GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

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

(PLEASE NOTE DATE AND VENUE FOR THIS MEETING)

Peter Lachecki
Chair

September 2019

AGENDA

				Approximate Timings
1.	Welcome and Apologies			12:30
2.	Declarations of Interest			
3.	Patient Story			12:31
4.	Minutes of the meeting held on 11 July 2019	**PAPER**	**For Approval**	13:00
5.	Matters Arising	**PAPER**	**For assurance**	13:02
6.	Chief Executive's Report	**PAPER** (Deborah Lee)	**For information**	13:04
7.	Board Assurance Framework	**PAPER** (Emma Wood)	**For assurance**	13:14
8.	Trust Risk Register	**PAPER** (Emma Wood)	**For assurance**	13:24
9.	Quality and Performance:			13:30
	- Assurance Report of the Chair of the Quality and Performance Committee - meeting held on 31 July 2019 & 28 August 2019	**PAPER** (Alison Moon)	**For assurance**	
	- Quality and Performance Report	**PAPER** (Steve Hams, Rachael de Caux, Mark Pietroni)	**For assurance**	
	- Guardian report on Safe Working Hours for Doctors and Dentists in Training	**PAPER** (Mark Pietroni)	**For assurance**	
10.	Finance and Digital:			13:50
	- Assurance Report of the Chair of the Finance and Digital Committee - meeting held on 25 July 2019 & 29 August 2019	**PAPER** (Rob Graves)	**For assurance**	
	- Financial Performance Report	**PAPER** (Sarah Stansfield)	**For assurance**	

11.	People and Organisational Development:			14:00
	- Assurance Report of the Chair of the People and Organisational Development Committee - meeting held on 19 August 2019	**PAPER** (Balvinder Heran)	**For assurance**	
	- People and Organisational Development Report	**PAPER** (Emma Wood)	**For assurance**	
12.	Audit and Assurance:			14:10
	- Assurance Report of the Chair of the Audit and Assurance Committee – meeting held on 2 July 2019	**PAPER** (Claire Feehily)	**For assurance**	
13.	Assurance Report of the Chair of the Estates and Facilities Committee – meeting held on 8 July 2019 & 3 September 2019	**VERBAL** (Rob Graves)	**For assurance**	14:15
14.	Annual Safeguarding Reports - Safeguarding Adults - Safeguarding Children	**PAPER** (Steve Hams)	**To Receive & Discuss**	14:20
15.	Infection Control Annual Report	**PAPER** (Steve Hams)	**To Receive & Discuss**	14:30
16.	Minutes of the meeting of the Council of Governors held on 19 June 2019	**PAPER** (Peter Lachecki)	**For information**	14:40
	Governor Questions			
17.	Governors' Questions – A period of 10 minutes will be permitted for Governors to ask questions			14:45
	Staff Questions			
18.	A period of 10 minutes will be provided to respond to questions submitted by members of staff			14:55
	Public Questions			
19.	A period of 10 minutes will be provided for members of the public to ask questions submitted in accordance with the Board's procedure.			15:05
20.	New Risks Identified	**VERBAL** (All)		15:15
21.	Items for the Next Meeting	**VERBAL** (All)		
22.	Any Other Business			15:20
	Close			**15:30**

COMPLETED PAPERS FOR THE BOARD ARE TO BE SENT TO THE CORPORATE GOVERNANCE TEAM NO LATER THAN 17:00 ON TUESDAY 3 SEPTEMBER 2019

Date of the next meeting: The next meeting of the Main Board will take place on **Thursday 10 October 2019** in the **Cabinet Suite, Shire Hall** at **12:30**

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

Board Members

Peter Lachecki, Chair

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

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE TRUST BOARD HELD IN THE LECTURE HALL, SANDFORD EDUCATION CENTRE, CHELTENHAM GENERAL HOSPITAL ON THURSDAY 11 JULY 2019 AT 12:30

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

PRESENT	Peter Lachecki	PL	Chair
	Deborah Lee	DL	Chief Executive
	Lukasz Bohdan	LB	Director of Corporate Governance
	Rachael De Caux	RD	Chief Operating Officer
	Steve Hams	SH	Director of Quality and Chief Nurse
	Mark Hutchinson	MH	Chief Digital and Information Officer
	Simon Lanceley	SL	Director of Strategy and Transformation
	Mark Pietroni	MP	Director of Safety and Medical Director
	Sarah Stansfield	SS	Director of Finance
	Emma Wood	EW	Director of People and Organisational Development and Deputy Chief Executive
	Claire Feehily	CF	Non-Executive Director
	Rob Graves	RG	Non-Executive Director
	Balvinder Heran	BH	Non-Executive Director
	Alison Moon	AM	Non-Executive Director
	Mike Napier	MN	Non-Executive Director
IN ATTENDANCE	Suzie Cro	SC	Deputy Director of Quality
	Anne Davies	AD	Governor
	Marie-Annick Gournet	MAG	Associate Non-Executive Director
	Jill Hall	JH	Interim Head of Corporate Governance
	Bilal Lala	BL	Associate Non-Executive Director
	Craig Macfarlane	CM	Head of Communications and Marketing
	Suzanne White	SW	PA to Chief Operating Officer

The Chair welcomed all to the meeting with a special introduction to Dr Mark Haslam, Consultant in Anaesthesia and Intensive Care Medicine, Ian Mean, Chairman Organ Donation Committee, Kate Hurley, Specialist Nurse Organ Donation and 3 members of staff.

161/19 DECLARATIONS OF INTEREST **ACTIONS**

There were none.

162/19 PATIENT STORY

SC introduced Jill Hall who shared her inspiring story of how she turned the tragic death of her son into hope and joy through the gift of organ donation. JH said she has always been a strong believer in organ donation but had no idea that her personal experience would change her life forever. JH presented a film that told her story and the story of organ donation from the mother's side. JH asked everyone to see that through the gift of giving you get so much more back. Link to the video below:

Jill's story

PL thanked JH for sharing her story.

163/19 ORGAN DONATION ANNUAL REPORT

PL asked MP to introduce the Organ Donation Annual Report.
MP highlighted the excellent performance of the team and introduced the team,

Ian Mean, Chairman of the Organ Donation Committee, Dr Mark Haslam and Specialist Nurse Kate Hurley. Dr Haslam explained that he has been involved in organ donation since 2009. The figures submitted to the Board this year represent the hard work of the nursing team on both sites supported by Specialist Nurses and consultants. Everybody who is considered to be a potential donor is referred. The number of patients who become donors is very low but all potential donations are identified and Specialist nurses are available during the whole process to support families in their decision making.

One third of families who say no to organ donation later regret their decision.
The national consent rate is 70% and Gloucestershire are leading the way with 80% consent rate. IM confirmed there is good community engagement with 58% of approximately 633,000 people signed up to the organ donation register and the national average is 34%. The success is due to a change in culture in the team that now has total focus from both nursing and medical teams.

There is a new campaign 'Pass it On' being launched at the end of the year. £18m has been spent in Wales on a media campaign so we need to leverage everything locally and get as much advertising as possible, for example, posters on buses. IM advised that there is a greater need to target older people to become organ donors and the other challenge is the Muslim community but there is now a Muslim representative on the Committee to help with this. There is also a Sub Committee and IM said that one member of this Committee is the longest surviving heart transplant patient in the world.

KH highlighted the key challenges of the new legislation.
There is a campaign for an opt-in system named 'Deemed Consent' also known as *Max and Keira's Law* after two young children, Max who received a heart transplant and Keira who donated her heart. It was given royal ascent in March 2019 and has gone through public engagement and guidance documents are in progress for implementation in Spring 2020. This would mean that if patients have neither opted in nor opted out on the organ donation register or not discussed their wishes with their families then patients in these circumstances they will be deemed a donor. KH said it is important that we continue to carry on with good practice and refer all patients so the Specialist Nurses who are upskilled in this area to start the conversation early. Staffing has been challenging but the team will have a second Specialist Nurse in post at the end of the year. IM thanked the Chair and Chief Executive for their personal support and visibility in this area.

PL thanked JH and the team for taking time to come to talk to the Board and asked anyone for comments.

In response:

- RD thanked JH for her story and asked if she had any contact with her son's donor recipients. JH confirmed she remains in contact with 2 of the recipients and said it was a comfort to hear how they are living their lives through her loss.
- DL commented on the emphasis JH placed on the care given to her son and asked if the team had any reflections that could enhance the care that they give; KH reassured the Board that this is absolutely the same level of care provided to patients at the Trust.
- MN stated that he did not think the name 'Pass It On' Campaign was very inspiring. KH explained that the campaign is about not only passing on your organs but also your wish or choice that you want to do so and passing on the message to everyone else and sharing on social media and that it was in fact being very well received by most. JH commented that many of her son's friends signed up to the organ donation register

which was very comforting to her. IM has been asked to become involved in the marketing of this campaign in the region.
- RD asked if patients' families were against the decision how is this discussed. KH said it is key not to discuss organ donation too early in the process when supporting families and discuss with families how they feel about the process and to ensure they understand the process.
- JH asked how tissue donation is promoted. MH said tissue donation is a major issue and there is a separate tissue donation service. The Trust run organ donation and tissue donation as a 'package' and discuss both. JH highlighted that there is not enough in the press about tissue donation. Nurses are encouraged and upskilled to be able to speak to families about potential tissue donation. JH said it is important to communicate that this is not a grotesque process that can put families off.

PL again thanked the team.

164/19 MINUTES OF THE MEETING HELD ON 13 JUNE 2019

RESOLVED: That the minutes of the Board meeting held on 13 June 2019 be agreed as a correct record and signed by the Chair subject to the following amendments:

- Page 5, item 151/19 Quality and Performance Committee Assurance Report, AM advised that there is limited assurance on the outstanding alert due and limited assurance that the system had changed enough.
- Page 6, item 151/19 Quality and Performance Report - EW advised that the comment on dementia metric poor performance where the Trust had changed the medical staff form should read medical 'clerking' form.
- Page 7, item 151/19 Learning From Patient Stories – the PALS team were moving from strength to strength and not 'form' strength to strength.

165/19 MATTERS ARISING

JUNE 2019 – 149/19 CHIEF EXECUTIVE'S REPORT – PL HAD HEARD THAT THE NHSI CAPITAL REVIEW WOULD NOW NOT BE PART OF THE AUTUMN SPENDING REVIEW.
Ongoing: SS agreed to check that exploring alternative routes to capital was on the work plan of the Finance and Digital Committee.

Regarding exploring alternative routes to capital, SS thought this was now located in the Estates and Facilities Committee but MN advised that the Estates and Facilities Committee would pick up the property aspects as part of the Estates Strategy and if there are opportunities or implications for partnerships but not the overarching piece. It was agreed it should be managed via the Finance and Digital Committee. SS agreed to check on the work plan.

166/19 CHAIR'S UPDATE

PL asked for comments on the Chair's update and there were none.

167/19 CHIEF EXECUTIVE'S REPORT

DL presented the Chief Executive's Report to the Board and highlighted that the Strategic Objectives were 'soft' launched at the 100 Leaders session last week and wanted to take the opportunity to formally launch them as part of the public meeting today through the graphic that CM and the communication team

had put together. The Board watched the video-graphic.

In response to the Chief Executive's Report:

- AM congratulated the Board on the TrakCare upgrade which took place on the 1st and 2nd July. MH gave a brief update and advised that the upgrade was successful with only a couple of blips on the first day, one of which was ED discharge summaries going out a few hours late but very few issues that mainly went unnoticed. He noted that limited testing had been done with regards to the reporting and the team has put in a lot of work over the last week to validate the reports both internal and external which have now been signed off this week. MH has confidence in his team who can now report safely and being able to report RTT and other national reporting requirements. MP also thanked MH as a lot of hard work had been done overnight with no issues.

5 YEAR STRATEGIC PLAN 2019-2024

SL reminded the Board of the context for the launch which is the culmination of the Trust's Five year Strategic Plan which sets out an ambitious yet achievable programme to transform hospital services and provide care for the next generation of patients at Gloucestershire Royal Hospital, Cheltenham General Hospital and Stroud Maternity Unit. The plan is called *Our Journey to Outstanding* which includes significant and exciting transformation which gives us every opportunity to achieve our vision of *Best Care for Everyone.*

In response:

- LB commented on the different words used in the narrative on the printed leaflet and the animation and asked if this was intention. CM confirmed it was and reflected the different mediums used.
- AM asked if this will be available in other languages and how this will be communicated. CM said this had not been fully considered but he would give thought to the options and update the Board. **CM**
- BH commended the presentation and said it was very positive which demonstrates the journey the Trust wants to take in a very positive and importantly, very accessible way.
- DL asked CM what the next steps were for presenting to wider audiences. CM confirmed that a global email will be issued with access to the YouTube video and his team will be ensuring corporate materials for example used in recruitment and induction, templates, and processes reflect the new strategic CM is also investigating the possibility of going out to social media channels following the internal launch.

168/19 TRUST RISK REGISTER

LB presented the Trust Risk Register and noted that it reflected last month's discussions. Closure of 2018/19 risks has now been completed and the report reflects this. LB also advised that two new risks relating to the Emergency Department had been approved by TLT for addition to the Trust Risk Register which were highlighted in the report.

RESOLVED: That the Board receive the report as assurance that the Executives are actively controlling and pro-actively mitigating risks so far as is possible and approve the change to the Trust Risk Register as set out.

169/19 QUALITY AND PERFORMANCE:

ASSURANCE REPORT OF THE CHAIR OF THE QUALITY AND PERFORMANCE COMMITTEE - MEETING HELD ON 26 JUNE 2019

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

- AM pointed out the Committee discussion on the deteriorating patient and associated risks on the Risk Register. The Committee had asked for a review and if there is a perceived risk, for this to be added to the relevant register whilst further work is done.
- Serious Incident Report – with reference to the deteriorating patient AM has asked for the addition of timelines around incidents and ensuring there is a 24 hour clock.
- Seven Day Services standards assurance briefing was presented by LB on behalf of MP and there were four standards where there was a self-assessment of which two were achieved. There was a suggestion on carrying out an audit with some assurance that improvements are taking place and it was agreed at Committee to delegate the Chief Executive to oversee submission by the end of the week. This had been done.
- There is a lot of work going on around end of life care and some indicators are not rated as high as expected based on the work. The NAAS tool is becoming very comprehensive and will include end of life indicators in it.
- There was a brief conversation on Australian flu around concerns of the high level of flu early in the season and the Trust's planning was taking this into account.
- Maternity – AM reported that there is a lot of assurance of the system working well and feedback has been received on staff learning around positive safety culture.
- The Patient Experience Report by Deputy Director of Quality demonstrated the enormous amount of work which was discussed at Committee.
- AM noted that it was good hear that Executive Directors are aligned to the seven Integrated Locality Partnerships.

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

QUALITY AND PERFORMANCE REPORT

SH presented the Quality and Performance Report highlighting the following points:

- Infection control norovirus issues where the number of bed days lost increased to 66 as a result of the outbreaks. SH advised that there was also a potential outbreak at Cheltenham General Hospital this week. SH also highlighted that the team have worked hard to ensure patients are protected. There has been one case of MRSA reported. PL asked if it would be sensible to look at different approaches as it is slightly unusual to have MRSA at this time of the year. SH confirmed investigations have gone back to the first patient and learning is to come from the index case. SH advised that the case at Cheltenham General Hospital may have been brought in by a relative. Signage was increased and visiting hours reduced during this period of infection.
- The gap in dementia screening was discussed at Quality and Performance Committee. Although NHSI would prefer real time data the Trust are continuing with manual auditing of a selection of patient's notes to ensure more representative capture of what is happening, whilst a solution is found within the Trust's information system.
- RD reported that quarter one emergency performance is the worst nationally, since records began but the Trust has managed to stay

within the upper quartile and thanked the teams and system partners.
- In relation to performance, RD advised that the team are working on achieving 2ww cancer performance by the end of July. We are ahead of trajectory on RTT but not where we want to be for delivering for patients. RD also advised that the team are bringing down 52 week waiters and are on trajectory.
- MP queried the Chair's report on still birth suggesting a 20% reduction is required when we are already 40% below the national average. DL confirmed this has been resolved and is a 10% reduction between 2015 and 2020/21 due to progress in the first five years of a ten year plan.

In response:
- RG asked what staff morale and team spirit is like given the pressures in ED with the continuing unprecedented demands for the time of year. RD confirmed this it remains challenging but the A&E Delivery Board are focussing on ways to recover. Acuity of patients is less but activity numbers are still high. SN also confirmed that substantive nurse staffing was improved and this was helping with morale and workload.
- DL queried why cancer 31 days is showing red but achieving the standard and asked if there should be something that allows us to reflect that the trajectory is better than national. RD agreed to review this and update Board next time. **RD**
- DL asked what has changed in the recovery plan to give confidence that we will achieve 2ww. RD confirmed that issues in Endoscopy had been addressed which had contributed significantly to the dip in performance. DL asked the Quality and Performance Committee to look at confidence in getting back to delivery and importantly maintaining it given volatile nature of recent performance. LB agreed to add it to the Committee's work plan. **LB** **For work plan**
- DL reported that there has been positive media in Twitter about the day surgery unit and staff phoning patients afterwards. DL also noted that questions were asked on surgical site infection and expressed concern as to why we were asking patients to report surgical site infection given we had agreed to move away from this practice recently. SH confirmed that national guidelines are followed and the team follow up with patients using these measures; he did not believe that this 'informal' survey of patients by DSU staff informed our reported figures but he would doubt check. **SH**

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

LEARNING FROM DEATHS REPORT

MP presented the Learning from Deaths Quarterly Report and highlighted the following points:

- There has been a change of process in which data is collected to ensure learning is shared across the organisation.
- The standard indices of mortality are slightly better than average at Cheltenham and average at Gloucester. MP has done a comparison with other Trusts and is working on an analysis report with twin sites Trusts. Patient feedback at the time of the death certificate process is recorded in the report.
- New Medical Examiner process is beginning to be rolled out and MP advised that the doctor will not work in the same department as the one in which the patient dies.
- MP advised that funding processes are being changed.

In response:

- CF advised that the next stage is assurance that new themes have been understood correctly and to keep it progressing. MP stressed that he will ensure learning is carried out across the whole hospital.
- RG commented on the excellent report which gives assurance and highlighted the tables showing the number of SJRs with excellent care and asked if this is a term we want to use consistently. MP confirmed this is a national process which is applied locally.
- DL asked what determines if we do an SJR or not. MP said there are a number of statutory triggers and departments can define their own triggers; there is no national guidance on percentages. MP has asked Divisions if they want to revise the triggers. DL asked if our triggers could be compared with other Trusts and MP agreed to look at this and feedback in the next report. **Removed** **MP**
- DL commented that we have historically had a higher Summary Hospital-level Mortality Indicator (SHMI) and asked if the work to understand post discharge death is still ongoing. MP said he is currently reviewing the countywide death process with the CCG. System issues have come up through the Mortality Group and DL asked for this to be discussed further in Quality and Performance in 3-6 months. MP and AM to discuss further and agree action. **MP/AM**
- RG asked what the process is of sharing learning on sub optimal practice. MP explained that Divisions share learning during the Mortality meeting. MP advised that the processes are informal and discussed how he intended to establish a system whereby learning is shared across the whole hospital as a formal process. DL said she would appreciate a presentation to a future Quality and Performance Committee on this, when the work was further advanced. LB and MP agreed to choose a date for addition to the Quality and Performance Committee work plan. **LB/MP**
- MN asked if the report could show the number of deceased patients who could become a donor that go on to become a donor. DL said the information is available but would prefer to keep this separate from this report; MP agreed.
- AM pointed out that neo natal deaths are discussed but do not feature particularly and we need to learn from all deaths in all areas of the Trust. MP said that for maternity and children there are very robust Child Death Review (CDR) processes and the number of deaths is small. Child deaths are done at regional or national level and MP will give thought to how the Board is sighted on child death. **MP**

RESOLVED: That the Board noted the report and that the Medical Director further develops the report to address the gaps discussed.

CNST INCENTIVE SCHEME REPORT

SH presented the report and highlighted the following:

- There are 10 key maternity safety actions that Trusts are asked to deliver on and we are now on the second year. Evidence confirms that the Trust meets all 10 safety actions and the report is for information and approval.

In response:

- PL asked as assurance if all the information is recorded and SH said each element has a detailed component behind it, describing the underpinning evidence.

RESOLVED: That the Board **a**pproved the report.

170/19 FINANCE AND DIGITAL

ASSURANCE REPORT OF THE CHAIR OF THE FINANCE AND DIGITAL COMMITTEE - MEETING HELD ON 27 JUNE 2019

RG presented the assurance report highlighting the following points:

- RG asked for it to be noted that as far as finances are concerned month two continued on plan but the second half of the year presented much greater challenge due to the phasing of savings..
- The Cost Improvement Programme (CIP) has a big part to play in break-even performance by the end of the year.
- There needs to be a greater understanding of what is in the pipeline for the Cost Improvement Programme (CIP). Achieving targeted level is influenced by the vacancy factor but this was likely to reduce as recruitment took place.
- RG said there was an outstanding presentation from two of the Finance Business Partners describing the processes they go through and work they do within the Divisions. The discussion highlighted that from a financial systems point of view the system is outdated and needs replacing; a business case to invest is in development.
- RG advised that the Digital agenda is being revised to include topics to be discussed on a 6 month review cycle and other topics to be discussed on a monthly basis to make better use of the Committee time.

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

FINANCIAL PERFORMANCE REPORT

SS presented the financial performance report highlighting the following points:

- Cost Improvement Programme (CIP) performance shows an over delivery against plan at month 2.
- There is a £10m gap in the £22m programme which needs to be identified.
- There is an increase in cash balance planned as there is a ring fence of cash balance to support the Capital Programme throughout the year.

In response:

- DL noted Phil Church's appointment to the Trust for an initial period of 3 months to refresh the support to CIP delivery and has discussed twinning service line leads with other Trusts to get other ideas.
- MN advised that the next meeting will concentrate on a deeper dive looking at CIP gaps.

RESOLVED: That the Board note the report.

171/19 PEOPLE AND ORGANISATIONAL DEVELOPMENT

ASSURANCE REPORT OF THE CHAIR OF THE PEOPLE AND ORGANISATION DEVELOPMENT COMMITTEE – MEETING HELD ON 17 JUNE 2019

BH presented the assurance report highlighting the following points:

- BH said discussions had taken place on how the Risk Register and Disclosure and Barring System (DBS) checking can be strengthened.
- There are health & safety concerns particularly on whether or not there are enough resources and whether contract management resources are

as robust as they could be. The Committee want further assurance on how to strengthen health & safety expertise. EW is leading a review of this as part of her new oversight of corporate governance and risk.
- The People and OD Strategy is excellent and the challenge was raised as to whether there is enough done on quality impact assessment and ensuring diversity was at the forefront. EW explained the work being done in this area.
- Issues were raised on digital competencies of the workforce going forward and is there automation that can be introduced.
- BH reported that good process is being made on temporary staffing which is more sustainable.

RESOLVED: That the Board note the report and assurance provided.

PEOPLE AND ORGANISATION DEVELOPMENT REPORT

EW presented the People and Organisation Development Report and highlighted the following points:

- The key operational targets are turnover, vacancies and recruitment trajectories.
- The Trust is in the top quartile for benchmarking in sustainability rates, vacancy targets and turnover but the biggest challenge is the retention issue.
- Debate on targets required had occurred, particularly around shifting the focus of responsibility from Human Resources staff to Divisions in respect of staff retention.
- Cultural challenges were also discussed.
- Operational metrics will start to flow into the Executive Review process so scrutiny happens at correct level to allow the People & OD Committee to focus on more strategic matters.

RESOLVED: That the Board note the report.

PEOPLE AND ORGANISATION DEVELOPMENT STRATEGY

EW presented the People and Organisation Development Strategy and highlighted the following points:

- The strategy has been discussed at the People and OD Committee since October and there has been formal engagement with Non-Executive Directors; EW thanked the team for their input. This is the final draft for approval by the Board.
- Discussions have taken place about what we want to achieve around milestones and a review of where the Trust is now and where we want to be.
- Key metrics are articulated on what is required to deliver but also what we expect our patients and staff to say looks and feels different.
- Strategic measures will now be discussed at the People and Organisation Delivery Group (PODG) and operational measures will be pushed down to the Divisions in Executive Reviews to try to get them to own certain areas.
- One of the challenges is on equality and diversity inclusion in human rights (EDI) and following reflection from the Committee these are discussed in the same way as the Trust values. The measures to be achieved will be threaded into the three pillars. EW said that staff are fully engaged and a more simpler version will be produced for staff. The unions particularly liked the roadmap of where we are and where we want to be which is an honest opinion and an aspiration of where the staff would like us to be as an organisation.

In response:

- CF commented that with the conversations around ICS and the potential to work with system partners could this be developed with a strategy of this time length and how can it be sufficiently agile to respond to different structural maps with ICS. EW confirmed that within the enabling pillars there are milestones capturing some of the ICS activity for example workforce sustainability areas. EW said some milestones are currently capturing ICS activity and capturing under the initiative called 'developing new pathways' in the Trust i.e. musculoskeletal pathways, new physio pathways.
- CF also pointed out that some areas refer to old language such as STP and EW will double check this as the narrative should read ICS.
- RG congratulated EW on the strategy and metrics for each pillar which are exemplary.
- DL agreed and said this has created an excellent strategy 'template' for other areas to follow and thanked EW for the additional work she and her team had done to produce this.
- EW is working on getting countywide leadership on workforce and PL said this is a great step up for others.
- PL referred to the Governance chart on slide 28 and asked if there are Committees reporting to People and OD Committee. EW explained the executive and non-executive reporting lines.

RESOLVED: That the Board approve the People and Organisational Development Strategy.

ANNUAL EQUALITY REPORT

EW presented the Annual Equality Report and the following points were highlighted:

- The report is published in the format of government requirements based on objectives given in 2015/16 and setting up objectives for the next four years.
- Governors, patients and staff have been involved in the format and this is now presented to the Board for approval and note as the report needs to be published on the website by the 1st August.

In response:

- SH said there is poor representation of ethnicity amongst senior staff and asked what we are doing to address this. EW explained a number of actions including 'bias' training for recruiters and the inclusion of BAME staff on all senior appointment panels.
- DL said that TLT had had a very good discussion on the plan, the previous week and had asked that the leads agree that are the top priorities where we want to 'shift the dials, the most' and then to be clear on the high impact actions which would drive these improvements.

172/19 ANNUAL MEDICAL REVALIDATION AND APPRAISAL REPORT

MP presented the Annual Medical Revalidation and Appraisal Report and highlighted the following points:

- The GMC provides assurance to the public demonstrating that doctors are fit to practise and have an appraisal.
- MP advised that more appraisers need to be recruited which he is actively engaged in.
- A Steering Group meets twice a year.
- There is no requirement for appraisers to be medical and MP advised that a lay appraiser is one area to be explored as they have sat in on appraisals.
- Every doctor has to have a designated officer and responsible officer

who has to confirm that the doctor is fit to practice at the end of a 5 year cycle.
- MP confirmed that the vast majority of doctors have completed appraisals and those who have not are likely to be on maternity or sick leave. Compliance was very good.
- MP advised that eight substantive Consultants are in dispute and this is being actively managed; this is a very small proportion and reflects national practice.
- MP said there are six doctors who move around regularly on temporary short term contracts and their responsible officer changes so they are difficult to manage particularly around concerns on their fitness to practice. PL asked if this was a concern and MP said that he is not permitted to enquire from their previous responsible officer until the day they start working at the Trust. DL asked what the rationale is behind this and not sharing information. MP said this is set down in statute and set out in strategic health authorities. The question can be asked at interview if there are any issues but if information is not declared this can be dealt with when he becomes the responsible officer.

In response:
- PL asked who appraises the appraisers. MP said there is a peer review model for appraising them in their appraiser role; this had been held up as best practice.
- RD asked how an appraiser is selected. MP said Elinor Beattie is the Revalidation Officer in the Trust allocates someone in a different speciality and ideally different Division, to carry out the appraisal.
- AM said that she could not see a lay person listed and do we provide a responsible officer to other Trusts. MP said a responsible officer can only act in their own Trust but others can ask if we can be a designated body but nobody has.

RESOLVED: That the Board note the report.

173/19 AUDIT AND ASSURANCE

ASSURANCE REPORT OF THE CHAIR OF THE AUDIT AND ASSURANCE COMMITTEE MEETING HELD ON 2 JULY 2019

CF presented the Assurance Report of the Audit and Assurance Committee and highlighted the following points.
- There was a good progress report from the internal auditors.
- The Trust has sought advice of internal auditors on best practises with RTT arrangements and divisional governance.
- The Trust has now received formal confirmation of last year's accounts from the external auditors. There was significant delay and CF said there will be discussions on what action the Trust may take with respect to the audit provider.
- The costing report was checked by EY and CF said it was a disappointing outcome on no assurance as to how things are working in the Trust. SS added that the national costing audit is commissioned by NHSI auditing Trusts who are considered to be high risk. SS assured the Board that there is a plan in place to improve the quality and depth of costing.

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

174/19 ASSURANCE REPORT OF THE CHAIR OF THE ESTATES AND FACILITIES

COMMITTEE – MEETING HELD ON 8 JULY 2019

MN gave a verbal update on the Assurance Report of the Estates and Facilities Committee and the following points were highlighted:

- MN noted that this was the first official Committee meeting since changing the remit from the previous GMS Committee and he felt the meeting was going from strength to strength.
- A Contract Management Group (CMG) has been established chaired by RD, meeting bi-monthly, to oversee performance of GMS as a subsidiary. The Estates & Facilities Committee will also meet bi-monthly with a more strategic focus. The Contract Management Group (CMG) has taken on a number of issues from the Committee and RD will give a verbal update in the future. An exception report from the CMG will be discussed at future Committee.
- MN advised that the Trust Estates Strategy, which is a work in progress document, had been updated and was presented by SL to the Estates Committee. There is a lot of work still to be done to understand the state of the Estate and it is anticipated that sign off will be in September but the Committee had been pleased with the progress.
- MN advised that the ICS Estates Strategy Check List will go to the NHSI on the 15th July and this document accurately covers what is in the pipeline for the Estates Strategy.
- MN reported that the backlog maintenance for the Trust is just over £60m and last year the figure was £53.5m, however, significant backlog maintenance is expected to fall from £12.5m to £7.5m and this was a concern that the Estates Strategy would need to address.
-

In response:

- Members of the Committee confirmed that they felt it was becoming much more effective and the CMG would aid further.

RESOLVED: That the Board note the report.

175/19 GOVERNOR QUESTIONS

- AD asked how realistic are the Journey to Outstanding objectives are and can the Trust be certain of getting there. PL said the strategy is rightly ambitious but there is a lot of well thought through underpinning strategies and DL reiterated that these are not just hopes but plans with milestones and measurable outcomes to ensure delivery.
- AD commented on the Risk Register and the hope to leave a cubicle free for patients to have scans etc. in A&E. AD highlighted a recent incident of a patient self-referring to Gloucestershire Royal Hospital. She was a mental health patient left in a full A&E Department and dealt with by a Locum who discussed the patient on the phone and sent her home without checking that she had a safe place to go.
- SH responded by saying that he was very disappointed to hear of the patients experience and would be very happy to investigate if more information were available. He added that there is only one dedicated mental health assessment room available at Gloucestershire Royal Hospital and when this room is occupied patients are cared for in a cubicle. He said there was no excuse for a lack of privacy and dignity but maintaining confidentiality was a challenge due to the open plan nature of all A&E departments but he would remind staff of the importance of this. He also stressed that locum doctors are expected to maintain our standards and values and there was never any excuse for poor care.
- MP advised that in due course there will be a mental health room on the

Acute Medical Initial Assessment Unit (AMIA) which would help.

176/19 STAFF QUESTIONS

There were none.

177/19 PUBLIC QUESTIONS

There were none.

178/19 NEW RISKS IDENTIFIED

There were none.

179/19 ITEMS FOR THE NEXT MEETING

There were none.

180/19 ANY OTHER BUSINESS

PL thanked LB for his hard work and commitment and wished him well on his new post in Oxford. In turn, LB thanked everyone for his appointment in the Trust and said it was important for the team to continue to support each other and set the tone and continue to lead the organisation well.

DATE OF NEXT MEETING

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

EXCLUSION OF THE PUBLIC

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

The meeting ended at 15:30.

Chair
12 September 2019

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

TRUST BOARD – SEPTEMBER 2019

MATTERS ARISING

CURRENT TARGETS

Target Date	Month/Minute/Item	Action with	Issue	Action	Update
July 2019	June 2019 – 149/19 Chief Executive's Report	**SS**	PL had heard that the NHSI capital review would now not be part of the Autumn Spending Review. If it were to be the case, what would the implications be for the Trust? JS agreed that it was not a helpful outcome to the overall capital framework and presented a further period of uncertainty.	In response, work was underway to look at alternative routes to capital and this was to be discussed further at the Finance and Digital Committee. SS agreed to check that exploring alternative routes to capital was on the Committee's work plan.	*Closed: This is on the Finance & Digital Committee workplan for September*
September 2019	July 2019 – 167/19 Chief Executive's Report	**CM**	AM asked if this will be available in other languages and how this will be communicated.	CM said this had not been fully considered but he would give thought to the options and update the Board.	*Closed: Board papers will now incorporate a message advising that a translation service is available on request. Contact details will also be provided. This message will also be added to the website.*
September 2019	July 2019 – 169/19 Quality and Performance Report	**FTD**	DL queried why cancer 31 days is showing red but achieving the standard and asked if there should be something that allows us to reflect that the trajectory is better than national.	FTD agreed to review this and update Board next time.	*Closed: August QPR (page 4) illustrates the performance against trajectories agreed with NHS I. The commentary has been updated in September Board papers (August data) in the exceptions to illustrate the number of breaches (small for 31 days); the specialities and the national performance.*

September 2019	July 2019 – 169/19 Quality and Performance Report	**SH**	DL also noted that questions were asked on surgical site infection and expressed concern as to why we were asking patients to report surgical site infection given we had agreed to move away from this practice recently.	SH confirmed that national guidelines are followed and the team follow up with patients using these measures; he did not believe that this 'informal' survey of patients by DSU staff informed our reported figures but he would doubt check.	*<u>Completed:</u>* *The national surveillance guidelines are followed as outlined below:* *Active surveillance is undertaken by Trust surveillance colleagues to identify patients with SSIs during their initial inpatient stay.* *Other post-discharge surveillance methods are recommended, especially for short-stay procedures, but remain optional. They comprise:* *a) systematic review of patients attending outpatient clinics or seen at home by clinical staff trained to apply the case definitions and* *b) wound healing questionnaires completed by patients 30 days after their operation].* *Data derived from these optional methods are not currently included in the national benchmarks or used for outlier assessment but provide a sensitive measure of an individual hospital's infection risk to inform local assessment of trends.*
September 2019	July 2019 – 169/19 Learning from Deaths Report	**MP**	DL asked what determines if we do an SJR or not. MP said there are a number of statutory triggers and departments can define their own triggers; there is no national guidance on percentages. MP has asked Divisions if they want to revise the	MP agreed to look at this and feedback in the next report.	*<u>Closed</u>:* *There is no national guidance and local Trusts have not responded / don't have a target. In GHT W&C review 100% of deaths and D&S is >50%. Medicine and Surgery is more variable and has reduced recently as*

			triggers. DL asked if our triggers could be compared with other Trusts.		*the 'within 24 hours of admission' trigger has been removed following analysis that showed that it was not contributing above other triggers.* *Hospital Mortality Group has agreed that each specialty should review 10% of all deaths each year or a minimum of 10 deaths. Discussion included setting a higher figure of 25% of deaths but for some service lines this would be a large number. It was agreed to review this in 6 months' time.*
September 2019	July 2019 – 169/19 Learning from Deaths Report	**MP/AM**	MP said he is currently reviewing the countywide death process with the CCG. System issues have come up through the Mortality Group and DL asked for this to be discussed further in Quality and Performance in 3-6 months.	MP and AM to discuss further and agree action.	*Closed:* *Scheduled for Feb 2019 as part of a wider discussion about the LeDR process.*
September 2019	July 2019 – 169/19 Learning from Deaths Report	**MP/AM**	RG asked what the process is of sharing learning on sub optimal practice. MP advised that the processes are informal and discussed how he intended to establish a system whereby learning is shared across the whole hospital as a formal process.	DL said she would appreciate a presentation to a future Quality and Performance Committee on this, when the work was further advanced. LB and MP agreed to choose a date for addition to the Quality and Performance Committee work plan.	*Closed:* *Scheduled for Feb 2019 as part of a wider discussion about the LeDR process.*
September 2019	July 2019 – 169/19 Learning from Deaths Report	**MP/AM**	AM pointed out that neo natal deaths are discussed but do not feature particularly and we need to learn from all deaths in all areas of the Trust. MP	Child deaths are done at regional or national level and MP will give thought to how the Board is sighted on child death.	*Closed:* *MP has discussed with the Chief of Service who will check the dates of annual reports and make sure that*

			said that for maternity and children there are very robust Child Death Review (CDR) processes and the number of deaths is small.		*timelines are coordinated with Q&P / Board.*
September 2019	July 2019 - 169/19 Quality & Performance Report	**LB**	DL asked what has changed in the recovery plan to give confidence that we will achieve 2ww. RD confirmed that issues in Endoscopy had been addressed which had contributed significantly to the dip in performance. DL asked the Quality and Performance Committee to look at confidence in getting back to delivery and importantly maintaining it given volatile nature of recent performance.	Action: LB agreed to add it to the Committee's work plan.	*Closed: A detailed brief on Endoscopy was taken to the August Quality & Performance Committee which reported that the 3 x patients who had breached the 2ww had been treated. In addition, clinic utilisation has increased and all remedial actions have been taken.*

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

TRUST BOARD – SEPTEMBER 2019

REPORT OF THE CHIEF EXECUTIVE

1. Our Trust

1.1 Operationally, we ended the quarter with a number of positive achievements. Despite the number of patients attending our hospital A&E departments increasing and referrals to our specialist teams rising, we achieved 91.06% as a system against the 90% trajectory for the 4 hour A&E waiting standard – a huge achievement and indeed we were the highest performing system nationally for the most recently published month. We are also beginning to make noticeable inroads into the numbers of patients who are overdue their follow up care, we are ahead of our trajectory for eliminating those patients who have waited more than 52 weeks for their care and yet again delivered the 6/52 diagnostic waiting standard for which we are now recognised as the highest performing Trust in the region. Challenges however remain, particularly in respect of cancer waiting time performance and 62 days pathways specifically; as previously discussed, this remains one of the Trust's highest quality priorities.

1.2 Whilst operational performance is an important measure of quality, the Trust is equally focussed on other dimensions of quality and one such approach is the Nursing Assessment and Accreditation Scheme (NAAS) which we introduced last year. Wards and departments across the Trust have been demonstrating the power of quality improvement in their areas but, despite huge efforts, one of our areas had not progressed beyond their initial RED rating. I was delighted therefore to hear that the Gloucestershire Royal Emergency Department had been GREEN rated in last week's assessment having leap frogged Amber. Without doubt, this has been a whole team effort, aided by improvements in staffing and the contribution of teams who support ED. However, if I had to point to the driving force behind this huge improvement then I'd observe it's about leadership; time and time again, improvements - whether they be in care quality, culture, staff morale, money or performance - track back to the quality of leadership and I think this is a great example. Congratulations to everyone who contributed to this huge achievement.

1.3 Despite improvements in nursing staffing in A&E as mentioned above, staff vacancies across a number of our wards and departments continues to represent a significant challenge and one that, despite best efforts, is longstanding. I am delighted therefore to announce that the Trust is just one of 14 Trusts nationally that have been selected to work with the Chief Nursing Officer for England to implement her vision for nursing and nursing care entitled *Shared Governance: Collective Leadership*. One aspect of this hugely exciting vision is the adoption of aspects of global best practice and notably work done in the USA by the American Nursing Credentialing Centre (ANCC), which has demonstrated huge benefits to the attraction, recruitment and retention of nurses. Steve Ham's, Director of Nursing and Chief Nurse led our application and I'm delighted we have been successful. Steve will share more over the coming weeks about the programme (*Pathways To Excellence)* and what it entails but what's clear from my first glimpse is that it has the potential not only to positively affect nurse recruitment but to address some of our thorniest issues when it comes to ensuring a truly outstanding experience for all of our patients, every day.

1.4 Patient experience has many dimensions and we know often starts before the patient event presents to one of our services; outpatient services are a great example of this. I am absolutely delighted therefore that this month we launched our new look letter templates for outpatient appointments. I have lost count of the feedback from patients, carers and staff about the confusion caused by the current letters; everything from the CGH headquarters address dominating the letterhead (irrespective of appointment location), acronyms to frustrate even the acronym enthusiasts and on occasions a

complete absence of directions to the clinic location. The new templates have been developed under the auspices of our *Outpatient Transformation Programme* alongside staff and patients and, whilst a fairly transactional set of changes of themselves, really do have the potential to transform patient experience in outpatients, in my view. Thanks to Debbie Dewitt and colleagues for their work on this.

1.5 One sign that a Trust is beyond 'turnaround' and starting to look up and out is when it embraces something that some may describe as a "nice to do". And, whilst personally, I certainly don't see embracing sustainability as something that is optional, it's taken a while for it to rise up the agenda and for the team to create the capacity to address this important topic meaningfully. I am regularly e-mailed by staff raising concerns about practice which impacts negatively on the environment or about positive things staff are doing to contribute, which speaks to the passion in our workforce to do our bit in the 'green' space. In just the last fortnight I've had concerns raised about the recently introduced blue plastic pharmacy transportation bags (it turns out they are recyclable but we are now looking into a biodegradable version and whether they are necessary at all) and following a Twitter comment from another Trust, Dr Charlie Sharp, Lou Buckle and colleagues in pharmacy are promoting an inhaler recycling scheme. I'm delighted therefore that Steve Hams has taken up the "green" gauntlet and will be starting the *Big Conversation* at our sustainability launch event on the 27th September. Steve will be taking soundings on the appetite within the Trust to consider putting a motion to the Trust Board to follow in the footsteps of Newcastle NHS Foundation Trust.

1.6 In my view, the Holy Grail, when it comes to tackling agendas that some might view as 'non-core', is to ensure they are embedded in day to day 'must do' activities or major priorities. I was delighted therefore to receive a note from one of my team to share some initial estimates about the impact of the first phase of our electronic patient record (EPR) roll-out; whilst the focus of our EPR for nursing is about *releasing time to care* and ensuring safe reliable practice through the introduction of things life *e-observations*, I was delighted to be told that the translation of just ten core paper nursing documents into our EPR will save more than one million pieces of paper, around 80 trees, 20,000 kw of energy and reduce our carbon footprint by 60 tonnes. Oh and for good measure, saves just over £42,000! Given we have more than a 1000 paper based, nursing documents EPR has a massive contribution to make to our sustainability efforts. Huge thanks to Steve Hams for stepping out of his comfort zone to lead this agenda.

1.7 The next time the Board meets, myself and 24 colleagues will have participated in another NHS Military Challenge where we will have competed against 17 other NHS Trusts from the South West Region. There has been a phenomenal response to this year's 'call to action' with 25 staff, from 11 different departments and eight staff groups coming together to form two teams for each of our hospitals; staff engagement at its best. As well as promoting team building, having fun and hopefully bringing home a medal (or two…) the event is a chance for the 243 Field Hospital to recruit budding reservists to join their ranks. The Trust has a very supportive employment policy which enables staff to contribute to the reservists through special leave and other support. With Salisbury NHS Trust being victorious three out of four years, hopes for a Gloucestershire victory are not high but if previous years are anything to go by, 24 staff will have a life changing experience (for the good…).

1.8 Earlier this year we brought greater focus to three of our values - Caring, Listening, Excelling – and asked staff what they thought we should do to ensure they became more than "words on a page". Staff are very clear that what matters the most - from boardroom to bathroom – is a singular message that says it is how the values are lived in practice i.e. how we treat one another, our patients and partners that makes the difference. Staff engagement sessions are now underway throughout September to explore and identify the behaviours that we all want to see and experience at work. This will not only help us to "call out" behaviours that don't align to our values but will enable us to recruit staff who are already recognised for these positive behaviours.

Alongside the engagement sessions, there is a short survey (which takes 5 minutes to complete) and I was surprisingly thought provoked by completing it myself and have asked all staff to try and find the time to do the same.

1.9 September is also host to national *Organ Donation Week* and the Board received a presentation in July from members of our local Organ Donation Committee. The focus of this year's campaign is the upcoming change to the law, entitled *Max and Keira's Law* after the young recipient of a heart and his generous donor Keira. *Presumed Consent* as it will be termed, will become law next spring which in simple terms means that, unless you have formally opted NOT to be a donor, then you will be registered as one. However, what's clear from countries that have gone ahead with this approach is that it is not an instant panacea to the shortage of organs for donation and, of itself, brings new challenges for those working with families who find themselves facing such huge decisions at a time of tragedy. As the Board is aware, we fair very well as a county compared to the rest of the country with high levels of registered donors but there are some groups - one being Black, Asian and minority ethnic (BAME) communities - who are less well represented amongst donors and this will be a focus for our efforts.

1.10 For some of us, and especially colleagues in our communications team, the end of the summer signals several months of frenzied activity to prepare for our annual staff awards. The awards have gone from strength to strength and this year we are aiming for yet another development with a live 'web-cast' of the evening with the aim to enabling those not fortunate enough to have been shortlisted and attend the evening to get a small sense of the occasion. I have visions of house parties all around the county, attended by teams sharing their colleague's moment of fame and glory; I've suggested a party pack for those who are organising the event and await their reply… Nominations for this year's awards have now closed, with the new junior doctor category proving especially popular and a record number of nominations by patients and family members for the *Patients' Choice Award.* The ceremony will take place on Wednesday 27th November, again at Hatherley Manor due to the generosity of local sponsors and our Trust charity.

1.11 Last Friday we treated our first patient on our new *Varian Truebeam Linear Accelerator* or, to most of us, a fantastic bit of kit to deliver radiotherapy treatment to our patients with cancer. The equipment was funded by a national capital award following a stellar application put together by Bridget Moore and colleagues. This will enable more patients to be treated locally who might otherwise have to go further afield and reduce the amount of time patients spend receiving their treatments.

1.12 Our Accelerated Development Programme (or talent pool) continues to gather momentum. The initial concerns that this approach would switch focus to the few, at the expense of the majority, don't appear to have come to fruition and it is clear from feedback that those in the first two 'pools' are benefiting enormously. One of the less common characteristics of the GHFT approach is the ability for applicants to self-nominate. Whether nominated through the appraisal route, or self-referred, the assessment process is equally rigorous but I think this inclusive approach will serve us well when we consider the evidence pertaining to bias – conscious and unconscious – that results in some talent not being recognised and supported as such.

1.13 Finally, numerous comings and goings in the leadership team:

- We welcome Elaine Warwicker to the Board as our latest non-executive director. A long-standing Cheltenham resident, Elaine has considerable Executive Board level experience in a number of commercial sectors including retail, financial services and the energy sector.
- After more than a decade's service we say goodbye to Dr Mark Silva in his capacity as Chief of Service, Medicine Division and welcome Dr Ian Shaw into the role. Ian has been acting as Interim for the past six months. We are

fortunate that Mark will continue to practice clinically as a consultant neurologist in the Trust.

- Jon Burford, Divisional Chief Nurse retires after almost 40 years of nursing service in Gloucestershire and does so proudly wearing his Chief Nursing Officer's Award; Jon will return part-time to pursue his interests in practice development. Jo Harvey, currently matron in children's service, will take up the role on secondment for the next six months pending substantive recruitment to the role.
- Gavin Hitchman will be joining us from University Hopsitals Bristol as Divisional Director for Quality and Nursing. Thanks go to Eve Olivant who has ably acted in the role for the last six months.
- Lukasz Bohdan, Director of Corporate Governance left the Trust as the end of August to pursue his career with the University of Oxford.
- Mark Pietroni has been appointed substantively as Medical Director following completion of necessary training for the role, following a successful six months as our interim MD.
- Zack Pandor, who served the Trust as Chief Information Officer and more recently working in our learning and development team is leaving us to take up pastures new in the local Commissioning Support Unit.

