitally enabled best care.

Mark Hutchinson
Executive Chief Digital Information Officer

Digitally Enabled Best Care for Everyone

As an exemplar Digital Hospital, signified by achieving HIMSS level 6, our Trust will deliver consistently safe, reliable, high quality care in an environment that is loved by staff and reassuring to patients.

Patients treated in hospitals that make use of digital technologies to provide care will consistently have better outcomes than those treated in hospitals with a low digital maturity.

Our Trust currently has one of the lowest digital maturity levels for a trust of its size and demographic and is heavily reliant on the movement of paper to facilitate the provision of care.

HIMSS (Healthcare Information and Management Systems Society) is a non-profit international organisation whose goal is to promote the best use of IT and management systems in the healthcare industry. HIMSS have created the EMRAM (Electronic Medical Record Adoption Model) digital maturity model to enable providers of care to measure IT adoption and maturity within their organisations. Hospitals that have achieved a high HIMSS level consistently report significant reductions in medical errors, have improved readmission rates, higher operating margins, lower staffing costs, greater staff satisfaction, reductions in duplicate orders and in general have improved patient safety and the overall quality of clinical care.

As of September 2019, the Trust has a score of 0.02 out of 7. The HIMSS road map provides us with a clear strategic direction that allows the focused prioritisation of investment to ensure the optimal delivery of solutions that will enable safe, consistent, high quality care.

By providing our staff digital solutions not only will we improve the safety and reliability of care that we provide but we also improve the experience of our colleagues. At a time when we have workforce challenges, evidence supports the idea that staff have a better experience and are more inclined to move to work in hospitals that have improved digital maturity. By working digitally, supporting our colleagues with the skills to confidently embrace technology and by harnessing the rich data outputs from our solutions, we will become a leading example of a trust that provides outstanding digital care in the NHS.

STAGE	HIMSS Analytics EMRAM EMR Adoption Model Cumulative Capabilities
7	Complete EMR; External HIE; Data Analytics, Governance, Disaster Recovery, Privacy and Security
6	Technology Enabled Medication, Blood Products, and Human Milk Administration; Risk Reporting; Full CDS
5	Physician documentation using structured templates; Intrusion/Device Protection
4	CPOE with CDS; Nursing and Allied Health Documentation; Basic Business Continuity
3	Nursing and Allied Health Documentation; eMAR; Role-Based Security
2	CDR; Internal Interoperability; Basic Security
1	Ancillaries - Laboratory, Pharmacy, and Radiology/Cardiology information systems; PACS; Digital non-DICOM image management
0	All three ancillaries not installed

What does HIMSS Level 6 look like for our organisation?

Currently our Trust does not meet the requirements to tick the level one box.

HIMSS methodology means that you must complete all of the of the previous level before you can achieve the next.

This strategy will see us achieving HIMSS Level 6 in the next five years.

We will choose how we navigate through these levels according to our need, priority and investment, which may mean that our progress is not linear, however, with the right direction and strategic funding we will reach level 6 by the end of the strategy.

HIMSS 1

Trust wide, we will have:

Laboratory, Pharmacy, Radiology and Cardiology Information systems

Picture Archiving and Communication system (PACS) e.g. X-Rays, MRIs

The ability to store and manage non-Dicom images such as photographs electronically e.g. photographs of skin lesions in dermatology

HIMSS 2

Trust wide, we will have:

A single place to access all clinical information (CDR) e.g. Sunrise EPR

Systems used that demonstrate internal operability to enable all clinical information go be accessed in one place e.g. accessing infoflex, chemocare through Sunrise EPR

HIMSS 3

Trust wide, we will have:

50% of Nursing & AHP documentation captured and stored within Sunrise EPR e.g. risk assessments, progress notes, E-Observations

Medication Administration recorded electronically

Role- based access, i.e. Staff accessing Sunrise EPR will have different access rights depending on their role e.g. an HCA will not be able to prescribe medication on the system

HIMSS 4

Trust wide, we will have:

The ability for clinicians to place orders and requests electronically e.g. ordering a blood test

The order system will have support built into it to making it safer e.g. prompt a specific test if specific symptoms are recognised or query a test if a recent one is on the system

90% of Nursing & AHP documents captured and stored within Sunrise EPR

Basic business Continuity Plans in place for an EPR, e.g. including back-up data provision

HIMSS 5

Trust wide, we will have:

Doctors documentation captured electronically, using structure templates e.g. First Assessment, Ward round, Outpatients, Referral notes

Security Systems should be in place to prevent and detect intrusion or risks to the EPR

HIMSS 6

Trust wide, we will have:

Medication and products ordered and verified electronically, using barcodes and scanners e.g. medication, blood products and human milk

Barcodes used for specimen collection

Clinical decision support functionality throughout the EPR e.g. on the entering of a diagnosis a treatment regime is prompted including tests, medication and referrals needed (order sets/ treatment bundles)

EPR Security Risk Assessments in place and regularly reviewed

What does care in a HIMSS Level 6 hospital mean to patients?

Safer, More Reliable, High Quality Care

Patient perspective

The hospital staff have all of the information I need to plan my care so I don't have to tell them what has happened before.

↓

The electronic record contains all the relevant information about me, helping the staff to look after me even if they haven't met me before or have forgotten my details.

↓

The electronic system means I get the right treatment at the right time. I don't have to wait for things and because the information is shared with my GP and other people who care for me, this helps to keep me well.

↓

The system has all the right information about me, which means the team can be proactive in my care and treatment. As a result, I am very happy with my care.

↓

I am confident in the care the trust provides and hope that staff know they are doing a great job. I expect I'll be back again so I hope they liked looking after me!