2 Our System and Community

2.1 In Gloucestershire we are aiming high. We want everyone to have access to the very best healthcare and to be best placed to manage their own health in partnership with clinicians and other health care professionals. With this exciting aim, we have recently entered the next phase of our public engagement activities.

2.2 Perhaps inevitably, given the passionate feelings we all hold about healthcare and the NHS, there has been a great deal of commentary and some misinformation circulating concerning the future of services across the County and, notably, with respect to Cheltenham General Hospital's A&E Department. The narrative remains unhelpfully mixed in places with some commentators suggesting that minds have been made up, whilst others are calling for clear proposals and less discussion. Despite recent reports, I can confirm that no decisions have been made about the level of care or range of services to be provided at either hospital and there are no plans to close the hospital's A&E department, as has been suggested.

2.3 We do believe that our two hospitals offer us enormous potential and both will play a vital role in providing care for the next generation of patients in Gloucestershire. What is clear, and therefore encouraging, is that all those who have engaged in these initial conversations have patients at the heart of their views, even where those views may appear to be at odds on occasions. For me, one of the most important aspects of our engagement is to ensure that everyone in the County understands that these conversations are not just about Cheltenham A&E but about urgent and emergency care in its broadest sense (and notably about urgent care delivered outside of the County's two acute hospitals) alongside discussions about a wide range of specialist services. We have the potential to deliver truly outstanding care in Gloucestershire and to develop services that will enable more local people to be treated in our County avoiding the need to have to travel to specialist centres in Birmingham, Bristol, Oxford and London; equally, we have the potential to be the employer of choice for the very best staff the NHS has to offer and will continue to develop in years to come – all of this will be beyond our reach if we do not recognise and respond to both the challenges and opportunities ahead. I strongly believe that this conversation is the start of creating a powerful legacy for healthcare in Gloucestershire and look forward to working with local people, our staff and our partners to shape this future together.

2.4 One way of ensuring that we reach all of the communities that we serve, is our roving *Information Bus* which is visiting numerous locations across the county; in its first week, more than 230 people visited the bus at its various 'drop ins' to hear more about the challenges facing healthcare in the county and to share their views on how we might

respond to them. Thankfully, the majority of those engaging in these conversations recognise the challenges and have been willing (and indeed keen) to share their thoughts on the different ways we might respond. Finally, and very importantly, should the conversations over the coming months result in proposals to change the way healthcare in the County is delivered then any such change will be subject to formal public consultation.

2.5 Finally, given our own ambitions for University Hospitals Status, I have watched with interest the genesis and development of *Research4Gloucestershire*. Chaired by our own Chairman, Peter Lachecki, in its embryonic phase, the network was formally launched on the 10th September. The footprint for its research activities is the partner organisations of the Gloucestershire Integrated Care System (ICS) working with the University of Gloucestershire and local diagnostics partner Cobalt Health. The value of research active organisations is well evidenced through their ability to attract and retain the best staff, through their propensity for being 'learning' organisations and, in the case of healthcare, affording patients access to care that wouldn't otherwise be available to them.

3 National and Regional

3.1 Brexit preparations for a 'no-deal' scenario remain high up the agenda with the National Strategic Commander, Keith Willetts continuing to leading preparations. The risks remain largely as perceived earlier in the year and the Trust's Executive Lead remains Sarah Stansfield, Director of Finance although given Sarah's planned departure at the end of October, this is now a shared responsibility with Rachael De Caux, Chief Operating Officer. Safeguards in respect of the supply chain for essential goods, including medicines remains nationally managed and to date there are no local issues that are not mirrored nationally. Regional co-ordination remains the modus operandi with a workshop planned for early September.

Phew exciting times; what a lot going on!

Deborah Lee
Chief Executive Officer

2nd September 2019

Gloucestershire Hospitals
NHS Foundation Trust

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

Report Title
Board Assurance Framework (BAF) - Quarter 1
Sponsor and Author(s)
Author: Jill Hall, Head of Corporate Governance Sponsor: Emma Wood, Deputy CEO and Director of People and OD
Executive Summary

Purpose

The purpose of this paper is to present the Board with the first iteration of the new BAF for 2019/20 following the approval of new Strategic Objectives set out in 'Our Journey to outstanding 2019 - 2024.' Each Board Committee was allocated scrutiny and assurance responsibility for one or more strategic objective(s) and over the last 2 months have reviewed the risks allocated to them. The Chairs report and minutes provide assurance of this process and the BAF reviewed at each committee is enclosed for information at appendix 2.

The Board has been allocated oversight of the principal risks 4.1, 4.2, 5.1, 5.3, 6.1, and 6.2. and as such should review the controls and assurances in place to assure itself that these are adequate. The current and target risks for these objectives have been agreed with the exception of 'Involved People,' principle risk 5.3 and the Board is asked to set and agree an appropriate rating.

As a first iteration and compilation of the committee BAF's, consideration will need to be given on how to enable adequate assurance without considering all the committee detail. As such the Board may wish to consider how future reports may be presented.

The BAF highlights:

- An overview of the 10 strategic objectives and the 36 principle risks to delivery, inclusive of their scoring as set out in appendix 1 below. The scoring of principle risks follows the usual 5x5 impact and likelihood matrix as outlined in the Risk Management Strategy and familiar to the Board;
- An overview of the scores for current risks and target risk scores as agreed at committees. A summary of this exercise is provided below as Appendix 1;
- An overview of the key controls and assurance mechanisms for managing the Strategic Objectives and mitigating the principle risks explored and scrutinised at committees;

Recommendations

The Board is asked to:

a. Review the controls and assurances in place for those principle risks allocated to the Board and assure itself that these are adequate;
b. Agree the current and target scores for the risk 5.3 under Involved People;
c. Note the content of the report and review the opening position of the BAF as agreed by committees;
d. Discuss and provide a steer on how the BAF may be presented to the Board for assurance in the future;
e. Discuss and agree the next steps suggested.

Impact Upon Strategic Objectives
The BAF is an assurance framework relating to the delivery of all Strategic Objectives.
Impact Upon Corporate Risks
The BAF's links to risks are cross referenced within the documentation
Regulatory and/or Legal Implications
As a Foundation Trust it is important that the BAF works as a tool to support the Board's assurances in terms of self-certification on compliance with its Terms of Authorisation CQC well led domain requires a robust management of risk and assurance framework of all good and outstanding Trusts.
Equality & Patient Impact
The management of risk and assurance that the Trust is being managed effectively to deliver the strategic objectives will positively impact upon patient safety and experience and the equitable provision of services.

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						
Quality & Performance Committee	**Finance & Digital Committee**	**Audit & Assurance Committee**	**People and OD Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
July 2019	July 2019		August 2019			

Outcome of discussion when presented to previous Committees
The Committees reviewed and agreed the elements of the Board Assurance Framework relating to Strategic Objectives owned by the Committee. The Committees used the BAF to inform agenda/work plan setting. The Committees recommend the Board take assurance from their scrutiny of the BAF

Introduction

The Board Assurance Framework (BAF) provides a means by which the organisation can focus on the principle risks which might compromise achieving its Strategic Objectives. The BAF identifies the key controls which are in place to manage and mitigate risks and also enables the board to gain assurance about the effectiveness of these controls.

The BAF describes the principle risks to achieving the ten strategic objectives as set out in 'Our journey to Outstanding 2019 – 2024 and is a tool to enable effective scrutiny and challenge. It is a structured means of identifying the main sources of risk, assurance and controls in a coordinated way to enable discussion and challenge to take place at Board level.

This report describes progress made since the Boards Strategy and Development session in June 2019. Over quarter 1 the Executives and Non-Executive Directors reviewed the strategic objectives and identified a number of principle risks to achieving these.

Strategic objectives were assigned to relevant board committees with delegated responsibility to provide assurance to the Board on progress. During the last reporting cycle (Q1) the Committees scrutinised the relevant BAF sections and updated them. These are attached to this report as Appendix 2. The Committee Chairs report and the minutes of meetings provide evidence of the discussions and the main point of challenge.

Scoring of principle risks was prioritised using a 5x5 impact and likelihood matrix as outlined in the Risk Management Strategy and familiar to the Board as part of usual risk management protocols. Scores were provided for current risks and target risk scores agreed. A summary of this exercise is provided below as Appendix 1

The BAF, its structure and lay out was approved at the Audit Committee (June 2019) and utilised at Board Committees during July and August 2019.

2. Board Assurance Framework

The BAF is aligned to the following 10 strategic objectives:

Board Assurance Framework Strategic Objectives	
1. Outstanding Care	We are recognised for the excellence of care and treatment we deliver to our patients, evidenced by our CQC Outstanding rating and delivery of all NHS Constitution standards and pledges
2. Compassionate Workforce	We have a compassionate, skilful and sustainable workforce, organised around the patient, that describes us as an outstanding employer who attracts, develops and retains the very best people
3. Quality Improvement	Quality improvement is at the heart of everything we do; our staff feel empowered and equipped to do the very best for their patients and each other
4. Care without Boundaries	We put patients, families and carers first to ensure that care is delivered and experienced in an integrated way in partnership with our health and social care partners
5. Involved People	Patients, the public and staff tell us that they feel involved in the planning, design and evaluation of our services
6. Centres of Excellence	We have established Centres of Excellence that provide urgent, planned and specialist care to the highest standards, and ensure as many Gloucestershire residents as possible receive care within the county
7. Financial Balance	We are a Trust in financial balance, with a sustainable financial footing evidenced by our NHSI Outstanding rating for Use of Resources

8. Effective Estate	We have developed our estate and work with our health and social care partners, to ensure services are accessible and delivered from the best possible facilities that minimise our environmental impact
9. Digital Future	We use our electronic patient record system and other technology to drive safe, reliable and responsive care, and link to our partners in the health and social care system to ensure joined-up care
10. Driving Research	We are research active, providing innovative and ground-breaking treatments; staff from all disciplines contribute to tomorrow's evidence base, enabling us to be one of the best University Hospitals in the UK

Each Executive Director has been allocated responsibility for a Strategic Objective and associated principle risk and will update the BAF to reflect the mitigating actions and controls which have been implemented. The Board will ensure that assurances are robust and action plans to address gaps in assurance and /or controls are appropriately prioritised, monitored and progressed including achievement of target scores. The Board will do this within committees or directly at Board meetings.

The Board takes assurance from its committees via the Chairs reports and minutes of meetings describing the detailed discussion at these forums.

The BAF summary (appendix 1) provides an analysis of the risks which may threaten the achievement of the strategic objectives. As it is an iterative document these risks may change in the forthcoming months, they may be removed or new ones added.

3. Next Steps

The BAF will undergo a number of iterations over the coming weeks and months. The Board is asked to consider the following proposals designed to strengthen the approach to deliver more robust assurance on the effectiveness of controls:

- the Audit and Assurance Committee continues to act as the custodian of the BAF aligning it to the Annual Governance Statement and focussing the Board's agenda on strategic risk imperatives;
- further iterations of the BAF to include an explanation of how the target risk and current risk ratings were agreed to enable greater transparency;
- a further developed Quarterly report template to enable an easy review of assurances;
- consider if the Strategic objectives which are aligned to multiple committees should be streamlined for ease of reporting and scrutiny.

Appendix 1 – Summary of the risk ratings

Strategic Objectives			Principal risk												
			ID	Principle Risk	Executive Lead	Assuring Committee	Risk rating					Assurance rating			
							Q1	Q2	Q3	Q4	Target	Q1	Q2	Q3	Q4
1	Outstanding Care	We are recognised for the excellence of care and treatment we deliver to our patients, evidenced by our CQC Outstanding rating and delivery of all NHS Constitution standards and pledges	1.1	Risk that we fail to identify quality and safety risks to the delivery of excellent care leading to avoidable harm, poor patient experience and reputational damage	Director of Quality and Chief Nurse	Quality and Performance	12				4				
			1.2	Risk that there is a lack of access to performance information, intelligence and insight and / or failure of assurance processes that inhibits our ability to make timely decisions			9				3				
			1.3	Risk that we fail to deliver the Trust's enabling Quality Strategy			8				1				
			1.4	Risk that we breach CQC regulations or other quality related regulatory standards			12				4				
2	Compassionate Workforce	We have a compassionate, skilful and sustainable workforce, organised around the patient, that describes us as an outstanding employer who attracts, develops and retains the very best people	2.1	Risk that we are unable to match recruitment needs (due to notational and local shortages) with suitably qualified clinical colleagues	Director of People and OD	People and OD	6				4				
			2.2	Risk that continued poor levels of staff engagement measured by national and local surveys may negatively impact upon retention, attraction and patient experience			6				4				
			2.3	Risk that we fail to deliver the Trust's enabling People and OD strategy			1				1				
			2.4	Risk that we fail to attract, recruit and retain candidates from diverse communities resulting in the Trust workforce not being representative of the communities we serve			6				4				
3	Quality improvement	Quality improvement is at the heart of everything we do; our staff feel empowered and equipped to do the very best for their patients and each other	3.1	Risk of failure to deliver the Quality Framework and associated distributed quality leadership. This would delay the development of an empowered workforce close to the patient and prevent the required cultural change/embedding of quality improvement	Medical Director	Quality and Performance	12				6				
			3.2	Risk that we fail to deliver the Trust's enabling Quality Strategy and implement the Quality Framework			12				6				
4	Care Without Boundaries	We put patients, families and carers first to ensure that care is delivered and experienced in an integrated way in partnership with our health and social care partners	4.1	Risk that individual organisational priorities and decisions are not aligned, which would result in restriction of the movement of resources (including financial and workforce) leading to an impact upon the scope of integration	Chief Operating Officer	Board	6				4				
			4.2	Risk that the Primary Care Networks funding			9				4				

Strategic Objectives			Principal risk				Risk rating					Assurance rating			
			ID	Principle Risk	Executive Lead	Assuring Committee	Q1	Q2	Q3	Q4	Target	Q1	Q2	Q3	Q4
				model has adverse impact on integration											
5	Involved people	Patients, the public and staff tell us that they feel involved in the planning, design and evaluation of our services	5.1	Risk that we are unable to identify or get regular attendance from a cross section of patients and carers that represent our population, which could result in us implementing changes that do not fully address the needs of all our patients	Director of Strategy and Transformation	Board	9				3				
			5.2	Risk that operational delivery pressures prevent staff from contributing to co-design sessions resulting in staff feeling change is being implemented without their input		People and OD	16				4				
			5.3	Risk that as a result of some feedback through engagement and consultation not being not taken up, patients, the public and staff feel 'not listened to'		Board									
			5.4	Risk that the staff morale is adversely affected, should the Centres of Excellence vision and/or estates development get delayed and the expected patient and staff benefits do not get realised as/when expected		People and OD	12				4				
6	Centres of Excellence	We have established Centres of Excellence that provide urgent, planned and specialist care to the highest standards, and ensure as many Gloucestershire residents as possible receive care within the county	6.1	Risk that proposals to establish our Centres of Excellence model get delayed due to public opposition and/or legal challenge, delaying the realisation of patient benefits	Director of Strategy and Transformation	Board	12				8				
			6.2	Risk that the phased approach to implementation of our Centre of Excellence model is extended beyond reasonable timescales due to a range of dependencies e.g. estate, capital, workforce, technology delaying the realisation of patient benefits			9				6				
			6.3	Risk that the Strategic Site Development Programme fails to take account of the new roles/ways of working set out in the People and OD strategy, leading to suboptimal estate		People and OD	1				1				
7	Financial Balance	We are a Trust in financial balance, with a sustainable financial footing evidenced by our NHSI Outstanding rating for Use of Resources	7.1	Risk that we lack the capacity and capability needed to identify and/or deliver transformational, sustainable savings schemes	Director of Finance	Finance and Digital	15				6				
			7.2	Risk of expenditure exceeding budgets, resulting in worsening of Trust's underlying financial position.			12				6				
			7.3	Risk that the commissioner funding does not address structural funding deficit over the strategic period			20				12				
			7.4	Risk that we do not have sufficient capital			9				4				

Strategic Objectives			Principal risk				Risk rating					Assurance rating			
			ID	Principle Risk	Executive Lead	Assuring Committee	Q1	Q2	Q3	Q4	Target	Q1	Q2	Q3	Q4
				funding for transformation including the Centres of Excellence Programme and the Strategic Site Development Programme and/or cashflow risk due to phasing of the programmes											
			7.5	Risk that the Integrated Care System (ICS) model adversely affects the Trust's financial position			6				3				
			7.6	Risk of failure to deliver the required return on investment (ROI), especially in digital projects and programmes			9				4				
8	Effective Estate	We have developed our estate and work with our health and social care partners, to ensure services are accessible and delivered from the best possible facilities that minimise our environmental impact	8.1	Risk that the Trust cannot access sufficient capital to make required progress on maintenance, repair and refurbishment of core equipment and/or buildings to prevent cumulative degradation.	Director of Strategy and Transformation	Estates and Facilities	16				8				
			8.2	Risk that investment decisions are taken at organisational level rather than system resulting in inequity in the quality of NHS estate across Gloucestershire.			12				6				
			8.3	Risk that the failure to modernise and renew our estates results in adverse environmental impacts											
9	Digital Future	We use our electronic patient record system and other technology to drive safe, reliable and responsive care, and link to our partners in the health and social care system to ensure joined-up care	9.1	Risk that we fail to identify and embrace relevant innovations in digital technologies	Digital and Chief Information Officer	Finance and Digital	9				6				
			9.2	Risk that the Electronic Patient Record (EPR) programme and other technology programmes do not proceed as set out in the implementation plans, delaying the timeliness and/or scale of benefits expected			12				4				
			9.3	Risk that we fail to support leaders and staff to engage with the EPR and other technology programmes as required and the benefits are limited as a result			12				3				
			9.4	Risk that the Trust EPR cannot be appropriately linked to systems in primary care, community providers and other remote providers and/or lack of commitment from relevant external parties adversely affecting the ability to create joint health records and deliver best care for everyone			4				2				
10	Driving Research	We are research active, providing innovative and ground-breaking treatments; staff from all	10.1	Risk that we are unable to secure funding to support individuals and teams to dedicate time to research due to competing priorities limiting	Director of Strategy and Transformation	People and OD	4				4				

Strategic Objectives			Principal risk												
			ID	Principle Risk	Executive Lead	Assuring Committee	Risk rating					Assurance rating			
							Q1	Q2	Q3	Q4	Target	Q1	Q2	Q3	Q4
		disciplines contribute to tomorrow's evidence base, enabling us to be one of the best University Hospitals in the UK		our ability to extend our research portfolio											
			10.2	Risk that we do not identify and address relevant skills, capacity and capability gaps to allow us to achieve our research vision			8				4				
			10.3	Risk that the business case to secure University Hospital status does not demonstrate an acceptable return on investment delaying the realisation of patient and staff benefits			12				8				
			10.4	Risk that the business case for University Hospital status does not stack up and there is no additional funding to support a net investment in University Hospitals' status.			12				8				

Appendix 2

Strategic Objective 1: We are recognised for the excellence of care and treatment we deliver to our patients, evidenced by our CQC Outstanding rating and delivery of all NHS Constitution standards and pledges

Principal Risk ID **1.1**	Risk that we fail to identify quality and safety risks to the delivery of excellent care leading to avoidable harm, poor patient experience and reputational damage			
Principal risk to Achievement of the Objective *Including target and current risk score*	**Target score (C x L)**	4 x 1	**Current Score (C x L)**	4 x 3
Risk Owner (Executive Director)	Director of Quality and Chief Nurse		**Oversight/Assurance Committee**	Quality and Performance

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1. Risk Management Strategy 2. Health and Safety Policy 3. Risk assessment/risk register process 4. Procedure for 'Managing, Reporting And Reviewing Of Incidents/ Accidents, including Serious Incidents' 5. Risk Management Group 6. Health and Safety Committee 7. Divisional Quality Boards 8. Safety and Experience Review Group 9. Serious Incidents Panel 10. Patient experience insight data reviews (FFT, National Survey programme, Real-time Surveys) 11. Quality framework 12. Freedom to Speak up: Raising Concerns Policy (Freedom to Speak Up Guardian) 13. Gloucestershire CCG – Clinical Review Group 14. Journey to Outstanding (J2O) Executive visits to service areas	1st line/2nd line 1. Annual Report and Quality Account 2. Trust risk register report (Board and Quality and Performance (Q&P) 3. Assurance Report from the Chair of the Quality Committee to Board 4. Quality and Performance Report (Board and Q&P) 5. Serious Incidents (quarterly) Report 6. Patient Experience (quarterly) Report 7. People and OD Committee (Health and Safety) 8. Executive Divisional Reviews 9. Exception reports from divisions to Quality Delivery Group (QDG) 10. Exception reports from delivery groups (DG) to Q&P (Cancer DG, Emergency Care DG, Planned Care DG, QDG) 11. Reviews of divisional risks at Divisional Boards and Risk Management Group 12. Serious Untoward Incidents report (reviewed at Q&P and Board) 13. Freedom to Speak Up reports to People and OD Committee 14. QDG sub-committees (Infection Control Committee, Hospital Mortality Indicator Group, Safeguarding Committee) 3rd line 15. Reporting to national databases (NRLS)

		16. Reporting to external stakeholders (Coroner, Riddor, MHRA etc) 17. Internal audit report		
Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Quality strategy	Strategy being developed	SH	Q2 2019/20	
Quality Framework Quality and risk function capacity, capability and structure	Strengthening, centralisation, co-ordination and development of corporate and divisional risk resources	EW & AS	Q3 2019/20	
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Consistency of Corporate Division risk reviews	Establish and implement Corporate 'divisional Board' risk review/escalation process	EW & AS	Q2 2019/20	
Consistent risk reporting to Board Committees	Implement consistent risk reporting to Board Committees	EW & AS	Q2 2019/20	

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
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	4 x 4
C1798COO	The risk of delayed follow up care due to outpatient capacity constraints all specialities. (Orthodontics; ENT; Urology; Oral Surgery; Diabetic Medicine; Paediatric Urology; Endocrinology; Cardiology; Paediatric Surgery; Neurology; Colorectal and GI Surgery) Risk to both quality of care through patient experience impact (15) and safety risk associated with delays to treatment (4)	3 x 5
M2473Emer	The risk of poor quality patient experience during periods of overcrowding in the Emergency Department	3 x 5
C2667NIC	The risk of poor patient experience and/or outcomes as a result of hospital acquired C.Diff infection	4 x 3
C2669N	The risk of harm to patients as a results of falls	4 x 3
C1945NTVN	The risk of moderate to severe harm due to insufficient pressure ulcer prevention controls	3 x 4
S2568Anaes	The risk to patient safety of failure of anaesthetic equipment during an operation with currently very few spares to provide a reliable back up	5 x 1

S2775CC	The risk to patient safety of respiratory or/and cardiovascular instability and even death in the event of either an electrical or mechanical failure or as a result of needing to change over to a different mechanical ventilator	5 x 1

Principal Risk ID **1.2**	Risk that there is a lack of access to performance information, intelligence and insight and/or failure of assurance processes that inhibits our ability to make timely decisions			
Principal risk to Achievement of the Objective *Including target and current risk score*	**Target score (C x L)**	3 x 1	**Current Score (C x L)**	3 x 3
Risk Owner (Executive Director)	Director of Quality and Chief Nurse		**Oversight/Assurance Committee**	Quality and Performance

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1. Delivery Groups (Cancer DG, Emergency Care DG, Planned Care DG, Quality DG) 2. Quality framework 3. Divisional Operating Plans 4. Journey to Outstanding (J2O) visits to service areas 5. Delivery and assurance structures and escalation/reporting processes 6. National reporting of performance data to NHS Improvement	1st line/2nd line 1. Quality and Performance Report (reviewed at Quality and Performance Committee (Q&P) and Board) 2. Executive Divisional Reviews 3. Annual Report and Quality Account 4. Exception reports from delivery groups (DG) to Q&P (Cancer DG, Emergency Care DG, Planned Care DG, QDG) 5. Exception reports from divisions to Quality Delivery Group (QDG) 6. Clinical audit and self-assessment 3rd line 7. Improvement plan monitored by Gloucestershire CCG (Clinical Commissioning Group) Clinical Quality Review Group (CGRG), Health Overview and Scrutiny Committee (HOSC), CQC provider engagement meeting. 8. Internal audit 9. CQC inspection 10. Gloucestershire CCG review

Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Quality strategy	Strategy being developed	SH	Q2 2019/20	
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Consistency of Divisional	New Performance and	RD	Q2 2019/20	

Executive Reviews	Accountability Framework including consistent format of Divisional Executive Reviews and performance reporting			

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
	Not applicable	

Principal Risk ID **1.3**	Risk that we fail to deliver the Trust's enabling Quality Strategy			
Principal risk to Achievement of the Objective *Including target and current risk score*	**Target score (C x L)**	1 x 1	**Current Score (C x L)**	4 x 2
Risk Owner (Executive Director)	Director of Quality and Chief Nurse		**Oversight/Assurance Committee**	Quality and Performance

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1. Delivery Groups (Cancer DG, Emergency Care DG, Planned Care DG, Quality DG) 2. Quality framework 3. Nursing Assessment and Accreditation System (NAAS) 4. Gloucestershire Safety and Quality Improvement Academy (GSQIA) 5. Divisional Operating Plans 6. Journey to Outstanding (J2O) visits to service areas	1st line/2nd line 1. Quality and Performance Report (reviewed at Quality and Performance Committee (Q&P) and Board) 2. Executive Divisional Reviews 3. Annual Report and Quality Account 4. Benchmarking assessments by divisions at QDG 5. Exception reports from divisions to Quality Delivery Group (QDG) 6. Exception reports from delivery groups (DG) to Q&P (Cancer DG, Emergency Care DG, Planned Care DG, QDG) 7. Serious Untoward Incidents report (reviewed at Q&P and Board) 8. Q&P sub-committees: Infection Control Committee, Hospital Mortality Indicator Group 3rd line 9. Improvement plan monitored by Gloucestershire CCG (Clinical Commissioning Group) Clinical Quality Review Group (CGRG), Health Overview and Scrutiny Committee (HOSC), CQC provider engagement meeting. 10. Internal audit 11. CQC inspection

Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Quality strategy	Strategy being developed	SH	Q2 2019/20	
Divisional Operating Plans (yet to be aligned with the quality strategy)	Divisional Operating Plans to be aligned with the Quality strategy, once QS developed	CoSs	Q3 2019/20	

Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Delivery structure to support new strategy	Review and implementation of new delivery structures	EW & MP	Q4 2019/20	

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
	Not applicable	

Principal Risk ID **1.4**	Risk that we breach CQC regulations or other quality related regulatory standards			
Principal risk to Achievement of the Objective *Including target and current risk score*	**Target score (C x L)**	4 x 1	**Current Score (C x L)**	4 x 3
Risk Owner (Executive Director)	Director of Quality and Chief Nurse		**Oversight/Assurance Committee**	Quality and Performance

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1. Delivery Groups (Cancer DG, Emergency Care DG, Planned Care DG, Quality DG) 2. 2019 CQC inspection MUST DOs and SHOULD Dos action plan 3. Divisional Boards 4. Divisional Quality Meetings 5. Quality framework 6. Nursing Assessment and Accreditation System (NAAS) 7. Process for investigating Serious Untoward Incidents and Near Misses 8. Risk Management Strategy 9. Risk Register procedure 10. Procedure for 'Managing, Reporting And Reviewing Of Incidents/ Accidents, including Serious Incidents' 11. Freedom to Speak Up Policy 12. Divisional Operating Plans 13. Journey to Outstanding (J2O) visits to service areas 14. Delivery and assurance structures including Quality Delivery Group and Quality and Performance Committee	1st line/2nd line 1. Quality and Performance Report (reviewed at Quality and Performance Committee (Q&P) and Board) 2. Executive Divisional Reviews 3. Annual Report and Quality Account 4. Benchmarking assessments by divisions at QDG 5. Exception reports from divisions to Quality Delivery Group (QDG) 6. Exception reports from delivery groups (DG) to Q&P (Cancer DG, Emergency Care DG, Planned Care DG, QDG) 7. Q&P sub-committees: Infection Control Committee, Hospital Mortality Indicator Group 8. Committee and Board reports including evidence-based self-certification/self-assessments 9. Serious Untoward Incidents report (reviewed at Q&P and Board) 10. Q&P sub-committees: Infection Control Committee, Hospital Mortality Indicator Group 3rd line 11. CQC Improvement plan monitored by Gloucestershire CCG (Clinical Commissioning Group) Clinical Quality Review Group (CGRG), Health Overview and Scrutiny Committee (HOSC), CQC provider engagement meeting. 12. 7 Day Services self-assessment monitored by NHS Improvement 13. Internal audit 14. CQC inspection

Gaps in Controls	**Actions for gaps**	**Owner**	**Date**	**Update**

The control is not in place or not effective, due to the design of the control or the likelihood of it being effective				
Quality strategy	Strategy being developed	SH	Q2 2019/20	
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
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	4 x 4

Strategic Objective 1: We are recognised for the excellence of care and treatment we deliver to our patients, evidenced by our CQC Outstanding rating and delivery of all NHS Constitution standards and pledges

Quarterly Progress report			
Current assurances (positive and negative) *What is known about the effectiveness of the controls from the assurance framework?*	**General update** *E.g. milestones reached*	**Assurance Rating**	
		Proposed	**Agreed**
• Quality and Performance Dashboard in the Quality and Performance Report recently developed to include a scorecard and benchmarking amongst other changes • Quality Strategy to be signed off in September 2019 by Board	CQC rated the Trust as good in February 2019		

Strategic Objective 2: We have a compassionate, skilful and sustainable workforce, organised around the patient, that describes us as an outstanding employer who attracts, develops and retains the very best people

<table>
<tr><td>Principal Risk ID 2.1</td><td colspan="4">Risk that we are unable to match recruitment needs (due to national and local shortages) with suitably qualified clinical colleagues.

People & OD risk C1437P&OD: The risk of being unable to match recruitment needs with suitably qualified clinical staff (including: AHP's, Nursing and Medical), impacting on the delivery of the Trusts strategic objectives.
C908P&OD The risk of potential staff shortages associated with the development of the PCNs as part of the NHS LTP across; physio, pharmacy and Physician Associates. Extent of impact unknown at present.</td></tr>
<tr><td rowspan="2">Principal risk to Achievement of the Objective
Including target and current risk score</td><td>Target score (C x L)</td><td>Principal risk assessment for BAF: 2 x 2

2 x 2 C1437P&OD
1 x 1 C908P&OD</td><td>Current Score (C x L)</td><td>Principal risk assessment for BAF: 3 x 2

2 x 4 C1437P&OD
1 x 1 C908P&OD</td></tr>
<tr><td>Risk Owner (Executive Director)</td><td colspan="2">Director of People and Organisational Development (OD)</td><td>Oversight/Assurance Committee</td><td>People and OD</td></tr>
<tr><td colspan="3">Key Controls
What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups</td><td colspan="2">Sources of assurances on Controls
What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment</td></tr>
<tr><td colspan="3">1. People and OD Strategy- workforce sustainability and colleague experience pillar initiatives such as: Embed a strong unique employer brand to attract the best talent and embed, Develop new roles and career pathways, Understand supply changes and demands and analyse current and future needs, Develop and implement new workforce models within the Trust and with partners, Placement capacity and student experience and equity for all</td><td colspan="2">1. People and OD Committee review of Strategic Outcome measures, including:
People and OD Dashboard
Quarterly Sustainable Workforce Report
Annual Education Learning and Development Report
ICS Update
Operational exception reports</td></tr>
</table>

2. People and OD Delivery Group and monitoring progress of delivery groups and work streams focussed on sustainable workforce including (but not limited to): Recruitment and Retention Staff and Patient Experience Group Strategic Sustainable Workforce and Education Group Medical Education Board Workforce Planning	2. People and OD Delivery Group escalation report to Trust Leadership Team and Divisional Executive Reviews – opportunities to challenge recruitment and retention priority plans and to consider vacancies, turnover and divisional recruitment needs (new operational measures)
3. Projects to maximise intake capacity of Deanery students, nurse, midwifery and AHP student placements – and to improve the experience of students whilst on placement in GHFT (and aligned to the National Nurse Standards changes).	3. Medical Education Board and Education, Learning and Development group review placements alongside HEE feedback which is escalation to People and OD Delivery Group and TLT (as necessary)
4. The management of talent and succession planning, including projects to attract future workforce and boost retention such as: Apprenticeship growth, Advanced Development Pool, Itchy feet transfer windows, Keep in touch events, career clinics, , the national RePAIR programme, and the Professional Advocates programme	4. People and OD Delivery Group, prior to inclusion into the escalation report to Trust Leadership Team People and OD Committee Quarterly Sustainable Workforce Report Executive Review of delivery of Divisional Workforce Plans
5. ICS Workforce Plan Collaboration Central workforce planning for the system is overseen by the ICS Workforce Steering Group and 'One Place' project team	5. LWAB oversight and ICS reports to People and OD Committee TLT oversight of ICS programmes of work inclusive of People impacts

Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Development of Integrated workforce plans with consideration of PCN impact	To participate in ICS development of PCN offer.	Deputy Director of People and OD	September 2019	Development of GCS and GHT physio model underway to establish joint PCN offer. Initial workforce assessment shared, joint model development taking place August – September 2019.
Divisional Business plans (inc. workforce) do not currently extend beyond annual operating plan to support long term projections.	Creation of 5 year workforce plans, integrated with ICS and long term plan drivers.	Deputy Director of People and OD	October 2019	Divisional workshops have taken place during month. Divisions now engaged in development of plans

Dedicated Recruitment and Retention Lead (Nursing)	Recruit to post	Director of Quality and Chief Nurse	July 2019	Fran Wilson appointed to post, due to commence August 2019.
Lack of established link between Temporary Staffing, E Rostering and Transactional Recruitment and Retention Services	Expand role of MM to incorporate transactional recruitment services	Deputy Director of People and OD	July 2019	MM commenced role as Associate Director for Transactional Workforce mid July 2019.
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
NONE				

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
S2275	The risk of workforce issues with staff well-being arising from an ongoing lack of staff able to deliver the emergency general surgery rota due to reducing staffing numbers and vacancies	4 x 4 (safety)
F2335	Risk of agency spend in clinical and non-clinical areas exceeding planned levels due to ongoing high vacancy levels with the resulting impact of delivery of FY20 CIP programme	4 x 4 (finance)

<table>
<tr><td>Principal Risk ID</td><td>2.2</td><td colspan="4">Risk that continued poor levels of staff engagement measured by national and local surveys may negatively impact upon retention, attraction and patient experience</td></tr>
<tr><td colspan="2" rowspan="2">Principal risk to Achievement of the Objective
Including target and current risk score</td><td colspan="4">People and OD risks C2803P&OD The risk of continued poor levels of staff engagement and poor staff experience impacting negatively on retention, recruitment and patient experience</td></tr>
<tr><td>Target score (C x L)</td><td>Principal risk assessment for BAF: 2 x 2

3 x 1 C2803P&OD</td><td>Current Score (C x L)</td><td>Principal risk assessment for BAF: 3 x 2

3 x 3 C2804P&OD</td></tr>
<tr><td colspan="2">Risk Owner (Executive Director)</td><td colspan="2">Director of People and OD</td><td>Oversight/Assurance Committee</td><td>People and OD</td></tr>
<tr><td colspan="3">Key Controls
What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups</td><td colspan="3">Sources of assurances on Controls
What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment</td></tr>
<tr><td colspan="3">1. People and OD Strategy specifically initiatives under the colleague experience and transformation pillars including Develop a culture where our values are well embedded in all our practices and policy, Secure equity for all, Remove violence and aggression, bullying and harassment from colleagues' working lives, Promote health, safety and wellbeing, Embed new leadership and management practice, Deliver the best professional education, learning and development. A trajectory of staff survey result improvement has been published within the strategy</td><td colspan="3">1. Reports to People and OD Committee regarding staff survey action plans, exception reports from divisions on colleague engagement, Equality data (WRED, WDES, Gender Pay Gap audit), Freedom to speak up trends, Health and Safety reports and triangulation of staff experience in the performance dashboard</td></tr>
<tr><td colspan="3">2. Senior People and OD leaders are involved in programmes of work which may impact upon colleague engagement such as centres of excellence and strategic site delivery to ensure the staff voice is heard</td><td colspan="3">2. Scrutiny of employee issues at People and OD Delivery Group, Directors Operational Group and TLT</td></tr>
<tr><td colspan="3">3. Sickness management policies and implementation (D)</td><td colspan="3">3. People and OD Dashboard in People and OD Report (to Executive divisional reviews, People and OD Committee and Board)</td></tr>
</table>

4. Staff Patient Experience and Improvement Group identifying areas for action and overseeing projects including but not limited to: Exit Interviews HCA Turnover Staff Survey Action Plans		4. People and OD Delivery Group, prior to inclusion into the escalation report to Trust Leadership Team People and OD Committee Staff Engagement and Staff Survey Reports		
5. People and OD Delivery Group and monitoring progress of delivery groups and work streams focussed on sustainable workforce including (but not limited to): Recruitment and Retention Staff and Patient Experience Group Strategic Sustainable Workforce and Education Group Medical Education Board Equality, Diversity, Inclusion and Human Rights Freedom to Speak Up		5. People and OD Delivery Group escalation report to Trust Leadership Team		
Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Communication and Engagement Strategy	Strategy under development	Head of Communications	October 2019	On work plan for P&OD review in October 2019
Triangulation of data relating to staff experience	SPEIG to create and manage triangulation dashboard to support prioritisation of activity	Head of Leadership and OD	May 2019	Draft dashboard in use at SPEIG, requires further work to ensure it is useful and not overly cumbersome to populate. Implementation of ER casework tracker (May and June 2019) will support more efficient reporting from on casework (first reporting expected November 2019).
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
The need to deliver the engagement strategy as noted above				

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
S2275	The risk of workforce issues with staff well-being arising from an on-going lack of staff able to deliver the emergency general surgery rota due to reducing staffing numbers and vacancies	4 x 4 (Safety)

Principal Risk ID	**2.3**	Risk that we fail to deliver the Trust's enabling People and Organisational Development Strategy			
Principal risk to Achievement of the Objective *Including target and current risk score*		**Target score (C x L)**	Principal risk assessment for BAF:1x1 No entry on risk register relating to this principal risk	**Current Score (C x L)**	Principal risk assessment for BAF: 1 x 1 No entry on risk register relating to this principal risk
Risk Owner (Executive Director)		Director of People and OD		**Oversight/Assurance Committee**	People and OD

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1. Delivery teams in People and OD are familiar with the strategy and have team plans to deliver the milestones set as year 1-2, 3-4 and 5. Team and individual activity linked to appraisals are built around delivery of the strategy Delivery teams are building frameworks and reporting mechanisms to enable transparency of progress against strategic measures	1. People and OD Dashboard in People and OD Report (to People and OD Committee and Board) Sustainable workforce report to People and OD Committee
2. P&OD Senior leadership team and directorate wide meetings to review progress and interdependencies, alongside Succession planning of People and OD teams link to delivery of the strategy	2. Reports to the People and OD Committee, including but not limited to: Staff survey action plan Equality and diversity Freedom to Speak Up Staff friends and family quarterly survey results Annual health and wellbeing report Operational Dashboard
3. Divisions are held to account in the Executive review process for delivery of the operational measures **(D)**	2. Scrutiny of employee issues at People and OD Delivery Group, Directors Operational Group and TLT Monitoring of sickness, absence, recruitment and retention – HR Advisory Team review data monthly and included in People and OD dashboard

4. Delivery and assurance structures including People and OD Delivery Group, Health and Wellbeing Committee and People and People and OD Committee		4. People and OD Delivery Group escalation to TLT. Reports to the People and OD Committee, including but not limited to: Staff survey action plan Equality and diversity Freedom to Speak Up Staff friends and family quarterly survey results Annual health and wellbeing report Operational Dashboard Board and Divisional Executive Review escalation report		
Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Divisional Business plans (inc. workforce) do not currently extend beyond annual operating plan to support long term projections.	Creation of 5 year workforce plans, integrated with ICS and long term plan drivers.	Deputy Director of People and OD	October 2019	Divisional workshops have taken place during month. Divisions now engaged in development of plans
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Design of operational dashboard required to ensure it captures outcomes aligned to P&OD Strategy and team reporting needs are clarified and delivered	Review of Operational Dashboard through P&OD groups, delivery teams, and Executive Review	Deputy Director of People and OD	October 2019	Intention to present first draft to October 2019 People and OD Committee
Design of exception reports following executive review of matters pertaining to assurance process of P&OD committee to be devised	A template to be designed once the dashboard is finalised	Deputy Director of People and OD	End October 2019	Will be available by December 2019 committee

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
NONE		

Principal Risk ID **2.4** **Principal risk to Achievement of the Objective** *Including target and current risk score*	Risk that we fail to attract, recruit and retain candidates from diverse communities resulting in the Trust workforce not being representative of the communities we serve People and OD risks C2803P&OD The risk of continued poor levels of staff engagement and poor staff experience impacting negatively on retention, recruitment and patient experience People & OD risk C1437P&OD: The risk of being unable to match recruitment needs with suitably qualified clinical staff (including: AHP's, Nursing and Medical), impacting on the delivery of the Trusts strategic objectives.			
	Target score (C x L)	Principal risk assessment for BAF: 2 x 2 3 x 1 C2803P&OD 2 x 2 C1437P&OD	**Current Score (C x L)**	Principal risk assessment for BAF: 3 x 2 3 x 3 C2803P&OD 2 x 4 C1437P&OD
Risk Owner (Executive Director)	Director of People and OD		**Oversight/Assurance Committee**	People and OD

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1. People and OD strategy embeds EDI in all pillars and strategic and operational measures to improve diversity are in place. Objectives include to: Significantly strengthen the support provided to staff with disabilities and support/education offered to line managers who work with disabled colleagues. Improve the support and reporting mechanisms for colleagues when they experience or witness bullying, abuse, harassment or violence. Eliminate unfair discrimination. Each year we will refresh our equality of opportunity, diversity and inclusion action plan to ensure changing priorities are captured. Our key measures of success and metrics include National reports will show that the experience gap between colleagues with single or multiple protected characteristics have been eliminated. Staff survey reports will show that colleagues are treated fairly, unfair discrimination is eliminated and BAME staff are	1. Reports to People and OD Committee and Board: WRES and WDES standards Equality report (and progress against EDI aspirations) EDS2 Objectives Gender Pay gap annual report Staff Survey

not disproportionately subject to disciplinary or grievance processes.	
2. Freedom to speak up guardian	2. Freedom to speak up reports to People and OD Committee and Board
3. Numerous engagement forums including: The Trust Equality and Diversity Network Governors' strategy and engagement group Project specific engagement events	3. Colleague Engagement reports to People and OD Committee
4. Embedding Equality, Diversity and Inclusion into the operations of the Trust, such as: Equality, Diversity and Inclusion Action plan Equality and diversity consideration on cover sheets for Board, Committees and TLT Unconscious Bias Training for recruiting managers Retention and recruitment plans	4. Progress made against People and OD strategy and the EDI aspirations, as reported to TLT and the People and OD Committee and Board.

Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
NONE				

Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
NONE				

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
NONE		

Strategic Objective 2: We have a compassionate, skilful and sustainable workforce, organised around the patient, that describes us as an outstanding employer who attracts, develops and retains the very best people

Quarterly Progress report			
Current assurances (positive and negative) *What is known about the effectiveness of the controls from the assurance framework?*	**General update** *E.g. milestones reached*	**Assurance Rating**	
		Proposed	**Agreed**
• EDS2 objectives agreed by the Board in May 2019 • People and OD Strategy agreed by the Board in July 2019	• Staff health and wellbeing hub launched May 2019 • 5 Year workforce plan development has commenced across clinical Divisions (corporate and GMS to follow) to support Trust wide + ICS plan development • PCN Physiotherapy model under development. • ER casework tracker implemented. This will support more efficient reporting on casework and HR Advisory acivity (first reporting expected November 2019).	Moderate	

Strategic Objective 3: Quality improvement is at the heart of everything we do; our staff feel empowered and equipped to do the very best for their patients and each other

Principal Risk ID **3.1** **Principal risk to Achievement of the Objective** *Including target and current risk score*	Risk of failure to deliver the Quality Framework and associated distributed quality leadership. This would delay the development of an empowered workforce close to the patient and prevent the required cultural change/embedding of quality improvement.			
	Target score (C x L)	2 x 3	**Current Score (C x L)**	3 x 4
Risk Owner (Executive Director)	Executive Director of Safety and Medical Director		**Oversight/Assurance Committee**	Quality and Performance

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1. Quality Framework 2. Leadership development programmes	1. NHS Staff Survey, annually reported to People and OD Committee and Board. Staff survey action plan also reported to People and OD Committee. 2. Quality and Performance dashboard reported to Quality and Performance Committee 3. Quality framework monitored through Quality Delivery Group and Quality and Performance Committee 4. Divisional governance internal audit

Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Quality strategy, to include a section on the quality framework and the associated distributed quality leadership	Strategy under development	SH/MP/RD		
Review of divisional governance		MP		
Quality framework support structures not (fully) implemented	Implementation of support structures	AS	Q3 2019/20	
Success/ effectiveness measures to be developed	Development of success/effectiveness measures			

Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Divisional assurance framework	To be developed following divisional governance review	MP		

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
	Not applicable	

Principal Risk ID **3.2**	Risk that we fail to deliver the Trust's enabling Quality Strategy and implement the Quality Framework			
Principal risk to Achievement of the Objective *Including target and current risk score*	**Target score (C x L)**	2 x 3	**Current Score (C x L)**	NA re Quality Strategy 3 x 4 re Quality Framework
Risk Owner (Executive Director)	Executive Director of Safety and Medical Director		**Oversight/Assurance Committee**	Quality and Performance

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1. Gloucestershire Safety and Quality Improvement Academy (GSQIA) 2. Training Programme agreed	1. 6 monthly reports of GSQIA progress to Quality and Performance Committee 2. Feedback to GSQIA members/ divisions by quarterly newsletters of numbers attending and progress of projects 3. Monitoring of numbers trained through the GSQIA 4. Oversight of the quality strategy at Quality and Performance Committee, Board, and the Council of Governors 5. Monitoring of the quality framework at Quality Delivery Group and Quality and Performance Committee 6. Internal audit reports 7. CQC inspection

Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Quality strategy	Quality strategy being developed	SH/RD/MP	Q2 2019/20	
Quality framework support structures not (fully) implemented	Implementation of support structures	AS	Q3 2019/20	
Review of divisional governance		MP		
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Quality framework effectiveness measures to be developed	Development of effectiveness measures	AS	Q3 2019/20	

Divisional assurance framework	To be developed following divisional governance review	MP		
Related Risks from the Trust Risk Register				
Code	Risk description			C x L Score (Domain)
	Not applicable			

Strategic Objective 3: Quality improvement is at the heart of everything we do; our staff feel empowered and equipped to do the very best for their patients and each other

Quarterly Progress report			
Current assurances (positive and negative) *What is known about the effectiveness of the controls from the assurance framework?*	**General update** *E.g. milestones reached*	**Assurance Rating**	
		Proposed	**Agreed**
• GSQIA Bronze/Silver/Gold statistics • 2019 CQC inspection report			

Strategic Objective 4: We put patients, families and carers first to ensure that care is delivered and experienced in an integrated way in partnership with our health and social care partners

Principal Risk ID **4.1**	Risk that individual organisational priorities and decisions are not aligned, which would result in restriction of the movement of resources (including financial and workforce) leading to an impact upon the scope of integration			
Principal risk to Achievement of the Objective *Including target and current risk score*	**Target score (C x L)**	2 x 2	**Current Score (C x L)**	3 x 2
Risk Owner (Executive Director)	Chief Operating Officer		**Oversight/Assurance Committee**	Board
Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*		**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*		
1. ICS delivery structures including programmes, ICS Executive and ICS Board 2. Trust Executives' membership of ICS structures 3. ICS operating plan		1. Reporting on ICS developments to Trust Board and Board Committees		
Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
ICS decision-making mechanisms and key decisions road map	Develop ICS decision-making mechanisms and key decisions road map	COO		Executive ownership across each locality Regular executive meetings to share updates from localities Directors Operational Group to include standing agenda item Quality and Performance Committee to include ICS standing agenda item
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Consistency of ICS reporting to partner organisations' Boards and across Board Committees	Implement consistent ICS reporting to partner organisations' Boards and across Board Committees	COO	Quarterly	
ICS governance arrangements	Being developed	CEX	Quarterly	

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
	Not applicable	

Principal Risk ID	**4.2**	Risk that the Primary Care Networks funding model has adverse impact on integration			
Principal risk to Achievement of the Objective *Including target and current risk score*		**Target score (C x L)**	2 x 2	**Current Score (C x L)**	3 x 3
Risk Owner (Executive Director)		Chief Operating Officer		**Oversight/Assurance Committee**	Board

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1. ICS delivery structures including programmes, ICS Executive and ICS Board 2. Trust Executives' membership of ICS structures and Place partnerships/locality networks 4. ICS operating plan 5. ICS and Trust Engagement with Primary Care Networks	1. Reporting on ICS developments to Trust Board and Board Committees 2. Workforce Committee

Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Visibility of PCN developments and Trust engagement with PCNs	Engagement with Primary Care Networks (via Place partnerships/locality networks	COO	Quarterly	
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Workforce plans – specifically recruitment to posts in primary care	ICS Workforce Planning	Director HR&OD	Quarterly	Trust workforce planning is in train for production Autumn 2019 to feed through to ICS plans

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
	Not applicable	

Strategic Objective 4: We put patients, families and carers first to ensure that care is delivered and experienced in an integrated way in partnership with our health and social care partners

Quarterly Progress report			
Current assurances (positive and negative) *What is known about the effectiveness of the controls from the assurance framework?*	**General update** *E.g. milestones reached*	**Assurance Rating**	
		Proposed	**Agreed**
• Reporting on ICS developments to Trust Board and Board Committees	• Trust engagement with ICS • Low level of ICS maturity with many elements (vision, governance, decision-making, risk management, engagement) under development		

Strategic Objective 5: Patients, the public and staff tell us that they feel involved in the planning, design and evaluation of our services

Principal Risk ID **5.1**	Risk that we are unable to identify or get regular attendance from a cross section of patients and carers that represent our population, which could result in us implementing changes that do not fully address the needs of all our patients			
Principal risk to Achievement of the Objective *Including target and current risk score*	**Target score (C x L)**	3 x 1	**Current Score (C x L)**	3 x 3
Risk Owner (Executive Director)	Director of Strategy and Transformation		**Oversight/Assurance Committee**	People and OD

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1. Silver Quality Improvement projects must involve patients when appropriate and are supported by the Patient Experience Improvement Team 2. Partnerships with existing external organisations in Gloucestershire e.g. Gloucestershire Deaf Association; Gloucestershire Maternity Voices Partnership 3. EDS2 Objectives (aiming to have conversations with the community around protected characteristics and to develop person-centred care charters) and an action plan to deliver them 4. Trust membership events 5. Governors Strategy and Engagement Group 6. Patient experience stories heard at every Board	1. Survey data including: 5 surveys from the National Survey Programme related to our services; Friends and Family Test; real time patient surveys; local surveys 2. Biannual Learning from Patient Stories Report 3. Council of Governors 4. Equality report to People and OD and the Board 5. Quarterly patient experience report to Q&P Committee 6. Themes and trends within the Annual Complaints Report

Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Fit for the future engagement and consultation	Strategy & plan being implemented	System wide GHFT: Jo Underwood & Craig MacFarlane	25/7/19	Strategy in development and implementation underway

Communication and engagement strategy	Strategy under development	Craig MacFarlane	25/7/19	Strategy in development
Divisional patient experience quality improvement plans	Under development	Divisional chief nurses		
Patient involvement key element of the Quality Strategy	Strategy under development	SH	Q2	The strategy will go to the Board for approval in September.
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)

Principal Risk ID	**5.2**	Risk that operational delivery pressures prevent staff from contributing to co-design sessions resulting in staff feeling change is being implemented without their input			
Principal risk to Achievement of the Objective *Including target and current risk score*		**Target score (C x L)**	Principle risk assessment for BAF: 4 x 1 No entry on risk register relating to this principle risk	**Current Score (C x L)**	Principle risk assessment for BAF: 4 x 4 No entry on risk register relating to this principle risk
Risk Owner (Executive Director)		Director of Strategy and Transformation		**Oversight/Assurance Committee**	People and OD

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1. Programme boards for initiatives include Senior members of the People and OD to ensure staff have a voice, monitor delivery and include staff engagement and internal communication plans **(D)**	1. Programme board initiatives report into DOG, TLT.
2. All major change is managed by the People and OD team to ensure published staff engagement and consultation protocols are followed adequately.	2. People and OD assurance framework enable escalation of issues to Trust Leadership Team. In addition the Trade Union Joint Staff Side constitution provides clear routes of escalation and a forum from which to debate and receive feedback on the management of change (attended by the CEO).
3. Proposals to engage staff which require release are subject to Director Operational Review and Trust Leadership Team approval	3. Programme board initiatives report into DOG, TLT. Divisional programmes of change are also highlighted through the Executive review process.
4. Numerous engagement opportunities and feedback mechanisms, including but not limited to: GSQIA (supported by the Patient Experience Team) and the Quality Improvement Strategy encourage staff-led improvements Events with various options for attending e.g. Centres of Excellence staff engagement sessions; engagement sessions	4. Staff Survey – reported to People and OD Delivery Group and Committee provides a thematic view of where colleagues feel involved or not. Further engagement information is captured via J2O executive visits feedback, Executive reviews and the Freedom to Speak Up Guardian (reporting into the People and OD Committee and the Quality Delivery Group).

on the new Trust Strategy and EDS2 Objectives Surveys for co-design purposes e.g. on the new Trust Strategy and EDS2 Objectives Back the floor, J20, Chief Executive Blog				
Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Communication and engagement strategy	Strategy under development	Head of Communications	Due October 2019	On workplan for People and OD committee for October 2019
Staff involvement key element of the Quality Strategy	Strategy under development	Director of Quality and Chief Nurse	Q2	The strategy will go to the Board for approval in September.
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
The need to deliver the strategies as noted above				

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
NONE		

Principal Risk ID	**5.3**	Risk that as a result of some feedback through engagement and consultation not being not taken up, patients, the public and staff feel 'not listened to'			
Principal risk to Achievement of the Objective *Including target and current risk score*		**Target score (C x L)**		**Current Score (C x L)**	
Risk Owner (Executive Director)		Director of Strategy and Transformation		**Oversight/Assurance Committee**	Board

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1. Staff survey action plan 2. Adult inpatient survey action plan 3. Communication and engagement to staff via Involve, weekly CEO blog, 100 Leaders, engagement events, Extended Leadership Network, Medical education board, executive walkabouts	1. Friends and family test 2. Staff survey 3. Annual Members meeting

Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Communication and engagement strategy	Strategy under development	Craig MacFarlane	27/7/19	Strategy in development. In the meantime key Trust priorities are being communicated
Fit for Purpose engagement and consultation	Strategy & plan being implemented	System wide GHFT: Jo Underwood & Craig MacFarlane	27/7/19	Strategy & plan being implemented

Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
	Not applicable	

Principal Risk ID	**5.4**	Risk that the staff morale is adversely affected, should the Centres of Excellence vision and/or estates development get delayed and the expected patient and staff benefits do not get realised as/when expected
Principal risk to		

Achievement of the Objective *Including target and current risk score*	**Target score (C x L)**	Principle risk assessment for BAF: 2 x 2 No entry on risk register relating to this principle risk	**Current Score (C x L)**	Principle risk assessment for BAF: 3 x4 No entry on risk register relating to this principle risk
Risk Owner (Executive Director)	Director of Strategy and Transformation		**Oversight/Assurance Committee**	People and OD

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1. Programme boards for initiatives include Senior members of the People and OD to ensure staff have a voice, monitor delivery and include staff engagement and internal communication plans.	1. Programme board initiatives report into DOG and TLT.
2. Clear and open communication , staff survey action plans and engagement through 100 Leaders, Engagement sessions, Extended Leadership Network, CEO Weekly blog, Involve	2. People and OD dashboard reported to People and OD Committee and Board will provide a view of any issues relating to staff morale and centres of excellence. In addition Freedom to Speak Up Guardian reporting into the People and OD Committee and the Quality Delivery Group will highlight potential areas of concern.
3. Centres of Excellence and One Place Pre-Consultation Business Case , engagement sessions and implementation plan	3. Centres of Excellence and One Place business cases reported to Board in addition to this the NHS Staff Survey reports could enable an overview of specific issues for staff relating to centres of excellence in qualitative narrative.
4. People and OD strategy initiatives within colleague experience will assist with ensuring open communication is maintained to staff, whilst the Freedom to Speak Up Guardian provides further support.	4. People and OD dashboard reported to People and OD Committee and Board will provide a view of any issues relating to staff morale and centres of excellence. In addition Freedom to Speak Up Guardian reporting into the People and OD Committee and the Quality Delivery Group will highlight potential areas of concern.
5. Proposals to engage staff which require release are subject to Director Operational Review and Trust Leadership Team approval	5. Programme board initiatives report into DOG, TLT. High level communication managed in agreement with Trust Board.

Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Communication and	Strategy under development	Head of	Due October 2019	On workplan for People and OD committee for

engagement strategy		communications		October 2019
Estates strategy	Strategy under development	Director of Strategy and Transformation	Sept 2019	Estates strategy to Trust Main Board Sept 2019
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
The need to deliver the strategies as noted above				

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
NONE		

Strategic Objective 5: Patients, the public and staff tell us that they feel involved in the planning, design and evaluation of our services

Quarterly Progress report			
Current assurances (positive and negative) *What is known about the effectiveness of the controls from the assurance framework?*	**General update** *E.g. milestones reached*	**Assurance Rating**	
		Proposed	**Agreed**
• Engagement sessions on Centres of Excellence with staff , the public and governors • Bi-annual learning from Patient Experience Stories report presented to the Board in June 2019	• Deputy Director of Quality and Head of Quality trained in co-design with the Point of Care Foundation		

Strategic Objective 6: We have established Centres of Excellence that provide urgent, planned and specialist care to the highest standards, and ensure as many Gloucestershire residents as possible receive care within the county

Principal Risk ID **6.1**	Risk that proposals to establish our Centres of Excellence model get delayed due to public opposition and/or legal challenge, delaying the realisation of patient benefits			
Principal risk to Achievement of the Objective *Including target and current risk score*	**Target score (C x L)**	4 x 2	**Current Score (C x L)**	4 x 3
Risk Owner (Executive Director)	Director of Strategy and Transformation		**Oversight/Assurance Committee**	Board

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1. One Place Pre-Consultation Business Case (PCBC), that includes our Centres of Excellence (CoEx) PCBC, includes a clear, evidence based case for change. 2. Public consultation is preceded by 3-month public engagement stage designed and supported by the Consultation Institute 3. One Place stakeholder engagement plan owned by Gloucestershire CCG and reporting into ICS Executives 4. Lessons learned from recent threat of legal action incorporated into engagement and consultation plan	7. Centres of Excellence Delivery Group managing development of final CoEx PCBC 8. Monthly CoEx progress report to Trust Leadership Team 9. Monthly One Place/ CoEx programme updates to ICS Executives and GHFT Board 10. Final version of One Place Outline PCBC to be approved by GHFT Board in November 2019, ahead of public consultation

Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
One Place stakeholder engagement plan is not yet approved	Plan to go to ICS Executives meeting	GCCG	15/08/2019	
One Place engagement programme	Need to ensure GHFT clinical representatives are able to support engagement programme	S Lanceley	31/07/2019	One Place engagement plan now confirmed – key dates & brief to be issued to clinicians
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance*	**Actions for gaps**	**Owner**	**Date**	**Update**

or the likelihood of it being effective				

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
	Not applicable	

Principal Risk ID	**6.2**	Risk that the phased approach to implementation of our Centre of Excellence model is extended beyond reasonable timescales due to a range of dependencies e.g. estate, capital, workforce, technology delaying the realisation of patient benefits			
Principal risk to Achievement of the Objective *Including target and current risk score*		**Target score (C x L)**	3 x 2	**Current Score (C x L)**	3 x 3
Risk Owner (Executive Director)		Director of Strategy and Transformation		**Oversight/Assurance Committee**	Board

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1. Centres of Excellence Pre-Consultation business case to include phased implementation plan 2. Estates Strategy 3. People & OD Strategy 4. Digital Strategy 5. Alternative routes to capital being explored through Capital Control Group 6. Centres of Excellence Clear communication and engagement through Involve, weekly blog, 100 Leaders	1. Centres of Excellence Delivery Group managing development of final CoEx PCBC 2. Monthly CoEx progress report to Trust Leadership Team 3. Monthly One Place/ CoEx programme updates to ICS Executives and GHFT Board 4. Oversight of Centres of Excellence implementation by Trust Board 5. Oversight of enabling strategies by relevant committees 6. Capital Programme Update provided to Finance and Digital Committee 7. Risks escalated through committees, Trust Leadership Team and to the Board

Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
New Estates strategy	Strategy under development	S Lanceley	September 2019	
New Digital strategy	Strategy under development	M Hutchinson	October 2019	
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
	Not applicable	

Principal Risk ID	**6.3**	Risk that the Strategic Site Development Programme fails to take account of the new roles/ways of working set out in the People and OD strategy, leading to suboptimal estate			
Principal risk to Achievement of the Objective *Including target and current risk score*		**Target score (C x L)**	Principal risk assessment for BAF: 1 x 1 No entry on risk register relating to this principal risk	**Current Score (C x L)**	Principal risk assessment for BAF: 1 x 1 No entry on risk register relating to this principal risk
Risk Owner (Executive Director)		Director of Strategy and Transformation		**Oversight/Assurance Committee**	People and OD

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1. People and OD Strategy maps new roles and ways of working under the workforce sustainability and transformation pillar including Develop and implement new workforce models within the Trust and with partners, develop new roles and career pathways, Deliver digital and technological efficiencies for people processes	1. Progress made against People and OD strategy reported on a 6 monthly basis to People and OD Committee
2. Oversight of strategic site development business cases at, TLT, Finance and Digital Committee and Trust Main Board.	2. Strategic site development programme OBC and FBC oversight at Board
3. Robust development of operational plan, including workforce plan,	3. Board oversight
4. Programme risks managed at SSD Programme Board and escalated through committee, TLT and Board within monthly progress reports	4. Board oversight

Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Estates Strategy	Strategy under development	Head of Strategy and	Sept 2019	Estates strategy to Trust Main Board Sept 2019

		Transformation		
Digital Strategy	Strategy under development	CIO	October 2019	New Digital strategy
Strategic site development programme OBC	Business case under development	Head of Strategy and Transformation	Dec 2019	OBC to Trust Main Board Dec 2019
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
The need to receive the strategies noted above and OBC by the timeline noted				

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
NONE		

Strategic Objective 6: We have established Centres of Excellence that provide urgent, planned and specialist care to the highest standards, and ensure as many Gloucestershire residents as possible receive care within the county

Quarterly Progress report			
Current assurances (positive and negative) *What is known about the effectiveness of the controls from the assurance framework?*	**General update** *E.g. milestones reached*	**Assurance Rating**	
		Proposed	**Agreed**
• Staff engagement sessions on Centres of Excellence • One Place engagement narrative reviewed by Trust Board in July • One Place stakeholder engagement plan not yet signed off	• Centres of Excellence Pre Consultation Business Case (PCBC) approved in June Board • One Place PCBC approved in July Board	Moderate	

Strategic Objective 7: We are a Trust in financial balance, with a sustainable financial footing evidenced by our NHSI Outstanding rating for Use of Resources

Principal Risk ID	**7.1**	Risk that we lack the capacity and capability needed to identify and/or deliver transformational, sustainable savings schemes			
Principal risk to Achievement of the Objective *Including target and current risk score*		**Target score (C x L)**	3 x 2	**Current Score (C x L)**	5 x 3
Risk Owner (Executive Director)		Director of Finance		**Oversight/Assurance Committee**	Finance and Digital

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1. Operational plan 2. Cost Improvement Programme 3. Engagement on CIP through Involve, CEO weekly blog, 100 Leaders, Extended Leadership Network 4. Improved engagement with budget holders on budget setting process 5. Capability development (Count Me In programme; PMO support to divisions)	1. Monthly CIP update to Finance and Digital Committee 2. Programme Management Office record and monitor the CIP progress 3. Financial Sustainability Delivery Group scrutiny of CIP delivery 4. Executive reviews with divisions include focus on financial recovery and CIP delivery 5. Audit reports

Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Finance strategy	Strategy under development	SS		
Communication and engagement strategy	Strategy under development	SL		

Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
F2927	*Risk that the Trust does not achieve the required cost improvement resulting in failure to deliver the Financial Recovery Plan for FY20*	*5 x 4*
Principal Risk ID	**7.2**	Risk of expenditure exceeding budgets, resulting in worsening of Trust's underlying financial position.

Principal risk to Achievement of the Objective *Including target and current risk score*				
	Target score (C x L)	3 x 2	**Current Score (C x L)**	4 x 3
Risk Owner (Executive Director)	Director of Finance		**Oversight/Assurance Committee**	Finance and Digital

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1. Operational plan 2. Cost Improvement Programme 3. Engagement on CIP through Involve, CEO weekly blog, 100 Leaders, Extended Leadership Network 4. Improved engagement with budget holders on budget setting process 5. Capital plan	1. Financial Sustainability Delivery Group reports 2. Monthly CIP update to Finance and Digital Committee 3. Monthly financial performance report to Finance and Digital Committee and to Board for assurance

Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Finance strategy	Strategy under development	SS		
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
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*	*4 x 4*
F2928	*Risk that the Trust's expenditure exceeds the budgets set resulting in failure to deliver the FY20 Financial Plan*	*4 x 3*
F2927	*Risk that the Trust does not achieve the required cost improvement resulting in failure to deliver the Financial Recovery Plan for FY20*	*5 x 4*
Principal Risk ID	**7.3**	Risk that the commissioner funding does not address structural funding deficit over the strategic period

Principal risk to Achievement of the Objective *Including target and current risk score*				
	Target score (C x L)	4 x 3	**Current Score (C x L)**	5 x 4
Risk Owner (Executive Director)	Director of Finance		**Oversight/Assurance Committee**	Finance and Digital
Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*			**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*	
1. Contract negotiations with commissioners informed by 'drivers of deficit' report			1. Financial performance report to Finance and Digital Committee and to Board	
Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Finance strategy	Strategy under development	SS		
Limited influence over commissioner funding	Work with the ICS to develop new approaches to contracting and a sustainable funding settlement	SS		
Limited influence over commissioner funding	5 year system planning	SS/RDC/SL		
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
F2723	*Risk that FY20 income recovery will be reduced as a result of being unable to submit accurate data to commissioner to support payment, arising from issues associated with TrakCare implementation*	*3 x3*

Principal Risk ID	**7.4**	Risk that we do not have sufficient capital funding for transformation including the Centres of Excellence Programme and the Strategic Site Development Programme and/or cashflow risk due to phasing of the programmes			
Principal risk to Achievement of the Objective *Including target and current risk score*		**Target score (C x L)**	2 x 2	**Current Score (C x L)**	3 x 3
Risk Owner (Executive Director)		Director of Finance		**Oversight/Assurance Committee**	Finance and Digital

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1. Capital plan 2. NHSI funding bids	1. Financial performance report to Finance and Digital Committee and to Board 2. Capital update to Finance and Digital Committee 3. External audit 4. Business cases (for Centres of Excellence Programme and for the Strategic Site Development Programme) presented to Finance and Digital Committee and to Board for approval 5. Oversight of Strategic Site Development Programme at Estates and Facilities Committee

Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Strategic capital funding options	Finance and Digital Committee oversight; Estates and Facilities Committee input	SL/SS		
Finance strategy	Strategy under development	SS		
Estates strategy	Strategy under development	SL/RDC		
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
F2522	*Risk that available capital is insufficient to support requirements associated with*	*4 x4*

	buildings maintenance, equipment renewal and backlog maintenance resulting in major operational impacts and increased costs	

Principal Risk ID	**7.5**	Risk that the Integrated Care System (ICS) model adversely affects the Trust's financial position			
Principal risk to Achievement of the Objective *Including target and current risk score*		**Target score (C x L)**	3 x 1	**Current Score (C x L)**	3 x 2
Risk Owner (Executive Director)		Director of Finance		**Oversight/Assurance Committee**	Finance and Digital

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1. One Gloucestershire strategy 2. One Place business case 3. ICS operating plan 4. Trust Executives' membership of ICS structures 5. ICS delivery structures including programmes, ICS Executive and ICS Board	1. Financial performance report to Finance and Digital Committee and to Board 2. Integrated Care System Delivery Board 3. STP Memorandum of Understanding 4. Reporting on ICS developments to Trust Board and Board Committees

Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Finance strategy	Strategy under development	SS		
ICS decision-making mechanisms and key decisions road map	Develop ICS decision-making mechanisms and key decisions road map			
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Consistency of ICS reporting to partner organisations' Boards and across Board Committees	Implement consistent ICS reporting to partner organisations' Boards and across Board Committees			
ICS governance arrangements	Being developed			

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
	Not applicable	

Principal Risk ID	**7.6**	Risk of failure to deliver the required return on investment (ROI), especially in digital projects and programmes			
Principal risk to Achievement of the Objective *Including target and current risk score*		**Target score (C x L)**	2 x 2	**Current Score (C x L)**	3 x 3
Risk Owner (Executive Director)		Director of Finance		**Oversight/Assurance Committee**	Finance and Digital

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1. Service Development Group peer review business cases 2. Recruitment to key roles for delivering the Electronic Patient Record (EPR) 3. Benefits workshop engaging senior colleagues across the Trust to map benefits and opportunities of the EPR 4. Capital plan 5. Theatre improvement and outpatient improvement implementation plans	1. Financial performance report to Finance and Digital Committee and to Board 2. Business Case approval by Finance and Digital Committee (and Board, where required)

Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Robust benefits identification, delivery and tracking across major projects		PMO		
Finance strategy	Strategy under development	SS		
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
	Not applicable	

Strategic Objective 7: We are a Trust in financial balance, with a sustainable financial footing evidenced by our NHSI Outstanding rating for Use of Resources

Quarterly Progress report			
Current assurances (positive and negative) *What is known about the effectiveness of the controls from the assurance framework?*	**General update** *E.g. milestones reached*	**Assurance Rating**	
		Proposed	**Agreed**
• NHSI current UoR rating of 'Requires Improvement'	• NHSI agreement to Financial plan for 2019/20 • Removal of the Trust from Financial Special Measures and the Trust moved from Segment 4 to Segment 3 of the NHSI Single Oversight Framework in 18/19		

Strategic Objective 8: We have developed our estate and work with our health and social care partners, to ensure services are accessible and delivered from the best possible facilities that minimise our environmental impact

Principal Risk ID **8.1**	Risk that the Trust cannot access sufficient capital to make required progress on maintenance, repair and refurbishment of core equipment and/or buildings to prevent cumulative degradation.			
Principal risk to Achievement of the Objective *Including target and current risk score*	**Target score (C x L)**	4 x 2	**Current Score (C x L)**	4 x 4
Risk Owner (Executive Director)	Director of Strategy and Transformation		**Oversight/Assurance Committee**	Estates and Facilities

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1. Capital programme priorities informed by Trust and Divisional risk registers 2. Develop pre-emptive business cases in anticipation of national calls for capital bids e.g. future STP waves, winter funding 3. Operationalise GHFT Estates Strategy to produce a Development Control Plan 4. Develop Managed Equipment Service (MES) Business Case 5. £39.5M Strategic Site Development Programme (SSDP) 6. Investigate and develop alternative sources of capital funding	1. Capital programme update to Finance and Digital Committee and Trust Board 2. SSDP OBC and FBC to Finance and Digital Committee, Estates Committee and Trust Board 3. Progress on operationalising Estates Strategy reported to Estates Committee 4. MES business case to Finance & Digital Committee and Trust Board in Q3 2019/20 5. Monitor and respond to national calls for capital bids 6. Use Estates Strategy and Development Control Plan to prioritise investment 7. All GHFT enabling strategies being approved by appropriate Board committees and then presented to Trust Board for assurance

Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
SSDP Full Business Case	OBC & FBC under development	SS/SL	OBC – Oct 2019 FBC – Feb 2020	
Finance strategy	Strategy under development	SS	March 2020	
Estates strategy	Strategy under development	SL	Sept 2019	Estates strategy to Trust Main Board Sept 2019
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance*	**Actions for gaps**	**Owner**	**Date**	**Update**

or the likelihood of it being effective				

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
C2895COO	Risk that patients and staff are exposed to poor quality care or service interruptions arising from failure to make required progress on estate maintenance, repair and refurbishment of core equipment and/or buildings to prevent cumulative degradation, as a consequence of the Trust's inability to generate and borrow capital	4 x 4

Principal Risk ID	**8.2**	Risk that investment decisions are taken at organisational level rather than system resulting in inequity in the quality of NHS estate across Gloucestershire.			
Principal risk to Achievement of the Objective *Including target and current risk score*		**Target score (C x L)**	3 x 2	**Current Score (C x L)**	3 x 4
Risk Owner (Executive Director)		Director of Strategy and Transformation		**Oversight/Assurance Committee**	Estates and Facilities

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1. Development & approval of Fit for The Future (One Place) Pre-Consultation Business Case 2. An approved (NHSE/I) ICS Estates Strategy	1. ICS Delivery Board 2. One Gloucestershire Estates Board & ICS Health Estates Group 3. All GHFT enabling strategies being approved by appropriate Board committees and then presented to Trust Board for assurance

Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Finance strategy	Strategy under development	SS	March 2020	
Estates strategy	Strategy under development	SL	Sept 2019	Estates strategy to Trust Main Board Sept 2019
ICS Estates strategy	Awaiting confirmation of NHSi requirements & timescales to submit	SL	tbc	

Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
	Not applicable	

Principal Risk ID	**8.3**	Risk that the failure to modernise and renew our estates results in adverse environmental impacts.			
Principal risk to Achievement of the Objective *Including target and current risk score*		**Target score (C x L)**		**Current Score (C x L)**	
Risk Owner (Executive Director)		Director of Strategy and Transformation		**Oversight/Assurance Committee**	Estates and Facilities

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1. Environmental impact & site assessments 2. £39.5M Strategic Site Development Programme 3. Trust Sustainability Strategy 4. GHFT Estates Strategy & Development Control Plan	1. Capital programme update to Finance and Digital Committee and Trust Board 2. SSDP OBC and FBC to Finance and Digital Committee, Estates Committee and Trust Board 3. Progress on operationalising Estates Strategy reported to Estates Committee 4. All GHFT enabling strategies being approved by appropriate Board committees and then presented to Trust Board for assurance

Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Finance strategy	Strategy under development	SS	March 2020	
Estates strategy	Strategy under development	SL	Sept 2019	Estates strategy to Trust Main Board Sept 2019
Sustainability Strategy	Current strategy ends in 2020	SH	April 2021	
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
C2895COO	Risk that patients and staff are exposed to poor quality care or service interruptions arising from failure to make required progress on estate maintenance, repair and refurbishment of core equipment and/or buildings to prevent cumulative degradation, as a consequence of the Trust's inability to generate and borrow capital	4 x 4

Strategic Objective 8: We have developed our estate and work with our health and social care partners, to ensure services are accessible and delivered from the best possible facilities that minimise our environmental impact

Quarterly Progress report			
Current assurances (positive and negative) *What is known about the effectiveness of the controls from the assurance framework?*	**General update** *E.g. milestones reached*	**Assurance Rating**	
		Proposed	**Agreed**
• Capital update to Finance and Digital Committee and Board • Monitor and respond to NHSE/I calls for capital bids • Development strategy to determine prioritisation of capital investment in the estate • Monitor and respond to NHSE/I calls for capital bids • Development strategy to determine prioritisation of capital investment in the estate • All GHFT enabling strategies being approved by appropriate Board committees and then presented to Trust Board for assurance • Oversight of Strategic Site Development Programme at Estates and Facilities Committee and Board • Oversight of operational plan, including workforce plan, at Board	• ICS Estates Strategy checklist approved by ICS Board and submitted to NHSI in July 2019 • DRAFT GHT Estates strategy in development and being shared with committee groups during July / August • FINAL Estates strategy to be submitted to GHT Main Board (closed) in September 2019 • SSD Programme progressing to revised timelines and reports to TLT, Estates Committee & Main Board. • SSD design phase underway ahead of completion of OBC for GHT Committee approval November/December 2019 • Finance Strategy due March 2020		

Strategic Objective 9: We use our electronic patient record system and other technology to drive safe, reliable and responsive care, and link to our partners in the health and social care system to ensure joined-up care

Principal Risk ID	**9.1**	Risk that we fail to identify and embrace relevant innovations in digital technologies			
Principal risk to Achievement of the Objective *Including target and current risk score*		**Target score (C x L)**	3 x 2	**Current Score (C x L)**	3 x 3
Risk Owner (Executive Director)		Digital and Chief Information Officer		**Oversight/Assurance Committee**	Finance and Digital Committee

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1. EPR business case and implementation programme 2. EPR Delivery Group 3. IM&T Programme Board 4. ICS Board for cross Gloucestershire opportunity awareness	1. Information, Management and Technology Programme Board 2. Digital Care Board 3. Digital update to Finance and Digital Committee and to Board

Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Digital strategy	Strategy under development	MH	10/10/19	Digital Strategy to go to October Board for approval.
Finance strategy	Strategy under development	SS		
Limitations in financial resource to support embracing identified opportunities/enablers		MH		

Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
	Not applicable	

Principal Risk ID	**9.2**	Risk that the Electronic Patient Record (EPR) programme and other technology programmes do not proceed as set out in the implementation plans, delaying the timeliness and/or scale of benefits expected			
Principal risk to Achievement of the Objective *Including target and current risk score*		**Target score (C x L)**	4 x 1	**Current Score (C x L)**	4 x 3
Risk Owner (Executive Director)		Digital and Chief Information Officer		**Oversight/Assurance Committee**	Finance and Digital Committee

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1. EPR Delivery Group 2. IM & T leads 3. Trak Optimisation Programme 4. Trak Care Optimisation Delivery Group 5. Digital Care Board 6. EPR Delivery governance structure has clearly defined internal and supplier side escalation routes, with regular touch points at each level to proactively mitigate potential issues. 7. Supplier representation across EPR delivery governance meetings. 8. EPR delivery team includes technical and PMO colleagues with previous successful Sunrise EPR experience and working with Allscripts. 9. Regular reporting to TLT and senior clinical forums	1. Digital update to Finance and Digital Committee via Digital Care Board, IM&T Programme Board, IT risk register, EPR Progress summary and Trak Optimisation Board summary 2. EPR delivery group and Trak Optimisation delivery group report into the Digital Care Board, which reports into the Trust Leadership Team 3. Monthly Digital Care Board report at Finance and Digital Committee detailing the progress of projects that report into the Digital Care Board

Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Digital strategy	Strategy under development	MH	10/10/19	Digital Strategy to go to October Board for approval.
Consistent senior clinical/nursing representation across governance structure include of increasing	CCIO/CNIO currently engaged from project team to Digital Care Board level, with conversations had to support	MH/SH	30/7/19	Deputy Medical Director has been actively engaged in kick off activity and engagement with SD forum. Deputy Chief Nurse involvement to commence with attendance at virtual demos

accountability at senior meetings.	Deputy Chief Nurse involvement to support capacity and additional senior nursing accountability of appropriate level.			to be held in July.
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
	Not applicable	

Principal Risk ID	**9.3**	Risk that we fail to support leaders and staff to engage with the EPR and other technology programmes as required and the benefits are limited as a result			
Principal risk to Achievement of the Objective *Including target and current risk score*		**Target score (C x L)**	3 x 1	**Current Score (C x L)**	4 x 3
Risk Owner (Executive Director)		Digital and Chief Information Officer		**Oversight/Assurance Committee**	Finance and Digital Committee

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1. EPR Communication and engagement strategy and plan to ensure active, consistent and meaningful involvement of all stakeholders (as appropriate) throughout the programming. Benefits mapping workshop with senior leaders across divisions and guiding principles. This will also support and enable local ownership of the EPR, rather than being seen as an IT driven /owned solution. 2. Communications to be delivered through existing and project specific channels including Involve, CEO weekly blog, 100 Leaders, Extended Leadership Network and, Digital blog, intranet page and digital inbox hosted by the Digital Transformation team 3. Senior clinical/ business ownership of delivery workstreams. 4. End users/clinicians to have ongoing opportunities to view the solution understand the functionality and benefits it offers through demos and involvement in solution defining, and engagement events through the programme. 5. Recruitment of clinicians within the EPR team permanently.	1. Digital update to Finance and Digital Committee and to Board 2. Digital Care Board

Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Digital strategy	Strategy under development	MH	10/10/19	Digital Strategy to go to October Board for

				approval.
Lack of senior buy in/support to support release of time/involvement in project such as testing, training, design. And ownership of the solution and its benefits at a local level.	Senior clinical project members proactively owning engagement with respective peer groups. Deployment methodology will enable forward planning of engagement points and will require support from leadership team(s) to support release of time.	MH/Execs		Initial benefits workshop held on 23/5/19 to commence engagement with senior clinical and operational colleague to understand the benefits Sunrise offers their teams and services, and commence scoping local benefits.
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
	Not applicable	

Principal Risk ID	**9.4**	Risk that the Trust EPR cannot be appropriately linked to systems in primary care, community providers and other remote providers and/or lack of commitment from relevant external parties adversely affecting the ability to create joint health records and deliver best care for everyone			
Principal risk to Achievement of the Objective *Including target and current risk score*		**Target score (C x L)**	2 x 1	**Current Score (C x L)**	2 x 2
Risk Owner (Executive Director)		Digital and Chief Information Officer		**Oversight/Assurance Committee**	Finance and Digital Committee

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1. EPR Procurement of open APIs and FHIR compliant system meaning the EPR will use JUYI to link 2. Joining Up Your Information (JUYI) implemented in partnership with external partners 3. EPR delivery group 4. Digital Care Board representation includes representatives from Gloucestershire Health Partners. 5. Delivery workstreams including clinical/business and IT leads with sufficient seniority and oversight/awareness of wider Gloucestershire strategy and requirements.	1. ICS Delivery Board 2. Digital Care Board 3. Digital update and ICS update to Finance and Digital Committee and to Board 4. JUYI Board

Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Digital strategy	Strategy under development	MH	10/10/19	Digital Strategy to go to October Board for approval.

Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
	Not applicable	

Strategic Objective 9: We use our electronic patient record system and other technology to drive safe, reliable and responsive care, and link to our partners in the health and social care system to ensure joined-up care

Quarterly Progress report			
Current assurances (positive and negative) *What is known about the effectiveness of the controls from the assurance framework?*	**General update** *E.g. milestones reached*	**Assurance Rating**	
		Proposed	**Agreed**
• Digital/IM&T assurance structure for EPR and wider programmes has significant representation from IM&T leads, senior clinical and operational colleagues and supplier representation – as well as wider Gloucestershire health partners. This has proven effective to date in supporting identifying a preferred solution during procurement, supporting mobilisation readiness activity, and has been effective in managing current suppliers (e.g. Intersystems). • Additional layer of oversight between specific project boards and Digital Care Board in the form of EPR Senior Leads has proven effective in maintaining effective oversight of EPR dependencies and enablers. All on track for EPR Programme and Dependent projects on Track for delivery to date.	• Continued active engagement with clinical and operational colleagues to understand clinical priorities/requirements to support defining and deploying of solution including benefits mapping session, visioning & guiding principles engagement and system demos. • Project governance and delivery structure has significant senior clinical representation, with each workstream having a business/clinical and IT lead.		

Strategic Objective 10: We are research active, providing innovative and ground-breaking treatments; staff from all disciplines contribute to tomorrow's evidence base, enabling us to be one of the best University Hospitals in the UK

Principal Risk ID	**10.1**	Risk that we are unable to secure funding to support individuals and teams to dedicate time to research due to competing priorities limiting our ability to extend our research portfolio C2531S&TR&D Non-recurring nature of research and development funding allocations			
Principal risk to Achievement of the Objective *Including target and current risk score*		**Target score (C x L)**	Principal risk assessment for BAF 4 x1 (same as risk register entry due to similarity of risk) 3 x 2 C2531S&TR&D	**Current Score (C x L)**	Principal risk assessment for BAF 4 x 1 (same as risk register entry due to similarity of risk) 4 x 2 C2531S&TR&D Business Domain
Risk Owner (Executive Director)		Director of Strategy and Transformation		**Oversight/Assurance Committee**	People and OD

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1. The Research 4 Gloucestershire initiative is focussing on its role to develop an integrated approach to research across the Gloucestershire Integrated Care system	1. Bi-annual research report to People and OD Committee and Board; oversight provided of the research strategy and research portfolio.
2. Annual business plan to key funder NIHR CRN – details plans to increase the number of commercial studies, which are a source of income.	2.Progress against all High Level Objectives – defined by the National Institute Health Research (NIHR) – reviewed and reported quarterly internally to Research and Innovation Forum and externally to WE Clinical Research Network
3. Support for non-NIHR funded studies is provided by the Gloucestershire Research Support Service (GRSS) via an SLA with the NHS research active organisations in the county and including Public Health in Gloucestershire County Council. Statement of intent to work more closely with the University of Gloucestershire signed.	3. Annual business plan submitted to West of England Clinical Research Network (CRN), who provide the main source of income to research through non-recurring, activity-based funding.

Gaps in Controls *The control is not in place or not effective, due to the design of the control or the*	**Actions for gaps**	**Owner**	**Date**	**Update**

likelihood of it being effective				
Research strategy	Strategy under development	Director of Strategy and Transformation	August	To be approved at People and OD committee August 2019
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
The need to receive the strategy noted above	To be considered at P& OD committee in August 2019	Director of Strategy and Transformation	August 2019	

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
NONE		

Principal Risk ID	**10.2**	Risk that we do not identify and address relevant skills, capacity and capability gaps to allow us to achieve our research vision			
Principal risk to Achievement of the Objective *Including target and current risk score*		**Target score (C x L)**	Principal risk assessment for BAF 4x1 No risk register entries relating to this principal risk	**Current Score (C x L)**	Principal risk assessment for BAF 4 x 2 No risk register entries relating to this principal risk
Risk Owner (Executive Director)		Director of Strategy and Transformation		**Oversight/Assurance Committee**	People and OD

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1. Capability and capacity assessments for new studies to maximise workforce utilisation	1. Oversight of the research portfolio by C&C, Delivery Teams and SMT Oversight of the research portfolio by CRN West of England
2. Review and closure of poor performing studies to release staff with regular review of staffing at relevant meetings.	2. Monthly 1:1's and SMT
3. The Research 4 Gloucestershire initiative is focussing on its role to develop an integrated approach to research across the Gloucestershire Integrated Care system	3. Oversight of research activity by R&D Forum and People and OD Committee
4. Annual business plan	4. Annual business plan submitted to Clinical Research Network West of England (CRN)
5. Novice researcher placements offered	5. Oversight of research activity by R&D Forum and People and OD Committee

Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Research strategy	Strategy under development	Head of Strategy and Transformation	August 2019	To be approved at People and OD committee in August 2019
Communication and engagement strategy	Strategy under development	Head of Communications	14/11/2019	
Gaps in Assurances *Cannot get evidence whether controls are*	**Actions for gaps**	**Owner**	**Date**	**Update**

effective due to the design of the assurance or the likelihood of it being effective				
Awaiting communication and engagement strategy as noted above				

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
NONE		

Principal Risk ID	**10.3**	Risk that the business case to secure University Hospital status does not demonstrate an acceptable return on investment delaying the realisation of patient and staff benefits			
Principal risk to Achievement of the Objective *Including target and current risk score*		**Target score (C x L)**	Principal risk assessment for BAF: 4 x 2 No risk register entries relating to this principal risk	**Current Score (C x L)**	Principal risk assessment for BAF: 4 x 3 (return and therefore risk is yet undefined) No risk register entries relating to this principal risk
Risk Owner (Executive Director)		Director of Strategy and Transformation		**Oversight/Assurance Committee**	People and OD

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1. The Research 4 Gloucestershire initiative is focussing on its role to develop an integrated approach to research across the Gloucestershire Integrated Care system	1 & 2 Reported to R&D Forum
2. Statement of intent to work more closely with the University of Gloucestershire signed.	
3. Task and Finish Group for identifying potential benefits and submitting Business Case for University Hospital status	3 & 4 Update reports to People and OD Committee and final business case submission anticipated in September 2019 prior to Board consideration
4. 4. Final Business case to go through People and OD delivery group and TLT before reaching committee	

Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Research strategy	Strategy under development	Director of Strategy and Transformation	August 2019	Strategy to be approved at People and OD committee in August 2019

Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Awaiting strategy as noted				

above				
Related Risks from the Trust Risk Register				
Code	Risk description			C x L Score (Domain)
NONE				

Principal Risk ID	**10.4**	Risk that the business case for University Hospital status does not stack up and there is no additional funding to support a net investment in University Hospitals' status.			
Principal risk to Achievement of the Objective *Including target and current risk score*		**Target score (C x L)**	Principal risk assessment for BAF: 4 x 2 No risk register entries relating to this principal risk	**Current Score (C x L)**	Principal risk assessment for BAF: 4 x 3 (unknown risk as no business case with funding requirements defined) No risk register entries relating to this principal risk
Risk Owner (Executive Director)		Director of Strategy and Transformation		**Oversight/Assurance Committee**	People and OD

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1. The Research 4 Gloucestershire initiative is focussing on its role to develop an integrated approach to research across the Gloucestershire Integrated Care system 2. Statement of intent to work more closely with the University of Gloucestershire signed	1. Reported to R&D Forum 2. Update reports to People and OD Committee and final business case submission anticipated in September 2019 prior to Board consideration

Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Research strategy	Strategy under development	Director of Strategy and Transformation	August 2019	To be approved at People and OD committee August 2019
Excess Treatment Savings	To be planned and delivered	Head of R&D		To be ratified
Increase commercial offer	To be planned and delivered	Head of R&D		To be ratified
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Excess Treatment Savings Report	To be planned and delivered	Head of R&D		To be finalised by December 2019
Related Risks from the Trust Risk Register				

Code	Risk description	C x L Score (Domain)
NONE		

Strategic Objective 10: We are research active, providing innovative and ground-breaking treatments; staff from all disciplines contribute to tomorrow's evidence base, enabling us to be one of the best University Hospitals in the UK

Quarterly Progress report			
Current assurances (positive and negative) *What is known about the effectiveness of the controls from the assurance framework?*	**General update** *E.g. milestones reached*	**Assurance Rating**	
		Proposed	**Agreed**
• Draft research strategy presented to Board in May 2019 indicating 4 draft objectives • Enabling strategy being written • Business Plan for UH status in development	• Particular growth areas are expected to be in reproductive health and childbirth, vaccines and palliative care. • There is a planned move towards opening an increasing number of larger observational studies to enable a wider number of our patients to have the opportunity to take part in research. • There will be a communications strategy to raise the profile (both internally and externally) and increase the number of GCP (Good Clinical Practice) trained staff to further embed the portfolio alongside routine care. • Work to increase capacity of R&D staff via process mapping and improvement started • Work to increase use of digital technology to increase efficiency started • Additional funding secured from Cobalt (1.8wte posts over 3 years) • 1.5million ophthalmology grant submitted		

Appendix 3
Assurance Ratings

Assurance Ratings – Source: BDO		
Level of Assurance	**Design Opinion**	**Effectiveness Opinion**
Substantial	Appropriate procedures and controls in place to mitigate the key risks.	No, or only minor, exceptions found in testing of the procedures and controls.
Moderate	In the main, there are appropriate procedures and controls in place to mitigate the key risks reviewed albeit with some that are not fully effective.	A small number of exceptions found in testing of the procedures and controls.
Limited	A number of significant gaps identified in the procedures and controls in key areas. Where practical, efforts should be made to address in-year.	A number of reoccurring exceptions found in testing of the procedures and controls. Where practical, efforts should be made to address in-year.
No	For all risk areas there are significant gaps in the procedures and controls. Failure to address in-year affects the quality of the organisation's overall internal control framework.	Due to absence of effective controls and procedures, no reliance can be placed on their operation. Failure to address in-year affects the quality of the organisation's overall internal control framework.

Risk Ratings

Risk ratings						
Score		Likelihood of risk occurring				
		1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
Consequence of risk occurring	5 Catastrophic	5	10	15	20	25
	4 Major	4	8	12	16	20
	3 Moderate	3	6	9	12	15
	2 Minor	2	4	6	8	10
	1 Negligible	1	2	3	4	5

Risk Meanings		
Colour	Score	Meaning
Green	(1-3)	Low risk
Yellow	(4-6)	Moderate risk
Orange	(8-14)	High risk
Red	(15-25)	Extreme risk

Gloucestershire Hospitals
NHS Foundation Trust

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

Report Title
Trust Risk Register
Sponsor and Author(s)
Author: Andrew Seaton, Quality Improvement & Safety Director Sponsor: Emma Wood, Director of People & OD, Deputy Chief Executive
Executive Summary

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

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

Changes in the reporting period
The Trust Leadership Team (TLT) met on 7 Aug and 4th September and considered two risks:

Risks that require further review by TLT:

S2930- The risk to patient safety & quality of care for Gloucestershire Emergency General Surgery

Executive lead: Director for Safety & Medical Director

Risks that have been approved by TLT for addition to the Trust Risk Register:

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.

Executive lead – Steve Hams. Scoring Safety 4 (Impact) x3 (Likelihood)=12

No risks on TRR have been upgraded in this period.

No risks were closed on the Trust Risk Register (TRR)

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

Implications and Future Action Required
Ongoing compliance with and continuous improvement to the risk management processes through performance review and actions at Risk Management Group.

Recommendations

To receive the report as assurance that the Executive is actively controlling and pro-actively mitigating risks so far as is possible and approve the changes to the Trust Risk Register as set out.

Impact Upon Strategic Objectives

Supports delivery of all objectives and effective governance

Impact Upon Corporate Risks

The Trust Risk Register is included in the report.

Regulatory and/or Legal Implications

Effective risk management systems are essential to meet regulatory requirements and demonstrate best governance practice for an organisation.
The risk of regulatory intervention (including fines) and poor patient experience resulting from the non-delivery of appointments within 18 weeks within the NHS Constitutional standards (Risk C2628COO)

Equality & Patient Impact

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

Resource Implications

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

Action/Decision Required

For Decision		For Assurance	√	For Approval		For Information	

Date the paper was presented to previous Committees and/or TLT

Audit & Assurance Committee	Finance and digital Committee	GMS Committee	People and OD Committee	Quality & Performance Committee	Remuneration Committee	Trust Leadership Team	Other (specify)
						7th Aug 2019 4th Sept 2019	

Outcome of discussion when presented to previous Committees/TLT

TLT recommended the Trust Risk Register to the Board endorsing the changes described above.