What does care in a HIMSS Level 6 hospital mean to patients?

Safer, More Reliable, High Quality Care

Benefits

- All previous documentation can be seen by clinicians, including information from colleagues and clinical teams
- The Shared Care Record (JUYI) can be accessed and previously recorded medical and drug history can be seen
- Previous allergies and alerts are easy to see

↓

- When observations are taken, NEWS 2 is automatically calculated and escalated if required
- Increased care is initiated if a risk assessment outcome dictates this
- Order sets can be used as treatment bundles to ensure consistent recording of a suspected diagnosis like sepsis
- The systems calculates the correct drug dosage and interactions or allergies are highlighted

↓

- Treatment is initiated promptly in a consistent manner
- Less time is wasted whilst decisions are made and treatment is progressed
- Treatment is proactive, preventing patients deteriorating and enabling us to step in before they become more acutely unwell

↓

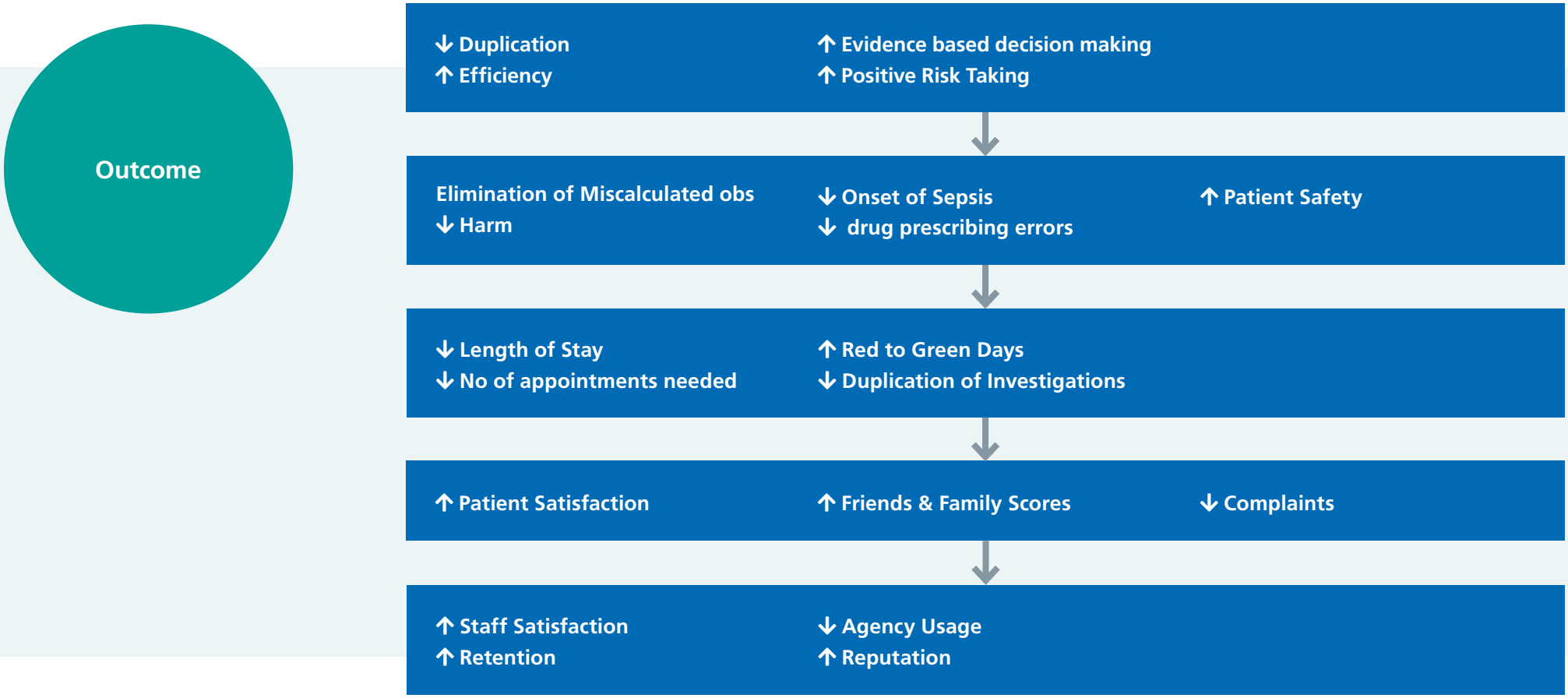
- Patients will recommend us a place for treatment
- Our reputation will be enhanced and there will be fewer complaints
- We can demonstrate how well we are caring for our patients
- Our partners and regulators have confidence in us

↓

- Staff feel positive about their work as their experience is improved
- People want to come and work for us and retention will be improved
- We have a good reputation

What does care in a HIMSS Level 6 hospital mean to patients?

Safer, More Reliable, High Quality Care



Where we are

HIMSS Level 0.02 / Good CQC rating

We have a number of disparate clinical systems that contain pockets of information but are not joined up

A large percentage of our colleagues have never worked digitally or outside this Trust

We have an old estate and the IT infrastructure is still recovering from significant long-term under-investment

We have limited ability to share our data and work collaboratively across the ICS

Multiple versions of data are stored in different locations, then processed in varying ways, producing conflicting outputs

The software that we use is largely old requires updating or replacing at a cost

We now have a stable Patient Administration System

Limited audit/ clinical data- based on pulling paper notes and interpreting them

We have a board willing to listen and embrace the benefits of digital technology

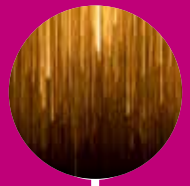
Where we are:
Experience

Where we want to get to

One place for clinicians to log into to find all of the information that they need

HIMSS level 6/ Outstanding CQC rating

Safe, Cyber secure Tools and Cyber Aware staff



Safe electronic prescribing and administration supported by technology

Staff supported to make the right decision by systems

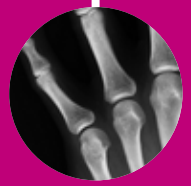
Electronic ordering of tests and requests

Connected, joined up information across the ICS

Documentation captured electronically

Paper light

All images taken are available electronically



Reliable data from digital tools and systems to inform evidence-based decision making

Confident, Competent, Safe and Aware Digital staff

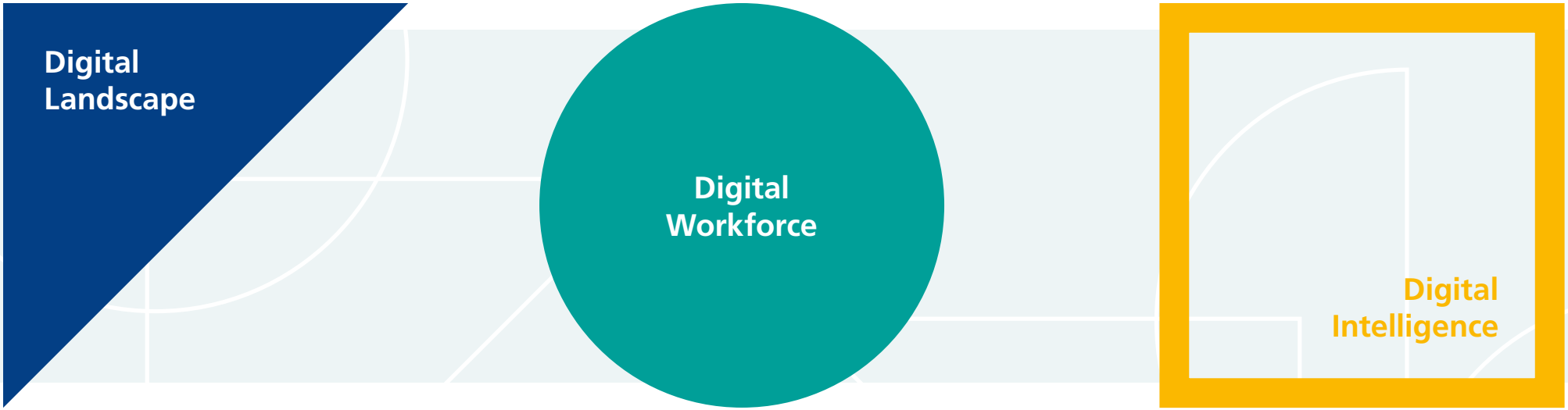
Use of data and information to proactively deliver better care

Known process for digital innovation/ ideas

We will use digital solutions for our corporate functions as well as our clinical ones

Where we want to get to:
Experience

How we are going to get there



Digital Landscape

By following the HIMSS road map, we can strategically invest in developing the solutions, tools and software to work in a connected, digital fashion.

These tools will be supported by reliable and fit for purpose hardware and an infrastructure that is resilient and professionally managed.

By strategically investing in our journey to HIMSS level 6, we will provide consistently safer and more reliable care.

Digital Workforce

From HCAs to our CEO, we will invest in all of our staff to ensure that they have the digital knowledge and skills to embrace the technology deployed within the Trust.

Digital working will become the expected normal and not an exception. By going on our journey to HIMSS level 6, we will invest and support our own staff to ensure we have a technical and specialist workforce who are skilled and able to deliver a professional support service.

Digital Intelligence

By utilising digital tools, solutions and technologies, the organisation will be in receipt of rich and vital intelligence that will allow us to proactively plan and provide our care.

This strategic period will see the Trust being able to access intelligence in a way that it hasn't before - this will allow us to evidence our patient outcomes, our activity and facilitate quality improvement and research. It will also provide assurance to regulators and external bodies in our quest for an "Outstanding" CQC rating.

Enabling Pillar: Digital Landscape

Key Initiatives

- IT Improvement
- Sunrise EPR Deployment
- Digital Transformation
- Subject to continued investment and prioritisation

Enabling Pillar: Digital Landscape

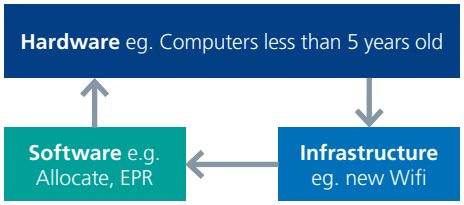
By achieving HIMSS level 6 we will provide the working environment that enables our staff to contribute towards delivering digitally enabled better care that is consistently high quality, safe and reliable.

In order to achieve HIMSS level 6, we must strategically invest in solutions that allow us to deliver foundations of digital functionality from which we can develop.

As a Trust, we have procured an EPR that we will evolve to become the one place clinicians access all of the useful information they need about patients to make timely and evidence-based decisions.

Alongside this, the optimisation of our patient administration system and commitment to improve our IT infrastructure and hardware will ensure that our colleagues can use digital tools that are resilient and reliable, allowing us to deliver timely and effective care.

We must ensure that key IT systems are professionally managed and up-to-date and that new tools procured have a future-focused approach that includes maintenance and upgrades where necessary.