Trust Risk Register - September 2019

Ref	Inherent Risk	Controls in place	Action / Mitigation	Controls status	Consequence	Likelihood	Current	Division	Highest Scoring Domain	Executive Lead title	Title of Assurance / Monitoring Committee
F2927	Risk that the Trust does not achieve the required cost improvement resulting in failure to deliver the Financial Recovery Plan for FY20	1. PMO in place to record and monitor the FY20 programme 2. Finance Business Partners to assist budget holders 3. Fortnightly CIP Deep Dives 4. Monthly monitoring and reporting of performance against target 5. Monthly Financial Sustainability Delivery Group 6. Monthly Finance and Digital Committee scrutiny 7. Monthly and Quarterly executive reviews 8. NHSI monitoring through monthly Finance reporting		Partially complete	Catastrophic (5)	Likely - Weekly (4)	20	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Finance	Director of Finance	Finance and Digital Committee
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 capital Risk that the Trust's future capital funding is with the resulting impact on business and service continuity.	1. Board approved, risk assessed capital plan including backlog maintenance 2. MEF and Capital Control Group 3. Capital funding issue and maintenance backlog escalated to NHSI 4. All opportunities to apply for capital made 5. Finance and Digital Committee oversight 6. GMS Committee and Board oversight	1. Prioritisation of capital managed through the intolerable risks process for 2019/20 Ongoing escalation to NHSI and system	Partially complete	Major (4)	Likely - Weekly (4)	16	Corporate	Environmental	Chief Operating officer	Executive Management Team
S2275	A risk of unsafe surgical service 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.	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 ED1. guardian of Safe working Hours. JavaScript:void(showFormPanel('panel-section2'))	Escalation Attempts to recruit 1. Agency/locum cover for on call rota 2. Nursing staff clerking patients 3. Prioritisation of workload 4. exsisiting 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	Partially complete	Major (4)	Likely - Weekly (4)	16	Surgical	Workforce	Medical Director	People and OD Committee, Trust Leadership Team

C2628COO	The risk of regulatory intervention (including fines) and poor patient experience resulting from the non-delivery of appointments within 18 weeks within the NHS Constitutional standards.	The standard is not being met and reporting is planned for March 2019 (February data). This risk is aligned with the recovery of Trak. Controls in place from an operational perspective are: 1.The daily review of existing patient tracking list 2. Additional resource to support central and divisional validation of the patient tracking list. 3.Review of all patients at 45 weeks for action e.g. removal from list (DNA / Duplicates) or 1st OPA, investigations or TCI. 4. A delivery plan for the delivery to standard across specialities is in place 5. Additional non-recurrent funding (between cancer/ diagnostics and follow ups) to support the reduction in long waiting	1.RTT and TrakCare plans monitored through the delivery and assurance structures	Partially complete	Major (4)	Likely - Weekly (4)	16	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Statutory	Chief Operating Officer	Quality and Performance Committee
F2335	The risk of agency spend in clinical and non-clinical areas exceeding planned levels due to ongoing high vacancy levels, with resulting impact of delivery of FY20 CIP programme	1. Challenge to agency requests via VCP 2. Agency Programme Board receiving detailed plans from nursing medical workforce and operations working groups 3. Finance agency report review on a 6 monthly basis 4. Turnaround Implementation Board 5. Quarterly Executive Reviews	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 8. Creation of a health and wellbeing hub aimed at reducing absence and reliance on costly temporary solutions 2. Promote higher utilisation of internal nurse and medical bank 3. Implementation of healthRoster for roster and Bank management 4. implementation of Master Vendor Agreement for Nursing Agency - improving the control of medical agency spend and authorisation 5. Finalise job planning 6. Ongoing recruitment processes including international recruitment 7. Creation of new medical roles such as Associate specialists	Partially complete	Major (4)	Likely - Weekly (4)	16	Corporate, Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Finance	Chief Nurse	Finance and Digital Committee, People and OD Committee
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	Incomplete	Moderate (3)	Almost certain - Daily (5)	15	Medical	Quality	Director of Quality / Chief Nurse	Divisional Board, Quality and Performance Committee, Trust Leadership Team
		1. Speciality specific review administratively of patients (i.e. clearance of duplicates) (administrative validation) 2. Speciality specific clinical review of patients	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. (Orthodontics; ENT; Urology; Oral Surgery; Diabetic Medicine; Paediatric Urology; Endocrinology; Cardiology; Paediatric Surgery; Neurology; Colorectal and GI Surgery) Risk to both quality of care through patient experience impact(15)and safety risk associated with delays to treatment(4).	3. Utilisation of existing capacity to support long waiting follow up patients 4.Weekly review at Check and Challenge meeting with each service line 5.Do Not Breach DNB (or DNC)functionality within the report for clinical colleagues to use with 'urgent' patients. 6. Use of telephone follow up for patients - where clinically appropriate 7. Additional capacity (non recurrent) for Ophthalmology and ENT specialities to support follow up capacity 8. Review of good practice across Divisions to feed through to corporate approach	3. Additional provision for capacity in key specialiities to support f/u clearance of backlog	Partially complete	Moderate (3)	Almost certain - Daily (5)	15	Medical, Surgical	Quality	Chief Operating Officer	Quality and Performance Committee
C2669N	The risk of harm to patients as a result of falls	1. Patient Falls Policy 2. Falls Care Plan 3. Post falls protocol 4. Equipment to support falls prevention and post falls management 5. Acute Specialist Falls Nurse in post 6.Falls link persons on wards 7. Falls monitored and reported at the Health and Safety Committee and the Quality and Performance Committee	4. Discussion with Matrons on 2 ward to trial process 1. Falls training 2. HCA specialist training 3. #Litle things matter campaign 4. Discussion with matrons on 2 wards to trial process	Partially complete	Major (4)	Possible - Monthly (3)	12	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Chief Nurse/ Quality Lead	Quality and Performance Committee, Trust Leadership Team
C2819N	The risk of serious harm to the deteriorating patient as a consequence of inconsistent use of NEWS2 leading to failure to recognise, plan and deliver appropriate urgent care needs.	Ongoing education on NEWS2 to nursing, medical staff, AHPs etc o E-learning package o Mandatory training o Induction training o Targeted training to specific staff groups, Band 2, Preceptorship and Resuscitation Study Days o Ward Based Simulation o Acute Care Response Team Feedback to Ward teams o Following up DCC discharges on wards • Use of 2222 calls – these calls are now primarily for deteriorating patients rather than for cardiac arrest patients • Any staff member can refer patients to ACRT 24/7 regardless of the NEWS2 score for that patient • ACRT are able to escalate to any department / specialist clinical team directly • ACRT (depending on seniority and experience) are able to respond and carry out many tasks traditionally undertaken by doctors o ACRT can identify when patient management has apparently been suboptimal and feedback directly to senior clinicians	Monthly Audits of NEWS2. Assessing completeness, accuracy and evidence of escalation. Feeding back to ward teams	Complete	Moderate (4)	Possible - Monthly (3)	12	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Quality	Director of Quality and Chief Nurse	Quality and Performance Committee
		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	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.								

C1945NTVN	The risk of moderate to severe harm due to insufficient pressure ulcer prevention controls	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.	4. NHS collabborative work in 2018 to support evidence based care provision and idea sharing Discuss DoC letter with Head of patient investigations Advise purchase of mirrors within Division to aid visibility of pressure ulcers update TVN link nurse list and clarify roles and responsibilities implement rolling programme of lunchtime teaching sessions on core topics	Incomplete	Moderate (3)	Likely - Weekly (4)	12	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Director of Quality and Chief Nurse	Quality and Performance Committee
C2667NIC	The risk to patient safety and quality of care and/or outcomes as a result of hospital acquired C .difficile infection.	1. Strengthened infection control team. 2. Deputy Director of Infection control in post 3. New cleaning regime introduced	1. Delivery of the detailed action plan, developed and reviewed by the Infection Control Committee. The plan focusses on reducing potential contamination, improving management of patients with C.Diff, staff education and awareness, buildings and the envi	Partially complete	Major (4)	Possible - Monthly (3)	12	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Director of Quality and Chief Nurse	Infection Control Committee, Quality and Performance Committee
M2268Emer	The risk of patient deterioration (Safety) due to lack of capacity leading to ED overcrowding with patients in the corridor	RGN and HCA now identified on every shift to have responsibility for patients in the ambulance assessment corridor. Where possible room 24 to be kept available to rotate patients 9(or identified alternative where 24 occupied) (GRH) 8am - 12mn consultant cover 7/7 (GRH) reviewed by fire officers safety checklist; Escalation to silver/gold on call for extra help should the department require to overflow into the third (radiology) corridor. Silver QI project undertaken to attempt to improve quality of care delivered in corridor inc. fleeced single use blankets and introduction of patient leaflet to allow for patients to access PALS. 90% recovery plan May 2019.	Complete CQC action plan Compliance with 90% recovery plan	Incomplete	Moderate (3)	Likely - Weekly (4)	12	Medical	Safety	Director of Quality and Chief Nurse	Divisional Board, Trust Leadership Team
S2568Anaes	The risk to patient safety of failure of anaesthetic equipment during an operation with currently very few spares to provide a reliable back up.	1. Prioritisation of operations 2. Maintenance by own medical engineering service	Request for 5 x Induction machines and 5 x anaesthetic machines Ensure risk raised to all surgical board meetings To request further equipment replacement before end of September 2017 to ensure all oldest machines are replaced. List of machine to be replaced on that action to be drawn up. E-mail to medical engineering to obtain that list. Review required 1. Application to MEF 2.. Loan request	Partially complete	Catastrophic (5)	Rare - Less than annually (1)	5	Surgical	Safety	Medical Director	Divisional Board, Medical Devices Committee, Quality and Performance Committee

S2775CC	The risk to patient safety of respiratory or/and cardiovascular instability and even death in the event of either an electrical or mechanical failure or as a result of needing to change over to a different mechanical ventilator.	1. Alarmed ventilators 2. All staff trained to hand-ventilate and portable ventilators available on both sites and in theatres Standard Servo will be delivered by the end of June 2019, MRI compatible will be delivered mid July. Old ventilator can be used as a backup until the other 2 have arrived	order Critical care ventilators ordered	Incomplete	Catastrophic (5)	Rare - Less than annually (1)	5	Surgical	Safety	Medical Director	Divisional Board, Quality and Performance Committee

REPORT TO MAIN BOARD – September 2019

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

This report describes the business conducted at the Quality and Performance Committee on 28th August 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
Risks and Risk Register	Update on deteriorating patient quality summit and sepsis programme of work	Sepsis programme built around a lead role, which has now become vacant. Are there any other constraints which could prevent us from progressing with these programmes, eg need to deliver CIP/initiative fatigue? What would stop the date for eobs intro being brought forward?	Actively looking for programme lead, noting this is an investment in role. Aware of needing to highlight 4-5 areas which are priorities to 'put right' and support staff to deliver Sequence of events needed as baseline to enable eobs to function, already been brought forward by 1 year.	Regular updates brought to committee
	Stryker drill update on actions taken	Cluster of datix reviewed with 7th event, what was decision making in review at 7 and not 3,4 5 or 6 events for example Would you expect the theatre to track datix in themes?	Incidents had been reviewed centrally , split into patient contact and non patient contact	Consider assurance on thematic review of'near misses' with pt contact incidents when individual incidents do not meet SI threshold
	Escalating risk in Emergency General Surgery Increasing workload (50% compared with 2 years ago) and	What is being done to further mitigate the risks pending engaging and consultation on the future configuration of	New Surgical Assessment Unit helping to manage workload; continuous attempts to recruit staff	Contemporary risk assessment outstanding but in hand with view to briefing paper going to

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	ongoing gaps in middle grade medical staffing rotas creating pressure on staff. Safety of service currently ensured through mitigations but reliant upon good will of consultant body to cover rota gaps, which is not a sustainable model.	services. Clarity sought on how long current model can be sustained.	including overseas, fellows and academic trainees Current service delivery monitored and in line with all other specialties, incidents and patient experience data reviewed for learning and improvement. Contemporary risk assessment underway to inform necessity for further action to be taken to ensure service remains safe and staff are not being exposed to inappropriate pressures and/or workload.	Trust Board when finalised.
Serious Incident report	Four cases closed, new template to capture key areas, conclusions, root causes, recommendations, wider learning New template welcomed , sets out areas clearly	What discussions, if any held with individuals when examples of poor care eg lack of observations completed? How does paed incident link to data sharing with ED? Re communication issues, is there anything deeper below that which needs addressing>	All staff involved included in debrief. Aimed to be supportive for learning, check also for competence issues Yes, risk of data sharing on the W and C Risk Register. Development of EPR the long term solution. C diff known risk with mitigations, Wider work ongoing to promote MDT working and improve	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
			communications	
Safeguarding annual reports	Comprehensive reports and summary presentation of 18/19 and priorities for 19/20 Good report, detail, bringing strands together. Clear leadership to strengthen process and outcomes.	How do we understand areas eg malnutrition which don't quite hit safeguarding threshold Very supportive of the ACE (adverse childhood experiences) work, need to ensure link with DL as H and WB Board Trust rep How do we measure the effectiveness of the work being done? What are the internal and external risks? What are the multi agency relationships like?	Stronger links between Learning Disabilties team and nutrition steering group. Investment in new roles ambassadors, Internal risks described and being mitigated	Need to include high level KPIs in regular reporting to Committee Future reports to include detail of all risk mitigation

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Emergency Care delivery group	Clear report on Trust and system figures. Noted that Glos system highest performer in England for June. positive improvement in some key metrics eg outliers, bed moves	Abuse and violence against staff noted, is it linked with waiting times? Do you look at specific waiting times in the range of 4-11 hours? 15 minute triage is deteriorating trend, what actions needed to improve it?	Good assurance on leadership grip and benchmark nationally Will review, sense is it is linked to out of hours, weekends. Data known, can be included in future reports Workflows are being reviewed to do more 'up front' e.g. x-ray requests which increase triage duration but reduce overall time in the dept. A reduction in % triage within 15 minutes was understood to be a risk. PDSA cycles being completed and expectation is that this will improve once new processes are embedded	
Quallity delivery group	Clear report detailing observation status and monitoring system in place eg routine, enhanced, quality summit C diff outbreak noted	Use of quality summit getting more established, is that approach achieving what you expect in terms of outcomes? Question about GIFRT and trust wide progress	Selective trust wide use of quality summit described, only called by CN or MD Collaborative approach to improvement. Large amount of work being undertaken in multiple specialties, detailed reports available	Detailed report due at next committee Agreed for 6 monthly summary progress updates to committee

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	Data on falls and pressure injury indicate further work needed	VTE and dementia noted as red rating for several months	Proactive leadership shown and dissatisfaction with current performance	Deep dive into both areas requested for next committee Update on additional focus and plans for improvement to future committee
Cancer delivery group	Ongoing NHSI support to deliver External visit from best performing Trust to share learning (Epsom and St Helier)Issues of histopathology and MR/CT capacity. Histo technical backlog now gone, business case for eliminating reporting backlog in train. Plan to increase MR/CT capacity from 5/7 to 7/7 being developed Noted haematology achieved 62 day standard for first time in 9 months	If the business cases are successful, can you recruit to the roles required?	Diagnosis of issues well understood and solution being sought for internal areas for improvement Easier in some areas, re histopathology, can continue to outsource if needed	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Planned Care delivery group	52 week performance ahead of agreed trajectory and on track. Detailed brief on endoscopy breaches x 3 all patients now treated. Clinic utilisation increased, more potential. Verbal update on Opthalmology deep dive by Commissioners. Several issues known worked on jointly, no urgent systemic safety issues noted at the meeting.		Good report on endoscopy and remedial actions taken. Recovery plan making progress	 Written brief to next committee System review of capacity in 6 months
Winter Plan	Draft document prior to submission to NHSi/E Clear reference to lessons learnt from 18/19. Modelling assumptions based on worst case scenario. Several examples of improvements in three main areas, escalation, clinical decision making, arrangements for medical staff eg conversion of admin area to beds, agreement to progress CDU, replication of Gallery ward model at CGH, medical cover now in 'super firms'	What are the man risks to the plan being successful? Feedback from staff last year included improvement sin coms needed	Internal actions being progressed. Risk of lack of health and social care system focus, planning and ability to contribute to the level needed. Potential lack of care home beds Clear comms plan in place and introduction of change protocol/toolkit	Further assurance needed re system winter plan following end of September system wide meeting to discuss, check and challenge assumptions.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Patient safety alerts	Briefing updating on system in place to ensure safety/patient alerts are received, acted on and priorities to be audited for compliance	Systematic improvements internally noted, what is the timeline?	Assurance on level of review and work in train Difficult to put timeline in currently, work in progress	6 monthly reports add to forward planner , earlier if any issues to be escalated.

ICS update , new demand and capacity tool being introduced across the system, should release need for multipe daily conference calls and offer contemporaneous information if system buy in

Alison Moon
Chair of Quality and Performance Committee

REPORT TO COUNCIL OF GOVERNORS – August 2019

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

This report describes the business conducted at the Quality and Performance Committee on 31st July 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
Corporate Risk Register	Two new risks added to Register Risk of patient experience during periods of overcrowding in ED 15 Risk of patient deterioration (safety) due to lack of capacity in ED leading to corridor use. 12 Emerging risk of use of Stryker 7 and 8 Orthopaedic drills	What is the appetite for level of monitoring a safety risk of 12 and experience risk of 15? What is the robustness of the 'where possible' for use of keeping room 24 free in ED? Is this action key for mitigation? if so, how ensure it is kept free? On wider point, who reviews compliance of manufacturers cleaning instructions? A pending risk in relation to the deteriorating patient was discussed and it was agreed would be assessed by the Director of Safety and Medical Director	Executive oversight Monitoring through delivery groups with exceptions to Q and P. Use of room 24 an ambition but noting it has other uses including use for bereaved relatives. Drills removed from service, manufacturer meeting taken place. Compliance with Manufacturers cleaning instructions picked up via Decontamination Group and also checked with GMS in Contract Management Group.	Regular reporting of Risk Register

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Serious Incidents	One new Never Event reported relating to the incorrect connecting of oxygen tubing to an air outlet. Three new Serious Incidents reported with common theme of patient falls and resulting in injury and or death.	This has been subject to national patient safety alert, much work previously done in the Trust with two audits completed to ensure air outlets are capped and/or removed, how do we know that there are no clinical areas where this remains a risk? Area of falls a concern, new focused resource introduced through the year but no positive systemic impact' seen yet as a result.	All areas audited and inspected twice. Deep dive on systems, process and actions in place to reduce numbers of patients who fall and risk of injury.	One further comprehensive inspection agreed. Agenda item at future Q and P Committee.
Board Assurance Framework	Detailed review of Strategic Objectives 1 and 3 1. Outstanding Care 2. Quality Improvement Good presentation and format.	Some entries under controls overlap with those listed under assurance. Should the Divisional Performance Framework be included? Some key controls listed with no visibility at assurance level, should they? Are they really key controls	Key controls listed recognised by Q and P members and considered as part of the standing agenda Performance Framework will be included	Further refinement of controls and assurances for future iterations

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Care Quality Commission action plan	Update on must and should do CQC action plan. 12 must dos outstanding, 3 Green, 9 amber and 0 red. 4 should dos on red.	Is there still momentum and will to close down the action plan? 1 should do in surgery awaiting a Trust steer? Why? What's the delay?	Assurance given that focus is on closing down the action plan successfully. oversight provided by Quality Delivery Group. Momentum continues with a view to moving must do actions into business as usual. Error, should have stated awaiting a 'national steer'	
Quality and Performance Report	**Emergency Care Delivery Group** Remain Upper quartile National UEC performance New national emergency care dataset (ECDS) will not be implemented at GHT until June 2020 System priorities include Cinapsis, Home First and focus on alternative pathways for frequent attenders at GRH System decision to agree investments?	Will the planned Clinical Decision Unit be a system priority? Where are the balancing measures agreed previously? With new/fresh COO and deputy COO eyes, is there anything else you think we can do internally?	CDU will require significant capital investment and revenue costs. Business case to come to Sept TLT. As Capital reduced by 20%, System will choose how prioritised. Balancing measures for discussion at ECDG. Internal Trust 90% 4 hour performance recovery plan monitored through ECDG. Internal ED escalation key area of review. Demand & Capacity across all workstreams in ED being repeated. Not necessarily more staff but staff working	Will be added to next committee update.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
			shifts to better meet service needs	
	Quality Delivery Group Surveillance update. Use of internal quality summits to focus on specific areas, adult inpatient survey, deteriorating patients and sepsis, hospital acquired pressure ulcers.	Why do quality summits cease once the action plan has been developed rather than after completed actions?	Using NHSE/I improvement model with maximum of 3 to 4 meetings to generate plans, monitored through existing governance routes, Divisional review and QDG.	Review at August Q and P Committee.
	Enhanced surveillance including specialist diabetes and care and lack of specialist nurse capacity	Noting the plan to recruit more specialist nurses, how do we know that patients currently receive the level of specialist expertise they need?	Patients have access to specialist medical staff, so a safe system in place. Senior nursing recruitment now completed with a view to developing the team.	
	Out of Date Policies, plan to have zero out of date from Sept 2019.	What is your confidence with the timeline? What has improved in the system if policy needs updating due to new legislation and not out of date?	Both corporate and divisional focus on achieving the target date.	
	Cancer Delivery Group 2ww demand putting pressure on the system, although recovery expected in next reporting period 62 day performance continues to	Are there 2 or 3 areas which if resolved would make the most improvements? Histopathology and	Will need to review Histopathology and Radiology recovery plans and gap analysis (demand & capacity).	System support for successful 2 week wait quality improvement

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	be variable. Noting urology backlog continues to reduce. 104 day position remains a concern	Radiology. Radiology includes capacity (equipment and reporting capacity) and aged equipment leading to failures and inefficiencies Have you linked in with major radiology charitable funds?	May require capital and / or staffing investment. May be a decision for Trust Board in light of competing demands. Fully aligned with Charitable Funds function	plan Further updates required at Q and p Committee.
	Planned Care Delivery Group RTT reporting now stabilised. Over-delivery of RTT trajectory 52week wait trajectory for achievement now Q1and clear plan to reduce to zero by end Q4 Clinical Harm review process revisited to include psychological aspects under review, with learning from NHSI 'best in class' and gap analysis from current Trust guidance	NHS Pensions. Number of Consultants wanting to reduce direct clinical time which could adversely impact waiting lists, RTT and cancer performance. Verbal brief of endoscopy surveillance issue i.e found not to be added to active RTT pathway when breached surveillance date (and JAG tolerances applied). 3 patients affected > 52 weeks. All treated. No apparent harm but await histology. Backlog cleared. Technical fix in process.	Planned Care Delivery Group. Active oversight surveillance patients Chiefs of Service reviewing Clinical Harm review process for long waiters with the Medical Director	Written brief to Q and P in August

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Annual complaints report	Comprehensive report. Reduction in complaints from 17/18 98% complaints acknowledged within 3 day standard. 13 cases referred to PHSO, 9 not upheld. Main themes • Values/behaviours • Clinical treatment, appointments, communications Change in organisational structure part way through year to same leadership as incidents and legal claims has made considerable improvements in responsiveness and learning.	Is important for future reports to focus on wider and embedded learning	Structural changes clearly have had a positive impact on the team and wider working by providing support and strengthening the process. Some examples of wider learning within the report	For future quarterly reports and annual report 19/20, more extensive focus on wider learning from experiences is encouraged.
Annual Infection Control report	Comprehensive report, noting a challenging year but an improved position from 17/18 in several areas. However not achieving the limits set for C.diff reduced from 72 to 56. but over limit of 36. Change in organisational structure part way through the year, Surgical Site Infection surveillance	Are we able to maintain pace and focus to ensure continued reduction in hospital acquired infections? Is there sufficient 'system' buy in to reducing infections across health and social care organisations in	Good evidence of compliance against the Hygiene Code of Practice for Infection Prevention and Control. IPC team strengthened, SSI resource into corporate team, Regular audits undertaken. IPC leadership linking	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	resource now part of corporate Infection Control Team.	Gloucestershire?	proactively with system partners	
Safer Staffing report	Regular report on safer staffing demonstrating comprehensive systems and processes in place for staff deployment on a daily basis.	The report has served a useful purpose, but seeking a casual link between staffing and nursing outcomes has been difficult when comparing in month performance.	Committee wishes to focus on impact of staffing levels on patient experience and quality of care. Also on implementation of strategic nursing review objectives. Twice yearly nursing safe staffing reviews will continue to be presented to Q&P for assurance on behalf of the Board.	Agreed that transactional reports fill rates would now be recommended to be received by People and Organisational Development Committee
Internal Audit reports	Full reports shared, noted been through Audit and Assurance Committee RTT clock stop Central Booking office, both rated moderate in design and operational effectiveness	Are the actions and timelines owned operationally?	Full ownership of actions and timescales.	

Trust Board to note:

- Discussion regarding recent South West Cheif Executive meeting with Simon Stevens (NHSE/I Chief Executive). Priorities include implemetation of Long Term Plan, urgent and emergency care and patients waiting 52 weeks
- Pathway to Excellence submission received for apporval post submission date, looks to be very exciting opportunity and Board will recieve a briefng if our expression of interest with NHS Imporvement is successful

Alison Moon
Chair of Quality and Performance Committee

MAIN BOARD - SEPTEMBER 2019

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

Executive Summary

Purpose

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

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

Quality Delivery Report

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

Quality Summits

Sepsis metrics

Sepsis and the deteriorating patient continue to be in the quality summit process. A draft improvement plan has been developed and was shared with QDG. Once the plan has been approved the responsibility for monitoring the delivery of the actions will be monitored through the Deteriorating Patient and Resuscitation Committee.

Inpatient Experience metrics (including Friends and Family Test data)

The DCNs are leading an inpatient survey improvement plan with the patient experience team, to deliver focussed improvement work in the areas highlighted by the surveys (FFT and National Survey Programme). Real-time surveys were commenced because of our FFT and Adult Inpatient Survey data and now our real-time data is showing improved scores for cleanliness of wards, and supporting patients with washing and meals.

We are currently procuring a new provider for FFT and Real-time surveys combined, to offer wards and specialties across the Trust greater understanding of the qualitative data that patients share about their experience, as well as just the satisfaction scores.

Preventing Harm – Falls and Pressure Ulcers

Our data obtained from Datix shows that the number of reported incidents grade 2 and 3 pressure ulcers needs further review and analysis. An initial draft improvement plan for pressure ulcers and falls was presented to the August Quality Delivery Group with the plan for a Quality Summit in early September.

Key issues to note for quality

Dementia indicator
Manual collection of dementia metrics is continuing until Electronic Patient Record (EPR) is in place which will be by December. Recent data collection trial had insufficient cases to provide assurance (3 of 20), particularly for performance in latter stages of dementia pathway where the cohort total reduces down further. Contemporaneous audit continues for monitoring.

VTE Indicator
Audit work continues to check the data reported onto Trak. Reporting will improve when the the EPR is in place.

Induction of Labour (IOL) and emergency Caesarean Section (CS) rates

The IOL audit last year showed the rate of CS for women being induced is 21% overall (35% for primips, 10% for multips). Audit is ongoing to identify areas for improvement, with data available in September 2019. It should be noted that the GHNHSFT has the lowest rates for induction in the region. This is favourable regionally and nationally.

The months where the CS rate has been high, have not necessarily been months with high rates of IOL. However, it is accepted that the chance of caesarean section is higher for women having their first baby, than for multips, and this should be part of counselling.

Performance

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

In July 2019, the trust performance against the 4hr A&E standard was 88.53%, including system performance was 92.20%. A 90% recovery plan has been completed and is being monitored at the Unscheduled Care leaders meeting.

In respect of RTT, we are reporting 81.80% for July 2019. Operational teams continue to monitor and manage the long waiting patients on the Referral to Treatment pathways. As reported previously to the Board we will continue to see 52 week breaches, teams are working hard to address the key specialties in this regard, further information is provided within the exception report, we are currently meeting 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 92.7%, (un-validated) continued compliance is expected, subject to fluctuations in referral rates.

The existing Cancer Delivery Plan which identifies specific actions by tumour site to deliver recovery has been developed and reviewed on a fortnightly basis. One tumour site (urology) continues to demonstrably impact the aggregate position with significant number of 62 day breaches.

Cancer 62 day Referral to Treatment (GP referral) performance for July was 71.7% (un-validated).

As last month, we are addressing our longest waiting patients and reviewing the opportunities for how we can support a reduction in the 104 patient cohort.

Conclusions

Our focus on our longest waiting patients in RTT pathways and Cancer delivery, with a particular focus on delivery against the 62 day trajectory and sustaining A&E performance is the priority for the

operational teams to continue the positive performance improvement, this is delivered through transformational change to patient pathways now robust operating models are developed.

RTT performance has been sustained above the agreed trajectory and 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 sustained performance.
For Cancer Delivery we have engaged the support of NHS I to facilitate our timed pathways and prepare for the 28 day standards, we have also undertaken a gap analysis of radiology and histopathology in relation to meeting those standards.

Quality delivery (with the exception of those areas discussed) remains stable, with exception reporting from divisions through QDG for monitoring and assurance. A number of quality summits are in progress, which will have improvement plans monitored through QDG, and audit plans are in place for key issues such as VTE, dementia and IOL and CS rates.

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

Recommendations

The Trust Board is requested to receive the Report as assurance that the Executive team and Divisions fully understand the current levels of poor performance and have action plans to improve this position.

Impact Upon Strategic Objectives

Current performance jeopardises delivery of the Trust's strategic objective to improve the quality of care for our patients.

Impact Upon Corporate Risks

Continued poor performance in delivery of the two national waiting time standards ensures the Trust remains under scrutiny by local commissioners and regulators.

Regulatory and/or Legal Implications

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

Equality & Patient Impact

Failure to meet national access standards impacts on the quality of care experienced by patients. There is no evidence this impacts differentially on particular groups of patients.

Resource Implications

Finance		Information Management & Technology	
Human Resources	✓	Buildings	
No change.			

Action/Decision Required

For Decision		For Assurance	✓	For Approval		For Information	✓

Date the paper was presented to previous Committees

Quality & Performance Committee	Finance Committee	Audit & Assurance Committee	Workforce Committee	Remuneration Committee	Trust Leadership Team	Other (specify)
✓					✓	

Outcome of discussion when presented to previous Committees

The key areas of focus remain for delivery of Operational and Quality targets. The delivery groups continue 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.

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report

Reporting period July 2019

to be presented at August 2019 Quality and Performance Committee

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Gloucestershire Hospitals NHS Foundation Trust

Executive Summary

Gloucestershire Hospitals NHS Foundation Trust

Delivery of agreed action plans remains critical to restore operational performance to the expected levels. During July 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 July was 88.53% against the STP trajectory at 85.90% against a backdrop of significant attendances. The system met the delivery of 90% for the system in July.

The Trust has met the diagnostics standard for July at 0.76%.

The Trust has not met the standard for 2 week wait cancer at 92.7% in July, 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								
Count of handover delays 60+ minutes	Trajectory	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	0	0	0	0								
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%								
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%								
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%								
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								
% 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%								
Cancer – urgent referrals seen in under 2 weeks from GP	Trajectory	93.00%	93.00%	93.00%	93.00%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%
	Actual	87.90%	86.50%	89.40%	92.70%								
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%								
Cancer – 31 day diagnosis to treatment (first treatments)	Trajectory	96.10%	96.20%	96.20%	96.20%	96.2%	96.1%	96.1%	96.1%	96.2%	96.2%	96.2%	96.2%
	Actual	92.00%	92.90%	93.50%	92.60%								
Cancer – 31 day diagnosis to treatment (subsequent – drug)	Trajectory	98.10%	98.30%	98.20%	98.90%	98.1%	98.0%	99.0%	98.0%	98.9%	98.0%	98.0%	98.0%
	Actual	100.00%	96.20%	100.00%	100.00%								
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	Trajectory	94.90%	94.40%	94.80%	94.30%	94.0%	95.1%	95.1%	95.1%	95.1%	95.1%	95.1%	95.1%
	Actual	96.40%	97.50%	96.30%	100.00%								
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	Trajectory	94.00%	95.50%	95.30%	94.80%	94.4%	95.1%	95.5%	95.4%	95.6%	94.8%	94.8%	94.8%
	Actual	94.00%	95.10%	100.00%	89.60%								
Cancer 62 day referral to treatment (screenings)	Trajectory	90.30%	90.90%	91.70%	90.90%	91.4%	91.7%	91.4%	91.4%	92.3%	90.6%	90.6%	90.6%
	Actual	100.00%	96.60%	85.20%	84.60%								
Cancer 62 day referral to treatment (upgrades)	Trajectory	100.00%	100.00%	100.00%	100.00%	100%	100%	100%	100%	100%	100%	100%	100%
	Actual	44.40%	57.10%	70.60%	100.00%								
Cancer 62 day referral to treatment (urgent GP referral)	Trajectory	81.80%	82.30%	82.40%	82.60%	84.3%	85.0%	85.2%	85.0%	85.0%	85.1%	85.0%	85.0%
	Actual	79.70%	70.70%	66.50%	71.70%								

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	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	% change from previous year Monthly (Jul)	YTD
GP referrals	13,418	13,332	12,842	15,690	14,814	11,965	14,521	13,202	14,044	13,094	13,415	12,709	12,061	-10.11%	-7.39%
OP attendances	13,983	12,721	12,318	14,284	14,707	11,084	14,083	12,474	13,525	12,663	13,025	13,063	13,856	-0.91%	-2.42%
Day cases	6,392	6,127	5,793	6,828	6,766	5,833	6,167	5,995	6,318	5,815	6,520	6,198	6,955	8.81%	10.24%
All electives	7,524	7,125	6,831	7,901	7,877	6,837	7,124	6,955	7,465	7,255	7,556	7,213	8,096	7.6%	9.04%
ED attendances	13,482	12,200	12,488	12,610	12,230	12,639	12,962	11,701	13,245	12,949	13,618	13,072	14,066	4.33%	6.11%
Non electives	4,823	4,602	4,668	4,878	5,088	5,081	5,132	3,085	4,900	4,696	4,861	4,586	4,802	-0.44%	0.07%

Trust Scorecard – Safe (1)

OVERALL SCORE

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

	18/19	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	19/20 Q1	19/20	Standard	Threshold
Infection Control																		
Number of trust apportioned MRSA bacteraemia	6	1	1	2	0	0	0	0	0	1	0	1	0	0	1	1	0	
MRSA bacteraemia – infection rate per 100,000 bed days												3.5			1.2	0.9	Zero	
Number of trust apportioned Clostridium difficile cases per month	56	7	6	3	4	4	1	6	5	4	7	6	7	10	20	30	2019/20: 114	
Number of hospital-onset healthcare-associated Clostridioides difficile cases per month														7		16	<=5	
Number of community-onset healthcare-associated Clostridioides difficile cases per month														3		14	<=5	
Clostridium difficile – infection rate per 100,000 bed days											24.7	20.8	25.5	35.7	23.6	26.6	<30.2	
Number of MSSA bacteraemia cases	164	13	8	14	9	4	2	25	30	31	0	1	1	4	2	6	<=8	
MSSA – infection rate per 100,000 bed days										31		3.5	3.6	14.3	2.4	5.3	<=12.7	
Number of ecoli cases	295	23	28	32	25	4	3	39	41	44	5	4	5	1	14	15	No target	
Number of pseudomona cases	59	8	3	3	3	1	0	11	12	12	1	0	0	2	1	3	No target	
Number of klebsiella cases	135	9	7	10	7	3	2	25	28	31	1	3	1	1	5	6	No target	
Number of bed days lost due to infection control outbreaks											40	66	83	70	186	259	<10	>30
Patient Safety Incidents																		
Number of patient safety alerts outstanding	5										5	1	0	0	0	5	0	
Number of falls per 1,000 bed days		6.9	6.3	7.5	7.3	6.8	7.2	6.8	7.1	6	6.6	6	5.3	6.6			<=6	
Number of falls resulting in harm (moderate/severe)	8	11	6	9	8	6	8	8	2	7	3	4	2	7			<=3	
Number of patient safety incidents – severe harm (major/death)	1	1	1	2	1	0	1	0	3	7	13	7	9	4			No target	
Medication error resulting in severe harm										0	0	0	0	0			No target	
Medication error resulting in moderate harm										1	1	3	0	2			No target	
Medication error resulting in low harm										12	10	15	10	11			No target	
Number of category 2 pressure ulcers acquired as in-patient		31	31								43	36	28	38			<=30	
Number of category 3 pressure ulcers acquired as in-patient		11	7								10	7	7	6			<=5	

Trust Scorecard – Safe (2)

OVERALL SCORE

	18/19	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	19/20 Q1	19/20	Standard	Threshold
Patient Safety Incidents																		
Number of category 4 pressure ulcers acquired as in-patient		0	0								0	0	0	0			Zero	
Number of unstagable pressure ulcers acquired as in-patient											3		3	14			<=3	
Number of deep tissue injury pressure ulcers acquired as in-patient										6	10	14	2	8			<=5	
RIDDOR																		
Number of RIDDOR		2	2	5	4	1	4	1	3	3	2	2	1	3	6		SPC	
Safety Thermometer																		
Safety thermometer – % of new harms		98.40%	97.70%	98.60%	98.50%	97.90%	97.30%	97.30%	97.70%	97.20%	96.20%	97.20%	98.10%	97.40%			>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%		64.00%		>=90%	<50%
Serious Incidents																		
Number of never events reported	1	0	0	0	0	0	0	0	0	1	1	0	0	1			Zero	
Number of serious incidents reported		0	4	4	2	1	1	3	0	3	2	3	4	2			No target	
Serious incidents – 72 hour report completed within contract timescale		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%			>90%	
Percentage of serious incident investigations completed within contract timescale		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%			>80%	
VTE Prevention																		
% of adult inpatients who have received a VTE risk assessment	93.20%	94.80%	94.60%	93.80%	94.80%	95.40%	90.70%	96.60%	94.20%	94.80%	95.40%	88.60%	95.80%	96.70%	93.20%	94.10%	>97%	<=95%

Trust Scorecard – Effective (1)

OVERALL SCORE

	18/19	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	19/20 Q1	19/20	Standard	Threshold
Dementia Screening																		
% of patients who have been screened for dementia (within 72 hours)	1.90%	1.70%	3.50%	2.30%	1.80%	2.60%	3.30%	1.90%	0.80%	0.60%	0.40%	0.30%	67.00%				>=90%	<70%
% of patients who have scored positively on dementia screening tool that then received a dementia diagnostic assessment (within 72 hours)	27.90%	11.10%	41.20%	18.20%	33.30%	22.20%	26.30%	40.00%	0.00%	33.30%	100.0%	50.00%	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%	12.50%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%					>=90%	<70%
Maternity																		
% C-section rate (planned and emergency)	26.78%									29.71%	28.93%	30.20%	29.19%	32.49%	29.76%	29.57%	<=25%	>=27%
% emergency C-section rate	14.13%									16.11%	16.31%	16.73%	15.78%	17.42%	15.97%	16.52%	No target	
% of women booked by 12 weeks gestation	89.80%	89.70%	86.60%	90.20%	89.40%	90.90%	89.60%	89.80%	90.50%	91.50%	90.10%	88.80%	89.10%	88.80%	89.30%		>90%	
% of women that have an induced labour	29.19%									31.17%	29.13%	27.96%	28.99%	28.38%	28.75%	28.54%	<=20%	>25%
% of women smoking at delivery	11.21%	10.17%	11.97%	9.76%	12.43%	12.18%	12.28%	7.79%	13.05%	10.46%	12.06%	11.22%	11.83%	9.78%	11.71%		<=14.5	
% stillbirths as percentage of all pregnancies > 24 weeks	0.26%									0.21%	0.39%	0.00%	0.00%	0.38%	0.10%	0.19%	<0.52%	
Mortality																		
Summary hospital mortality indicator (SHMI) – national data	104.7			102.6			104.7										Dr Foster	
Hospital standardised mortality ratio (HSMR)	94.5	96.4	98.1	99.8	100.8	99.1	97.7	97.2	95.2	94.5							Dr Foster	
Hospital standardised mortality ratio (HSMR) – weekend	96.8	97.9	96.6	98.4	101.7	101.4	99.3	101.3	97.2	96.8							Dr Foster	
Number of inpatient deaths										168	165	159	166	124	490	614	No target	
Number of deaths of patients with a learning disability										2	4	1	1	2	6	8	No target	
Readmissions																		
Emergency re-admissions within 30 days following an elective or emergency spell	6.90%	7.20%	7.20%	6.80%	7.10%	6.10%	7.10%	6.70%	6.90%	6.30%	7.40%	7.10%	6.40%		7.00%	7.00%	<8.25%	>8.75%

Trust Scorecard – Effective (2)

OVERALL SCORE

	18/19	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	19/20 Q1	19/20	Standard	Threshold
Research																		
Research accruals	1,621	149	147	121	199	96	84	71	81	91	115	119	134	123	435		No target	
Stroke Care																		
Stroke care: percentage of patients receiving brain imaging within 1 hour	36.90%	37.80%	47.00%	41.50%	34.30%	26.60%	31.90%	37.10%	32.70%	22.40%	52.10%	55.30%	43.80%	53.50%	50.20%	51.10%	>=50%	<45%
Stroke care: percentage of patients spending 90%+ time on stroke unit	90.80%	94.10%	97.20%	93.40%	80.70%	87.70%	91.90%	88.70%	84.10%	87.70%	85.70%	96.30%	87.10%		89.70%	89.70%	>=80%	<70%
% of patients admitted directly to the stroke unit in 4 hours										51.70%	68.10%	62.70%	62.00%	67.90%	64.10%	65.10%	>=80%	<72%
% patients receiving a swallow screen within 4 hours of arrival										70.70%	52.10%	59.20%	63.80%	66.30%	58.60%	60.70%	>=90%	<80%
Trauma & Orthopaedics																		
% of fracture neck of femur patients treated within 36 hours	76.00%	74.20%	88.70%	85.50%	67.70%	70.10%	75.00%	83.90%	85.60%	77.80%	77.00%	81.80%	82.20%	67.10%	80.00%	76.50%	>=90%	<80%
% fractured neck of femur patients meeting best practice criteria										77.78%	77.78%	81.82%	80.49%	65.70%	78.92%	75.29%	>=65%	<55%

Trust Scorecard – Caring

OVERALL SCORE

	18/19	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	19/20 Q1	19/20	Standard	Threshold
Friends & Family Test																		
Inpatients % positive	91.20%	91.70%	90.70%	91.90%	92.20%	90.90%	91.50%	91.90%	89.20%	91.50%	89.10%	90.80%	91.60%	90.70%	90.50%	90.60%	>=96%	<93%
ED % positive	83.10%	83.60%	82.00%	85.90%	82.70%	82.70%	81.00%	82.70%	82.80%	82.70%	82.70%	81.90%	85.30%	79.80%	83.20%	82.40%	>=84%	<81%
Maternity % positive	96.70%	93.30%	94.70%	0.00%	100%	98.20%	100%	100%	93.50%	97.50%	96.60%	97.00%	87.10%	96.20%	93.50%	94.10%	>=97%	<94%
Outpatients % positive	92.60%	93.30%	91.90%	92.30%	93.00%	92.50%	92.90%	93.40%	92.50%	93.10%	92.80%	93.20%	92.50%	92.80%	92.80%	92.80%	>=94%	<91%
Total % positive	91.20%	91.60%	90.30%	91.60%	91.80%	91.20%	90.90%	91.90%	90.70%	91.40%	90.60%	91.10%	91.40%	90.70%	91.00%	90.90%	>=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%	76.91%	76.91%	>=90%	
Are you involved as much as you want to be in decisions about your care and											94.06%	89.44%	89.65%	90.61%	90.55%	90.55%	>=90%	
Do you feel that you are treated with respect and dignity?											93.07%	97.16%	94.26%	96.09%	95.12%	95.12%	>=90%	
Do you feel well looked after by staff treating or caring for you?											96.97%	97.71%	95.37%	98.33%	96.65%	96.65%	>=90%	
Do you get enough help from staff to eat your meals?											95.96%	98.86%	95.93%	97.20%	97.08%	97.08%	>=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%	96.09%	96.09%	>=90%	
Do you get enough help from staff to wash or keep yourself clean?											96.97%	98.29%	94.74%	98.87%	96.63%	96.63%	>=90%	
MSA																		
Number of breaches of mixed sex accommodation	68	5	6	0	7	2	6	2	1	3	4	11	18	16	33	49	<=10	>=20

Trust Scorecard – Responsive (1)

OVERALL SCORE

	18/19	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	19/20 Q1	19/20	Standard	Threshold
Cancer																		
Cancer – urgent referrals seen in under 2 weeks from GP	90.00%	90.40%	88.90%	82.80%	91.70%	90.40%	94.30%	92.00%	93.90%	95.20%	87.90%	86.50%	89.40%	92.70%	87.80%	88.20%	>=93%	<90%
2 week wait breast symptomatic referrals	95.80%	96.00%	97.80%	98.90%	99.20%	94.60%	97.70%	95.50%	97.00%	95.60%	96.90%	97.30%	99.00%	96.30%	97.70%	97.50%	>=93%	<90%
Cancer – 31 day diagnosis to treatment (first treatments)	94.60%	96.80%	96.90%	93.50%	93.30%	93.20%	94.20%	92.90%	91.60%	92.10%	92.00%	92.90%	93.50%	92.60%	92.90%	92.90%	>=96%	<94%
Cancer – 31 day diagnosis to treatment (subsequent – drug)	99.90%	100%	100%	98.80%	100%	100%	100%	100%	100%	100%	100%	96.20%	100%	100%	98.60%	99.10%	>=98%	<96%
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	95.30%	96.00%	95.70%	94.30%	98.30%	96.80%	92.90%	93.20%	96.60%	96.60%	94.00%	95.10%	100%	89.60%	93.90%	90.90%	>=94%	<92%
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	99.30%	98.70%	100%	100%	98.60%	98.70%	98.60%	100%	98.90%	98.70%	96.40%	97.50%	96.30%	100%	97.50%	98.10%	>=94%	<92%
Cancer 62 day referral to treatment (urgent GP referral)	74.80%	74.70%	76.30%	69.00%	69.40%	78.70%	74.90%	76.80%	66.20%	77.40%	79.70%	70.70%	66.50%	71.70%	73.40%	73.40%	>=85%	<80%
Cancer 62 day referral to treatment (screenings)	96.50%	100%	100%	85.50%	93.50%	93.80%	100%	94.10%	96.40%	100%	100%	96.60%	85.20%	84.60%	93.60%	91.90%	>=90%	<85%
Cancer 62 day referral to treatment (upgrades)	68.90%	53.30%	100%	75.00%	73.30%	58.80%	70.00%	71.40%	60.00%	77.30%	44.40%	57.10%	70.60%	100%	54.50%	58.70%	>=90%	<85%
Number of patients waiting over 104 days with a TCI date	141	8	22	26	7	13	8	8	8	14	20	15	20	18	55	73	Zero	
Number of patients waiting over 104 days without a TCI date	347	28	24	30	39	37	27	42	37	25	19	30	21	37	70	107	<=24	
Diagnostics																		
% waiting for diagnostics 6 week wait and over (15 key tests)	0.45%	0.55%	1.27%	0.63%	0.03%	0.35%	0.20%	0.67%	0.21%	0.45%	0.54%	0.67%	1.08%	0.76%	1.08%	0.76%	<=1%	>2%
The number of planned / surveillance endoscopy patients waiting at month end	726	311	407	576	630	680	686	639	600	726	835	872	966	770	966	770	<=600	
Discharge																		
Number of patients delayed at the end of each month	37	47	44	41	44	40	34	29	24	43	45	39	18	43	18	43	<=38	
Patient discharge summaries sent to GP within 24 hours	50.50%	52.60%	49.70%	51.80%	51.60%	49.10%	47.20%	51.90%	49.60%	51.00%	56.60%	54.60%	53.30%		54.90%	54.90%	>=88%	<75%

Trust Scorecard – Responsive (2)