Key metrics

- HIMSS Level 6: 5 years
- Deployment and development of our EPR for clinical information to support decision-making, care provision and clinical outcomes
- Optimisation of our PAS (TrakCare, InterSystems) to provide accurate and timely data
- Consistently reliable infrastructure including WiFI for patients and staff
- Up-to-date and reliable hardware for all staff to use, regardless of location in clinical areas, office spaces and the education centres
- Services and teams will be supported to explore and implement digital ways of working
- Consistently well-performing IT service desk

Key initiatives and milestones

Key initiatives	Year 1–2 milestones	Years 3–4 milestones	Year 5
IT Improvement	We will ensure our users have access to resilient and reliable fit for purpose equipment and services, to include the replacement of all fax machines, Windows 10 upgrade, Wifi upgrade We will enable cross site communication by rolling out MDT videoconferencing equipment for use across sites We will gain Cyber Essentials Accreditation	We will be able to access and store medical images and photographs electronically We will have fully deployed next generation telecoms across the Trust We will have rolled out Intrusion Prevention and Detection solutions to keep our systems safe	We will have deployed Radio Frequency Identification to aid with the management of stock and equipment We will be an exemplary Digital Hospital
Sunrise EPR Deployment	We will roll out Sunrise EPR, Nursing Documentation and Risk Assessments across the Trust We will deploy the electronic recording of e-observations and the escalation of care requirements We will enable electronic ordering for radiology and pathology tests	We will deliver Electronic Prescribing across the Trust (commencing Yr 2) We will have paper lite outpatients across all specialties ED and Maternity will be utilising clinical functionality within Sunrise EPR We will have interfaced all key clinical systems through Sunrise EPR	Sunrise EPR is the one place that clinicians go to surface information about patients Full closed-loop prescribing that allows the process of prescribing to administration to be facilitated digitally.
Digital Transformation	There will be a digital element across all Trust wide transformation projects. Defined process for staff and patients to raise ideas and opportunities We will agree principles for the development of our estate to ensure refurbished areas and new build projects are digitally fit for purpose.	Digital Transformation will be consistently represented across the QI Academy and projects	Staff and patients recognise GHNHSFT as a Digital Hospital Digital solutions are routinely considered at the beginning of all transformation programmes

Enabling Pillar: Digital Workforce

Key Initiatives

- Confident and competent staff
- Skilled and Professional Specialists
- Digital Leaders
- Subject to continued investment and prioritisation

Enabling Pillar: Digital Workforce

As a Trust we will support and empower our staff to understand the opportunity of digital ways of working.

We will encourage and support them to explore digital ways of working and support them to confidently and competently use the solutions and technologies we deploy.

By utilising Sunrise EPR and digital tools, staff will improve the efficiency and quality of their work, utilising technology to add value within their day-to-day roles.

We will develop our Digital and Information workforce so that they have the skill and ability to provide a professional service to our colleagues and patients across the trust.

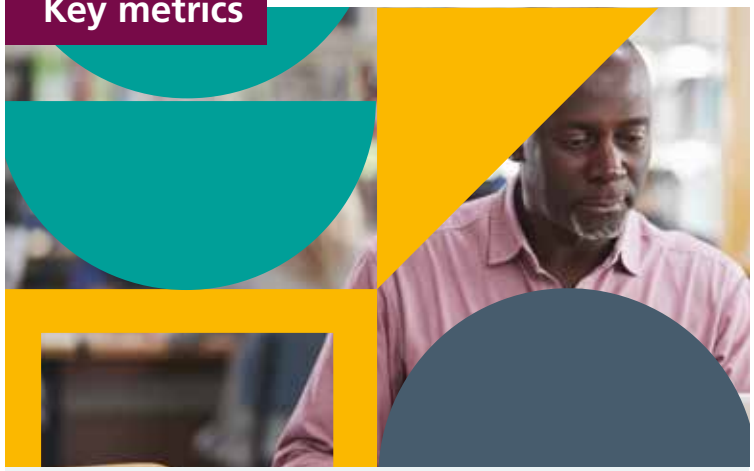
We will ensure our leaders understand the art of the digitally possible and understand why it is pivotal to delivering safe, reliable, high quality care.

We will embed digital skill requirements in all roles so that potential staff and existing staff understand our commitment and aspirations to excel digitally.

We will ensure that line managers are as committed to supporting digital development as they are other aspects of day-to-day work. We will embed digital self assessment into our annual staff reviews so that staff can have conversations about their needs and line managers can support development. We will ask staff how they feel about GHFTs digital journey by incorporating specific questions into the Staff Survey, providing us with rich and essential feedback that will enable us to address the needs of our colleagues. We will support our digital, IT and informatics teams to develop and make the most of opportunities provided by the ICS, local education facilities and the partners keen to support our digital journey.

In addition to this, we will continue to educate the leaders within the Trust about why investing and prioritising our digital journey is an important and fundamental requirement to being able to deliver safer, reliable and reactive, high-quality care.