OVERALL SCORE

	18/19	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	19/20 Q1	19/20	Standard	Threshold
Emergency Department																		
ED: % total time in department – under 4 hours (type 1)	89.60%	91.34%	90.26%	89.01%	90.54%	91.59%	87.55%	84.46%	86.08%	87.13%	86.01%	87.99%	86.80%	88.53%	86.95%	87.33%	>=95%	<90%
ED: % total time in department – under 4 hours (types 1 & 3)	92.78%	93.65%	93.45%	92.47%	93.60%	93.98%	91.29%	89.02%	90.21%	91.00%	90.39%	91.70%	91.05%	92.20%	91.06%	91.34%	>=95%	<90%
ED: % total time in department – under 4 hours CGH	96.40%	96.90%	96.00%	96.40%	96.90%	96.94%	95.47%	93.70%	95.50%	96.10%	94.66%	96.04%	96.40%	95.44%	95.37%	95.63%	>=95%	<90%
ED: % total time in department – under 4 hours GRH	86.20%	88.40%	87.40%	85.20%	87.30%	89.06%	83.82%	80.10%	81.60%	82.80%	81.89%	84.16%	82.77%	85.09%	82.95%	83.47%	>=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	0	0	0	Zero	
ED: % of time to initial assessment – under 15 minutes	87.40%	88.60%	90.70%	87.30%	88.80%	89.60%	85.40%	85.20%	83.60%	78.40%	75.80%	78.30%	77.30%	71.30%	77.20%	75.60%	>=95%	<92%
ED: % of time to start of treatment – under 60 minutes	33.50%	31.40%	34.30%	29.00%	36.70%	34.50%	32.10%	34.90%	32.40%	32.60%	32.00%	35.90%	37.20%	30.30%	35.00%	33.80%	>=90%	<87%
% of ambulance handovers that are over 30 minutes										7.90%	1.66%	1.28%	1.01%	1.25%	1.25%	1.23%	<=2.96%	
% of ambulance handovers that are over 60 minutes										0.10%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	<=1%	>2%
Operational Efficiency																		
Number of patients stable for discharge	73	71	75	80	75	76	69	74	72	77	86	77	63	79	75	76	<=70	
% of bed days lost due to delays											4.74%	3.78%	2.24%	3.42%	2.24%	3.42%	<=3.5%	>4%
Number of stranded patients with a length of stay of greater than 7 days	384	373	382	376	374	382	374	399	412	397	389	391	370	371	383	380	<=380	
Average length of stay (spell)	5.05	4.78	5.11	5	5.05	5.14	4.83	5.14	5.35	4.98	5.03	5.35	4.85	4.88	5.08	5.03	<=5.06	
Length of stay for general and acute non-elective (occupied bed days) spells	5.66	5.38	5.62	5.58	5.72	5.77	5.29	5.7	6.07	5.67	5.53	5.99	5.43	5.5	5.65	5.62	<=5.65	
Length of stay for general and acute elective spells (occupied bed days)	2.7	2.61	3	2.75	2.47	2.84	2.89	2.59	2.67	2.55	2.78	2.68	2.55	2.58	2.68	2.64	<=3.4	>4.5
% day cases of all electives										84.60%	80.00%	86.28%	85.92%	85.91%	84.15%	84.57%	>80%	<70%
Intra-session theatre utilisation rate										84.70%	87.80%	88.49%	85.50%	87.30%	85.00%	87.20%	>85%	<70%
Outpatient																		
Outpatient new to follow up ratio's										1.93	1.92	1.91	1.9	1.89	1.91	1.91	<=1.9	
Did not attend (DNA) rates										6.40%	6.80%	6.80%	6.80%	7.00%	6.80%	6.90%	<=7.6%	>10%

Trust Scorecard – Responsive (3)

OVERALL SCORE

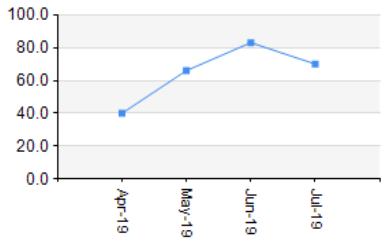
	18/19	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	19/20 Q1	19/20	Standard Threshold
RTT																	
Referral to treatment ongoing pathways under 18 weeks (%)										79.75%	79.46%	80.63%	81.11%	81.80%	81.11%	81.81%	>=92%
Referral to treatment ongoing pathways 35+ Weeks (number)										2,352	2,163	2,149	1,953	1,772	1,953	1,769	No target
Referral to treatment ongoing pathways 40+ Weeks (number)										1,860	1,699	1,748	1,626	1,437	1,626	1,434	No target
Referral to treatment ongoing pathways over 52 weeks (number)	95	113	125	105	103	105	97	89	97	95	93	91	90	78	90	75	Zero
SUS																	
Percentage of records submitted nationally with valid GP code	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	99.90%	99.90%		99.90%	99.90%	>=99%
Percentage of records submitted nationally with valid NHS number	99.80%	99.80%	99.80%	99.80%	99.80%	99.80%	99.80%	99.80%	99.80%	99.80%	99.80%	99.40%	99.80%		99.50%	99.70%	>=99%

Trust Scorecard – Well Led

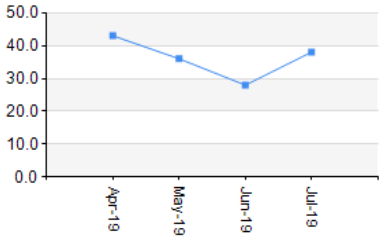
OVERALL SCORE

	18/19	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	19/20 Q1	19/20	Standard	Threshold
Appraisal and Mandatory Training																		
Trust total % overall appraisal completion	79.00%	74.00%	75.00%	79.00%	80.00%	79.00%	79.00%	79.00%	79.00%	81.00%	80.00%	81.00%	82.00%			81.00%	>=90%	<70%
Trust total % mandatory training compliance	89%	87%	88%	90%	91%	91%	91%	89%	89%	91%	91%	91%	92%			91%	>=90%	<70%
Finance																		
Total PayBill Spend		28.5	30.5	27.5	29.5	29.03	29.7	29.4	29.9	33.3	31.8	30.8	30.9	30.7				
YTD Performance against Financial Recovery Plan		0.18	0.2	0.2	0.2	0.4	0.04	-3	-6.6	-14.1	0.2	0.3	0.6	0.5				
Cost Improvement Year to Date Variance		2,365	2,342	2,975	2,994	2,013	1,593	0	-1,784	-3,378	0	1	1	2				
NHSI Financial Risk Rating		4	4	4	4	4	4	3	4	4	4	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		2	2	3	3	3	3	3	3	3	3	3	4	3				
Safe Nurse Staffing																		
Overall % of nursing shifts filled with substantive staff											96.55%	96.40%	95.10%	97.40%	96.00%	96.40%	>=75%	<70%
% registered nurse day											97.90%	97.90%	96.60%	98.70%	97.50%	97.80%	>=90%	<80%
% unregistered care staff day											97.00%	99.20%	99.40%	101.0%	98.50%	99.20%	>=90%	<80%
% registered nurse night											94.10%	93.50%	92.40%	94.80%	93.30%	93.70%	>=90%	<80%
% unregistered care staff night											100.3%	99.40%	104.8%	105.7%	101.5%	102.6%	>=90%	<80%
Care hours per patient day RN										6.2	4.61	4.6	4.7	4.8	4.6	4.7	>=5	
Care hours per patient day HCA										3.2	2.8	2.9	3	3	2.9	2.9	>=3	
Care hours per patient day total	7.1	7.4	7.2	6.8	7.2	7.1	7.3	7.3	7.2	8.1	7.4	7.5	7.7	7.8	7.5	7.6	>=8	
Vacancy and WTE																		
% total vacancy rate											9.03%	10.02%	9.54%				<=11.5%	>13%
% vacancy rate for doctors											8.07%	8.86%	8.53%				<=5%	>5.5%
% vacancy rate for registered nurses											12.09%	9.52%	9.42%				<=5%	>5.5%
Staff in post FTE											6181.16	6150.11	6148.56	6176.02			No target	
Vacancy FTE											610	683	650				No target	
Starters FTE											65.5	52.8	45.2	70.8			No target	
Leavers FTE											55.14	37.5	57.4	46.9			No target	
Workforce Expenditure and Efficiency																		
% turnover	11.80%	12.30%	12.00%	12.10%	11.90%	11.60%	11.70%	11.70%	11.90%	12.20%	11.80%	11.60%	11.60%	11.60%			<=11%	>15%
% turnover rate for nursing	10.99%										1.09%	10.93%	10.87%	10.90%			<=11%	>15%
% sickness rate	3.90%	3.90%	3.90%	3.90%	3.90%	3.90%	3.90%	3.90%	3.90%	3.90%	3.90%	3.40%	3.80%	3.80%			<=3.5%	>4%

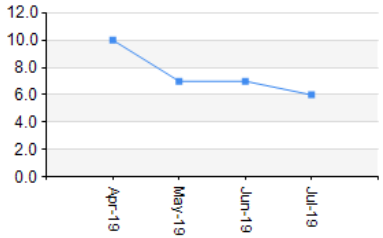
Exception Reports – Safe (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of bed days lost due to infection control outbreaks **Standard: <10**		There were five outbreaks of Norovirus in July, 4 of them starting in June. In order to control these outbreaks bays and wards were closed to prevent ongoing transmission of infection to other patients. Restricted visiting was also implemented across affected areas and internal and external communications were sent to inform staff and relatives of the outbreak and measures to take to prevent ongoing transmission of infection. The Infection Prevention and Control team and Site team worked together closely on a daily basis to control the outbreaks. Daily outbreak meetings were also held with staff from affected wards, the Deputy Director of Infection Prevention & Control, GMS managers, Infection Control Nurse and Doctor and site team. Wards were re-opened when symptoms of Norovirus had resolved for at least 48 hours and/or when isolation of symptomatic patients could be achieved and following amber cleaning of the ward environment. The root causes were determined to be a delay in isolation of a symptomatic patient and staff symptomatic whilst on duty (sudden onset during working hours).	**Associate Chief Nurse and Deputy Director of Infection Prevention and Control**

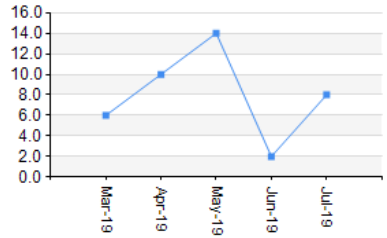
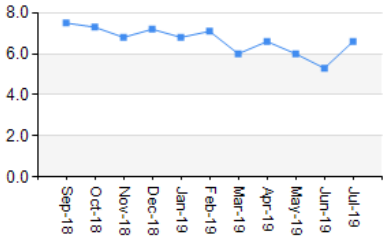
Exception Reports – Safe (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of category 2 pressure ulcers acquired as in-patient **Standard: <=30**		During July 2019 there were 38 hospital acquired category 2 pressure ulcers sustained in patients across 19 wards. High incidence was recorded on 4b, 8b, AMU, Avening and Gallery Ward. Hospital acquired category 2 pressure ulcers are reviewed at the weekly preventing harm hub which has been piloted in Surgery with other divisions joining from mid-August. Issues raised at the Hub include missed opportunities to complete risk assessment documentation, timely provision of equipment and robustness of pressure relieving measures. The Hub provides rapid feedback on the high impact actions required, the ward team are tasked to produce evidence of an improvement that is taken through the divisional pressure ulcer groups. Medicine and Surgery have plans to respond and reduce pressure ulcers. A Preventing Harm Summit is being planned to identify key areas of focus and drive rapid improvements across the trust.	**Deputy Nursing Director & Divisional Nursing Director - Surgery**

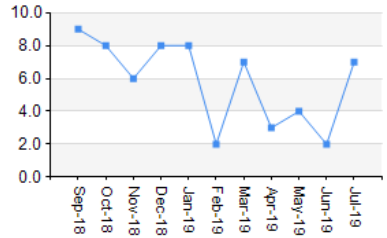
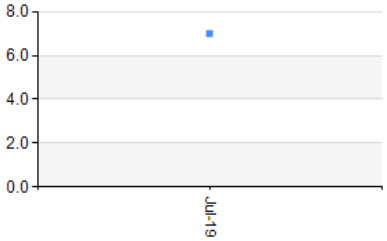
Exception Reports – Safe (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of category 3 pressure ulcers acquired as in-patient **Standard: <=5**		During July 2019 there were 6 hospital category 3 pressure ulcers sustained in patients across 6 wards. Hospital acquired category 3 pressure ulcers are reviewed at the weekly preventing harm hub which has been piloted in Surgery with other divisions joining from mid-August. Issues raised at the Hub include missed opportunities to complete risk assessment documentation, timely provision of equipment and robustness of pressure relieving measures. The Hub provides rapid feedback on the high impact actions required, the ward team are tasked to produce evidence of an improvement that is taken through the divisional pressure ulcer groups. Medicine and Surgery have plans to respond and reduce pressure ulcers. A Preventing Harm Summit is being planned to identify key areas of focus and drive rapid improvements across the trust	**Deputy Nursing Director & Divisional Nursing Director - Surgery**

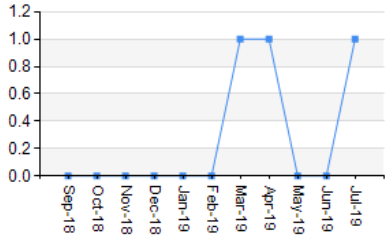
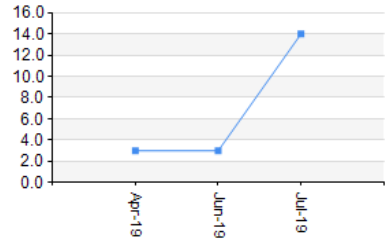
Exception Reports – Safe (4)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of deep tissue injury pressure ulcers acquired as in-patient **Standard: <=5**		During July 2019 there were 7 hospital acquired deep tissue injuries sustained in patients across 7 wards. Hospital acquired deep tissue injuries are reviewed at the weekly preventing harm hub which has been piloted in Surgery with other divisions joining from mid-August. Issues raised at the Hub include missed opportunities to complete risk assessment documentation, timely provision of equipment and robustness of pressure relieving measures. The Hub provides rapid feedback on the high impact actions required, the ward team are tasked to produce evidence of an improvement that is taken through the divisional pressure ulcer groups. Medicine and Surgery have plans to respond and reduce pressure ulcers. A Preventing Harm Summit is being planned to identify key areas of focus and drive rapid improvements across the trust.	**Deputy Nursing Director & Divisional Nursing Director - Surgery**
Number of falls per 1,000 bed days **Standard: <=6**		There has been an overall decrease in the incidence of falls in a 12 month rolling period of 14%, however this has not been associated with a decrease in harm from falls which has risen slightly as a proportion of the total. In response the trust are arranging a Preventing Harm Summit using the quality summit model facilitated by GQSIA.	**Director of Safety**

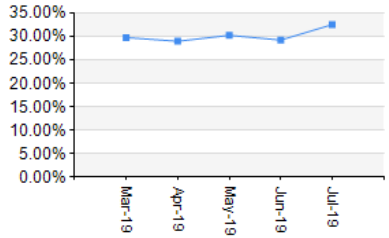
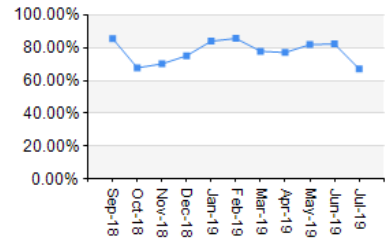
Exception Reports – Safe (5)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of falls resulting in harm (moderate/severe) **Standard: <=3**		There has been an overall decrease in the incidence of falls in a 12 month rolling period of 14%, however this has not been associated with a decrease in harm from falls which has risen slightly as a proportion of the total. In response the trust are arranging a Preventing Harm Summit using the quality summit model facilitated by GQSIA.	**Director of Safety**
Number of hospital-onset healthcare-associated Clostridioides difficile cases per month **Standard: <=5**		During July 2019 there were seven hospital-onset, healthcare-associated cases and three community-onset, healthcare-associated cases. Two cases were associated with a period of increased incidence on Snowshill Ward that is currently being managed as an outbreak with appropriate control measures being implemented, including a rapid deep clean facilitated by beds closures. Six of the seven cases have been reviewed using the Post Infection Review process, one meeting is yet to be convened. Issues identified were incorrect antimicrobial prescribing, equipment and environmental cleanliness and timeliness of isolation. Issues outside of Snowshill Ward which is being managed as an outbreak are being monitored through cleanliness assurance audits jointly between GMS and the Infection Prevention & Control Team, the implementation of a new antimicrobial prescribing app for junior medical staff.	**Associate Chief Nurse and Deputy Director of Infection Prevention and Control**

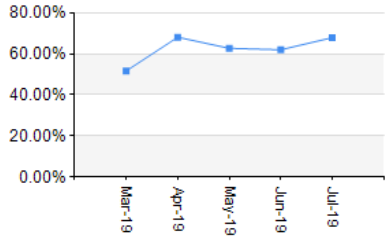
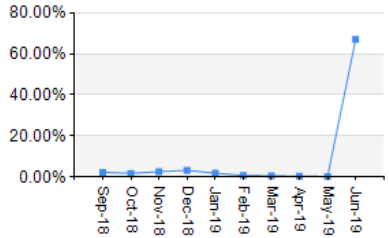
Exception Reports – Safe (6)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of never events reported **Standard: Zero**		The Never Event is following the Trust process for investigation and learning	**Director of Safety**
Number of unstagable pressure ulcers acquired as in-patient **Standard: <=3**		During July 2019 there were 9 hospital acquired unstageable pressure ulcers sustained in patients across 7 wards, with more than on 4b and Ryeworth. Hospital acquired unstageable pressure ulcers are reviewed at the weekly preventing harm hub which has been piloted in Surgery with other divisions joining from mid-August. Issues raised at the Hub include missed opportunities to complete risk assessment documentation, timely provision of equipment and robustness of pressure relieving measures. The Hub provides rapid feedback on the high impact actions required, the ward team are tasked to produce evidence of an improvement that is taken through the divisional pressure ulcer groups. Medicine and Surgery have plans to respond and reduce pressure ulcers. A Preventing Harm Summit is being planned to identify key areas of focus and drive rapid improvements across the trust.	**Deputy Nursing Director & Divisional Nursing Director - Surgery**

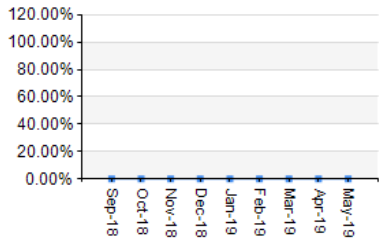
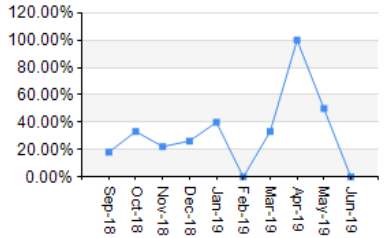
Exception Reports – Effective (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% C-section rate (planned and emergency) **Standard: <=25%**		Total CS rate = 32.49% Consultants currently investigating where possible reduction could be made. Rate of vaginal birth following CS low currently, therefore may require standard where vaginal birth default position unless obstetrician recommends against this. This has been instigated in some units throughout country. ?Increase offer of ECV for breech presentation pre-birth.	**Divisional Chief Nurse and Director of Midwifery**
% of fracture neck of femur patients treated within 36 hours **Standard: >=90%**		Action plan taken through Trauma Task and Finish. Consideration of orthogeriatric support being developed to support. Demand and Capacity review underway due to significant increases in the early part of 2019.	**Director of Operations - Surgery**

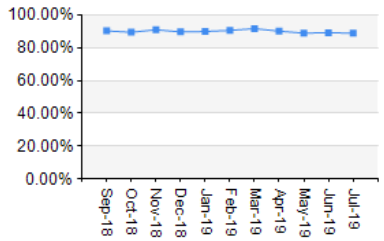
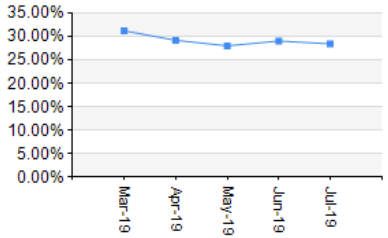
Exception Reports – Effective (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of patients admitted directly to the stroke unit in 4 hours **Standard: >=80%**		The service has improved on last month by 5.9%. Only 27 out of 84 patient did not get admitted onto the Stroke unit within the expected four hour window. Unlike in previous months the main themes are that the patient is already an inpatient on another ward when stroke diagnosis was made, leading to a delay in transfer or that there was an unclear diagnosis meaning the patient was kept on AMU for further observation. Only two patients were unable to transfer directly to the Stroke Unit due to lack of availability beds.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
% of patients who have been screened for dementia (within 72 hours) **Standard: >=90%**		EPR as the long term solution remains unresolved. Data collection methodology change from June 2019 onwards: 20 sets of notes will be audited every month and reported retrospectively in the QPR.	**Deputy Chief Nurse**

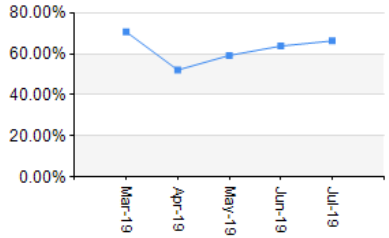
Exception Reports – Effective (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of patients who have received a dementia diagnostic assessment with positive or inconclusive results that were then referred for further diagnostic advice/FU (within 72 hours) **Standard: >=90%**		EPR as the long term solution remains unresolved. Data collection methodology change from June 2019 onwards: 20 sets of notes will be audited every month and reported retrospectively in the QPR. June audit results: N/A (unable to assess); no positive or inconclusive cases found.	**Deputy Chief Nurse**
% of patients who have scored positively on dementia screening tool that then received a dementia diagnostic assessment (within 72 hours) **Standard: >=90%**		EPR as the long term solution remains unresolved. Data collection methodology change from June 2019 onwards: 20 sets of notes will be audited every month and reported retrospectively in the QPR.	**Deputy Chief Nurse**

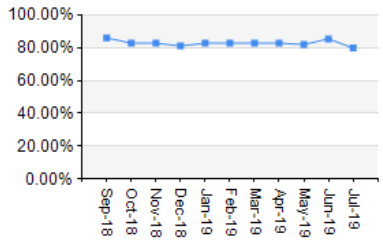
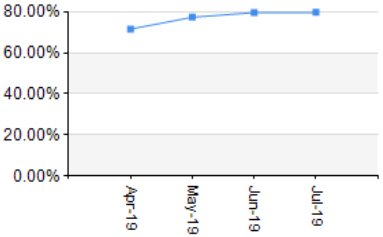
Exception Reports – Effective (4)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of women booked by 12 weeks gestation **Standard: >90%**		Ensure all midwives are completing the pregnancy page on Trak correctly..ie the pre booking date rather than booking at home date. Meet with all leads to identify any areas with sickness that may affect a timely booking and ensure a robust system for contacting and arranging booking. Ensure All community clinics held in GP practices have a system in place to contact maternity services if no available appointments for pre booking.	**Divisional Chief Nurse and Director of Midwifery**
% of women that have an induced labour **Standard: <=20%**		Current figures = 28.28%. We have benchmarked our performance against the South West; The South West induction of labour average is 31.2%. Discussion still required with medical staff as to what figure would provide assurance that we are not outlier within region and that induction of labour rate is as expected. Discussion will take place in September.	**Divisional Chief Nurse and Director of Midwifery**

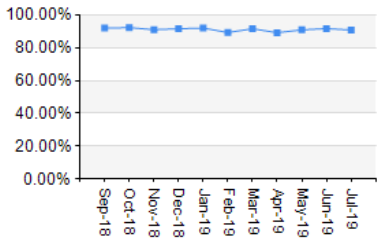
Exception Reports – Effective (5)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% patients receiving a swallow screen within 4 hours of arrival **Standard: >=90%**		Performance has improved on last month by 3%. 29 patients did not receive their swallow screen within four hours of arrival on the unit. The main themes related to under achievement are either that the patient was unfit for the swallow screen to take place, there was an unclear diagnosis of stroke and the patient was therefore transferred to AMU first for ongoing assessment or the patient was already on another inpatient ward when the stroke occurred.	**Director of Unscheduled Care and Deputy Chief Operating Officer**

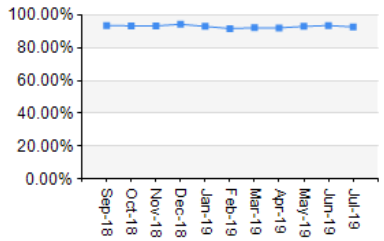
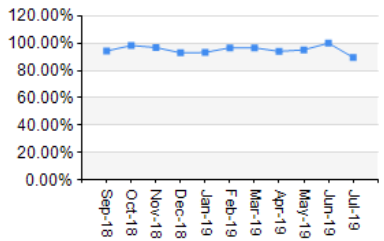
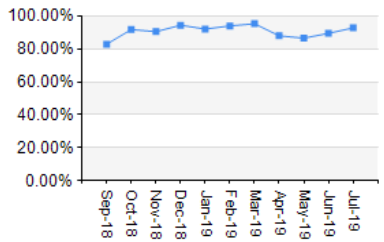
Exception Reports – Caring (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED % positive **Standard: >=84%**		This month the satisfaction score overall dropped to 79.7%; this was 85.14% at CGH, and 75.7% at GRH. The negative feedback shared by patients focussed on wait times, and a lack of pain relief/pain management from staff. Pain management and medication were areas identified in the Urgent and Emergency Care National Survey, and were prioritised as areas for action in a workshop with Picker. Pain management and medication were areas identified in the Urgent and Emergency Care National Survey and discussed at Unplanned Care Board. Included in safety metrics of Q&P report. Links with patient experience to do further observations.	**Deputy Director of Quality**
How much information about your condition or treatment or care has been given to you? **Standard: >=90%**		79.67% of respondents said Just the right amount of information in July, which shows no improvement from the National Inpatient Survey of 79%. This will form part of the action plan with DCNs to be monitored through QDG. Review Gallery Ward trial to see if the 4 questions has supported people having the right amount of information about their care. Include as a priority area for inpatient improvement plan.	**Head of Patient Experience Improvement**

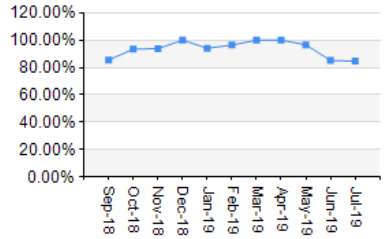
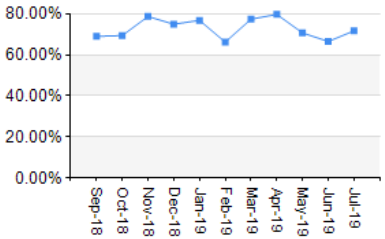
Exception Reports – Caring (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Inpatients % positive **Standard: >=96%**		FFT satisfaction score at 90.7%. Organisations nationally with higher satisfaction scores tend to use paper responses rather than text, and also tend to have lower response rates than ours. New rating system and plan for when and how FFT question is asked is being introduced in 2020 regarding FFT, which may impact our score. New approach for FFT being launched with gives an opportunity to review questions, when they are asked and how people respond. Patient experience team attending workshop in October, and introducing by April 2020.	**Deputy Director of Quality**

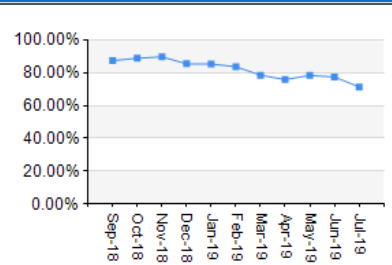
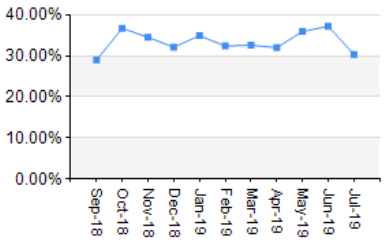
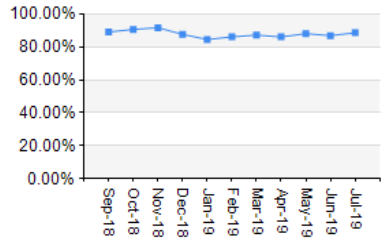
Exception Reports – Responsive (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Cancer – 31 day diagnosis to treatment (first treatments) **Standard: >=96%**		Performance = 92.6% Target 94% National performance 96% 22 breaches for uro 1 haem 1 head and neck	**Director of Planned Care and Deputy Chief Operating Officer**
Cancer – 31 day diagnosis to treatment (subsequent – surgery) **Standard: >=94%**		Performance = 50 tx 5 breaches 90% Target - 94% National performance = 91.3% 5 urology breaches	**Director of Planned Care and Deputy Chief Operating Officer**
Cancer – urgent referrals seen in under 2 weeks from GP **Standard: >=93%**		2ww performance - 2371 DFS 173 breaches 92.7% SWAG cancer alliance performance - 88.6% National performance - 90% Lower GI 99 (76.9%) Upper GI 40 (82.8%) Missed target by 6 breaches	**Director of Planned Care and Deputy Chief Operating Officer**

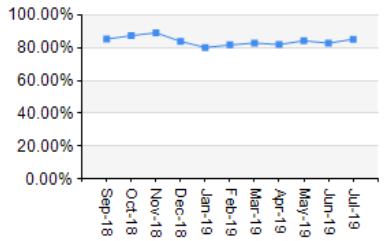
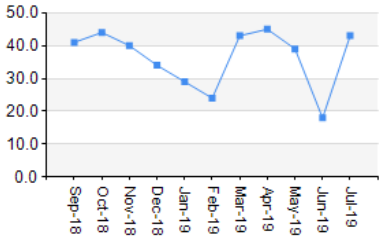
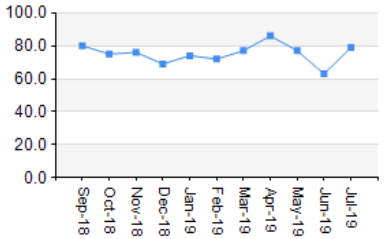
Exception Reports – Responsive (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Cancer 62 day referral to treatment (screenings) **Standard: >=90%**		Performance - 84.6% Standard - 90% National performance - 85.1% 3 breaches in Breast screening 1 breach in lower GI 1 patient choice breach 1 surg capacity 2 repeat diagnostics	**Director of Planned Care and Deputy Chief Operating Officer**
Cancer 62 day referral to treatment (urgent GP referral) **Standard: >=85%**		Performance - tx 195 55.5 breaches (71.5%) SWAG Cancer Alliance performance - 74.9% National performance - 76.7% Breaches 33.5 prostate 4 bladder 2 renal 4 gynae 3.5 H&N 3.5 Lower GI	**Director of Planned Care and Deputy Chief Operating Officer**

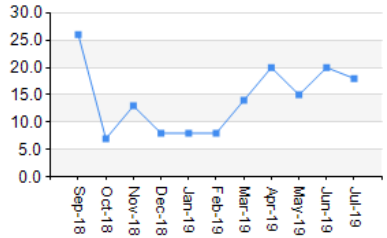
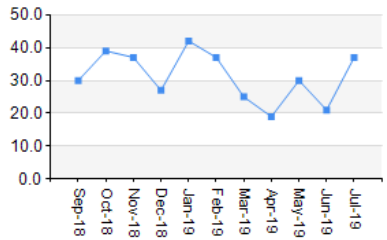
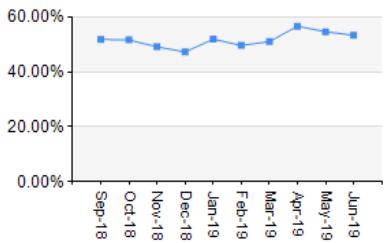
Exception Reports – Responsive (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % of time to initial assessment – under 15 minutes **Standard: >=95%**		Challenged to fully cover triage due to sickness within this clinical workforce group. Lack of space during times of high activity have contributed to delays in triage.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % of time to start of treatment – under 60 minutes **Standard: >=90%**		Attendances has increased. Significant sickness within the department for medical workforce. New sickness policy and process now implemented.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % total time in department – under 4 hours (type 1) **Standard: >=95%**		July's performance was 88.5%. August to date is 88.1% and the quarter is 88.4% Recovery plan to address a number of issues is being worked up and actions implemented to improve flow and quality of care. Overall attendances were higher in July than June and performance improved.	**Director of Unscheduled Care and Deputy Chief Operating Officer**

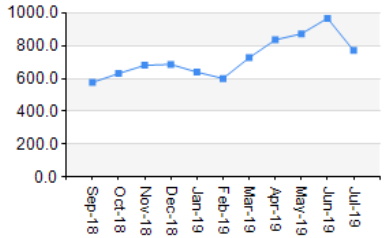
Exception Reports – Responsive (4)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % total time in department – under 4 hours GRH **Standard: >=95%**		July's performance was 88.5%. August to date is 88.1% and the quarter is 88.4% Recovery plan to address a number of issues is being worked up and actions implemented to improve flow and quality of care. Overall attendances were higher in July than June and performance improved.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
Number of patients delayed at the end of each month **Standard: <=38**		The trust is working very closely with the whole health system, currently there are delays due to patients awaiting social service assessments, including start up of packages of care, there are delays in D2A beds, in particular Stroke. The Deputy Coo is chairing the Patient Flow Steering group and flow multi professional work programmes are now in place.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
Number of patients stable for discharge **Standard: <=70**		The trust is working very closely with the whole health system, currently there are delays due to patients awaiting social service assessments, including start up of packages of care, there are delays in D2A beds, in particular Stroke. The Deputy Coo is chairing the Patient Flow Steering group and flow multi professional work programmes are now in place.	**Director of Unscheduled Care and Deputy Chief Operating Officer**

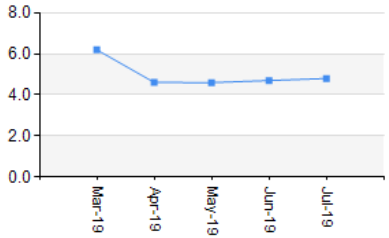
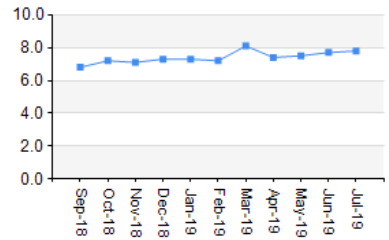
Exception Reports – Responsive (5)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of patients waiting over 104 days with a TCI date **Standard: Zero**		Row Labels Count of MRN Urological (excl. testicular) 10 Upper gastrointestinal 1 Lower gastrointestinal 1 Lung 1 Grand Total 13 62 day delivery plan Implementing 'management of long waiting cancer patients' policy	**Director of Planned Care and Deputy Chief Operating Officer**
Number of patients waiting over 104 days without a TCI date **Standard: <=24**		Row Labels Count of MRN Urological (excl. testicular) 19 Lower gastrointestinal 9 Upper gastrointestinal 2 Gynaecological 2 Haematological (excl. acute leukaemia) 1 Head & neck 1 Skin 1 Grand Total 35	**Director of Planned Care and Deputy Chief Operating Officer**
Patient discharge summaries sent to GP within 24 hours **Standard: >=88%**		Percentage sent within 24 hours remains static despite a number of improvement projects, education and training and performance reporting. Different approaches being worked up at present for implementation in August 2019.	**Medical Director**

Exception Reports – Responsive (6)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
The number of planned / surveillance endoscopy patients waiting at month end **Standard: <=600**		We have commenced with additional activity to be delivered by a third party provider (16 whole day list). We are also clinically revalidating all the patients according to the soon to be launched guidelines which will reduce the waiting list number by approximately between 30-50%. We have also recruited additional staff to utilise the fallow operating list.	**Medical Director**

Exception Reports – Well Led

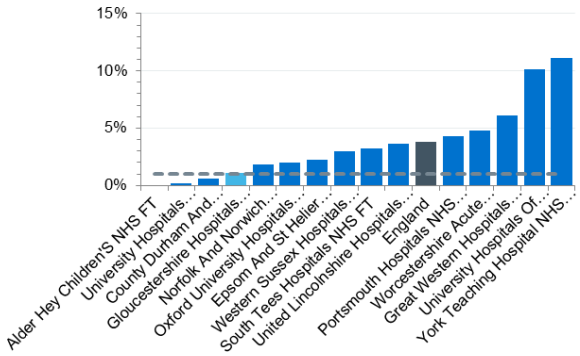
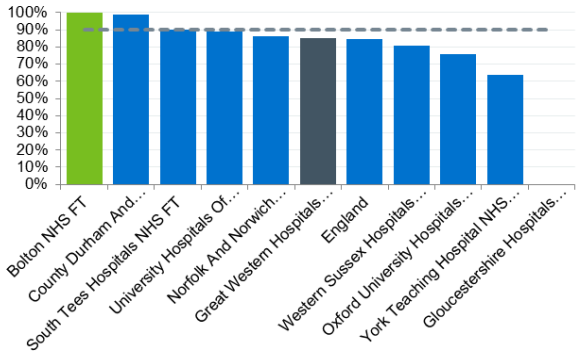
Metric Name & Standard	Trend Chart	Exception Notes	Owner
Care hours per patient day RN **Standard: >=5**		Focused work continuing to support Divisional Chief Nurses with management of rosters, further training in place to support ward managers with rosters. Matrons clinically supporting ward areas, where staffing shortfalls are present.	**Director of Nursing and Midwifery**
Care hours per patient day total **Standard: >=8**		Focused work continuing to support Divisional Chief Nurses with management of rosters, further training in place to support ward managers with rosters. Matrons clinically supporting ward areas, where staffing shortfalls are present.	**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

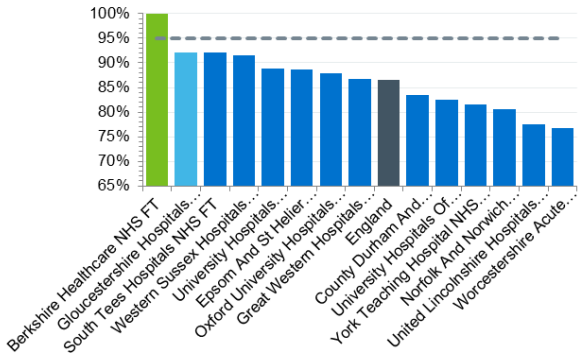
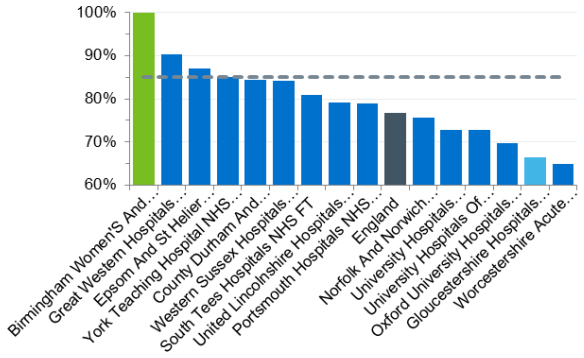
Metric	Period	Peer Group	Rank	Quartile
Diagnostics	Jun-19		90/171	3rd
Dementia	May-19		84/84	4th

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

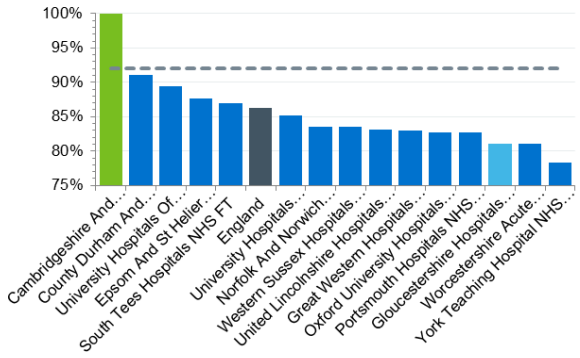
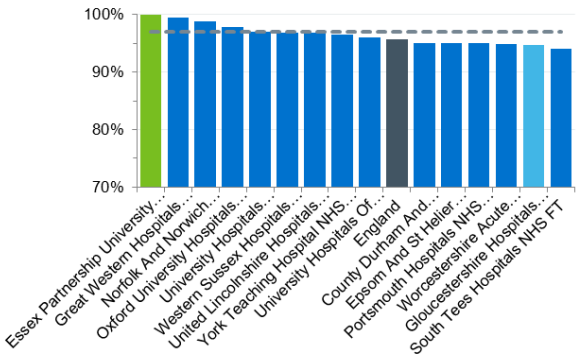
Metric	Period	Peer Group	Rank	Quartile
ED 4 Hour (Type 1 & Type 3)	Jul-19		19/120	1st
Cancer 62 Days GP Referrals	Jun-19		130/143	4th

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

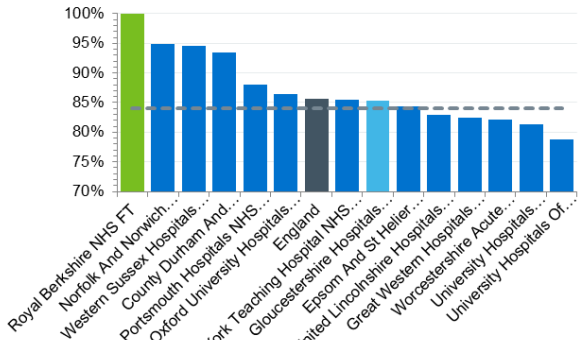
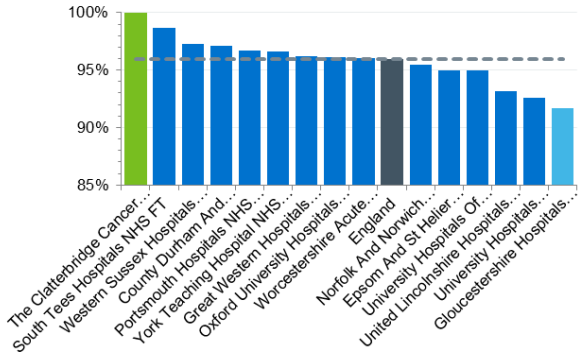
Metric	Period	Peer Group	Rank	Quartile
RTT	**Jun-19**		**159/180**	**4th**
VTE (published quarterly)	**Mar-19**		**119/149**	**4th**

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

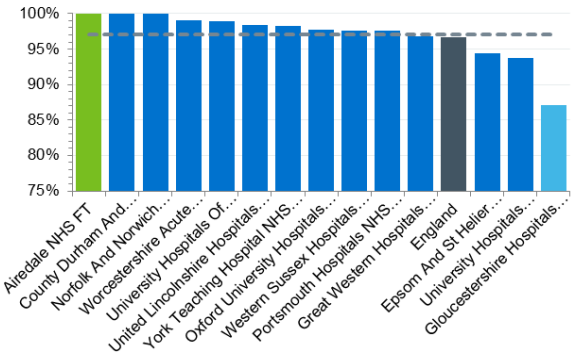
Metric	Period	Peer Group	Rank	Quartile
FFT - ED	Jun-19		80/131	3rd
FFT - Inpatient	Jun-19		135/146	4th

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	Jun-19		115/119	4th

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – 12 September 2019
Sandford Education Centre, CGH

Report Title
Guardian for Safe Working – Quarterly Report
Sponsor and Author(s)
Author: Dr Simon Pirie, Guardian for Safe Working Sponsor: Prof Mark Pietroni, Medical Director

Audience									
Board Members	**X**	Regulators		Governors		Staff		Public	

Executive Summary

Purpose
This report covers the period of 1 February 2019 – 30 April 2019

Key issues to note
There were 132 exception reports logged,which was a reduction from 165 the previous quarter. As such there have been a total of 3 fines to the value of £488.34. There are no correlations with Datix clinical incident reports for this period.

The new Doctor's contract and the BMA Fatigue and Facilities charter, will have an impacts on work schedules and reporting as more reports will be encouraged especially where new working hour rules are breached. We will closely monitor the reporting of missed breaks, which is currently minimal which we anticipate may increase. The People and OD Delivery Group and the Local Negotiating Committee have oversight of the new Facilities and Fatigue Charter and Junior Doctor implementation action plan to ensure the requirements of the new contract are fulfilled

Conclusions
The number of exceptions has fallen this quarter. This report is the first where we have been able to report on the sub-specialty involved in the exception report.

Implications and Future Action Required
We will now be able to monitor exception reports per specialty to provide more granularity on breaches

Recommendations

To receive the report as a source of assurance that Trust is compliant with the contractual standards for investigation and learning from exception reports.

Impact Upon Strategic Objectives

Effective investigation and implementation of learning will impact on the Quality objective – 'Quality improvement is at the heart of everything we do; our staff feel empowered and equipped to do the very best for their patients and each other.'

Impact Upon Corporate Risks

Mitigates (medical) workforce risks due to rota gaps or pressure of work.

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
Junior doctors are contacted after every exception report and patient safety concerns are investigated and escalated when required.

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

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

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

Quarterly Guardian Report on Safe Working Hours for Doctors and Dentists in Training

For Presentation to The Main Board
12 September 2019

1. Executive Summary

1.1 This report covers the period of 1.2.19 – 30.4.19. There were 132 exception reports logged; compared to 165 in the last quarter.

1.2 We have again needed to levy some fines. These are detailed below; there are a total of 3 fines to the value of £488.34. The Junior Doctor's forum is fully functioning and meets quarterly.

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.

2.2 Doctors in training may raise an exception report whenever working hours breach those set out in their personalized work schedule. An exception report is initially reviewed and addressed by the educational supervisor or nominated deputy. If appropriate, time off in lieu or payment for extra hours worked is agreed. In certain circumstances, a fine may be levied for exceeding safe working limits (see appendix for links to rota rules and pathways). The aim is to have a system in place where fines are not required. All doctors can access the system and submit exception reports whether in Deanery approved training posts or not. Feedback via Educational Supervisors for non-Deanery posts follows the same process but fines are not levied for non-Deanery posts.

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

High level data

Number of doctors / dentists in training (total):	419
Number of doctors / dentists in training on 2016 TCS:	419
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	
Oncology	**0**	**0**	0	0	**Palliative care - 1 St3+**
T&O	**0**	**0**	0	3	
Surgery	**0**	**0**	0	3	**OMF - 1 Spec Dr** **Ophthalmology - 1 ST1 & 1 Fellow** **ENT - 2 ST1 & 1 Spec Dr**
General Medicine	**1**	**1**	9	1	**Rheumatology - 1 Spec Dr** **Cardiology - 1 Spec Dr**
Paeds	**0**	**0**	0	0	
Obs & Gynae	**0**	**0**	0	0	

4. Locum Bookings

4.1 Data from finance team:

Total spend Feb ’19 – April ‘19 on Junior Medical Locum £782,339.04

5. Exception Reports (working hours)

Specialty	Exceptions raised
General/GI Surgery	6
Urology	2
Trauma/ Ortho	0
ENT	1
Vascular Surgery	0
Ophthalmology	11
Orthogeriatrics	
General/old age Medicine	61
Cardiology	9
Respiratory	5
Gastro	1
Neuro	10
Renal	11
Endocrine	4
Acute medicine/ ACUA	7
Emergency Department	1
Obstetrics and Gynaecology	0
Paediatrics	2
Anaesthetics	0
Oncology	1
GP	0
Total	**132**

6. Fines this Quarter

Fine by Department				
Rota cycle	**Department**	**Hours**	**Fine**	**When levied**
Feb '19 - Apr '19	Acute Medicine		86.18	March 2019
Feb '19 - Apr '19	COTE		9.58	March 2019
Feb '19 - Apr '19	Ophthalmology		392.58	March 2019

7. Issues Arising

7.1 2 reports were raised as 'immediate safety concerns'. The trainees were contacted, to confirm this status, but did not reply, and the details did not suggest immediate safety concern.

8. Actions Taken to Resolve Issues

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

9. Qualitative Information

9.1 The Allocate software for raising exception reports came into use on the 1st October 2017. This is the first quarter in which we have had more specific specialty data. This should prove very helpful in monitoring any 'problem' areas, and also the effects of any interventions.

10. Correlations to Clinical Incident Reporting

10.1 We are now looking for any links between exception reports and Datix reports being submitted. There were no Datix reports of harm correlating with dates of exception reports submitted during this quarter.

11. Summary

11.1 A total of 132 working hours exception reports have been made since the beginning of Feb '19 to end April '19; this is a reduction from last quarter. The software now allows more specific specialty data to be logged. The fines levied reduced in value this quarter.

Presenting Director: **Prof Mark Pietroni**

Date 02/09/2019

Recommendation

- For assurance

Appendices

Link to rota rules factsheet:
http://www.nhsemployers.org/~/media/Employers/Documents/Need%20to%20know/Factsheet%20on%20rota%20rules%20August%202016%20v2.pdf

Link to exception reporting flow chart (safe working hours):
http://www.nhsemployers.org/~/media/Employers/Documents/Need%20to%20know/Safe%20working%20flow%20chart.pdf

REPORT TO MAIN BOARD – SEPTEMBER 2019

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

This report describes the business conducted at the Quality and Performance Committee on 25th July 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
Financial Performance Report	Report presented covering: - Month 3 & cumulative financial performance with an actual deficit year to date of £8.0 million that is a favourable variance of £0.6 million compared to budget - Income and expenditure variance analysis - Detailed balance sheet & cash flow - Full year deficit/surplus profile by month	Is actual income recorded in a manner that is consistent with budget? Will the projected elevated cash balance (arising from early receipt of loans) lead to increased scrutiny from NHSI? How have PSF and FRF been treated in the accounts? Has the significant underspend in the administrative and other staff area lead to adverse operational consequences? What is the reason for the adverse spike in "other" agency costs in month 3?	Yes – income and expense match activity NHSI have been advised of the current arrangements which are understood and accepted Appropriate accruals have been made Vacancies principally in corporate functions and not affecting operational clinical teams The result of incorrectly posting some capital items	Accounting correction required in month 4

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Capital Programme Update	Detailed review of current year's capital plan by major project with supporting input on the planning and approval process and related funding procedures and applications	How are health and safety capital spending priorities established? Can the summary be expanded to show greater detail of the IT expenditure (the largest summary line in the analysis)?	Included as part of the annual process	Future reports to be expanded
Costing Transformation Plan	Detailed description of the requirement to participate in this mandatory process and the associated action plan that has been prepared to ensure compliance and on time submission of the required returns	Is the action plan focused on compliant reporting or does it address the wider benefit of increased reporting and analysis accuracy?	Current focus has been on submitting the return but the wider benefit of improved accuracy is well understood	Expanded communication and engagement work needed
Cost Improvement Programme Update	Detailed review of year to date performance by Division and programme (£3.6 million) and current projected total year. At month 3 the result is £1.3 million ahead of plan but current projections show slippage to a c. £9 million shortfall by year end. Mitigating actions were reviewed.	Is there adequate emphasis on transformational opportunities? Why do the procurement related projects not all have values assigned?	Yes and the tracking system will identify these as they develop Values are assigned once reliable assessments have been made	Deep dive in Procurement to be added to Committee work plan

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Clinical Productivity Update	Review of the job plan sign off performance which has achieved the 85% target together with proposed next steps in the process.	What work is being undertaken to analyse those roles where the SPA level exceeds 1.5?	Next stage of data gathering and analysis planned	
Agency Report	Review of the process and system improvements that have taken place with particular emphasis on the benefits that have been achieved by the roll out of the e-rostering system	Are there further opportunities that are not currently being pursued?	Yes – a number of areas and initiatives have been identified where further opportunities exist	Formalise opportunities in to a project plan
Board Assurance Framework (BAF)	Comprehensive review of the form and content of the BAF and discussion about its application and scoring		Ongoing work to further refine	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Digital Care Board Report	Project by project update and current status utilising a RAG rating system	Can project cost be added as an element to the report to increase understanding the scale of each project? Are the necessary supplier relationships in place to maximise the success of the pathology project?	Yes Yes and the opportunity presented by being the first UK user is very helpful	Cost information to be added to future reports
EPR Progress Summary	Review of activities in the project undertaken since the previous report and now planned. Particular emphasis on user engagement. Assessment of current project status in terms of schedule, budget, scope and risk	Are attendees at communication sessions a self-selecting group? Does a red rating to the data centre readiness project threaten implementation timing?	Yes but the team is also undertaking proactive visits to all user departments This reflects timing which is currently under discussion. Necessary infrastructure plans are on track	
IM & T Programme Board Project Update	Project status report indicating no new projects opened, one closed and one highlighted (telephony) where cost pressures have surfaced		Discussion in hand with telephony supplier	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
CITS Service Review	Review of recent project activity to improve service levels. Data indicates significant improvements in abandoned call rates, call answering time and operational queues	Comment – a good report and excellent language expressing ambition – “expect better, expect more”		

Rob Graves
Finance & Digital Committee

REPORT TO MAIN BOARD – September 2019

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

This report describes the business conducted at the Quality and Performance Committee on 29th August 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
Financial Performance Report	4 months' cumulative deficit at £8 million is a £0.5 million favourable variance against plan Key favourable variances: - Commissioner income £1.3m - Other income £1.0m - Pay £1.3m Partially offset by non-pay adverse variance Cash balance reflects recently received loan payments ahead of planned capital expenditure	What is the expected trend for agency cost? Why are non-NHS creditors showing negative balances in longer aged time periods? What is the approach for mitigating any shortfall in Cost Improvement Performance? Is the accounting treatment for pass through drugs (which can lead to some confusing numbers) mandated by NHS?	Current situation analysed in relation to vacancy levels which are being challenged where appropriate. Overall current trend expected to continue Under ongoing review – Board to be updated when analysis complete Yes – the approach is defined and cannot be modified	Analysis to be provided at next meeting Supplementary variance analysis will make impact clearer

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Capital Programme Update	Schedule by project including the requested analysis of the IT project expenditure. Clarification of how loan flow balances with expenditure plan	Can the IT analysis be incorporated in the detailed Digital update reports	Yes	Information to be added to relevant reports in the Digital agenda section
Cost Improvement Programme Update	Year to date performance of £4.9 million is an over achievement of £1.6 million against plan. Full year projection at £13.6 million continues to show an overall under performance against plan. Pipeline of new projects under review	How are plans for savings through vacany control stress-tested? Will the EPR project generate in year cost savings? Why does D & S not show a vacancy control saving in their plan?	Robust assessment process in place Net benefit realisation will commence in 20/21 Delay in their budget setting process prevented incorporation of planned savings, actual savings are being delivered	
Costing Update	Interim update on the progress of the mandated reporting submission and technicalities around NHSI “rules” with a recommended approach	Detailed questions covering the process - consensus reached on the approach to adopt		Key is to continue to deploy the wider costing improvement which is dependent on recruitment of a specialist

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Clinical Producticity Update	Job planning achievement now above 85% and 90% attainable. Lesser performing departments identified and under scrutiny Next phase of job activity planning described	When will it be logical to review the next phase of the project?		Set for October follow-up review
Digital Care Board Project Report	Detailed project progress report (Excl the seperate item for EPR) - No project closures this month - Chemocare a significant challenge with a critical deadline	How is the Chemocare issue being addressed? What contingency plans are needed?	Daily update reviewed by Executives. Checkpoint date established for risk and option appraisal	
Sunrise EPR Highlight Report	Detailed update on project elements with particular emphasis on communication and engagement. Recommendation for accelerated roll out Update on enablers	Does EPR Data Centre readiness (which is currently red rated) threaten implementation?	Rating under review as plans progress but not a threat to initial implementation arrangements	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Cyber Threat Management	Quantification of the number of CareCert notifications received by Countywide IT Services over the past 3 years and resulting impact on everyday business as usual activities. Highlights an evolving issue and workload that needs appropriate governance	Is there a data table capturing numbers of incidents and response rates?		Executives to consider the right metrics and the approach to keeping the Committee informed

Rob Graves
Finance & Digital Committee

Gloucestershire Hospitals NHS
NHS Foundation Trust

Report to the Trust Board

Financial Performance Report
Month Ended 31st July 2019

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 4.

The financial position as at the end of July 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 June the Group's consolidated position shows a year to date deficit of £8m. This is £0.5m favourable against plan. The position includes an impairment of £4.9m for the writing down of TrakCare capital expenditure incurred in previous financial years, which has no impact on the control total position. The Group's forecast year end position remains a deficit of £1.5m.

Statement of Comprehensive Income (Trust and GMS)

	TRUST POSITION			GMS POSITION			GROUP POSITION *		
Month 04 Cumulative Financial Position	Budget £000s	Actuals £000s	Variance £000s	Budget £000s	Actuals £000s	Variance £000s	Budget £000s	Actuals £000s	Variance £000s
SLA & Commissioning Income	159,264	160,552	1,288	0	0	0	159,264	160,552	1,288
PP, Overseas and RTA Income	1,601	2,172	571	0	0	0	1,601	2,172	571
Other Income from Patient Activities	152	568	416	0	0	0	152	568	416
Operating Income	24,626	24,369	(257)	15,333	15,402	68	25,924	25,764	(160)
Total Income	**185,642**	**187,660**	**2,018**	**15,333**	**15,402**	**68**	**186,940**	**189,055**	**2,115**
Pay	119,160	117,366	1,794	6,167	6,619	(453)	125,215	123,904	1,311
Non-Pay	67,384	70,665	(3,281)	8,360	8,103	258	61,821	64,843	(3,022)
Total Expenditure	**186,544**	**188,031**	**(1,487)**	**14,527**	**14,722**	**(195)**	**187,035**	**188,747**	**(1,711)**
EBITDA	**(901)**	**(371)**	**530**	**806**	**679**	**(127)**	**(95)**	**308**	**404**
EBITDA %age	**(0.5%)**	**(0.2%)**	**0.3%**	**5.3%**	**4.4%**	**(0.8%)**	**(0.1%)**	**0.2%**	**0.2%**
Non-Operating Costs	7,702	12,686	(4,985)	806	679	127	8,508	13,366	(4,858)
Surplus/(Deficit) with Impairments	**(8,603)**	**(13,057)**	**(4,454)**	**0**	**0**	**0**	**(8,603)**	**(13,057)**	**(4,454)**
Less Fixed Asset Impairments	0	4,918	4,918	0	0	0	0	4,918	4,918
Surplus/(Deficit) excluding Impairments	**(8,603)**	**(8,140)**	**463**	**0**	**0**	**0**	**(8,603)**	**(8,140)**	**463**
Excluding Donated Assets	147	146	(1)	0	0	0	147	146	(1)
Control Total Surplus/(Deficit)	**(8,456)**	**(7,993)**	**462**	**0**	**0**	**0**	**(8,456)**	**(7,993)**	**462**

* Group Position excludes £14.6m of intergroup transactions including dividends

Group Statement of Comprehensive Income

Gloucestershire Hospitals NHS
NHS Foundation Trust

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

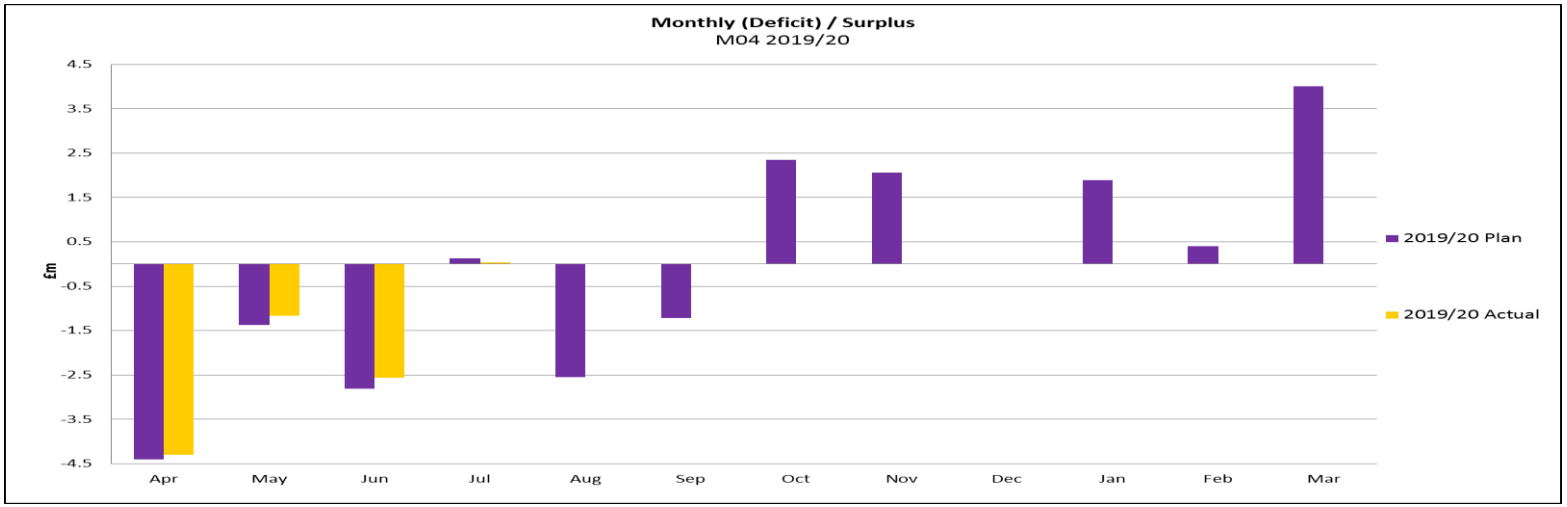
In July the Group's consolidated position shows an in month surplus of £36k on a control total basis, which is adverse against plan by £95k.

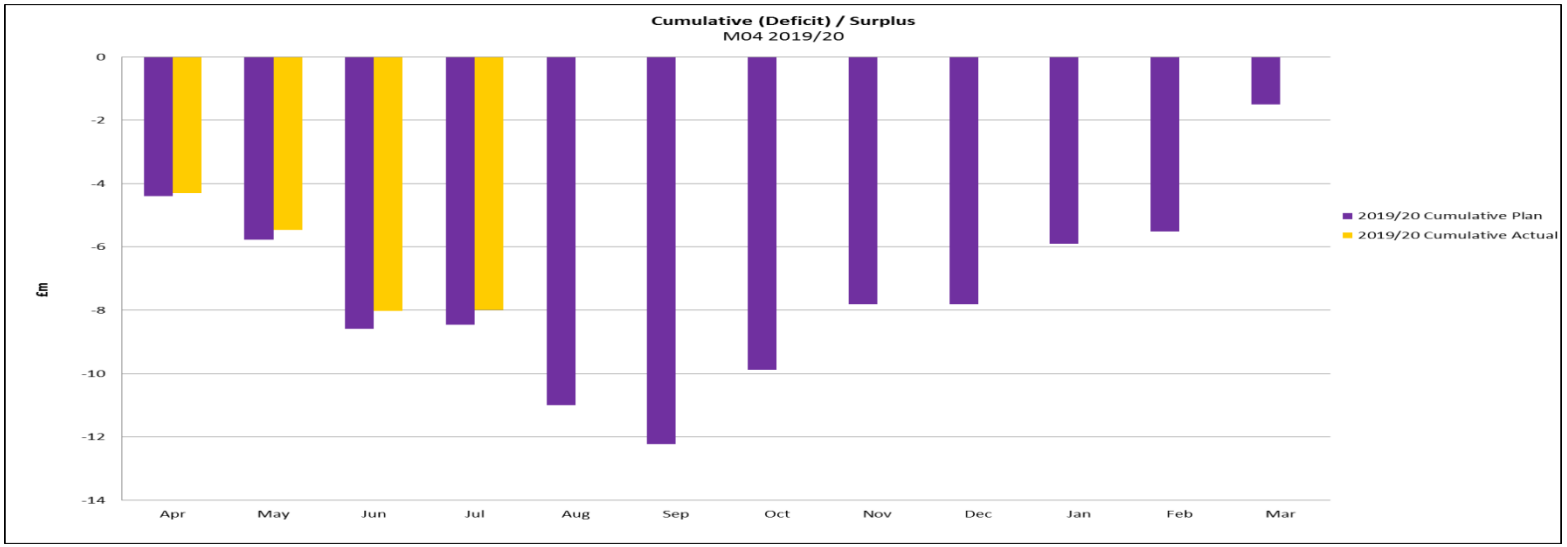
Month 04 Financial Position	Annual Budget £000s	M04 Budget £000s	M04 Actuals £000s	M04 Variance £000s	M04 Cumulative Budget £000s	M04 Cumulative Actuals £000s	M04 Cumulative Variance £000s
SLA & Commissioning Income	482,404	41,770	42,490	720	159,264	160,552	1,288
PP, Overseas and RTA Income	4,802	400	607	207	1,601	2,172	571
Other Income from Patient Activities	456	38	401	363	152	568	416
Operating Income	84,330	6,681	6,900	218	25,924	25,764	(160)
Total Income	**571,992**	**48,890**	**50,398**	**1,508**	**186,940**	**189,055**	**2,115**
Pay	365,118	30,949	30,699	250	125,215	123,904	1,311
Non-Pay	182,289	15,719	17,585	(1,866)	61,821	64,843	(3,022)
Total Expenditure	**547,407**	**46,668**	**48,284**	**(1,616)**	**187,035**	**188,747**	**(1,711)**
EBITDA	**24,584**	**2,221**	**2,113**	**(108)**	**(95)**	**308**	**404**
EBITDA %age	**4.3%**	**4.5%**	**4.2%**	**(0.4%)**	**(0.1%)**	**0.2%**	**0.2%**
Non-Operating Costs	25,526	2,127	2,114	13	8,508	13,366	(4,858)
Surplus/(Deficit) with Impairments	**(942)**	**94**	**(1)**	**(95)**	**(8,603)**	**(13,057)**	**(4,454)**
Less Fixed Asset Impairments	0	0	0	0	0	4,918	4,918
Surplus/(Deficit) excluding Impairments	**(942)**	**94**	**(1)**	**(95)**	**(8,603)**	**(8,140)**	**463**
Excluding Donated Assets	(558)	37	37	(0)	147	146	(1)
Control Total Surplus/(Deficit)	**(1,500)**	**131**	**36**	**(95)**	**(8,456)**	**(7,993)**	**462**

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.





Detailed Income & Expenditure

Gloucestershire Hospitals NHS
NHS Foundation Trust

Month 04 Financial Position	M04 Budget £000s	M04 Actuals £000s	M04 Variance £000s	M04 Cumulative Budget £000s	M04 Cumulative Actuals £000s	M04 Cumulative Variance £000s
SLA & Commissioning Income	41,770	42,490	720	159,264	160,552	1,288
PP, Overseas and RTA Income	400	607	207	1,601	2,172	571
Other Income from Patient Activities	38	401	363	152	568	416
Operating Income	6,681	6,900	218	25,924	25,764	(160)
Total Income	**48,890**	**50,398**	**1,508**	**186,940**	**189,055**	**2,115**
Pay						
Substantive	28,897	28,225	672	117,168	113,379	3,789
Bank	983	1,248	(265)	3,903	4,942	(1,039)
Agency	1,069	1,226	(157)	4,144	5,583	(1,439)
Total Pay	**30,949**	**30,699**	**250**	**125,215**	**123,904**	**1,311**
Non Pay						
Drugs	5,917	6,808	(891)	22,317	24,228	(1,910)
Clinical Supplies	3,261	3,328	(68)	13,050	13,530	(479)
Other Non-Pay	6,542	7,449	(907)	26,453	27,086	(633)
Total Non Pay	**15,719**	**17,585**	**(1,866)**	**61,821**	**64,843**	**(3,022)**
Total Expenditure	**46,668**	**48,284**	**(1,616)**	**187,035**	**188,747**	**(1,711)**
EBITDA	**2,221**	**2,113**	**(108)**	**(95)**	**308**	**404**
EBITDA %age	**4.5%**	**4.2%**	**(0.4%)**	**(0.1%)**	**0.2%**	**0.2%**
Non-Operating Costs	2,127	2,114	13	8,508	13,366	(4,858)
Surplus/(Deficit)	**94**	**(1)**	**(95)**	**(8,603)**	**(13,057)**	**(4,454)**
Fixed Asset Impairments	0	0	0	0	4,918	4,918
Surplus/(Deficit) after Impairments	**94**	**(1)**	**(95)**	**(8,603)**	**(8,140)**	**463**
Excluding Donated Assets	37	37	(0)	147	146	(1)
Surplus/(Deficit)	**131**	**36**	**(95)**	**(8,456)**	**(7,993)**	**462**

Non-Pay – expenditure is showing a year to date £3m overspend, reflecting overspends on pass through drugs and clinical supplies which are offset within income (£1.9m). The clinical supplies overspend of £0.5m reflects the continuing hire from Cobalt of MRI and CT Scanners (£0.3m), and tube repairs (£0.1m). The overspend on other non pay of £0.6m reflects expenditure mainly for outsourced clinical services for Glanso and 18 Weeks activity.

SLA & Commissioning Income – is reporting an over performance of £1.3m year to date, reflecting over performance on Gloucestershire CCG and Specialised Commissioning, offset by under performance on other commissioners.

PP / Overseas / RTA Income – is reporting a year to date over performance of £0.6m, reflecting private Oncology patients in D&S.

Other Operating income – the year to date under performance of £0.2m reflects lower GP and public health trainee income of £0.1m, CITS income of £0.2m, offset by higher R&D income of £0.1m. This performance is offset by lower expenditure.

Pay – expenditure is showing an underspend of £1.3m year to date reflecting an underspend on substantive budgets (£3.8m), offset by overspends on bank (£1m) and agency budgets (£1.4m).

Cost Improvement Programme

Gloucestershire Hospitals NHS
NHS Foundation Trust

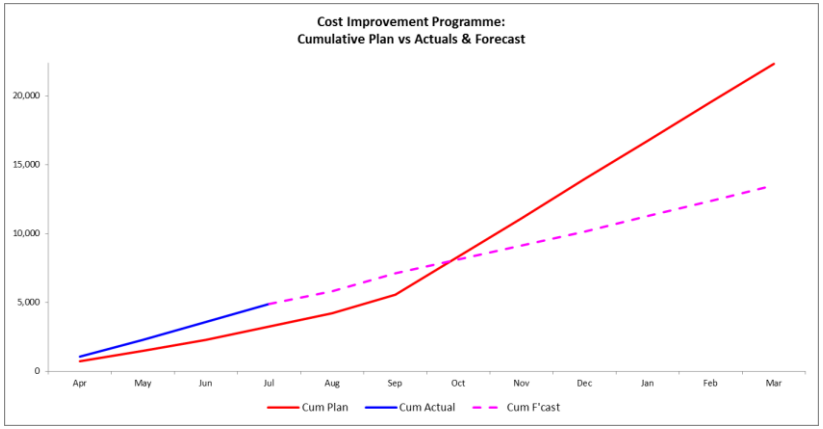
1. At Month 4 the trust has delivered £4.92m of CIP against the Year to date NHS Improvement target of £3.25m, this is an over performance of £1.67m. Within the month, the Trust has delivered £1.3m of CIP against an in-month NHSI target of £0.97m. Within the month, this is a positive variance of £0.4k which is largely due to vacancy factor (i.e. underspend against pay budgets).

2. At Month 4, the divisional year end forecast figures indicate delivery of £13.6m against the Trust's target of £22.4m.
This is an adverse variance of £8.8m. £2m of the identified schemes is Operational Growth margin. £2.5m relating to a review of Business Rates which is very high risk has been profiled into month 12 in the Trust's CIP plan submission (for NHSI) but has not been assumed within the internal CIP plan.

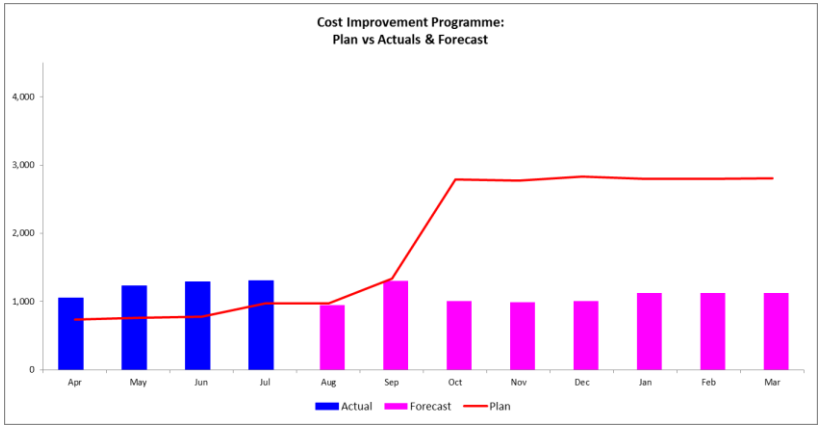
3. Oversight and scrutiny of the delivery of the 19/20 Cost Improvement Programme continues through weekly deep dives.
At Month 4, divisions were asked to provide a RAG rating against each of their schemes, this was reviewed and challenged by the interim consultant and Director of Programme Management.

4. The list of divisional, cross cutting and unpalatable 'opportunities' continue to be progressed with some benefits showing in Month 4. The interim delivery consultant continues to support the development of these.

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 M4 £000	B/S movements from 31st March 2019 £000
Non-Current Assests			
Intangible Assets	10,412	5,224	(5,188)
Property, Plant and Equipment	231,007	232,581	1,574
Trade and Other Receivables	4,640	4,654	14
Investment in GMS		0	
Total Non-Current Assets	**246,059**	**242,459**	**(3,600)**
Current Assets			
Inventories	7,571	8,184	613
Trade and Other Receivables	25,964	25,852	(112)
Cash and Cash Equivalents	7,317	19,537	12,220
Total Current Assets	**40,852**	**53,573**	**12,721**
Current Liabilities			
Trade and Other Payables	(54,315)	(72,328)	(18,013)
Other Liabilities	(5,837)	(2,518)	3,319
Borrowings	(12,527)	(11,954)	573
Provisions	(160)	(160)	0
Total Current Liabilities	**(72,839)**	**(86,960)**	**(14,121)**
Net Current Assets	**(31,987)**	**(33,387)**	**(1,400)**
Non-Current Liabilities			
Other Liabilities	(6,860)	(6,735)	125
Borrowings	(135,294)	(143,267)	(7,973)
Provisions	(1,434)	(1,434)	0
Total Non-Current Liabilities	**(143,588)**	**(151,436)**	**(7,848)**
Total Assets Employed	**70,484**	**57,636**	**(12,848)**
Financed by Taxpayers Equity			
Public Dividend Capital	172,676	172,676	0
Equity		0	
Reserves	23,915	23,915	0
Retained Earnings	(125,898)	(138,955)	(13,057)
Total Taxpayers' Equity	**70,693**	**57,636**	**(13,057)**

The table shows the M04 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 4 balance sheet position against the 2018/19 outturn

Current Assets

- Inventories have increased in month and are £0.6m higher than closing 2018/19 values, due to an increase in pharmacy stock.
- Cash has increased by £12.2m since the year-end, reflecting the deficit income and expenditure position, offset by borrowing, the movement in working balances and the timing of capital expenditure.

Non-Current Liabilities

- Borrowings have increased by £8m, reflecting working capital loan support.

Retained Earnings

- The retained earnings reduction of £13.1m 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 July	
	Number	£'000	Number	£'000
Total Bills Paid Within period	36,815	79,625	11,046	22,223
Total Bill paid within Target	31,079	68,134	10,201	19,199
Percentage of Bills paid within target	84%	86%	92%	86%

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 July 2019 £000
<12 months	
Loans from ITFF	2,988
Distress Funding	6,800
Obligations under finance leases	1,598
Obligations under PFI contracts	568
Balance Outstanding	**11,954**
>12 months	
Loans from ITFF	21,276
Capital Loan	4,334
Distress Funding	95,564
Obligations under finance leases	4,318
Obligations under PFI contracts	17,775
Balance Outstanding	**143,267**
Total Balance Outstanding	**155,221**

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 £8.7m of additional in-year borrowing from the DoH.

Cashflow : July

Gloucestershire Hospitals NHS
NHS Foundation Trust

Cashflow Analysis	Apr-19 £000s	May-19 £000s	Jun-19 £000s	Jul-19 £000s
Surplus (Deficit) from Operations	**(3,464)**	**(5,470)**	**(1,626)**	**835**
Adjust for non-cash items:				
Depreciation	1,229	1,229	1,229	1,229
Other operating non-cash	0	4,918	0	0
Operating Cash flows before working capital	**(2,235)**	**677**	**(397)**	**2,063**
Working capital movements:				
(Inc.)/dec. in inventories	113	0	298	(202)
(Inc.)/dec. in trade and other receivables	1,444	2,810	92	(4,458)
Inc./(dec.) in current provisions	0	0	0	0
Inc./(dec.) in trade and other payables	(2,349)	916	154	16,467
Inc./(dec.) in other financial liabilities	0	(1,055)	0	0
Net cash in/(out) from working capital	**(792)**	**2,671**	**544**	**11,807**
Capital investment:				
Capital expenditure	(1,129)	(1,629)	(1,729)	(3,125)
Capital receipts	0	0	0	0
Net cash in/(out) from investment	**(1,129)**	**(1,629)**	**(1,729)**	**(3,125)**
Funding and debt:				
PDC Received	0	0	0	0
Interest Received	3	3	3	3
Interest Paid	(124)	(294)	(114)	(259)
DH loans - received	2,442	3,368	2,887	0
DH loans - repaid	0	0	0	0
Finance lease capital	(488)	(488)	(488)	(488)
Interest element of Finance Leases	(12)	(12)	(12)	(12)
PFI capital element	(68)	(68)	(68)	(68)
Interest element of PFI	(38)	(38)	(38)	(38)
PDC Dividend paid				
Net cash in/(out) from financing	**1,715**	**2,471**	**2,170**	**(862)**
Net cash in/(out)	**(2,441)**	**4,190**	**588**	**9,883**
Cash at Bank - Opening	**7,317**	**4,876**	**9,065**	**9,653**
Closing	**4,876**	**9,065**	**9,653**	**19,537**

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

Cashflow Key movements:

The Cash Position – reflects the Group position. The Trust has drawn down loan support of £8.7m 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:

- £8.6m - committed cash, reflecting a pre payment from Health Education England of £5.2m
- £4m - GMS cash

Capital Programme

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 July 2019

Capital Summary	Internal YTD Plan £k	YTD Spend £k	YTD Var £k	19/20 Full Year Plan £k	FOT 19/20 Spend £k	Forecast Variance £k
Health & Safety Projects	692	1,000	308	2,605	2,825	220
Environmental Works	93	18	(75)	350	350	0
Non Health & Safety Projects	316	434	118	975	991	16
Committed Schemes	123	144	21	460	476	16
Service Reconfiguration	2	2	0	9	9	0
Major Equipment Replacement	5	1	(5)	1,020	1,021	1
IM&T	2,880	2,811	(69)	9,883	9,883	0
MEF	664	400	(264)	2,490	2,490	0
Other Schemes	1,456	485	(971)	6,908	4,130	(2,778)
Contingency/Leases Capitalisation	210	0	(210)	1,300	1,300	0
Overspend/(Underspend)	**6,441**	**5,295**	**(1,146)**	**26,000**	**23,476**	**(2,524)**

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

The year to date spend is behind plan which largely reflects delay of those schemes still dependant on external financing. The forecast has reduced due to a directive from NHSI.

Points to note:

- The work continues within the Women's Centre, to replace the carbon steel piping that has been failing. The H&S budgets have been reprioritised to accommodate this replacement work which should be complete by September 2019.
- The EPR project is progressing to plan, with commercial milestone payments made to the supplier along with Citrix licences.
- The enabling works to enable the relocation of staff at Victoria Warehouse and Pullman Court continues and is estimated to complete within budget. The estates work is complete and the IT work is progressing.
- During July, the Trust was advised by NHSI that the national planned capital spend is not affordable. We were therefore asked, as an ICS, to reduce our planned capital spend by 20% by either slipping schemes or reprioritising schemes. For GHT, this required a reduction of £2.5m which is reflected in the forecast outturn.

Recommendations

Gloucestershire Hospitals NHS
NHS Foundation Trust

The Committee is asked to note:

- The Trust is reporting a year to date actual income and expenditure deficit on a control total basis of £8m at July 2019. This is £0.5m favourable against plan.

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

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

Date: **August 2019**

Gloucestershire Hospitals
NHS Foundation Trust

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

Report Title
Financial Performance Report – Month 4 2019/20
Sponsor and Author(s)
Author: Jonathan Shuter, Director of Operational Finance Sponsor: Sarah Stansfield, Director of Finance
Executive Summary

Purpose

To provide assurance to the Board with regard to the Group financial performance, incorporating the Trust and Gloucestershire Managed Services, for the period ended 31st July 2019.

Key issues to note

- At Month 04 the Trust is reporting a cumulative deficit of £8m which is £0.5m favourable against plan.
- Commissioner income is £1.3m favourable against plan.
- Other NHS patient related income is £0.4m favourable against plan.
- Private and paying patients' income is £0.6m favourable against plan.
- Other operating income (including Hosted Services) is £0.2m adverse against plan.
- Pay expenditure is showing a favourable variance of £1.3m against plan.
- Non-pay expenditure is showing an adverse variance of £3m against plan.
- Non-operating costs are £4.9m adverse against (reflecting the impairment of TrakCare) – this is reversed out from a control total point of view leaving a small favourable variance to the planned position.
- The closing cash position contains a high level of committed cash – relating to planned expenditure for both revenue and capital.

Conclusions

The Trust position in favourable to plan as at Month 4 of the 2019/20 financial year. The second half of the year requires a material decrease in run-rate to deliver the planned deficit position.

Implications and Future Action Required

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

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

Impact Upon Strategic Objectives

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

Impact Upon Corporate Risks

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

- The risk of agency spend in clinical and non-clinical areas exceeding planned levels due to ongoing high vacancy levels, with resulting impact of delivery of FY20 CIP programme
- Risk that available capital is insufficient to support requirements associated with buildings maintenance, equipment renewal and backlog maintenance resulting in major operational impacts and increased costs
- Risk that the Trust does not achieve the required cost improvement resulting in failure to deliver the Financial Plan for FY20

Regulatory and/or Legal Implications

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

Equality & Patient Impact

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

Resource Implications

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

Action/Decision Required

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

Date the paper was presented to previous Committees and/or TLT

Audit & Assurance Committee	Finance & Digital Committee	Estates & Facilities Committee	People & OD Committee	Quality & Performance Committee	Remuneration Committee	Trust Leadership Team	Other (specify)
	29TH August 2019						

Outcome of discussion when presented to previous Committees/TLT

The paper was scrutinised at Finance & Digital Committee. A number of challenges were received and these are reflected in the Chair's report from the Committee.

REPORT TO TRUST BOARD – September 2019

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

This report describes the business conducted at the People and Organisational Development Committee on 19 August 2019 indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Risk Register	Risk register was noted and discussion held on the impact of Primary Care Networks on staff attrition and the recruitment gaps	Are the GP's expressing interest in a collaborative model of physio provision? Recruitment gaps remain a concern for some roles. Should this risk be on the Trust Risk Register?	The GP lead in the CCG is collating interest and encouraging GPs to use their funding for a shared model. Workforce supply (and retention) is a score of 12 under the domain workforce and as such under Trust Risk Management policy and linked to Trust risk appetite does not meet the criteria for escalation to Trust Risk Register. In terms of recruitment gaps it was noted 1. Vacancy gap and fill rate are not the same. 2. Fill rate and any potential risk to patient safety is overseen by the Quality and	None to be included in Octobers new Dashboard which links to strategic measures To provide a report at October committee on the activities linked to recruitment and retention strategic measures as agreed within the People and OD strategy

			Performance committee. 3. Recruitment gaps are different depending on the types of staff/grades 4. Trust is high performing in terms of retention data 5. Retention initiatives are ongoing. 6. Not all recorded vacancies are true gaps given the discrepancy between purchase ledger data and divisional decisions to fill vacancies with alternative posts 7. People and OD committee receive regular reports on recruitment, retention and trajectory improvement plans for hard to fill areas	
BAF / New objectives	BAF reviewed and discussion held on key controls and the alignment of 2 strategic objectives (5&6) to the People and OD committee	Key controls should be summarised into the top 5, with corresponding assurance measures. Dividing the assurance		Next BAF to highlight key controls only and number these to enable a read across to numbered assurances Director of People and

		committee for strategic objectives would appear to separate out a part of an objective from the whole and risk silo review and assurance		OD to raise with Executive team to resolve
Staff Survey Action plan and priorities 2019/20	Reviewed key themes of staff survey plan and divisional returns. - Improving quality of appraisal - Bullying and harassment - Health and Wellbeing	What are the actions to assist with improving the quality of the appraisal experience	Extensive learning and development opportunities are available for new and existing managers and a current survey is asking feedback from colleagues on the current system. Actual compliance (having an appraisal) is rising	
		Why have two divisions not responded to the request for their plans? (surgery and medicine)	Staff engagement is discussed at executive reviews and plans are in place	Divisional plans to be sent to committee members for assurance
		When will the Trust have other means to collect information from staff in the form of real time information?	There are multiple ways in which we collect real time information from subject based surveys, to informal meeting of staff, J2O visits, formal gatherings, engagement events, communication packages. The means and method of collecting real time information via any 'technical means' and other	

			engagement ambitions and plans will be described in the comms and engagement enabling strategy.	
HSE Update (resources)	Update provided on HSE Improvement notice, a specific incident and health and safety resources			Next health and safety report to provide further detail on the incident - next steps, progress on actions
Equality, Diversity, Inclusion, human rights action plans and priorities	Two action plans developed to focus on improving patient experience and also staff experience. 4 new quality objectives 2019/24 WDES data and report has been submitted to NHS England	None		None

Research strategy	Research strategy described 4 pillars – • Increasing visibility and awareness. • Celebrating success • Increasing equity of access. • Growing our collaborations. Ambition and research strategy approved subject to ensuring the content is formatting into the strategy template	None		None
University hospital status	Paper welcomed as an update on the business case preparation	Why is the step change in research grant income part of phase 3 and what is the monetary value of this step change? Is the ambition to hold University status across the ICS in 4-5 year too long? At what point should we apply for the status?	This is part of phase 3, as it can take time to build new research pipelines. Partners are committed to the idea but keen to see how the Trusts application is received. At present research allocations are not typically made to systems. Options on timing will be built into the business case. The ambition is to start to create cultural change and do things differently which will support the application rather than simply achieve the badge.	None

Strategic sustainable workforce update	Workshops have been taking place across all divisions and specialities to review demographic data, national supply data, demand and future service provision to meet the national requirement for a Trust and ICS 5 year workforce plan by Autumn 2019. Progress has been positive.	How do we manage establishment modelling given funding is annualised (annual contracting)?	The methodology scrutinises current needs and projections mapping to known changes in activities and assumed financial forecasting (Long term plan indicates some funding commitments)	None
Adult inpatient Nursing review	Review of winter staffing using safe care live was noted Identified 40 WTE nursing gaps and an over establishment in Health Care Assistants (HCA) Medicine has the largest gap and there is a review of staff mix and grade on each shift There is a 3 year investment cycle to enhance nurse skill mix with HCA's. Additional Investment is being provided for leadership and new roles (e.g. nutritional support)	Are we on track to invest? If investment doesn't happen could Committees gain additional assurances on mitigations?	Challenge with finances may impact investment but risks will be reviewed as part of the intolerable risk process where funds are allocated and/or reallocated. Any slippage would be raised at Quality and Performance and Board	None

Gender Pay (Dr SAS) update	Further analysis of gender pay in medical grades (SAS Dr's) is multifactorial: - Length of service - Salary sacrifice impact on hourly rate of pay - On call enhancements - Starting salary when international experience is assessed and matched to a salary	NONE		NONE
Performance dashboard	Appraisal and Statutory Mandatory training compliance continues to rise Trust benchmarks well with model hospital peers and has a low turnover rate and vacancy gap comparatively.	HCA retention issues are still high? Can we benchmark against hospital university status and outstanding Trusts rather than model hospital where CQC ratings may be less than good?	HCAs remain a focus for divisions The business case preparation for University Hospital Status includes the data on how the Trust compares and we are retaining and attracting staff comparatively to the best University Hospitals	Additional data can be provided in the new dashboard (October)
Education, Development, Learning	Comprehensive half year report received which highlighted progress made on career paths,			None

update	development of new skills pathways and ICS collaboration. Positive work with local partners has also increased the availability and supply of placements for adult nursing students Of note the Trust has met the government target for apprenticeships and now offers standards across 25 disciplines from level 2-7	Are new placements offers taken up and how do we ensure the quality of these?	All placements have been taken up. Mentors are being upskilled in house and by Universities. Additional programmes of development include the national Repair project. A new programme of work to look at the cultural differences between students and placement providers is under way within the sector.	
Hub Update	Data shared regarding hub use and the use of associated services such as staff welfare and the EAP	None		None

Board note/matter for escalation

The matters arising item outlining the governance arrangements for security (Violence and Aggression) to be shared with the Estates and Facilities Committee Chair

Balvinder Kaur Heran
Chair of People and OD Committee, 19 August 2019

Gloucestershire Hospitals NHS
NHS Foundation Trust

Workforce Information Dashboard

People and OD Committee, August 2019

Alison Koeltgen, Deputy Director of People & OD

Gloucestershire Hospitals NHS
NHS Foundation Trust

Introduction and Overview

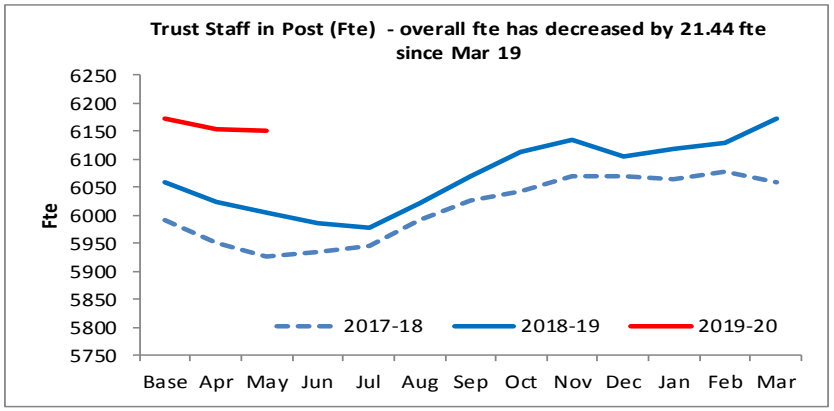
- The purpose of this presentation is to provide an overview to the People and OD Committee of the key performance indicators which link to our strategic priorities:

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

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

Performance summary:

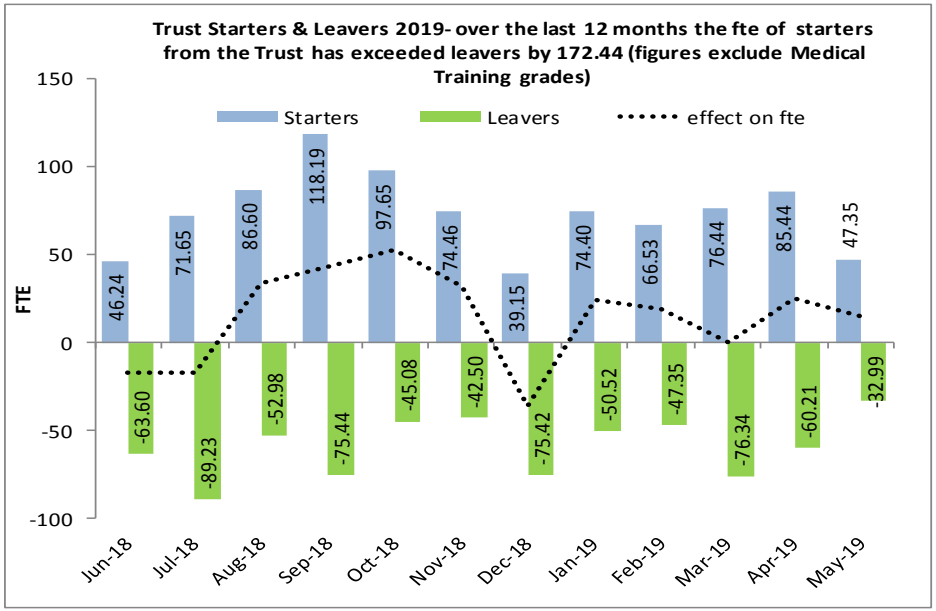
	VACANCY RATE	SICKNESS (May)	TURNOVER	APPRAISALS	MANDATORY TRAINING
Performance (in month)	10.21%	3.35%	n/a – rolling annual figure	81%	91%
Rolling Annual performance	n/a	3.85%	11.62%	n/a	n/a
Target	Not identified	3.50%	11%	90%	90%
Movement since last report	↑ 0.8	↔	↓0.18	↑2%	↑1%

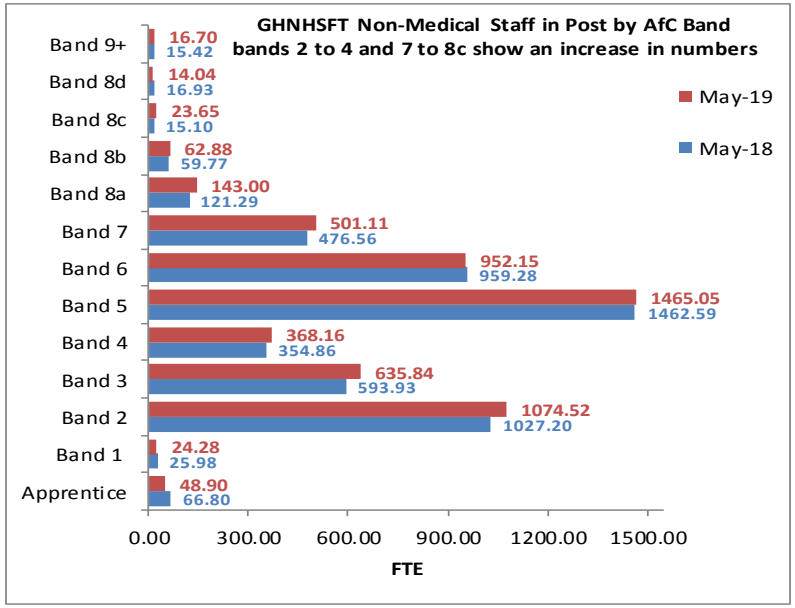


GHNHSFT Staff in post - change over year

FTE in Post	May-18	May-19	Increase/decrease	
Add Prof Scientific and Technic	235.87	232.21	-3.66	-1.55%
Additional Clinical Services	1,096.36	1,126.02	29.66	2.71%
Administrative and Clerical	1,304.59	1,378.25	73.66	5.65%
Allied Health Professionals	332.74	341.01	8.27	2.49%
Estates and Ancillary	29.15	28.51	-0.64	-2.20%
Healthcare Scientists	210.73	224.12	13.39	6.35%
Medical and Dental	816.38	835.62	19.24	2.36%
Nursing and Midwifery Registered	1,979.96	1,984.36	4.40	0.22%
Total	**6005.78**	**6150.10**	144.32	2.40%

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





Note: the above data for starters & leavers now includes bank to substantive and vice versa

Key Issues:

- Numbers of staff in post decreased by 21.44 since March 2019. Over the last 12 months, fte in post has increased by 144.32.
- Bands 1, 5, 6 numbers are relatively stable but Apprentices show a reduction in numbers. Other Bands show increases.
- May again saw a greater proportion of starters compared to leavers, which matches the general trend over the past 12 months (excluding December and March).

Retention

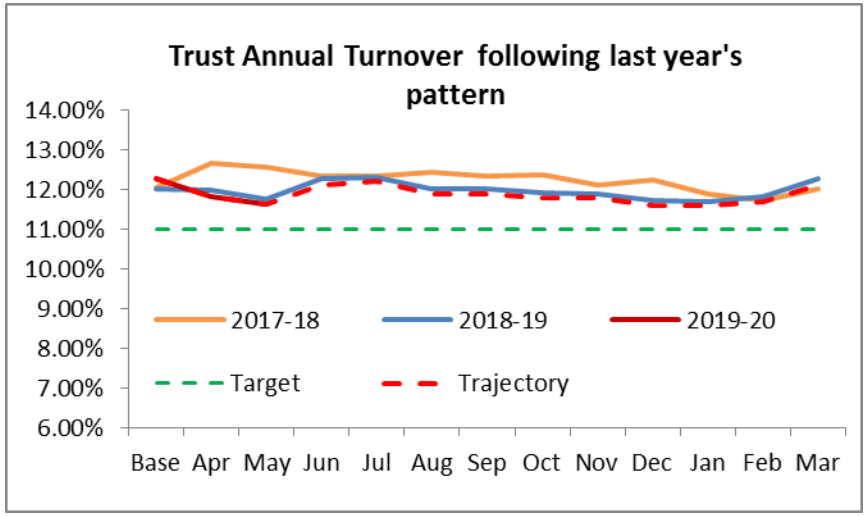
Gloucestershire Hospitals NHS
NHS Foundation Trust

Description	Current Performance			Movement since last Month		
	12 months to 31st May 2019	Actual % TO	KPI % TO			Previous Month
Turnover is measured using the total leavers(fte) as a percentage of the average fte for the reporting period. The Trust target is 11% with the red threshold above 15% and below 6%. NB Turnover now reported as fte based - in line with QPR reporting	**Trust Total**	11.62%	11.00%	↘	decrease	11.80%
	Corporate	12.45%	11.00%	↗	increase	12.05%
	Diagnostics & Specialty	11.00%	11.00%	↘	decrease	11.44%
	Medicine	13.64%	11.00%	↗	increase	13.52%
	Surgery	11.84%	11.00%	↘	decrease	12.43%
	Womens & Children	7.81%	11.00%	→	stable	7.87%
	Add Prof Scientific and Technic	9.62%	11.00%	↘	decrease	10.16%
	Additional Clinical Services	15.73%	11.00%	→	stable	15.79%
	Administrative and Clerical	11.35%	11.00%	↘	decrease	11.78%
	Allied Health Professionals	15.26%	11.00%	↘	decrease	15.69%
	Estates and Ancillary	2.62%	11.00%	↘	decrease	3.68%
	Healthcare Scientists	10.83%	11.00%	→	stable	10.88%
	Medical and Dental	4.36%	11.00%	→	stable	4.39%
	Nursing and Midwifery Registered	10.93%	11.00%	→	stable	10.99%
	Staff Nurses	13.70%	11.00%	↘	decrease	13.88%

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

Benchmarking: NHS iView uses a different methodology for calculating Turnover, How ever it can be used for comparison betw een Trusts/ Groups of Trusts

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



Key Issues:

- Turnover is measured using the total leavers(fte) as a percentage of the average fte for the reporting period.
- Turnover is now reported as fte based - in line with QPR reporting
- When benchmarked against similar sized Trusts, our Trust shows a lower rate of overall Turnover and places us in a favourable position when we compare Nursing and Midwifery turnover.
- Nurse Turnover and HCA Turnover (Additional Clinical Services) remains a concern – especially within the Medical Division (16.22% Staff Nurse Turnover)
- AHP Turnover remains high and impacts on the continued vacancy pressure particularly within areas such as radiography.
- The newly published interim NHS people plan (launched 5.6.19) specifies a commitment to grow the number of substantive nurses employed by the NHS by 40,000 , by 2024. The strategy to achieve this outlined within the interim people plan, mirrors a number of the key strategic aims developed as part of our People and OD strategy, with key themes extracted from the NHS long term plan.