Key metrics



- Positive response from staff survey
- Annual capture of staffs' digital skill development needs or opportunities with % compliance
- Development of digital super user coaching network
- Satisfactory IG and cyber aware training
- Improved staff retention within Digital and IM&T areas
- Delivery of digital leadership training (Board, Exec and TLT level)

Key initiatives and milestones

Key initiatives	Year 1–2 milestones	Years 3–4 milestones	Year 5
Confident and Competent Staff	We will embed a review of digital ability within the annual 'my development conversation' We will assess staff confidence via the NHS Staff survey for the first time and establish a baseline We will develop a digital super user programme We will work alongside ICS colleagues to deliver a joined-up approach to improving digital literacy	We will develop or adopt a digital self-assessment tool for all staff to use to enhance their annual 'my development conversation' We will continue the development of the super user programme to align coaching, mentoring and onward educational opportunities where possible We will have a network of super users and experts that are regularly involved in Sunrise EPR development	All new job descriptions will have a digital expectation embedded to support the Trust's desire to be a digitally enabled hospital We will have staff that are keen to embrace new digital ways of working and innovation
Skilled and Professional Specialists	We will participate in the ICS Countywide Clinical Informatics development programme We will ensure all Individual Digital/ IM&T teams' journeys to outstanding are refreshed to ensure teams support the delivery of a reliable and professional corporate service	We will develop divisional CCIOS and CNIOs to support strategic development of digital tools and solutions to deliver better care and improve care outcomes We will achieve Three-Star IT Service Desk accreditation to demonstrate professional standards achieved	We will be a Trust that people actively seek employment to work with our digital tools to deliver digitally enabled care
Digital Leaders	We will deliver Executive and Board level Digital Leadership sessions We will be part of the delivery and collaborative work delivered by the Countywide ICS Digital Strategy	We will have a leadership team that have an understanding of the importance of becoming a HIMSS level 6 Trust and the benefit that it will bring our patients and staff	We will have a board and Trust Leadership Team who are fully committed to the continued importance of digital technology

Enabling Pillar: Digital Intelligence

Key Initiatives

- Reliable Reporting
- Culture of Data Quality
- Turning Data into Intelligence
- Subject to continued investment and prioritisation

Enabling Pillar: Digital Intelligence

By using open source, appropriate digital tools, we will be able to surface and utilise rich data that will help us analyse our performance, our activity and share information with our partners.

GHFT will be a trust that can proactively plan services based on real time, accurate data. In addition to this we will be able to evidence and demonstrate the reliable, consistent, high quality nature of our care.

By adopting digital technology and tools we will be producing rich, high quality intelligence that can be used to proactively feed our service delivery. We will have an accurate picture of our performance, our outcomes and our activity. This data can be made readily available to colleagues both within our Trust and across the ICS/ wider organisations that may benefit from having access.

The ability to harness intelligence provides research and audit opportunities that allow us to continually evaluate and improve our care. By utilising data and intelligence, we will be able gain further momentum on our successful quality improvement journey and further contribute to the Trust's increasing research agenda. This will provide rich intelligence across the Trust, the ICS and the national agenda, improving our population health management ability.

Key metrics

- Clinical Audit performance
- Increased number of digitally enabled QI projects
- Real time ADT and data feeds to ICS tools
- Accurate and reliable analysis and data modelling to inform operational, activity and financial measurements
- Reduction in data quality issues
- Quality assurance to regulators and inspectors about our delivery of care
- Compliance of statutory and mandatory reporting
- Data sharing across the ICS

Key initiatives and milestones

Key initiatives	Year 1–2 milestones	Years 3–4 milestones	Year 5
Reliable Reporting	We will implement standardised reporting solution across the organisation We will utilise new Sunrise EPR functionality to gather reliable clinical information to measure our performance, quality and outcomes	We will have 'One version of the Truth' from a data perspective across the organisation, capturing data once and using for multiple reporting purposes We will deliver full patient pathway reporting across multiple service areas	Sunrise EPR data is utilised to proactively review and continuously improve service delivery We are respected and acknowledged for our ability to evaluate clinical information from an audit, research and assurance perspective
Culture of Data Quality	Development of business as usual data quality team We will deliver a new and refreshed Data Quality Strategy We will continue the optimisation of TrakCare	We will embed data quality adherence into divisional reviews to ensure leaders are aware of the impact of data quality issues and potential variation We support research staff by providing them with access to a multitude of rich intelligence	All staff will be proud of the data quality culture that they are a part of and understand their role in this
Turning Data into Intelligence	All Business Intelligence analysts will be trained to make full use of the data using statistical approaches and modelling techniques We will ensure digital tools (statistical packages, mapping and simulation software) are up-to-date and available. Movement to a population health approach to analytics, ensuring intelligence can be moved into actions	We will become affiliated with academic facilities to ensure best practice approaches to analysis can be maintained	We will proactively use our intelligence to plan, mould and evaluate our services, allowing us to continually improve, feeding into Trust and ICS plans We will provide intelligence to inform our countywide population health programme to best deliver services for the citizens of Gloucestershire

NHS
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Digital Strategy

V3, October 2019

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD – JANUARY 2020

From Estates and Facilities Committee Chair – Mike Napier, Non-Executive Director

This report describes the business conducted at the Estates and Facilities Committee held 13 January 2020, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Matters Arising	Outstanding action on control of medical devices.	Do we have an effective means to control this critical and valuable category of equipment?	At present: No. Action taken up by COO to work with Trust executives to address this.	Matter will be taken up by Audit and Assurance Committee to gain assurance that a solution will be implemented.
GMS Chair's Report	GMS senior management have been holding talks with representatives from Unite and Unison trade unions, with a joint meeting with ACAS on 6 January. The dispute is around the new GMS terms and conditions.	The unions plan to ballot their members on possible industrial action.	GMS Board and management are monitoring the situation and continue to engage with the unions to seek a resolution.	This will be an ongoing issue for the next few months. Any industrial action is very unlikely before early Summer, due to due process and timescales. Updates will be provided to Committee.
	There is a forecast negative variance for GMS financial out-turn as a result of the overspend on cleaning (see below).	Is this being monitored by the Trust? How does it impact the Trust's financial position?	There is ongoing dialogue between the two finance teams. The variance will be recorded at the Group level.	This variance will be monitored by the Finance and Digital Committee.
GMS Contract Management Group (CMG) Report	CMG received the latest performance report, with KPIs, from GMS. Cleaning in High Risk areas remains below standards.	What is being done to address the cleaning issue?	GMS are working with Infection Control on agreed actions to bring cleaning back up to contracted levels. Assurance is taken through reports to Infection	GMS and the Trust are reviewing the cleaning standards, and the time required to meet contractual standards. ICC, CMG, DOG and TLT are providing scrutiny