Vacancy levels – May 2019

Gloucestershire Hospitals NHS
NHS Foundation Trust

Staff Group	Recurrent Funded wte	Contracted	Vacancies	VR%
Add Prof Sci Tech	279.65	313.19	- 33.54	-11.99%
Additional Clinical Services	1,300.04	1,137.43	162.61	12.51%
Administration & Clerical	1,508.94	1,344.05	164.89	10.93%
Allied Health Professionals	374.44	339.89	34.55	9.23%
Estates & Ancillary	29.39	28.53	0.86	2.93%
Healthcare Scientist	158.99	143.53	15.46	9.72%
Medical & Dental	905.04	834.44	70.60	7.80%
Nursing & Midwifery	2,270.72	1,988.96	281.76	12.41%
Grand Total	**6,827.21**	**6,130.02**	**697.19**	**10.21%**

Reg Nursing & Midwifery	Recurrent Funded wte	Contracted	Vacancies	VR%
Corporate Division	94.70	81.48	13.22	13.96%
Diagnostics & Specialty Division	184.95	172.62	12.33	6.67%
Medicine Division	694.77	602.12	92.65	13.34%
Surgery Division	846.43	708.35	138.08	16.31%
Womens & Children Division	449.87	424.39	25.48	5.66%
Grand Total	**2,270.72**	**1,988.96**	**281.76**	**12.41%**

Non Registered Nursing	Recurrent Funded wte	Contracted	Vacancies	VR%
Corporate Division	23.60	16.88	6.72	28.47%
Diagnostics & Specialty Division	75.96	73.18	2.78	3.66%
Medicine Division	350.92	277.02	73.90	21.06%
Surgery Division	320.86	281.77	39.09	12.18%
Womens & Children Division	113.14	97.33	15.81	13.97%
Grand Total	**884.48**	**746.18**	**138.30**	**15.64%**

Highlights:

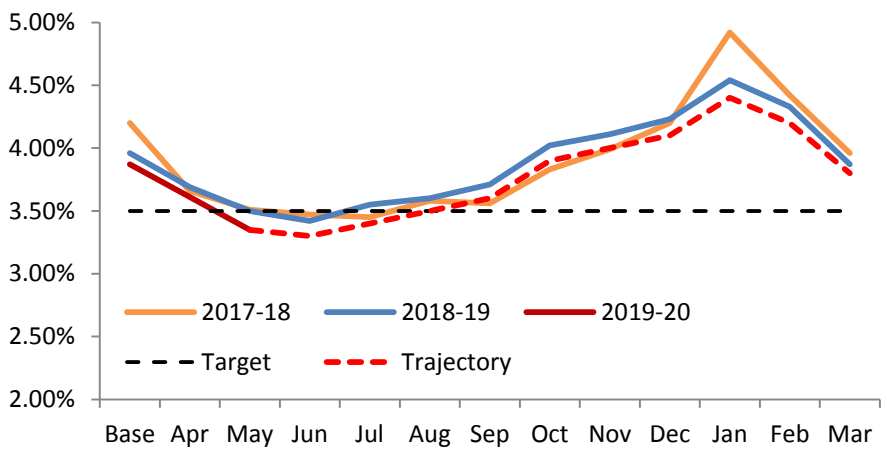
- key factors which should be considered when interpreting this high level data:
  - Data is, at this point in time, presented at a very high-level - therefore will not always highlight departmental level variance associated with bandings and / or local capacity and demand issues. For example, AHP's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

Sickness Absence

Description	Current Performance			Maternity	Total	Sickness Absence by month						Movement
Sickness Absence is measured as percentage of available Full Time Equivalents (FTEs) absent against available FTE. The Trust target Is 3.5% with the red threshold 0.5% above this figure.	12 months to May 19 (Annual)	**Sickness**	**KPI**	Absence	Absence	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Apr to May
		% Abs	**% Abs**									
	Trust Total	3.85%	3.50%	2.77%	6.62%	4.23%	4.54%	4.33%	3.87%	3.61%	3.35%	decrease
	Corporate	3.74%	3.50%	1.60%	5.34%	4.26%	4.22%	3.28%	2.83%	3.08%	2.89%	decrease
	Diagnostics & Specialty	3.93%	3.50%	2.15%	6.08%	4.70%	4.95%	4.98%	4.33%	3.77%	3.15%	decrease
	Medicine	3.58%	3.50%	2.99%	6.57%	3.59%	4.25%	4.72%	4.25%	4.00%	3.38%	decrease
	Surgery	3.98%	3.50%	2.99%	6.97%	4.23%	4.42%	3.89%	3.84%	3.37%	3.42%	decrease
	Womens & Children	3.99%	3.50%	4.51%	8.50%	4.41%	4.89%	4.63%	3.59%	3.77%	4.05%	increase
	Add Prof Scientific and Technic	3.11%	3.50%	2.87%	5.98%	3.45%	2.37%	3.00%	2.79%	2.19%	2.57%	increase
	Additional Clinical Services	5.08%	3.50%	2.91%	7.99%	5.65%	6.28%	6.26%	5.50%	5.36%	3.82%	decrease
	Administrative and Clerical	3.88%	3.50%	1.36%	5.24%	4.38%	4.64%	3.77%	3.59%	3.57%	3.43%	decrease
	Allied Health Professionals	3.03%	3.50%	3.11%	6.14%	3.87%	3.83%	4.23%	3.41%	2.32%	3.18%	increase
	Estates and Ancillary	7.25%	3.50%	0.00%	7.25%	4.56%	4.44%	5.38%	6.13%	2.93%	3.44%	increase
	Healthcare Scientists	2.72%	3.50%	1.91%	4.63%	2.81%	3.09%	2.59%	2.83%	2.63%	2.47%	decrease
	Medical and Dental	1.67%	3.50%	2.70%	4.37%	1.54%	1.99%	2.35%	1.79%	1.75%	1.33%	decrease
	Nursing and Midw ifery Registered	4.37%	3.50%	3.72%	8.09%	4.62%	4.89%	4.81%	4.33%	3.95%	4.09%	increase

NB Sickness Absence data is run in arrears Jun 19 data w ill be available from 25 Jul 2019. **Data is subject to late recording, so the most recent month's % may rise.**

Trust Monthly Sickness Absence following usual pattern but lower than previous years



Highlights:

- Annual sickness absence of 3.85% remains lower than the national average for Large Acute Trusts
- Long term (over 28 days) sickness rate accounts for just over half of fte lost (51.9%) but only 4.7% of episodes.
- The estimated cost of annual sickness absence (lost hours, not replacement) is £7,234,626
- MSK and Mental Health remain the top reasons for absence.
- The Trust Health and Wellbeing Hub successfully launched in May 2019 and now provides increased support to staff , helping them to access services related to Mental, Physical and Financial health. This includes the addition of an Employee Assistance Programme, offering 24/7 telephone support.

Triangulation (Sickness and Turnover) & Intervention

Gloucestershire Hospitals NHS
NHS Foundation Trust

	%SA	fte	Movement since previous month	Short Term	Long Term
GRH Head & Neck Theatre - Pay Only 7	11.83	33.31	↘	3.53%	8.30%
Phlebotomy Services Trustwide 21441	11.31	32.83	↗	2.61%	8.70%
Day Surgery Ward 72022	9.66	29.86	↘	3.10%	6.57%
Pre-Analytical Area - Trustwide 22022	9.17	30.80	↗	2.05%	7.12%
Trauma Ortho Fracture Clinic 43941	9.03	21.81	↘	3.28%	5.75%
Ward 2a T&O Trauma & Spinal Unit 701	8.87	37.47	↘	2.41%	6.46%
Onward Care Team 13693	8.72	22.92	↗	4.79%	3.93%
Orthopaedic OPD 77022	8.27	20.96	↘	2.34%	5.93%
SCBU - GRH 31422	7.28	69.04	*new*	3.71%	3.56%
Ward 7b CAPD Renal 74322	7.06	30.13	*new*	3.20%	3.86%
Oncology Admin 12841	6.54	44.74	*new*	1.86%	4.68%
Eyford Unit 41341	6.39	20.59	*new*	1.40%	5.00%

June 18 to May 19	% Turnover	Average FTE	Leavers	since previous month
Alstone Ward - Orthopaedic 35341	49.44%	20.35	10.06	↘
Woodmancote CGH GOAM 73441	41.25%	30.06	12.40	↗
Ward 6a Stroke 34822	33.92%	21.02	6.09	↗
Ward 3b T&O Trauma 74422	31.55%	27.79	9.43	↗
Ward 2b ENT Spec Surgery 73122	28.98%	27.01	6.55	↗
Ward 2a T&O Trauma & Spinal Unit 70	26.42%	32.29	10.19	↘
Ward 9b Acute (Unsched Care) 41522	24.68%	20.67	5.00	→
Prescott Ward 34541	24.42%	31.07	7.67	↘
Audiology - GRH 23522	24.23%	31.04	8.20	↘
Avening Ward (Resp) 34141	24.23%	34.23	8.36	↘
Shared Serv-Procurement 85098	24.19%	25.52	6.00	→
AMU 72922	21.63%	43.46	9.40	↗
Cardiology Ward GRH 74222	21.04%	35.29	7.43	↗

Key Points to Note:

- The above tables show the top areas of concerns for sickness absence and turnover.
- The triangulation of the two metrics above highlighted T&O as an area of concern discussed at the last few POD Committee meetings. This has been further investigated and a number of ER cases and a patient complaint from this area were reviewed, with the involvement of the Divisional Chief Nurse and HR Business Partner. Additional HR Support has been put in place for the leadership team to ensure that the response to these issues is appropriate and inline with policy, whilst addressing development needs. We expect this to show on the reported stats for some time (rolling figure), however remain confident that measures are in place to improve attendance and retention in these areas.
- Further scrutiny of these actions and their effectiveness takes place via. the Executive review process.
- The Executive review process has also focussed on retention within the medical division , which has contributed to the decision to launch a secondment opportunity for a Nurse Recruitment and Retention lead – to support continued focus in this area (post holder commences Mid August 2019)
- Through the Staff and Patient Experience Group we attempted to maintain a 'super dashboard' from which to triangulate a wide range of sources of data, including but not limited to: patient experience information, NAAS, freedom to speak up and ER case information. However, due to the large number of manual systems involved, updating this dashboard in a useful way has proven to be time consuming and problematic. It was therefore agreed at July SPEIG to utilise existing Nurse metrics and review this alongside the development of a new workforce pack for the Executive Review process, which will include a Staff and Patient Experience section. Through better divisional triangulation of these hotspots, our Staff and Patient Experience Co-ordinator will be able to validate and test divisional and trust wide project priorities against the data set, whilst highlighting anomalies. This new Executive review workforce pack is being developed through September and will align to the measurable outcomes identified in the new People and OD Strategy and feed into the new performance dashboard (first draft to P&OD Committee in October 2019).

Appraisal & Mandatory Training

Workforce Committee GHNHSFT May 2018 – July 2019

Gloucestershire Hospitals NHS
NHS Foundation Trust

Appraisals	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19		Movement June to July	
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%			
Corporate	72%	72%	74%	78%	84%	86%		84%	82%	82%	79%	79%	80%	80%		→	stable
Diagnostics	74%	74%	74%	81%	84%	81%		80%	79%	82%	82%	83%	82%	82%		→	stable
Medicine	71%	72%	73%	75%	75%	76%		75%	76%	78%	77%	79%	82%	82%		→	stable
Surgery	78%	76%	76%	79%	78%	76%		78%	78%	80%	80%	81%	83%	86%		↗	increase
Women & Children	76%	76%	78%	79%	79%	79%		80%	80%	82%	81%	82%	80%	82%		↗	increase
Trust	**74%**	**74%**	**75%**	**79%**	**80%**	**79%**		**79%**	**79%**	**81%**	**80%**	**81%**	**82%**	**83%**		↗	increase

Mandatory Training	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul 19	Movement	May to June
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%		
Corporate excl Bank	88%	88%	89%	90%	91%	91%		88%	91%	91%	91%	91%	92%	93%	↗	increase
Diagnostics	90%	90%	91%	93%	93%	94%		94%	93%	93%	94%	93%	94%	95%	↗	increase
Medicine	85%	85%	86%	88%	89%	89%		89%	88%	88%	88%	88%	89%	89%	→	stable
Surgery	87%	87%	88%	90%	90%	91%		90%	90%	90%	91%	90%	91%	92%	↗	increase
Women & Children	84%	85%	89%	91%	91%	91%		90%	89%	89%	89%	89%	91%	92%	↗	increase
Trust	87%	87%	88%	90%	91%	91%		89%	90%	90%	91%	90%	**92%**	92%	→	stable

Blank columns mean there was no data created this month

- Appraisals have risen by 1% for the sixth consecutive month taking us to 83% for July 2019 with a significant increase by the surgical division to 86%
- Mandatory training remained at 92% overall in July although a small increase was seen in most of the Divisions

Statutory & Mandatory Training

Gloucestershire Hospitals NHS
NHS Foundation Trust

Training Compliance Report 31 July 2019; Overall compliance rate of 92%

Summary Breakdown of Compliance Rate by Training Competency and Staff Group

Training Competency / Staff Group	Trust Compliance	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical Staff - Consultants	Medical Staff - SAS	Medical Staff - Training Grades	Nursing and Midwifery Registered
318|LOCAL|Blood Transfusion|	89%	92%	89%	n/a	100%	n/a	83%	93%	84%	56%	92%
318|LOCAL|Code of Confidentiality|	90%	94%	88%	93%	94%	86%	91%	93%	88%	52%	92%
318|LOCAL|Conflict Resolution|	85%	88%	82%	88%	92%	78%	89%	98%	93%	89%	84%
318|LOCAL|Deprivation of Liberty Safeguards Level 1|	90%	97%	85%	n/a	96%	n/a	91%	94%	84%	86%	92%
318|LOCAL|Equality Diversity and Human Rights|	98%	99%	94%	99%	99%	99%	100%	99%	96%	93%	99%
318|LOCAL|Fire Safety|	89%	95%	86%	92%	93%	81%	93%	91%	85%	58%	91%
318|LOCAL|Health Safety and Welfare|	95%	97%	91%	96%	98%	99%	97%	98%	89%	86%	96%
318|LOCAL|Information Governance and Data Security|	90%	94%	86%	94%	95%	92%	95%	94%	86%	54%	92%
318|LOCAL|Medicines Management|	85%	91%	78%	n/a	n/a	n/a	100%	n/a	n/a	n/a	88%
318|LOCAL|Mental Capacity Act Level 1|	90%	97%	85%	n/a	96%	n/a	91%	94%	84%	86%	92%
318|LOCAL|Moving and Handling Level 1|	88%	94%	84%	91%	92%	84%	94%	89%	84%	55%	90%
318|LOCAL|Moving and Handling Level 2 (2yr)|	84%	85%	83%	44%	93%	80%	90%	82%	81%	82%	85%
318|LOCAL|Prescribing|	67%	50%	n/a	n/a	n/a	n/a	n/a	88%	77%	47%	n/a
318|LOCAL|Resuscitation Level 2 Adult Basic Life Support (2yr)|	89%	88%	87%	56%	94%	80%	93%	85%	83%	74%	92%
318|LOCAL|Safeguarding Adults Level 2|	93%	97%	89%	0%	97%	n/a	90%	95%	87%	87%	95%
318|LOCAL|Safeguarding Children Level 2|	83%	88%	79%	88%	91%	n/a	81%	89%	73%	88%	82%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	93%	96%	90%	93%	n/a	90%	97%	91%	n/a	100%	n/a
NHS|CSTF|Infection Prevention and Control - Level 2 - 1 Year|	90%	94%	88%	67%	95%	n/a	91%	95%	87%	56%	94%
NHS|CSTF|Preventing Radicalisation - Basic Prevent Awareness - 3 Years|	95%	97%	90%	96%	98%	97%	97%	99%	90%	89%	96%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	95%	97%	90%	96%	98%	97%	97%	100%	90%	90%	97%
NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - 3 Years|	95%	97%	90%	96%	98%	97%	97%	99%	90%	88%	96%

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

Compliance Rate Highlight key:
Less than 70% | 70% - 80% | 90% and above

Prescribing has been consistently low as a topic in percentage terms but is actually a small number of staff. This will be taken to ELD Operational Group in August for a review of the Training needs analysis

Professional, Scientific and Technical Services and AHPs compliant in most subjects

Some of the key topics at level 2 for A&C staff appear to be low and worthy of further investigation. With the move of the Manual Handling Team into the Education and Development Service from 1st June, and a wider review of these topics and MH in particular will commence in the Autumn

Medical Trainees remains a challenge and is linked to national project work. It is hoped recent agreements as to which induction programme is used and what topics covered will improve this situation late 2019 and into 2020

Gloucestershire Hospitals
NHS Foundation Trust

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

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

Purpose

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

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

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

Key issues to note

- Numbers of staff in post decreased by 21.44 since March 2019. Over the last 12 months, fte in post has increased by 144.32.
- Bands 1, 5 and 6 staff group numbers are relatively stable however Apprentices show a reduction in numbers. Other Bands all show increases.
- May saw a greater proportion of starters compared to leavers, which matches the general trend over the past 12 months (excluding December and March).
- Rolling annual turnover is following normal seasonal trends, in month all professional groups remained stable or reflected a decrease in turnover. Overall Turnover is at 11.62%.
- When benchmarked against similar sized Trusts, Gloucestershire Hospitals Trust shows a lower rate of overall Turnover and we place in a favourable position when comparing Nursing and Midwifery turnover.
- Nurse Turnover and Health Care Assistant Turnover (Additional Clinical Services) remains a concern – especially within the Medical Division (16.22% Staff Nurse Turnover)
- Annual sickness absence of 3.85% remains lower than the national average for Large Acute Trusts
- Long term (over 28 days) sickness rate accounts for just over half of fte lost (51.9%) however only 4.7% of episodes. Musculoskeletal and Mental Health remain the top reasons for absence.
- The Trust sickness rates remains lower than the national average for Large Acute Trusts - 4.34% Sep 18 (GHFT were 3.75% from same report) and shows how long term (over 28 days) sickness accounts for just under half of absence taken (48%).
- Appraisals rose to 83% for July, marking the 6th 1% increase per month in a row. Surgery have done particularly well going from 83% to 86% this month.
- Mandatory training rose to 92% overall in June and has remained there in July

Next Steps – Development of a Revised Performance Dashboard

The new People and Organisational Development strategy with its mix of strategic and operational measures will become the new dashboard and work continues to embed these changes and ensure People and Organisational Development teams can deliver reports on the metrics the Trust wish to monitor.

Through the Staff and Patient Experience Group we attempted to create and maintain a 'super dashboard' from which to triangulate a wide range of sources of data, including but not limited to: patient experience information, Nurse Accreditation and Assessment Service, freedom to speak up and ER case information.

However, due to the large number of manual systems involved, updating this dashboard in a useful way has proven to be disproportionately time consuming and problematic. It was therefore agreed at July's Staff and Patient Experience Improvement Group to utilise existing Nurse metrics and review this alongside the development of a new workforce pack for the Executive Review process, which will include a more dynamic Staff and Patient Experience section. Through better divisional triangulation of these hotspots, our Staff and Patient Experience Co-ordinator will be able to validate and test divisional and trust wide project priorities against the data set, whilst highlighting anomalies. This new Executive review workforce pack is being developed through September 2019; this will align to the measurable outcomes identified in the new People and Organisational Development Strategy and feed into the new performance dashboard (first draft to People & Organisational Development Committee in October 2019).

Whilst we continue to progress our Exit Interview project, exit questionnaire compliance is beginning to improve. In March 2019 Exit Questionnaire compliance was presented to the People and Organisational Development Committee at only 28%. Since then this has increased to 35% (July 2019). In addition to this significant efforts are being made within Divisions to meet face to face with individuals who are leaving and to gather more intelligence/ themes. The new executive review pack will be designed in a way to capture this intelligence and feed this into the new People and Organisational Development Performance Dashboard.

Recommendations

The Committee is asked to note the trends illustrated in the People and Organisational Development Performance Dashboard and measures detailed within to improve performance. The committee is also asked to note that the future dashboards will contain different material and reporting in line with the new People and Organisational Development strategy

Impact Upon Strategic Objectives

Reflects known pressures and priorities relating to the delivery of a compassionate, skilful and sustainable workforce, organised around the patient that describes us as an outstanding employer who attracts, develops and retains the very best people. Ensuring the right staff are available for patient care will also impact upon the objective 'Outstanding care.'

Impact Upon Corporate Risks

The risks on the People and Organisational Development risk register relating to this report are:

- C2803P&OD: The risk of continued poor levels of staff engagement and poor staff experience impacting negatively on retention, recruitment and patient experience.

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

Regulatory and/or Legal Implications

The success of the Trust in managing People measures could impact upon future CQC ratings.

Equality and Patient Impact

Having the right staff in the right place with the right skills impacts positively on patient care.
Treating staff fairly will improve perceptions of equality indicators and there is a known link between satisfied staff and good patient care.

Resource Implications

Finance	✓	Information Management & Technology	
Human Resources	✓	Buildings	

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

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

Outcome of discussion when presented to previous Committees/TLT

Committee assured with progress especially with Appraisal and Mandatory Training. The Trust benchmarked well with other model hospital peers and has comparatively low turnover and vacancy gap. Health Care Assistant's to remain a focus and comparisons with University hospitals to follow.
A new data set linked to Strategic Objectives will be presented at the People and Organisational Development Committee in October.

REPORT TO MAIN BOARD – SEPTEMBER 2019

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

This report describes the business conducted at the Audit and Assurance Committee on 2nd July 2019, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Counter Fraud update (CF)	Regular update report on Trust's CF arrangements for 2019-20, confirming satisfactory progress in year to date as per plan. Increased work is underway to examine how CF, bribery and corruption risks are assessed, monitored and managed. The Trust has participated in Series 2 of the BBC's Fraud Squad NHS. The Cttee was updated re current CF investigations. A second report addressed resilience of CF team in terms of its significant levels of collective experience and plans to address staffing shortfalls. Plans include restructuring. A Memo or	How can we be assured that differential approaches are not taken to different staff groups when investigating fraud? Are there adequate staff resources available to the service? Does the risk of fraud currently feature within the Trust's wider risk management arrangements? Could doing so provide a way to further extend divisional engagement?	Further report planned on risk-related aspects to September Cttee meeting. The application of corporate policy and relevant professional standards was explained. There was a high level of confidence that an equitable approach between staff is maintained. Resource levels have been agreed and yes, once recruitment plans are implemented, staffing levels will be adequate. Exec agreed to examine the possibility.	

	Understanding with another Trust in the region is a further source of support.			
Internal Audit	Internal audit items included an update on the 2019/20 Internal Audit programme. We considered two audit reports and management responses. RTT Clock stops review received Moderate audit ratings for both the 'Design' and 'Effectiveness' of internal control arrangements. Divisional Governance Audit Report. A briefing was received to demonstrate Executives' response to the IA findings and recommendations and associated action plan for strengthening divisional governance.	Are check and challenge resources adequate and recurrently funded? Are proposed timescales for training in the rules around clock stops sufficiently urgent? The Cttee welcomed the comprehensive approach that is being taken.	Yes and their being a centralised resource is good practice. Yes, given the scale and depth of work required to ensure correct spread of training and compliance. Some areas, eg Opthalmology are already demonstrating good results in these processes.	Quarterly progress updates to Cttee.

External Audit Report 2018/19	The external auditors, Ernst and Young (EY), confirmed their unqualified opinion of the Trust's financial statements for 2018/19. They provided a comprehensive report on the scope and focus of their work. The external audit report was delayed and the Cttee was able to discuss the circumstances with the Audit partner. EY were very clear as to the quality and responsiveness of the work undertaken by the Trust's finance team.	The Cttee commended the Finance Director and her colleagues for the quality f work undertaken in challenging circumstances. The Cttee sought and received assurance from EY that the resources and assumed timings for the GMS audit and the review of the Trust's charitable funds accounts have been confirmed to be adequate. EY agreed to provide a briefing on the circumstances of the delay to the Council of Governors in August.		
National Costing Audit Report	The report covered the NHS Costing Transformation Programme, a national project with the aims of improving costing in the NHS and mandating Patient Level Costing. The audit of Costing in the Trust reported a No Assurance opinion.	The Cttee was assured of intentions to address shortfalls in this area. It has not, hitherto, been a high priority, however an action plan has been developed to address the issues raised. This includes the need to recruit some specialist staffing resources. The Cttee was assured that the timescales appear to be realistic, assuming recruitment is successful.		

Claire Feehily, Chair of Audit and Assurance Committee, July 2019.

REPORT TO TRUST BOARD – September 2019

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

This report describes the business conducted at the Estates and Facilities Committee held 8th July 2019, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Matters Arising	Post-implementation review of GMS.	Requested by the NEDs.	To be received by the Audit & Assurance Committee – it is now on the Work Plan.	
	Security service improvements	The proposal that has been presented doesn't appear to take account of best-practices seen elsewhere.	New proposal for security arrangements will be reviewed by the DOG meeting.	This issue was raised by the People and OD Committee some months ago. It will be received back in the E&F Committee once considered by Trust leadership.
	Hard services	Committee needs to see a more comprehensive report on Planned Preventive Maintenance and urgent breakdowns/failures.	The COO reported that equipment breakdowns were c.1500 faults, 20% infrastructure, the remainder operational. Urgent Faults very low <1/month. Planned Preventative Maintenance at no point breached tolerances and trend expected to recover and improve due to recruitment to key vacancies.	Whilst detailed papers have been reviewed at CMG, and Committee was verbally briefed on this, assurance is still sought on whether GMS has an effective management system in place for the maintenance of facilities and equipment.

GMS Contract Management Group Report	This report was superseded by a verbal report from the COO on the newly-formed Contracts Management Group (CMG). All operational key performance indicators are currently being met.		The CMG will meet bi-monthly alternating with the E&F Committee, which will receive the CMG reports on contractual performance of GMS.	Assurance will be via Exception report from GMS Contract Management Group.
Trust Estates Strategy	Committee received an update on progress. There is good progress on understanding demand, but the current and future supply is still to be developed.	The Strategy needs to be in the NHSI – recommended structure. The clinical strategy needs to be translated into estates metrics (space, beds, facilities, etc.) to be meaningful A full six-facet survey is still required	A work plan is in place and resources have been contracted. The Trust is on track to deliver this. There will be a review on what value a full six-facet survey will give us vs. the information we now have from this process.	The final version of the Strategy is to be signed-off in September. The Estates Strategy will be transferred to the Trust's "enabling strategy" format with contents aligned to the NHSI recommended format.
ICS Estates Strategy Checklist	This was presented ahead of being submitted to NHSI on 15th July. It was noted that this is not an Estates Strategy, but an update in line with NHSI "checklist" template.	Limited opportunity to challenge, given the timeline. However, the document is in good shape. The £60million backlog maintenance figure submitted in ERIC report for the Trust was questioned.	There is data behind this new number, which will be presented to Committee. It was noted that the High/Significant backlog is expected to reduce from £12.6mln to £7.5mln for 2020/21.	The basis of the new backlog maintenance estimate to be presented to Committee.

Analysis of GMS Terms and Conditions and Recruitment	A review of the degree of success in filling "hard-to-recruit" positions as a result of GMS' new terms and conditions of employment. At this stage, it is not possible to draw definitive conclusions. There are some trends emerging that indicate that market supplements are required, and that using NHS Jobs is not the best route to market.	How is the market supplement being managed and controlled, as it would be easy to over-inflate pay.	The recruitment strategy is being overseen by Trust HR under the sponsorship and steering of the GMS Board.	An updated report will be provided at the end of 2019.
AOB		NEDs raised the question of how we received assurance on H&S statutory compliance. This came from the Quality and Performance Committee.	A report was received by this Committee in Summer 2018 which provided assurance that GMS have effective processes and controls in place. This will be further reviewed by the CMG.	

Mike Napier
Chair of Gloucestershire Managed Services Committee
13th August 2019

REPORT TO TRUST BOARD – September 2019

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

This report describes the business conducted at the Estates and Facilities Committee held 3rd September 2019, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Matters Arising	National Cleaning Standards	Questions still remain about the cost and implications of meeting national standards.	This is being actively monitored by the new Contract Management Group, and by the Infection Control Group in terms of quality.	Report to be submitted to Committee at next meeting
GMS Contract Management Group Report	Exception report provided by the COO. Major items reported: 1. Proposals for new security arrangements. 2. New transport strategy is being developed, which will include proposals on parking 3. Trust has received a Fire Safety non-compliance.	Need to address shirt-term requirements. This is also urgent, but analysis and report-out will take time. What are the costs of compliance?	Security proposals have been supported by TLT. Parking allocation is being looked at first. Transport is also an Estates Strategy issue Trust Fire Officer is overseeing this and Capital Control Group has reviewed the investments required.	Proposals to come back to Committee at next meeting.

Strategic Site Development Programme (SSDP), including Trust Estates Strategy	Monthly Strategic Site Development Project report was presented. The project is on track, with OBC due to come to Trust Board in December. There are concerns around NHSE/I and Dept. of Health & Social Care approval process and timescales for the OBC & FBC which are on the critical path. Estates Strategy is going through internal governance process so that it can be included as an appendix to the SSPD OBC	When will the preferred options be determined? When will Committee have an opportunity to comment on the Estates Strategy?	Project is on track. Some slippage as OBC was due to go to Board in October. Short-listed options will be shared with Board in November ahead of OBC approval in December. . The Estates Strategy will be shared with Committee once feedback from TLT has been incorporated.	If required, a sub-group of the Committee will be convened by conference call to provide feedback & challenge.
GMS BAF	The Board Assurance Framework was presented. It is now a robust and fit-for-purpose tool regularly reviewed by the GMS Board.	Have GMS considered all the risks around staffing – especially with an aging demographic profile?	This risk has been identified, but not yet captured in the GMS risk register.	

Estates and Facilities Risk Register	This now includes all risks facing the Trust in this domain. It mirrors many risks also held by GMS, but also includes Trust-only risks, especially on estates strategy and site development.		The register now addresses the gaps in risk management that had been flagged at this Committee in previous months. The register is robust and the process to manage risks on an ongoing basis appear sound.	

Mike Napier
Chair of Gloucestershire Managed Services Committee
3rd Sept 2019

Gloucestershire Hospitals
NHS Foundation Trust

Annual Report
Safeguarding Adults
Year to 31st March 2019

Prepared by: Jeanette Welsh – Lead for Safeguarding Adults
Lynne McEwan-Berry – Senior Safeguarding practitioner
Graham Rowe – Senior Safeguarding practitioner
Sally Unwin – Safeguarding Midwife
Jim Welch – Mental Health Liaison Team manager

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1.Introduction and executive summary

Safeguarding adults is fundamental to the care delivered within the Trust, as a regulated health care provider our Trust must provide assurance against Care Quality Commission's (CQC) Regulation 13: ''Safeguarding service users from abuse and improper treatment''. http://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-13-safeguarding-service-users-abuse-improper

This report is made to the Trust Quality and Performance Committee to assure members of the Trust wide arrangements in place to meet this regulation related to safeguarding of adults. An update is provided on activity, performance and monitoring relating to the Safeguarding of Adults with Care and Support Needs (Care Act 2014) and the safeguarding of adults under local Domestic Abuse Multi Agency Risk Assessment and Conference pathway (MARAC).

A progress report is provided on the application within practice of the Mental Capacity Act (MCA), the Deprivation of Liberty Safeguards (DoLS) and Mental Health Act detentions. Liberty Protection Safeguards legislation (LPS) will replace DoLS legislation on 1st October 2020.

The Care Act 2014 (section 42) governs safeguarding activity and applies to an adult aged 18 or over who:

- has care and /or support needs (whether or not the local authority is meeting those needs) and;
- is experiencing or at risk of abuse or neglect; and
- as a result of those care and support needs is unable to protect themselves from the risk of , or the experience of abuse or neglect.

This includes people with capacity who self-neglect.

The domestic abuse pathway incorporates safeguarding of young people, aged 16 to 18 years of age. This is coordinated under the Multi Agency Risk Assessment and Conference (MARAC) Information Sharing agreement.

The safeguarding of adults works in partnership with safeguarding children pathway. This is particularly evident as part of FGM detection in an adult and also where a patient, who is also a parent, presents with issues known to cause problems for their children e.g. mental health problems, substance mis-use. Across all pathways, there is a need to always think of the family as a whole as part of safeguarding responses and to consider whether there is any other person at who may also be at risk.

A report is also provided on mandatory safeguarding adult training compliance and Trust wide systems in place to support staff in delivering safeguarding of adults within practice.

2. Governance and Accountability arrangements

2.1 Safeguarding Adults Team within Gloucestershire Hospitals

The Director for Quality and Chief Nurse is the Executive Board member responsible for safeguarding, and the Deputy Chief Nurse has delegated authority as the Trust Safeguarding lead, including chair of the Trust Safeguarding Strategic Group.

The Trust Safeguarding Operational and Strategic Groups, meet bi-monthly alternately and in addition members of the Safeguarding Adults Team attend and contribute to the Countywide Strategic Safeguarding Group, which brings together the named professionals from all the County Health Trusts, Commissioning Team and General practice.

The Deputy Director of People is the Senior Manager Responsible for allegations and liaises with the Local Authority Designated Officer if concerns are raised about Trust staff working with adults.

Steve Hams	Executive Lead for Safeguarding
Carole Webster	Deputy Chief Nurse, Trust lead for Safeguarding
Jeanette Welsh	Lead for Safeguarding Adults (1.0 WTE)
Lynne McEwan-Berry	Care and Support Needs workstream (1.0 WTE)
Graham Rowe	Domestic Abuse workstream (0.6 WTE)
Sarah Barnes	Safeguarding Adults at Risk and DoLS assistant (1.0 WTE)

A secondment of a Band 6 nurse into this team has now finished and the issue of a replacement is being considered. The Safeguarding Lead post has recently been appointed and work is progressing on co-locating all safeguarding staff and the HIDVAS (Hospital-based Independent Domestic Violence Advocates) in one office to be known as the 'Safeguarding Hub'. This will facilitate increased cross-workstream working enabling the most appropriate specialist to lead on the less clearly defined cases.

2.2 Role and Responsibility of the Gloucestershire Safeguarding Adults Board (GSAB)

The main function of a Safeguarding Adults Board is to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area who meet the section 42 criteria of the Care Act 2014.

GSAB publish an annual report on their activity and performance. The Gloucestershire Safeguarding Unit currently have c. 6000 contacts per year, or which c.1000 result in an investigation and only a small proportion of these are found to meet the threshold for section 42. As a result GSAB have been able to prioritise working on harder to manage high risk individuals who are either very complex and/or in the 18 – 25 year age range and 'inherited' from Safeguarding Children.

2.3 Safeguarding Adults Operational Group (GHT)

Over the last year an operational safeguarding adults group has been formed to mirror the work of the Safeguarding Children Operational Group and work on the detail of safeguarding adult issues. The purpose of this group is to:

- Ensure safeguarding adults processes are in place across the Trust and that they are adhered to
- Recommend to the Safeguarding Strategic Committee policy changes required as a result of learning from safeguarding enquiries
- Recommend to the Safeguarding Strategic Committee policy and practice changes required as a result of local or national development
- Monitor implementation of the Care Act, the Mental Capacity Act, Deprivation of Liberty Safeguards and Domestic Abuse legislation within GHT

Attendance has not been consistent, but has gradually increased in Trustwide representation over the year. Meetings are now scheduled bi-monthly alternating with Safeguarding Strategic Committee.

2.4 Monitoring arrangements

This team maintains a secure log and reports on:

a) Safeguarding Adult at Risk concerns
These relate to concerns of possible abuse or neglect or self-neglect where the harm is considered to be by an ''other" and not linked to Trust care experience. Under Safeguarding Pathway all safeguarding Adult at Risk concerns are required to be reported to Adult Social Care Team by Trust care teams.

b) Safeguarding Adult Allegations
These relate to GHNHSFT care experience raised under safeguarding pathway to Gloucestershire Safeguarding Adult Unit and reported within Datix. Trust Safeguarding Adult Allegation reporting to CQC is via Datix.

c) Deprivation of Liberty Safeguards (DoLS) considerations
DoLS applications made by Trust clinical teams, daily monitoring of practice, tracking, and outcome reporting. This includes completion and submission of the required DoLS outcome notification forms to CQC, for every DoLS application made.

d) Domestic abuse referrals
Risk levels re-assessed and additional background work done prior to onward referral

e) Information sharing requests
Largely related to domestic abuse referrals generated by agencies other than GHT.

f) Safeguarding Log
GHT secure repository of high risk safeguarding information not generated by health and therefore not able to be included in patients' health record.

2.5 CQC 'must do' actions

At their last inspection, whilst rating GHT 'good' overall, the CQC had 3 concerns related to safeguarding:

a) Mental Capacity Act
The concern was specifically related to the Surgical Division (Regulation 11, Need for Consent) – please see section 4 below for detail on performance and work undertaken to address CQC concerns.
b) Deprivation of Liberty Safeguards
The concern was specifically related to the Surgical Division (Regulation 13, Safeguarding service users from abuse and improper treatment) – please see section 5 below for detail on performance and work undertaken to address CQC concerns.
c) Managing patients living with mental health needs (Regulation 13, Safeguarding service users from abuse and improper treatment) – please see section 8 below for detail on work undertaken to address CQC concerns.

3. Trust Safeguarding Adult Activity Report

The Safeguarding Adults Team activities include:

- Safeguarding casework
- Safeguarding Adult Reviews (when convened)
- Domestic Homicide Review (when convened)
- Monitoring and logging of all Deprivation of Liberty Safeguards (DoLS) and informing CQC of the outcomes
- Monitoring and logging of all information requests for multi-agency meetings
- Assessing all domestic abuse referrals prior to escalating to MARAC

3.1 Over the past year activity relating to safeguarding of adults at risk has increased, as has that related to adults presenting and living with risk factors or with vulnerability factors, where their needs do not meet the section 42 safeguarding pathway criteria.

The Safeguarding Adults Team are gradually improving actions and guidance where needs of the adult do not meet safeguarding adult pathway and signposting staff to alternative services and supporting pathways. Where a missed opportunity is identified by the Safeguarding Adults Team follow-up actions are then taken to ensure patient safety and that safeguarding response pathway is then followed. The missed opportunity

is escalated to the relevant clinical lead and Matron for their review and for implementation of learning actions. All are reported within Datix, monitored at Divisional level and also to Trust Safeguarding Adult Operational Group.

Since May 2019 a monthly meeting has been held with each Divisional Chief Nurse in support of quality improvements under safeguarding response pathway.
Risk C1373NSafe on Trust Safeguarding Strategic Board Risk Register reflects this risk and the actions, at June 2019, to mitigate this risk.

3.2 Trust activity data on the number of safeguarding concerns raised by GHNHSFT, under the Care Act and Safeguarding pathway, continues to differ from the data reported by Gloucestershire's Safeguarding Adult Board (GSAB). Trust data shows a higher number of concerns being reported each month than are captured within the GSAB report. The Safeguarding Adults Team has confidence in our Trust data and is working in partnership with Senior Hospital Adult Social Care Team and Gloucestershire Safeguarding Adult Board to resolve this discrepancy. It has been requested by GSAB that Trust safeguarding concern data now be submitted for inclusion within GSAB activity reports. This will commence in July 2019.

3.3 CQC require that our Trust to have access to information on safeguarding outcome data. No Trust staff have access to the Adult Social Care Team IT system ERIC, therefore there is no current means to establish the outcome of each safeguarding concern raised unless information on the outcome of each is shared by the relevant Adult Social Care Team. The Safeguarding Adults Team is exploring options to resolve this with Gloucestershire Safeguarding Adults Unit.

3.4 Actions to ''Make Safeguarding Personal', as required by the Care Act 2014, are promoted with clinical teams, so that they discuss their concerns with the adult at risk first and where possible to seek consent ahead of a safeguarding concern referral being made. Whilst consent is not essential for safeguarding referrals, it is preferable that the individual concerned expresses their preferred outcome.

3.5 Ways are being explored to ensure that, where a safeguarding concern has been identified at presentation or during admission, this also be communicated to the GP within the medical discharge summary. This is covered in Trust Safeguarding Policy and training, but needs support within discharge summary formatting.

3.6 The Safeguarding Adults Team is working with the Tissue Viability Team to establish the implications for practice of the recent NHS England Pressure Ulcer and Safeguarding guidance. This will also support the review of the GSAB Multi agency Pressure Ulcer and Safeguarding policy. GHT is represented on the GSAB NHS all partner group reviewing the Multi-agency policy.

3.7 Our Trust is a core, committed and proactive partner as part of GSAB Fire Safety and Development Sub Group. The Safeguarding Adults Team have therefore been promoting the Fire Safety checks to staff caring for adults at risk who may be self-neglecting or living within a hoarded property or who may be dependent on alcohol or substance. This free service is also promoted as part of safe discharge planning by Hospital Adult Social Care Team, ward staff and Hospital Care Navigator Team. A member of Gloucestershire Fire and Rescue Service is currently in post within Hospital Adult Social Care Team as a Care Navigator.

3.8 Review of the Trust Safeguarding Adult at Risk Operational Policy commenced in June 2019. This will also involve a review of the safeguarding concern referral pathway where the adult at risk is a current in-patient. In April 2019 a change to this pathway was proposed by Senior Hospital Adult Social Care Team and Gloucestershire Safeguarding Adult Unit. The impact of this change on other pathways will need to be fully explored

ahead of any change being agreed or implemented as there is strong possibility of duplication of work.

3.9 The Safeguarding Adults Team are working with the head of GSAU and have established a programme of monthly, unannounced joint clinical visits to wards, both at Cheltenham General Hospital and Gloucestershire Royal Hospital. During the joint clinical visits, conversations are held with the care team and the care record is reviewed.
The clinical visit programme is viewed as demonstrating our open and transparent Trust culture and is valued by the head of GSAU as an opportunity to understand the different nature of the hospital environment and pressures, compared to care homes.

3:10 A Safeguarding Adult campaign calendar to promote staff awareness and knowledge of key Trust policies underpinning safeguarding has been devised for the forthcoming year.
Safeguarding Adult Events during quarter one of 2019:

- May 2019 - Dementia Action Week
- 3rd and 10th June – Mental Health Act awareness weeks
- 17th and 24th June Mental Capacity Act awareness weeks
- 17th June – National Scams Awareness Week
- July – Deprivation of Liberty awareness Month
- August – Safeguarding Adult at Risk awareness month

A joint Safeguarding Adult and Safeguarding Children Communications sub group is to be established in July 2019. This will report to Trust Safeguarding Adult Operational Group and Safeguarding Children Operational Group.

3.11 The Deputy Chief Nurse has established the principle of Safeguarding Ambassadors in each clinical care to raise awareness, provide team training, to cascade and champion best practice in relation to Safeguarding, MCA, DoLS and the Mental Health Act. This is an action for 2019/2020.

3.12 Safeguarding allegations are reported within Datix either as an incident or as a Complaint and investigated by the assigned senior Datix/Complaint lead for that clinical area. During 2018 there has been more integrated working between Safeguarding Adults Team, Trust Complaints Team and Trust Human Resources Team.

Safeguarding allegations may be reported to GSAU by an external source however may not relate to safeguarding pathway. These are also reported within Datix for investigation and learning and are still required to have the outcomes reported to GSAU by the Safeguarding Adults Team.

Within the 2018/2019 report, no safeguarding adult at risk allegation has been substantiated as abuse under safeguarding pathway.

Learning from these allegations has resulted in the following Safeguarding Quality improvements being championed within Divisions:

- Discharge planning and discharge communications
- Documentation, particularly relating to the presence of bruising
- Prevention of Hospital category 3 or above Pressure Ulcers
- Best practice application of the MCA within practice
- Best practice application of the Mental HealthAct within practice
- Prevention of missed opportunities to safeguard
- Promotion of person centred, compassionate care
- Participation within the Enhanced Care pilot project
- Ensuring that where any safeguarding allegation is raised that this is promptly investigated and the outcome and associated learning reported under safeguarding pathway.

A Trust specific Allegations Management protocol and Staff Allegations Guidance leaflet is in development. This will adopt the Positions of Trust guidance produced by GSAB and will follow the allegations reporting guidance produced by CQC. A task and finish group has met and actions are in progress. This work stream is coordinated by the Deputy Director of People and Organisational Development.

3.13 In addition to the number of referrals to other agencies in the Domestic Abuse pathway and risk information sharing, the Safeguarding Adults Team also collate data relating to:

- Time to referral following risk assessment.
- Response time for information sharing when requested by partner agencies.
- Notification of risk to time alerts activated on Trakcare.
- Figures regarding number of alerts reviewed and now de-activated
- High-risk victims of Domestic Abuse who are under 18 years of age (also reported within the Safeguarding Children Dashboard)
- 'Linked children' are now also being added for alert consideration. ('Linked children' are children who may not live in a house-hold living within Domestic Abuse risk but who do still have contact with Perpetrators of Domestic Abuse).
- Identification of Domestic Abuse victims where strangulation, choking or suffocation is involved to evidence proposed changes in county-wide policies and protocols.
- Identification of serial perpetrators of Domestic Abuse (where a perpetrator has more than one victim, either currently or serially)
- Identification of risks posed to Trust staff where an individual has been identified as posing a risk to the safety of public sector staff.

3.14 Over the past 18 months the Hospital Independent Domestic Violence Advocates (HIDVAs) have embedded and developed their role within GHT, providing a service that could not be provided by Trust Safeguarding staff. They are now an essential part of the safeguarding service offered by GHT, but the Board are asked to note that the project is due to end in March 2020 and their support for the continuance of this collaboration would be valued. This service is jointly commissioned by the CCG and Gloucestershire County Council.

Benefits seen since the HIDVAs started working in the Trust are:

- a regular Trust wide newsletter informing staff of local innovations and national awareness campaigns.
- Reduction in length of stay, attributed to more timely and safe discharge of those at risk.
- Reduction in Emergency Department admissions to wards, due to more timely and safe discharge of those at risk.
- Timely access to appropriate services for our patients, with HIDVA providing and or signposting to support much sooner. This also has a positive impact on reducing risk to those families.
- Provision of support to trust staff who disclose Domestic Abuse and support for staff working within the '2020' Staff Advice and Support Hub.
- In addition of 100 Trust staff trained in Domestic Abuse Stalking and Harassment (DASH) risk assessment during 2018 a further 50 Trust staff trained to date within 2019.
- Art project installation displayed within public access space at Gloucestershire Royal Hospital site to raise awareness of Domestic Abuse.
- A fortnightly drop-in service within maternity on the 2nd Monday each month.
- 6 weekly meetings with Trust Hepatology department as this specialist team identify numerous victims of Domestic Abuse who are also living with complicated health and social issues.
- Domestic Abuse Champion training (starting June 2019)
- Involvement in public awareness events, with manned stands within main Atrium at Gloucestershire Royal Hospital site, including involvement in National Suicide Prevention Week.