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
			Control Committee (ICC), up to the Quality and Performance Committee. Additional agency resources are being deployed while recruitment to substantive posts is being undertaken. A co-commissioned external audit on cleaning had be completed in December 2019 and will be reported to CMG and Committee	and assurance. A new Cleaning risk has been added to the Trust Risk Register with an overall score of 16.
	Maintenance and repair of urgent faults KPI was below KPI standard.	Is this a declining trend or a "blip" in performance?	There had been a sharp increase in reactive maintenance which had taken priority. Assurance is sought via the CMG to Committee. Latest KPI data now shows improvement.	
	A site-based risk assessment had been carried out in October on security arrangements. A number of proposals had been made to reduce the number of non-clinical assaults.	Will the proposals be effective? What are the costs and can the Trust allocate funds to cover?	The Security Management Group has been re-established to oversee implementation of the Security Implementation Programme, to be overseen by the CMG. Funds have been identified and earmarked for this project.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Strategic Site Development Programme	Outline Business Case is being written at present and the plan is to present it to the Finance & Digital Committee on 30 January and the full Board in February.	The risk around the public linking this development to the Fit for the Future is possibly underscored?	The Strategic Site Development is not dependent on the Fit for the Future outcomes – it is future-proofing the Estate and will accommodate whatever the outcome of FFTF. The Citizens' Jury to sit later this month will provide good feedback on how big an issue this might be.	
Management of Clinical Waste	A paper was received on how the Trust currently handles clinical waste into three streams: Incineration, Alternative Treatment, Offensive Waste (which currently goes to landfill). The Trust currently complies with all statutory requirements, although more than is desired is going to landfill.	How can the amount going to landfill be reduced, or eliminated?	There is currently a limitation on the ability of current suppliers, and the Trust/GMS remain in dialogue with NHSE and procurement to improve the situation.	
Climate Emergency – Next Steps	The Trust's Board declared a Climate Emergency at its meeting on 19 December 2019. This update briefed Committee on the steps taken to date, which includes another "Big Green Conversation" on 20th Dec, a review of actions taken so far	Is our overall target of becoming Carbon Neutral by 2050 ambitious enough?	The CERG will work with Gloucestershire County Council, who are considering an earlier date to become Carbon Neutral. The Trust will aim to match their target date. The CERG's terms of	Committee will receive the Management Plan, progress reports and exception reports from the CERG.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	and of plans and targets going forward. A new Climate Emergency Response Group (CERG) has been established to develop and implement the Trust's Sustainable Development Management Plan.		reference were received and endorsed by Committee.	

Mike Napier
Chair of Estates and Facilities Committee
14 January 2020

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD – FEBRUARY 2020

From Audit and Assurance Committee Chair – Claire Feehily, Non-Executive Director

This report describes the business conducted at the Audit and Assurance Committee on 7 January 2020, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Counter-Fraud Progress Report	Cttee commended a detailed update on Counter-Fraud progress, including: - Awareness campaign and induction events with staff - Participation in nursing programme at Uni. Of Gloucestershire - Improved uptake of e-learning package - Good response to Annual Counter-Fraud survey - Memo of Understanding with Gloucestershire Constabulary - Work to review compliance with Conflicts of Interest policy esp re	Is there optimum cross-ICS cooperation in Counter-Fraud activity?	Yes, a very high standard of countywide cooperation.	

	pharmaceuticals.			
Internal Audit (IA) Progress Report **IA Report: Consultant Job Planning**	Good progress reported against 2019/20 Audit Plan. Early thinking on 2020/21 Moderate level of assurance re design and effectiveness of controls. 96% of job plans reviewed and 85% signed off.	Is it the intention that all Divisions will eventually be examined in the audit plans? (Medicine planned for 20/21.)	Yes, there will be a rolling programme of coverage.	
GMS Audit Report	Discussion concerning reporting requirements between Group Audit and Risk and GMS' own Audit deliberations. Important to provide sufficient assurance as to completeness and appropriacy of subsidiary's audit arrangements, while not overlapping with work of Estates and Facilities Cttee. Some key touch points will include eg how Trust is to be sighted on GMS Audit Plan.			Further discussions to take place to develop proposals for improved arrangements to be adopted by Trust and GMS Boards.
External Audit arrangements	Discussion outside Cttee to review end-of-year arrangements and to derive assurance re confidence in planned timetable and resource levels.	Series of questions as to adequacy of resources; quality of dialogue with Trust Finance team; escalation arrangements in event of any difficulties or slippage.		

Claire Feehily, Chair of Audit and Assurance Committee, January 2020.

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – FEBRUARY 2020
Lecture Hall, Redwood Education Centre, GRH commencing at 12:30

Report Title
TRUST STATEMENT ON MODERN SLAVERY
Sponsor and Author(s)
Author: Sim Foreman, Trust Secretary Sponsoring Director: Emma Wood, Deputy CEO and Executive Director of People
Executive Summary

Purpose

To provide an update on the Trust statement on Modern Slavery.

Key issues to note

There is a mandatory requirement for the Trust to have a public statement by the Board on our recognition of and work towards compliance with the Modern Slavery Act (2015) (the Act).

The statement must be updated each financial year to reflect the organisations' ongoing commitment to its aims and requirements.

The Board approved the statement for the period to the end of March 2018 in November 2018 and this was published on the Trust's website.

The Trust Secretary has followed up with relevant leads in Safeguarding, Procurement and HR to understand whether any additional measures or arrangements have been introduced to strengthen the Trust's approach to combatting and eradicating modern slavery.

The Safeguarding Lead confirmed that there have been some (non-confirmed) referrals related to suspected slavery and trafficking affecting patients raised by staff. However these are a low proportion of the overall safeguarding incidents. All of the referrals were escalated and reported to the National Helpline for Modern Slavery.

Next Steps

The Trust Secretary will have further conversations with colleagues in the Trust to seek assurance on the work and controls in place across the organisation to support and promote compliance with the Act.

It is proposed that the annual review of the Modern Slavery statement be brought forward closer to the year-end reporting period covered i.e. April or May for the year ending in March.

Recommendations
The Board is asked to NOTE the ongoing work taking place across the Trust to ensure that slavery and human trafficking is not taking place in any of its supply chains, and in any part of its own business and to APPROVE the updated statement.
Impact Upon Strategic Objectives
Identification and eradication of modern slavery links to Outstanding Care (for patients), Compassionate Workforce (through safeguarding and training) and Effective estate (linked to the human and socio-

economic elements of the supply chain).

Impact Upon Corporate Risks

Failure to meet and fulfil duties related to modern slavery could impact on ethical and reputational risk.

Regulatory and/or Legal Implications

The Trust has statutory duties and responsibilities under the Modern Slavery Act 2015 and failure to update the statement would be a breach of these.

Equality & Patient Impact

Applicable to the extent of providing public, patient and staff assurance about the Trust's practices and to ensuring patients suspected of being subjected to modern slavery are provided with the appropriate care, support and protection.

Resource Implications

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

Action/Decision Required

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

Date the paper was presented to previous Committees and/or Trust Leadership Team (TLT)

Audit & Assurance Committee	Finance & Digital Committee	Estates & Facilities Committee	People & OD Committee	Quality & Performance Committee	Remuneration Committee	Trust Leadership Team	Other (specify)
			16 Dec 2019				

Outcome of discussion when presented to previous Committees/TLT

The People and OD Committee NOTED the update and ENDORSED the statement for Board approval.

Gloucestershire Hospitals
NHS Foundation Trust

TRUST STATEMENT ON MODERN SLAVERY

We fully support the Government's objectives to eradicate modern slavery and human trafficking.

Modern slavery is the recruitment, movement, harbouring or receiving of children, women or men through the use of force, coercion, abuse of vulnerability, deception or other means for the purpose of exploitation. Individuals may be trafficked into, out of or within the UK, and they may be trafficked for a number of reasons including sexual exploitation, forced labour, domestic servitude and organ harvesting.

The Trust (GHNHSFT) fully supports the Government's objectives to eradicate modern slavery and human trafficking and recognises the significant role the NHS has to play. We are strongly committed to ensuring our supply chains and operational activities are free from ethical and labour standards abuses.

Slavery and human trafficking statement for financial year 2018/19

During the last financial year the Trust took, and continues to take, the following steps to ensure that slavery and human trafficking is not taking place:

- We confirm the identities of all new employees and their right to work in the United Kingdom
- All staff are appointed subject to references, health checks, immigration checks and identity checks. This ensures that we can be confident, before staff commence duties, that they have a legal right to work within our Trust
- We have a set of values and behaviours that staff are expected to comply with, and all candidates are expected to demonstrate these attributes as part of the selection process
- By adopting the national pay, terms and conditions of service, we have the assurance that all staff will be treated fairly and will comply with the latest legislation. This includes the assurance that staff received, at least, the national minimum wage from 1 April 2015
- We have various employment policies and procedures in place designed to provide guidance and advice to staff and managers but also to comply with employment legislation
- Our equality and diversity, grievance, respect and dignity at work for staff policies additionally give a platform for our employees to raise concerns about poor working practices
- Our policies and practices promote and support diversity and inclusion both as an employer and service provider; we recognise and acknowledge that diversity and inclusion are key corporate social responsibilities and a Diversity Network for all staff has been in place since 2017
- Our mandatory safeguarding training includes modern slavery as a topic; all clinical staff receive training as part of our Trust bespoke level 2 safeguarding adult e-learning training and also level 3 safeguarding adult training
- Our Trust "Safeguarding Adult at Risk Policy", and the countywide multi-agency safeguarding policy, to which our Trust is a partner signatory, also includes modern slavery and we have produced communications materials to raise awareness amongst staff and anyone working on or otherwise attending our sites
- Our Freedom to Speak: Raising Concerns (Whistleblowing) Policy gives a platform for employees to raise concerns for further investigation, and our Freedom To Speak Up Guardian and Safeguarding teams actively ensure they are accessible to staff
- Our standard terms and conditions require suppliers to comply with relevant legislation. A large proportion of the goods and services procured are sourced through Government supply frameworks and contracts also require suppliers to comply with relevant legislation

Review of effectiveness

We intend to take further steps to identify, assess and monitor potential risk areas in terms of modern slavery and human trafficking, particularly within supply chains. We aim to:

- Raise awareness and support our staff to understand and respond to modern slavery and human trafficking, and the impact that each and every individual working at our Trust can have in keeping present and potential future victims of modern slavery and human trafficking safe
- Ensure that all staff continue to have access to training on modern slavery and human trafficking which will provide the latest information and the skills to deal with it
- Embed Social Value best practice into commercial processes which will achieve improved Social Value awareness and compliance across all our commercial activities
- Impact assess all new or reviewed policies for diversity and inclusion compliance

The Board of Directors has considered and approved this statement and will continue to support the requirements of the legislation.

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes our slavery and human trafficking statement for the financial year ended 31 March 2019.

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – 13 FEBRUARY 2020
Lecture Hall, Redwood Education Centre, GRH commencing at 12:30

Report Title
Guardian Report on Safe Working Hours for Doctors and Dentists in Training – 1 August 2019 to 31 October 2019

Sponsor and Author(s)
Author: Dr Simon Pirie, Guardian for Safe Working Sponsor: Prof Mark Pietroni, Director of Safety and Medical Director

Executive Summary
Purpose This report covers the period of 1 August 2019 to 31 October 2019 Key issues to note There were 183 exception reports logged, increased from 104 the previous quarter. There were no fines levied. No correlation with Datix clinical incident reports for this period. Conclusions The number of exceptions has increased this quarter, but no fines were levied. Implications and Future Action Required N/A

Recommendations
The Junior Doctors' forum is functioning well and has agreed to fund several initiatives to improve training and development for our trainees.

Impact Upon Strategic Objectives
N/A

Impact Upon Corporate Risks
N/A

Regulatory and/or Legal Implications
Under the 2016 Terms and Conditions of Service (TCS) for Junior Doctors, the Trust provides an exception reporting process for working hours or educational opportunities that vary from those set out in work schedules. The Guardian oversees exception reports and assures the board of compliance with safe working hour's limits.

Equality & Patient Impact
N/A

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

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

Gloucestershire Hospitals
NHS Foundation Trust

PUBLIC BOARD – 13 FEBRUARY 2020

QUARTERLY GUARDIAN REPORT ON SAFE WORKING HOURS FOR DOCTORS AND DENTISTS IN TRAINING – 1 AUGUST 2019 TO 31 OCTOBER 2019

1. Executive Summary

1.1. This report covers the period of 1 August 2019 to 31 October 2019. There were 183 exception reports logged; compared to 104 in the last quarter.

1.2. This quarter, no fines were levied.

2. Introduction

2.1. Under the 2016 Terms and Conditions of Service (TCS) for Junior Doctors, the Trust provides an exception reporting process for working hours or educational opportunities that vary from those set out in work schedules. The Guardian oversees exception reports and assures the board of compliance with safe working hour's limits. The Terms and conditions have been updated in 2019, with further requirements being monitored.

2.2. The structure of this report follows guidance provided by NHS Employers.

High level data

Number of doctors / dentists in training (total):	369
Number of doctors / dentists in training on 2016 TCS:	369
Amount of time available in job plan for guardian:	2PA
Administrative support:	4Hrs
Amount of job-planned time for educational supervisors:	0.25/0.125 Pas
	(first/additional trainees to maximum 0.5 SPA)

3. Junior Doctor Vacancies

Junior Doctor Vacancies by Department					
Department	**F1**	**F2**	**ST1-2**	**ST3-8**	**Additional training and trust grade vacancies**
ED	**0**	**0**	0	0	**2x Specialty Dr**
Oncology	**0**	**0**	0	0	**1x Clinical fellow**
T&O	**0**	**0**	5	1	
Surgery	**0**	**1**	0	0	**Ophthalmology - 1 ST1**
General Medicine	**0**	**1**	5	2	**Rheumatology - 1 Spec Dr** **Gastro - 1 Spec Dr and 1 Locum Dr** **Dermatology – 1 Clin fellow, 1 Assoc spec, 1 Staff Grade** **Cardiology – 2 Clin fellows**
Paeds	**0**	**0**	0	0	
Obs & Gynae	**0**	**0**	0	1	

4. Locum Bookings

4.1. Data from the Finance team:

Total spend Aug ’19 – Oct ‘19 on Junior Medical Locum £866,809

5. Exception Reports (working hours)

Specialty	Exceptions raised
General/GI Surgery	28
Urology	3
Trauma/ Ortho	1
ENT	0
Vascular Surgery	0
Ophthalmology	23
Orthogeriatrics	7
General/old age Medicine	60
Cardiology	8
Respiratory	4
Gastro	0
Neuro	8
Renal	6
Endocrine	3
Acute medicine/ ACUA	10
Emergency Department	0
Obstetrics and Gynaecology	0
Paediatrics	2
Anaesthetics	0
Oncology	13
Haematology	7
GP	0
Total	**183**

6. Fines this quarter

6.1. There were NO fines this quarter.

7. Issues arising

7.1. Three reports were listed as 'immediate safety concerns', however, on discussing with teams and reviewing the information in the reports, there were no actual immediate safety concerns identified.

8. Actions taken to resolve issues

8.1. Immediate potential safety concerns were addressed by contacting the trainee or team to clarify the circumstances.

9. Correlations to clinical incident reporting

9.1. There were no Datix reports of harm noted that correlated with dates of exception reports submitted during this quarter.

10. Junior Doctors' Forum

10.1. The Junior Doctor's forum meets every other month. The forum has agreed to fund new laptops for QI/audit projects in this quarter. Also, some funds have been allocated to the wellbeing peer group and to a bookings app which can be used to access education from the training fellows, thus broadening access to education for our trainees.

11. Summary

11.1. A total of 183 working hours exception reports have been made since the beginning of August 2019 to end October 2019; this is an increase from last quarter. No fines were levied during this quarter.

Author: Dr Simon Pirie, Guardian of Safe Working Hours
Presenter: Prof Mark Pietroni, Director of Safety and Medical Director