- Close partnership working relationship with Mental Health Liaison Team.
- Individual Domestic Abuse 'management plans' for use within the Emergency Department to support patient and staff.
- Working alongside the Homeless Healthcare Team, which has a positive impact on reducing Emergency Department presentations for some individuals.

The University of Gloucestershire have been commissioned to undertake an evaluation of the HIDVA project and the Safeguarding Adults Team are collaborating with this.

3.15 There is a national requirement to report FGM in adults and in children. This data is reported by Trust Safeguarding Children Operational Group within their Safeguarding Children Dashboard and within the Trust Safeguarding Adult Dashboard.

A review and update of the Trust Female Genital Mutilation (FGM) Detection, in an adult, action card is in progress between Safeguarding Adults Operational Group and Safeguarding Childrens Operational Group. When agreed this will form part of both Trust Safeguarding Adult and Safeguarding Children Policies. This is currently included within Trust staff Safeguarding training packages and is also part of the female urinary catheterisation training programme.

3.16 As part of actions linked to Gloucestershire's Anti-Slavery Partnership Board our Trust is developing a simple, bespoke, response pathway to guide Trust staff in detection and response actions, including referral actions with and without consent and the information sharing required with the police following Home Office guidance.

Partnership working has commenced between Gloucestershire Pubic Protection Bureau and the Trust Safeguarding Adults Team to progress this. This will enable and enhance the Trust response to concerns linked to 'County Lines', exploring the need for an information sharing protocol as part of this pathway.

4. Mental Capacity Act and Safeguarding of Adults

4.1 The improvement plan in response to the CQC report 'Must Do' action to ensure best practice application of the Mental Capacity Act includes:

a) A review of the Trust MCA policy to ensure clarity of practical application – this has been completed

b) Development of a Trust Mental Health Team to ensure that any patient with a cognitive impairment is assessed within 24 hours and a management care plan is put in place – a part-time Mental Health lead has been recruited and will start on 1st October 2019. Recruitment has started for a nurse consultant for dementia.

There are already dementia and learning disability specific nursing care plans in place for patients within 24 hours of admission and the use of a purple butterfly in bedhead signage and on wristbands visually reminds staff that such patients required reasonable adjustments to care provision. A care planned for cognitively impaired patients will be developed by the MCA delivery group.

c) Training needs analysis to be completed, focused initially on the surgical division – this will be undertaken by the MCA delivery group, but initial scoping discussions have already taken place.

d) Development of mandatory face-to-face (and in situ) MCA competency based training, including focused refresher sessions – an e-learning package is already in place and completion of that by nursing staff is being monitored in the NAAS audits. Training compliance reports show 90% completion of this e-learning. Additional face-to-face clinical area based sessions are timetabled every week and delivered by the

Safeguarding Adults Team with support from the Trust legal advisor. This will be further strengthened as Safeguarding Adults training develops.

e) Review of consent training – this is in progress with the Deputy Medical Director and additional scoping has been done within theatres.

f) Embed partnership working with Learning Disability and Mental Health Liaison team as part of the wider safeguarding hub – learning disability and mental health liaison staff are now each represented on the Trust Safeguarding Adults Operational Group and the Mental Health Liaison Team have moved into larger office accommodation which enables full age-range working. Links between both learning disabilities and mental health liaison and safeguarding staff are already strong.

(Cross reference - Risk C2738MD on Trust Safeguarding Strategic Board Risk Register)

4.2 A Trust wide MCA Delivery group has been established, led by Trust Deputy Chief Nurse. Membership includes senior nursing staff, medical staff and Allied Health Care Professionals from each Division, speciality and from key clinicians Trust wide.
This group will have the responsibility to develop and implement the Trustwide MCA improvement plan and a supporting communication plan. Each senior divisional representative will have the responsibility to embed and to demonstrate the necessary culture change to ensure that the 5 principles of the MCA are core to each patient contact, delivered by every member of the care team. One of the first actions of the Trust MCA Delivery Group will be to review and to define the staff groups required to attend Trust wide MCA and DoLS face to face training also to recruit additional MCA/DoLS trainers, from within clinical teams, to support delivery of this Trust wide training programme.

4.3 DoLS in current practice and Liberty Protection Safeguards (LPS), when LPS is introduced in October 2020, are entirely dependent on the application of the MCA within practice. Improvements in DoLS practice are wholly co-dependent upon improvements within MCA practice.

4.4 Feedback from Trust clinicians on the Trust bespoke Mental Capacity Act Sticker has been very positive. Use of the sticker within the care record has recently demonstrated good practice as part of audits, case reviews and Safeguarding Reviews. Actions have been implemented to remind and to support that the sticker be used to evidence the capacity assessment in relation to one decision only, with a separate sticker required for each decision being assessed.

4.5 Our Trust is a core partner of Gloucestershire's Multi agency Mental Capacity Act Governance Group. This group reports to Gloucestershire Health and Wellbeing Board and to GSAB. During 2019 a priority objective for each MCAGG partner organisation is to audit, monitor and report on the application of the MCA within practice within their organisation.

This is done through joint audit visits with a member of the Trust Safeguarding Adults Team and the chair of the MCAGG in a programme of unannounced, monthly joint clinical visits to wards, both at Cheltenham General Hospital and Gloucestershire Royal Hospital. During the joint clinical visits, conversations are held with the care team and the care record is reviewed. 30 patients care records are audited during each visit and the results reported to Trust MCA Delivery Group and to the County wide MCAGG.

5. Deprivation of Liberty Safeguards (DoLS) Activity Report

5.1 The improvement plan in response to the CQC report 'Must Do' action to ensure best practice application of the Deprivation of Liberty code of practice includes:

a) Undertake a review of the DoLS standards policy to ensure clarity of practical application and consistency with new guidance – this has been completed

b) Development of a Safeguarding Hub to bring together all safeguarding resources alongside recruiting a head of safeguarding to build capacity within the team – a Lead for Safeguarding Adults has been recruited and is now in post. Safeguarding staff across the organisation are aware of the development of a central safeguarding hub and will be moving to join that as the office base develops.

c) Development of DoLS advisory team – this function is currently provided within the Safeguarding Adults Team. We are conscious that this provision will need to change to enable the Trust to fulfil the requirements of LPS and modelling for this is underway.

d) Develop competent multi-professional completion of MCA assessments – being led by MCA delivery group.

e) Development of face-to-face training including focused refresher training – e-learning completion rate at level 1 is currently 90%, focused refresher sessions are underway and longer initial face-to-face training at level 2 is being designed.

f) Review availability and quality of ward resources and make necessary changes – completed.

g) Develop a ward-based safeguarding ambassador programme – underway.

(Cross reference - Risk C2786NSafe on Trust Safeguarding Strategic Board Risk Register)

5.2 Trust wide DoLS activity for clinical teams is increasing on a daily basis and is set to increase. There is also considerable administrative workload in relation to the Trust wide tracking, monitoring and reporting of the pathway.

5.3 DoLS in practice is co-dependent on best practice application of the MCA by care teams as a patient assessed, at that time, to lack capacity for the decision relating to being in hospital for care and treatment (at that time) is not able to leave hospital and is therefore eligible for DoLS. This is the ‘’Acid Test’’ for DoLS as not being free to leave, even where there is no objection or attempt to leave, is considered as meeting the criteria for continuous supervision and control.

5.4 On a typical day, across all Trust adult in-patient settings that there are potentially 100 patients who would be required to be assessed to determine if needs met the ‘Acid Test’ for DoLS. At June 2019 the number of DoLS applications being made, on a monthly basis, ranges from 22 to 27.

For some wards patient turnover is high and the frequency of DoLS applications being made by the nursing team will therefore also be high. Scoping demonstrated that a medical ward typically may have 15 new DoLS applications every 7 days. Care of the Elderly speciality has the highest number of eligible patients on a frequent and regular basis.

5.5 Currently DoLS applications have to be faxed to Gloucestershire County Council DoLS Team. This will be changing to e-referrals during summer 2019. Sample completed DoLS application form sections are being developed by the Safeguarding Adults Team to help clinical staff in completing their e-DoLS application in readiness for this change.

5.6 Gloucestershire has a backlog of approximately 1600 submitted county wide DoLS applications awaiting assessment by the external County wide DoLS Team. Each application is screened and assessed, with Best Interests Assessment (BIA) allocation following a risk-based approach.

Gloucestershire County wide DoLS Team, to date, have requested not to receive the additional DoLS extension request form at day 6 following a Trust Urgent DoLS application and where there has been no assessment by their team. To date where there has been risk factors identified; the need for urgent DoLS BIA assessment is escalated by the Trust Safeguarding Adults Team. The DoLS extension application will not routinely be processed by the external Gloucestershire County wide DoLS Team, however will ensure that our Trust is able to demonstrate to CQC its compliance with the DoLS legal pathway.

5.7 The Trakcare DoLS clinical alert is to be implemented into Trust clinical practice. This is being timed to coincide with the of the new external County wide DoLS Team e-DoLS application. It will then be possible to run an active daily DoLS report from Trakcare. The DoLS alert is only valid for the duration of the DoLS application, for a single in-patient episode only and is required to be removed by the care team when needs no longer meet DoLS or at the point of patient discharge.

6. Liberty Protection Safeguards

6.1 In July 2018, the Government published the Mental Capacity Act (MCA) Amendment Bill. This Bill replaces the Deprivation of Liberty Safeguards (DoLS) with a scheme known as the Liberty Protection Safeguards (LPS). This received Royal Assent at the end of May 2019 and comes into force in law on the 1st October 2020, with the new Trust wide arrangements to assess, authorise and administer LPS required to be implemented by our Trust on this date.

6.2 Within our Trust, our adult in-patients, whose needs are currently eligible under DoLS will still be eligible under LPS, as the 'Acid Test' for DoLS is not changed. In addition, for the majority of LPS applications, these will be made where patient needs are in response to an urgent and immediate situation as opposed to previously planned arrangements anticipated to take place as part of a planned, future admission.

Unlike DoLS which only applies to adults aged 18 years and above, LPS will also apply to those aged 16 and above.

6.3 LPS will significantly change the requirements relating to those who will have legal responsibility for undertaking and managing the new assessment and authorisation process. This includes our Trust. At this time for DoLS assessment, DoLS Independent Mental Capacity Advocacy (DoLS IMCA) arrangement and DoLS formal authorisation is the responsibility of the external Local Area Authority DoLS Supervisory Body. Under LPS, for patients aged 16 years and above who are in-patients within GHNHSFT, all the formal assessment, formal authorisation and administration requirements will now be the responsibility of our Trust.

6.5 The LPS code of practice is currently being drafted by the Department of Health and will be followed by public consultation later this year. It is anticipated that the final draft will be presented to Parliament in spring 2020.

A senior level meeting coordinated by the Commissioning Director for Adults within Gloucestershire County Council, is being held in support of establishing and implementing the new LPS arrangements.

6.6 A Trust LPS implementation group will be required to be established to explore and scope Trust need, patient demand, financial implications, resource identification, including staffing resources. The information gained from the recent Trust wide DoLS scoping exercises will support this. There will also be a need to draft and present a Trust LPS Service business case and when agreed to progress implementation of the new service model into practice. This will include staff training requirements in the implementation and delivery of LPS in practice.

7. Learning disabilities

Learning disabilities patients make up a proportion of patient attendances at GHT, in common with every other group of people and we are proud of our Learning Disabilities Liaison Team (LDLT), who the CQC rated as providing an outstanding service at our last inspection.

The Learning Disability Steering Group meets every quarter and manages most business related to patients with learning disabilities. In regard to safeguarding within this patient group a national Learning Disability standards audit was required. Unfortunately only the patient and staff experience sections were completed, not the organisational review. This is now being remedied.

There has been one LeDeR review in the period and we are awaiting the action plan to enable us to review organisation level actions and inactions. In the absence of this action plan we have started work on what we anticipate will be the actions required.

In the forthcoming year the LDLT will be represented at the Safeguarding Adults Operational Group meetings.

8. PREVENT

PREVENT is a community safeguarding programme aimed at safeguarding people and communities from the threat of terrorism. It is 1 of the 4 elements of CONTEST, the Government's counter-terrorism strategy. PREVENT aims to stop people becoming terrorists or supporting terrorism.
PREVENT forms part of Safeguarding Adult at Risk Pathway in the event that an adult with care and support needs, under the Care Act (2014) is suspected of, or detected to have been recruited into risk activities linked to PREVENT or marginalised.

The South west and Gloucestershire as a county are considered to be low priority areas in relation to PREVENT risk. Gloucestershire's PREVENT Partnership Board is attended by our Trust Lead, the Associate Director of Education and Development. She attended the Regional NHS Prevent conference in 2019 and updated training in light of this.

PREVENT is included within Trust Mandatory Safeguarding Adult Level 1 Training. Training compliance at June 2019 is 94%.
PREVENT is also included within Trust face to face level 3 Safeguarding Adult at Risk Training. A review of the Trust PREVENT training needs analysis is in progress.

9. Mental health and safeguarding

9.1 The improvement plan in response to the CQC report 'Must Do' action to assure them that if staff use restraint on patients; this is in line with current national guidance and good practice and that staff are educated and supported to manage patients living with mental health needs safely includes to:

a) Launch and embed the Trust restraint policy – this was ratified in November 2018 and an Enhanced Care improvement programme is underway, including metrics for violence and aggression. This has reduced the need for 'specialling' by RMNs and reduced patients' levels of agitation.

b) Launch and embed the Trust Mental Health Act – Sectioned Patient Policy – this was ratified in November 2018. Several sessions were run during Mental health Awareness week, targeting senior staff meetings and all clinical areas.

c) Provide focused fresher training for staff – the mental health liaison team manager is developing and e-leaning packaged and has undertaken face-to-fae training with

matrons and site managers. Within the Emergency departments a Quality Improvement project has changed the triage system for patients presenting with mental health needs, which is resulting in more timely referrals to the mental health liaison team.

d) Embed partnership working with Mental Health Liaison Team – dedicated mental health intranet page being established, MHLT have moved into purpose-designed office space and MHLT manager is working closely with Safeguarding Adults Team to cross-check patients of concern.

e) Publish and enhanced care strategy and implementation plan – this has been completed.

9.2 The Gloucestershire High Intensity Network project was implemented during the year with a small cohort of extremely high intensity users of all public services. This is starting to improve the lives of the cohort members, but it is too early to publish results. This is part of a national project taking a different approach to very high risk patients.

9.3 The MHLT includes a Frequent Attender Manager for mental health presentations who has worked collaboratively with the GHT Lead for Safeguarding Adults to exceed the Mental Health CQuIN targets. Frequent attenders with mental health problems are now quickly identified and managed.

9.4 In a new appointment funded by the CCG, the MHLT now includes a Frequent Attender Manager for patients with primary alcohol problems. Whilst existing systems have been able to quickly populate a large workload, it is too early to measure the impact of this post.

10. Human Trafficking

10.1 This remains a very low number of overall safeguarding adult concerns received. It is usually suspected either at point of admission or during discharge planning. Awareness is covered in safeguarding training,. As with all safeguarding, until staff learn to suspect such things are happening, a risk may remain in a delay in detecting. As part of staff training there is now further insight of top occupations of victims of trafficking. Very cheap hand-carwash facilities and nail bars are amongst the top occupations of victims of trafficking.

11. Safeguarding Training

11.1 New intercollegiate guidance was published in August 2018 which will change the training required and provided by the Trust going forward as 50% of initial and update training must be face-to-face.

11.2 Level 1 Trust bespoke Safeguarding Adults e-learning is currently mandatory for all Trust staff. At year end 2018/2019 training compliance was 94%.

11.3 Level 2 Trust bespoke Safeguarding Adults e-learning is mandatory for all clinical and patient facing Trust staff. At year end 2018/2019 training compliance was 91%.

11.4 Trust bespoke Safeguarding Adult at Risk 1½ hour face to face training is mandatory training for defined clinical and patient facing Trust staff groups. This will be replaced with a full day Safeguarding Adults training for all registered professional staff.

11.5 Our new Safeguarding Adult Training Needs Analysis will also be crossed referenced to GSAB Training pathway. GSAB define that level 3 safeguarding adult training is

multi agency training, in that professionals from different organisations and providers learn together.

11.6 Our Trust is participating in the NHS England and 2getherNHSFT Safeguarding Adults level 3 Multi Agency ''Sim training'' Research project. Our Trust is a core member of the Project steering group and has 20 places allocated for Trust staff to attend this training across 2019. Our Trust has supported the pilot testing of the day, ahead of the programme commencing. Our Trust has submitted Trust staff specific resource information to support the development of the virtual guide, the 'Chat Bot' which accompanies this training project.

12. Risks and Issues Identified at June 2019

12.1 Within our Trust the missed opportunities to safeguarding adults at risk are reducing. (Cross-reference - Risk C1373NSafe on Trust Safeguarding Strategic Board Risk) The additional Trust Safeguarding resources and the safeguarding hub model will further mitigate this risk. Trust Safeguarding Ambassadors will also have a positive impact in support of prevention of missed opportunities.

12.2 Safeguarding pathway response actions require referral to and involvement of Adult Social Care Team. During times of 5pm to 9am and at weekend's access to Adult Social Care Team is via the County wide Emergency Duty Team.

12.3 Trust care teams do not have access to information regarding safeguarding concerns which have been raised to Adult Social Care Team prior to presentation or admission.

12.4 The Safeguarding Adults Intercollegiate training requirements (August 2018) will required additional training time out of clinical areas and will increase the need for the Safeguarding Adults Team to deliver this training.

12.5 Increasing the number of DoLS applications being made by care teams will have an impact on clinical workload and the time required to be spent by clinical staff in completion of the DoLS application. In practice this is in the main undertaken by registered nurses. Completion of the e-application will still have an impact on workload for clinical teams. There will also be the requirement for the care team to also complete the additional DoLS extension application at day 6.

12.6 The introduction in October 2020 of the Liberty Protection Safeguards (LPS) will have significant implications for our Trust as a whole and for care teams. A new model will be required to be scoped and implemented. All aspects of LPS pathway will be the responsibility of our Trust and under Trust management; this will have a significant financial implication as our Trust will be both the managing body and the supervisory body for this new pathway. Our Trust will also be responsible for any legal challenges or objections and for the administration of all aspects of this pathway.

12.7 Safeguarding of adult patients who do not attend planned Out Patient Department appointments was highlighted as an action from a Serious Adult Review – ways of ensuring this is done are being scoped, but this remains a risk in the meantime.

12.8 The HIDVA pilot scheme has only been funded for 2 years (from October 2017). Gloucestershire Clinical Commissioning Group have agreed funding to extend the pilot to March 2020, after this date funding of Hospital IDVAs is uncertain. HIDVA Team is considered an essential patient service and that there would be a negative impact if this service was not continued.

13. Safeguarding Adult Priority Objectives 2019/20

13.1 Complete Safeguarding Adult Hub, incorporating staff working in divisions and HIDVAs

13.2 Renewal of HIDVA contract in March 2020

13.3 Alignment of metrics across Adults and Children

13.4 Map extent of alcohol-induced problems across age-range

13.5 Work alongside EPR/Trakcare projects to ensure safeguarding risk assessments and actions are consistent across points of entry

13.6 Work on establishing Liberty Protection Safeguards (in place of DoLS) from October 2020

13.7 Design of new Adult Safeguarding training to comply with Intercollegiate guidelines

14. Recommendations

14.1 Trust Quality and Performance Committee is asked to note the activity reports in relation to the safeguarding of adults across our Trust.

14.2 Trust Quality and Performance Committee is asked to note the priority objectives for 2019/2020

Annex Documents

A. *Trust Safeguarding Adult Combined Dashboard- 2018/19*

TRUST BOARD – September 12 2019
Lecture Hall
Sandford Education Centre

Report Title	
Safeguarding Adults Annual Report April 2018 – March 2019	
Sponsor and Author(s)	
Authors	Jeanette Welsh, Lead for Safeguarding Adults Carole Webster, Deputy Chief Nurse
Sponsor	Steve Hams, Director of Quality and Chief Nurse

Executive Summary

Purpose

This report is presented to the Trust Board to assure members that the Trust arrangements are in place to safeguard adults, that mandatory training is being delivered and that staff are supported in the challenging roles of safeguarding adults within the Trust. It will demonstrate the process for monitoring the effectiveness of all of the above, based on local and national standards.

Key issues to note

1. Safeguarding activity has increased across all work streams within Safeguarding Adults compared to the previous year.
2. The Trust has benefited greatly from the presence on site of two Hospital Independent Domestic Violence Advocates (HIDVAs) and we are supporting work to extend their work in the Trust from a project to an ongoing substantive role. This is funded by the Gloucestershire Clinical Commissioning Group and Gloucestershire County Council.
3. Actions required by Serious Adult Reviews and Care Quality Commission are all either in progress or completed. No Domestic Homicide Reviews were published in the year concerned, nor have any in progress reached the point of making recommendations.
4. Priorities for the coming year are preparing for the change from Deprivation of Liberty Safeguards to Liberty Protection Safeguards in 2020; providing Intercollegiate-compliant adult safeguarding training and working with the harder to safeguard groups highlighted in Gloucestershire Safeguarding Adults Board reports.

Conclusions

Safeguarding is a cross-divisional clinical activity which takes place in all care settings including the community (in both unscheduled and planned care), in all service areas where hospital professionals support adults at risk.

Current data shows evidence of 15% of paediatric hospital attendances required staff to consider and assess the welfare/safeguarding component of the child or parents care. Whilst percentages are lower for adult safeguarding the links between family members are significant and often overlooked in the episodic nature of secondary healthcare.

The clinical work in relation to safeguarding requires strategic support in a number of areas. Auditing and governance processes for safeguarding will benefit from improved data to evidence the quality of practice and outcomes.

Recommendations
The Trust Board of Directors is asked to note the report and be assured that the trust is delivering a safeguarding adult programme that is compliant with Care Quality Commission regulation 13.
Impact Upon Strategic Objectives
Through effective delivery of all safeguarding activity throughout the Trust will enable us to meet the local and national standards. This will enable us to meet the aspirations of 'outstanding' in the Safe and Effective domains and outstanding overall in relation to Care Quality Commission fundamental standards.
Impact Upon Corporate Risks
Improving our processes in delivery of safeguarding adults and children across the organisation will provide assurance that the principles and duties of safeguarding adults, children and young people are applied every time through high quality health care. (C2838 C2786 C1373)
Regulatory and/or Legal Implications
Demonstrates compliance with the Care Quality Commission regulation 13 – safeguarding service users from abuse.
Equality & Patient Impact
An effective safeguarding adults and adults at risk programme will have a positive patient impact on patients and ensure they are adequately protected.

Resource Implications			
Finance		Information Management & Technology	
Human Resources	√	Buildings	

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

Date the paper was presented to previous Committees						
Quality & Performance Committee	**Finance Committee**	**Audit & Assurance Committee**	**Workforce Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
28/8/19						Safeguarding Strategy Group 14/8/2019
Outcome of discussion when presented to previous Committees						
The Quality and Performance Committee noted and approved the report, there was also an acknowledgement of the transformational changes that have taken place in the last 12 months and the additional work required to mitigate future challenges, most notably Liberty Protection Safeguards.						

TRUST BOARD – September 12 2019
Lecture Hall
Sandford Education Centre

Report Title
Safeguarding Children Annual Report April 2018 – March 2019
Sponsor and Author(s)
Authors Dr Sara Motion Named Doctor for Safeguarding Children Vivien Mortimore, Named Nurse for Safeguarding Children Carole Webster, Deputy Chief Nurse Sponsor Steve Hams, Director of Quality and Chief Nurse
Executive Summary
Purpose This report is made to the Trust Board to assure members that the Trust arrangements are in place to safeguard children, that mandatory training is being delivered and that staff are supported in the challenging roles of safeguarding children within the Trust. It will demonstrate the process for monitoring the effectiveness of all of the above, based on local and national standards. Key issues to note There have been rises in total numbers of children and young people accessing urgent care pathways, with evidence in these groups and for the unborn child, that the welfare concerns recognised have increased. The increases in significant injuries in pre-mobile infants, and in hospital attendances for adolescents with emotional and self-harm are highlighted areas of concern. Conclusions Safeguarding is a cross-divisional clinical activity which takes place in all care settings including the community (in both unscheduled and planned care), in all service areas where hospital professionals support children and young people. Current data shows evidence of 15% of paediatric hospital attendances required staff to consider and assess the welfare/safeguarding component of the child or parents care. The information flow between the different departments within the hospital, and from the hospital out to key staff who safeguard children across the 'system' is an area that requires further development. The clinical work in relation to safeguarding requires strategic support in a number of areas. Auditing and governance processes for safeguarding will benefit from improved data to evidence the quality of practice and outcomes.
Recommendations
The Trust Board of Directors is asked to note the report and be assured that the trust is delivering a safeguarding children programme that is compliant with Care Quality Commission regulation 13.

Impact Upon Strategic Objectives
Through effective delivery of all safeguarding activity throughout the Trust will enable us to meet the local and national standards. This will enable us to meet the aspirations of 'outstanding' in the Safe and Effective domains and outstanding overall in relation to CQC fundamental standards.
Impact Upon Corporate Risks
Improving our processes in delivery of safeguarding adults and children across the organisation will provide assurance that the principles and duties of safeguarding children and young people are applied every time through high quality health care. Linked to risks, C1374, C2430 and C1850.
Regulatory and/or Legal Implications
Demonstrates compliance with the Care Quality Commission regulation 13 – safeguarding service users from abuse.
Equality & Patient Impact
An effective safeguarding children risk programme will have a positive patient impact on patients and ensure they are adequately protected.
Resource Implications

Finance		Information Management & Technology	
Human Resources	√	Buildings	

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

Date the paper was presented to previous Committees						
Quality & Performance Committee	**Finance Committee**	**Audit & Assurance Committee**	**Workforce Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
28/8/2019						Safeguarding Strategy Group 14/8/2019
Outcome of discussion when presented to previous Committees						
The Quality and Performance Committee noted and approved the report, there was also an acknowledgement of the transformational changes that have taken place in the last 12 months and the additional work required to mitigate future challenges, specifically in relation to activity and digital connections between professionals and organisations.						

Gloucestershire Hospitals
NHS Foundation Trust

Annual Report
Safeguarding Children
Year to 31st March 2019

Prepared by: Dr Sara Motion – Named Doctor for Safeguarding Children

Contents

MAIN BOARD (QUALITY AND PERFORMANCE COMMITTEE)
JULY 2019

Children's Safeguarding Annual Report 2018-9

1. Introduction to Annual report of Trust Activity and Performance in Children's Safeguarding

1.1 Safeguarding Children effectively requires all Trust staff to consider child welfare at every contact. Unscheduled attendances for children to the Trust have increased and indicators of increased pressure on all age groups of children are evidenced in the Gloucestershire Public Health summary and work plan. The increased workload and demands on the Trust Children's Safeguarding processes and clinical practice is evident.

1.2 This report summarises activity and progress over the last year and will share information on future developments required.

2. Executive Summary

Headline information from the last 12 months includes:-

The number of unscheduled attendances to ED and paediatrics has increased, with a total of 34,989 unscheduled attendances across both services in 12 months
10 infants under 6 months were confirmed with serious non-accidental injuries, as compared with 6 similar serious cases in the preceding 12 months.
Adolescent self-harm attendances and admissions continue to increase.
Day case dental surgery is now the most frequent scheduled children's surgical procedure and there are a rising number of children where this need for surgery is a marker of child neglect

3. Trust Safeguarding Activities

3.1 Completed actions from the work plan of 2018-19

- The safeguarding children's dashboard (# 1) has been piloted and launched, progressing work to enable management oversight; analysis of trends and evidence KPI's.
- Individual Management Reviews (IMR's) were delivered alongside the co-associated multiagency working, as GHT's contribution to the 4 commissioned (by Gloucestershire Children's Safeguarding Board GCSB) Serious Case Reviews (SCRs). Additionally, there has been preliminary work on 3 further SCRs over the last 12 months, all likely to be published in the next 12 months.
- Targeted learning was Implemented across ED, Paediatrics, O&G/midwifery from the James SCR (infant Death) (IMR from 2017/criminal case 2018; SCR published in 2019).
- Pre-mobile infant injury pathway was piloted between ED and Paediatrics.
- Safeguarding children policy was reviewed and updated.
- Training was launched and delivered for deployment of the Child Protection Information Sharing System (CP-IS) into unscheduled care areas namely ED, Paediatric Assessment Unit and Maternity Triage.
- Training was launched and delivery commenced alongside development of the Trust operational pathway for FGM.
- The process for confidential information sharing with the redeployed Multiagency Safeguarding Hub (MASH) was operationalised.

- GHT named professionals contributed to the GSCB improvement plan and then the development of the new children's safeguarding partnership GSCE (Gloucestershire Safeguarding Children Executive).

3.2 Additional completed activity

Has focused on the two specific themes of infant injuries and attendances for adolescent issues and self-harm. There has also been work on Trust staff activity for children at legal threshold points (delivering joint assessment with social care and police; section 47 strategy meetings; child protection conferences and also with Trust service delivery for 'children in care'). There has in addition, been focus on the detail of the important communication pathways for Trust staff to their key partners outside the Trust.

Completed activity has included:-

- Focused activity on the vulnerability risk factors for the pre-mobile infant, which included :-
  - Continuing the work already in progress, on pathways which deliver increased focus on the pre-birth screening for infant welfare issues, to offer additional parental support and increased understanding of the risks for their infants. In this last year, 21% (1282) of pregnancies (6102 births in '18/'19) were identified to have a level of vulnerability benefiting from support relevant for the infant. There were also 116 referrals to social care at the threshold of suspected significant harm (this represented a significant risk of harm documented in 1.9 % of pregnancies. This is a rise from the previous year; with 1.5 % similar referrals in '17/'18).
  - 2 serious Incident (SI) analyses on infants with serious non-accidental head injury were joined with a multiagency thematic analysis on infant injury (Jan '19) (#2) with a developed single agency and multiagency operational Action Plan.
  - Operationalising of the prevention initiative – PUPP (Preventing Unplanned Pregnancies in vulnerable women), aiming to lower the prevalence of infants and children experiencing social and emotional adversity.
  - Launch of the ICON initiative. This is a program for all professional groups to share with parents the risks of shaking/rough handling of infants and has been championed by Trust staff since a SCR infant death in 2016, with the countywide launch of ICON in '19/'20.
  - A midwifery led Silver QI project has developed a pilot pathway to implement the introduction of the ACE (Adverse Childhood Experience) enquiry in to maternity services, together with strategies and information sharing to deliver more effective 'early help' actions for the most vulnerable pregnancies. The aim being to identify risk and build resilience to promote positive parenting, breaking the cycle of adversity.
  - Launch of new Trust guideline on assessment of Injury in the pre-mobile infant.
  - Launch of a new Trust guideline on radiology investigation of suspected non-accidental injury in infants.
  - IMR analyses on two separate SCR's highlighting that the inter-agency county pathways for children exposed to and experiencing child sexual abuse (CSA) are in need of review and further development/commissioning.
  - IMR's prepared on 2 further SCR's agreed in 2018, one of which is also the subject of Adult homicide review (DHR) – with mother and daughter murdered by mother's partner in fatal domestic violence episode.
  - During '18-'19, there has been activity and input needed on 7 separate SCR's, 4 were commissioned in the last 12 months – 2 of which were completed but not published by April 2019, and the other 2 are in process. A further 2 will be included in the work of 2019-20 to be actioned in the next 12 months. The seventh, is the James SCR (see 3.1) first completed in 2016, but with publication delayed by criminal proceedings and the need for revision of the report by the overview author.

- Targeted work on adolescent needs :-
  - The children's Safeguarding Dashboard (#1) highlights that Self Harm ED assessments and admission numbers have increased from previous years. There were 434 Self Harm related admissions in the last year, increasing from 323 in the previous 12 months. This parameter is identified to be above the England expected average. The total number of ED Self Harm attendances (all categories of harm <18yrs) increased from 793 in '17/18 to 1046 in '18/19
  - Adolescent audit and analysis commissioned by GCS and undertaken by the Trust Safeguarding Specialist Nurse, highlighted that 82% of ED attendees for drug overdoses under 16 years are female and similarly, 61% of ED attendees for drug/alcohol misuse in the 18-29yr age group are female. This client group are the future prospective mothers and there is strong national evidence that infant alcohol and drug related harm is increasingly an identified cause of social, emotional and learning difficulties in children, with one study reporting as many as 3% of children to have been adversely affected by maternal alcohol consumption in pregnancy. Highlighting this information for the Public Health Team is therefore equally important
  - Statutory medical reports from Trust staff, on children who need a legally defined level of additional funding and support for a Disability or Special Educational Need (Education, Health and Care EHC plan), identify that an average of 30% of plans identify childhood adversity (multiple ACE events) to be the cause of the child's learning and emotional difficulty. In the last year 610 reports were provided for children at the highest level of additional need, suggesting that approximately 200 children over the last year had significant educational need, linked to adversity, and needed the highest level of practical educational support (it is also this group that are at increased risk of school exclusion. The rates of school exclusions triggered by emotional and behavioural issues in Gloucestershire continue to be above the UK average and are a specific area of concern and analysis for the Local Authority).

4. Governance, Accountability & Leadership arrangements

4.1 Safeguarding Childrens Team within Gloucestershire Hospitals

The Director for Quality and Chief Nurse is the Executive Board member responsible for safeguarding, and the Deputy Chief Nurse has delegated authority as the Trust Safeguarding lead, including chair of the Trust Safeguarding Strategic Group.
The Trust Named Nurse and Named Doctor for Children's Safeguarding provide professional leadership.

The Trust Safeguarding Children Operational and Safeguarding Strategic Group meet bi-monthly and in addition the Named professionals attend and contribute to the Countywide Strategic Safeguarding Health Group, which brings together the named professionals from all the County Health Trusts, Commissioning Team and General practice.

The Deputy Director of People is the Senior Manager Responsible for allegations and liaises with the Local Authority Designated Officer if concerns are raised about Trust staff working with adults.

4.2 County arrangements for Children's Safeguarding

As specified in Working Together 2018, Local Safeguarding Children's Boards across the UK are being replaced by a Partnership, led by 3 Safeguarding Partners (i.e. now with equal representation from Social Care, Health and Police) The partner agencies have a 'shared and equal duty to child safeguarding'. The lead Health safeguarding agency is the Clinical Commissioning Group (CCG), but GHT will have representation at each of the subgroups of the new GSCE (Gloucestershire Safeguarding Children Executive)

4.3 Children in Care and Children at Legal Thresholds including Child Protection (CP) Plans; CP-IS

The processes to alert staff to children on CP plans have been embedded in the Trust work for several years. In 2019-20 there is to be enhanced focus on Children in Care and their pathways of support when in our care; this being the focus of the annual specific training within paediatrics in 2019.

For unscheduled attendances, children in these legally registered categories should be notified using the CP-IS (National Child Protection Information Sharing System). The need for effective electronic access to CP-IS has been a focus of operational work for the Trust Named Nurse/Doctor for over 2 years. This has been delivered using direct access to the Summary Care Record portal. However this has limitations and continues to need an effective, fully integrated solution that works seamlessly with the trust's PAS and EPR; as yet not achieved. Some progress has been made to enable this as part of the TrakCare T2018 upgrade which is a pre-requisite to taking the TrakCare integrated CP-IS to a solution. However a date to implement has yet to be agreed.

4.4 Supervision of safeguarding work

Supervision increases levels of effective practice and managerial oversight; and offers staff some emotional support with this emotive area of work in addition to supporting learning from reflective practice. This is now routinely embedded in the Women and Children Division and ED, with nursing supervision further improved by the recruitment of the Children's Safeguarding Specialist Nurses to the team in February 2018. Staff are supported with, and increasingly confident, use of escalation procedures.

4.5 Staff Development

Learning for Trust staff is lifted from the analysis of ACI's, complaints, serious case reviews (SCR's), clinical audit and, where relevant, child deaths. These different activities feed in to an action plan that is a focus of the Safeguarding Children's Operational Group activity.

4.6 Audits/QI focus over the last year have included focus on:-

- Midwife pathway for communicating infant welfare risks to GP practice
- Communication pathway from unscheduled care to the Public Health Nurse Team
- Staff practice in early recognition of concerns, use of the 'risk screening' questions in unscheduled care
- Adolescent self-harm
- Thematic analyses of systems and care via 3 IMR's (15 children) and 2 SI investigations (2 infants)

4.7 Training and staff development

- Level 1& 2 completion rates have stayed above 90%
- There was specific focus on the issues that impacted on Level 3 training figures in the last year and there will be a need for a development plan for safeguarding training in 2019-20 due to revision of the national intercollegiate guidance published in January 2019
- Further investment in staff to deliver face to face training, needs to be explored due to current staff capacity issues

4.8 Serious Case Review investigations (SCR)

- Under new arrangements going forward these will in future be referred to as Child Safeguarding Practice Reviews **(**CSPR)
- Rapid reviews now take place prior to a decision going to the national team with respect to commissioning an SCR or CSPR. Each case for consideration requires a chronology for multiagency review by the SCR sub group prior to a decision being made
- 3 new SCR's were commissioned in the last year requiring the Named Doctor and Named Nurse to complete IMR's on safeguarding process for 16 different children, with identified service developments to be operationalised in the

forthcoming year. These reports are in due course published nationally. For each SCR there is both a Trust IMR action plan and a Partnership action plan to deliver. This is important work in representing the Trust, co-working with the external children's agencies and leading to the development of improved countywide systems for children.

4.9 Female Genital Mutilation (FGM)

National guidelines are currently being implemented for reporting, although the FGM-IS (Female Genital Mutilation Information Sharing System) has not yet been implemented within the Trust. Trust Policy is written and operational procedures are designed with planned full implementation in the year 2019/20. The data collection and reporting is via a pathway to a specified O&G Consultant.

5. Risks and current challenges with delivering effective safeguarding clinical care

5.1 Child and Adolescent Mental Health and Self Harm attendances

The rise in these attendances and admissions is evidenced in the Dashboard (1) and section 3.2 in this report but there are also significant operational issues in relation to the ability of children and adolescents (CYP) to access timely and appropriate assessment of their mental health status. Current capacity issues in CAMHS leads to CYP with no acute medical needs being admitted for social, emotional and mental health reasons and not receiving the right assessment, support or therapeutic interventions at times of significant need. The issue is on the GHT Risk Register and Gloucestershire Public Health will be informed of this trend. This area of assessment, support and care for CYP will need to have specific focus from the newly configured Safeguarding Partnership board (GSCE). Work with commissioners has been ongoing for some time. In 2017, a joint project between CCG and GCS (the IRIS project) was launched with the aim to support people with complex mental health and social care needs. The pilot phase is completed and there is a plan for staff recruitment and development of specialist residential accommodation, to begin in 2020.

5.2 IT/EPR related issues and child safeguarding

Successful children's safeguarding depends on staff recognising the signs of concern, and communicating these effectively to co-professionals. The following are examples of ongoing issues where improved IT support and data collection could increase levels of safe and effective practice and care.

- The areas of development needed with the clinical care record have been highlighted and a work plan commenced with the Trust IM&T team. This work has progressed slowly, being linked to the delay in the roll out of an EPR and the TrakCare recovery programme. The Trust is now implementing Sunrise Clinical Manager as its EPR solution and the requirement will be delivered as part of the EPR implementation. There are a number of key documents that need to be both available to front-line clinical staff, and embedded in electronic pathways that can be audited. The high volume of need is evidenced by the number of forms manually scanned and sent by email to the public health nurse team signalling that the child's Trust attendance highlighted a welfare risk (2,888 forms sent from ED, from a total of 29,800 0-18yr ED attendances in 2018-'19 as an example). Other examples include the need for known family welfare information to be present and readily accessible in the infant EPR; and for the child's legal status information to be readily accessible at the point of care.
- Electronic communication with partner systems e.g. Liquid Logic (Local Authority) and the Health system of GCS. The interface with both these important links for Trust staff is not robust; a lived example of this has been the technical issues with use of the electronic referral process to children's social care. Effective links will increase child safety and better allow the trust to audit performance. This has been raised with GCC.
- Data capture for steps in clinical care - staff share that the time needed to

deliver the professional input to keep children safe has increased. The Trust does not have a robust system to capture this activity. This increases emotional and physical stress on staff and impacts on the detail and quality of care across the system. Evidencing this is important. An example of this is included in the Dashboard (#1), where data in the last year has been manually collected on the requests for information from staff for the Child Protection Case Conference (children's legal planning meeting) - 1976 requests in last 12 months compared with 1953 in 2017/18. The Trust needs accurate data on the numbers and quality of staff professional reports submitted and data on staff attendance at legal planning meetings. This data is needed to begin to give assurance that Trust Staff are contributing relevant information for decisions and the planning needed for a child e.g. at Section 47 threshold.

5.3 Administrative support for safeguarding children

Trust work to safeguard children has been impacted by a lack of continuity and consistency with administrative support. This support work is intense and requires skill. The named professionals have reflected that support for the safeguarding team may need to be reviewed to ensure more consistent and resilient cover for the team. Unfortunately certain administrative outcomes have not been possible in the last 12 months. An example of this is that the Trust clinical case record has not been updated with the alert, nor correspondence information for children on legal protection plans with an estimated 2000 clinical case records currently incomplete. Much of the related information arrives to the Trust in electronic form and could be placed directly on the electronic record, there is a plan in place to address this.

5.4 Media interest in children's safeguarding work

Safeguarding children work always attracts media interest. Over the past year there has been pressure from a Gloucestershire group of parents 'The Parent Carer Alliance', who engaged BBC 5 live (#4) to profile some of the issues experienced by Gloucestershire families in relation to allegations of 'fabricated illness' situations and the multiagency response they experienced. All health Trusts were included in the allegations and Trust investigation confirmed that GHT followed appropriate procedures of care. The episode has initiated a county multi-agency improvement plan, but highlights the level of profile and public interest in the staff actions around infant and children's safeguarding and protection.

6. Conclusions

6.1 This is a system under pressure, increased unscheduled care child attendances, with evidence of increases in levels of need and vulnerability from the antenatal pathways through to 18 years of age.

6.2 The following are needed to improve the safety and quality of Safeguarding Children's work

7. Priorities for Future Work within GHT 2019/20

- Development of IT/EPR systems to support the safeguarding work that is required to safely and effectively safeguard the vulnerable infant/child/young person, from pregnancy booking until the 18th birthday, to be delivered through a dedicated children's Safeguarding IT action plan
- Agreed indicative data which can be captured electronically to provide managerial oversight, assist service development, deliver quality assurance and facilitate this work. An example of this is 'the requests for information' from GHT, for children who are at the threshold of 'significant harm' and scheduled for Legal planning meetings / 'Child Protection Case Conference'.
- To further progress the GHT Children's Safeguarding Dashboard and associated data analysis
- Further develop processes to ensure the sharing of key risk information on parents or carers to be available on the infant/child record at point of care (ideally electronically)

- Review the content of the Trust discharge information and the need to have a dedicated field to share the relevant welfare/safeguarding information.
- Ensure appropriate levels of administrative and management support
- Training review to consider a potential need for investment in staff to support Face to Face training and revision of the online/mandatory training
- Review of staff capacity to deliver the operational children's safeguarding work.
- To refocus staff on the GHT clinical practice tools (safeguarding triage/decision support tool) to ensure that child welfare is routinely considered in each clinical contact.
- To operationalize the drafted GHT pathways of care for Children in Care & FGM
- To progress Trust understanding of the relevance of ACE experiences in childhood and their impact on adult health and therefore the demand on adult services and to deliver the Maternity pilot on ACE's to facilitate better understanding of the benefits of earliest support for parents.
- To review the Children's Safeguarding Training programme with the revised 2019 intercollegiate Guidance
- To continue current and existing Trust operational, strategic and governance work streams

8. Priorities for Contribution to Gloucestershire's Multiagency Work Plan 2019/20

- To deliver outcomes on the 7 SCR's in progress, and action the highlighted service development and training to GHT staff
- To complete work with the GSCE Partnership Board on the review of the unborn baby protocol
- To complete work with the GSCE partnership board on pathways of care for injuries in pre-mobile infants
- To complete work with partner agencies on the pathway for babies and children being discharged into care
- To continue work with commissioners on pathways of care for CYP who present to GHT with self-harm, overdoses and mental health conditions
- To work with the GSCE Partnership board on pathways of care for CYP with alleged sexual abuse and harm
- To work with the GSCE Partnership Board on pathways of care for situations where there are concerns around parents and carers with potential concerns around 'Fabricated illness'

The Board is asked to

Acknowledge the scope and detail of the work completed in the last year, and be aware of the risks and challenges identified. Endorse the priorities, which will form the basis of a detailed work plan for the coming year

Appendices
1. Safeguarding Childrens Dashboard
2. ACE's information

Author:	**Dr Sara Motion** **Named Doctor for Safeguarding Children**
Report reviewed by:	**Vivien Mortimore,** **Named Nurse for Safeguarding Children**
Presenting Director:	**Steve Hams** **Director of Quality and Chief Nurse**
	Carole Webster **Deputy Chief Nurse August 2019**

Gloucestershire Hospitals
NHS Foundation Trust

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

Report Title	
Infection Prevention and Control Annual Report 2018/19	
Sponsor and Author(s)	
Author:	Craig Bradley Associate Chief Nurse and Deputy Director of Infection Prevention and Control
Sponsor:	Steve Hams Director of Quality, Chief Nurse and Director of Infection Prevention and Control

Executive Summary

Purpose

The purpose of this report is to provide an update to the board on performance relating to the Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infection within Gloucestershire Hospitals NHS Foundation Trust.

The report details performance and activity during 2018/19.

Key issues to note

The annual objective for Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia is 0 avoidable cases. In total the trust had 6 trust-apportioned bacteraemias reported for the financial year. There was 1 in the previous year. The increase was in part due to an outbreak of MRSA amongst intravenous drug users in Gloucester.

The annual objective for Clostridioides difficile (C. *difficile*) was 36 cases. Performance for the trust was 56 trust-apportioned *C. difficile* cases. In the previous year there were 72 cases, therefore this represents a 25% reduction.

In relation to cleaning, Gloucestershire Managed Services are supporting the trust to make improvements in cleaning standards. These are detailed in the report.

Implications and Future Action Required

The infection prevention and control team have embarked on an ambitious plan to reduce harm from healthcare associated infection during the next financial year with a focus on improving our surgical site infection surveillance, reducing MRSA bacteraemia, to further reduce our *C. difficile* rate and contribute to the countywide reduction of Gram negative bloodstream infections.

Recommendations

The Trust Board of Directors is asked to note the report and be assured that the trust is delivering a robust infection prevention and control programme and is compliant with its obligations under the Code of Practice for the Prevention and Control of Infections.

Impact Upon Strategic Objectives

The infection prevention and control programme is key to delivery of the Trust's quality strategy. A robust, effective programme improves patient safety, improves patient experience and promotes a positive culture through leadership and governance arrangements related to infection prevention and control.

Impact Upon Corporate Risks

The Infection Control Committee review risks and controls associated with healthcare associated infection and reports these through to Quality and Performance Committee quarterly.
Regulatory and/or Legal Implications
Providing clean safe care is a Care Quality Commission regulated activity and this report satisfies the requirements within the Health and Social Care Act for the Director of Infection Prevention and Control to report annually to the board on progress.
Equality & Patient Impact
Potential impact on patient care as described on the risk register.

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

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

Date the paper was presented to previous Committees and/or TLT							
Audit & Assurance Committee	**Finance & Digital Committee**	**Estates & Facilities Committee**	**People & OD Committee**	**Quality & Performance Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
				31/07/19			ICC 18/07/19

Outcome of discussion when presented to previous Committees/TLT
Both Infection Control Committee and Quality and Performance Committee noted the annual report and acknowledged the efforts of all those involved whilst recognising the progress with the challenges that remain.

Gloucestershire Hospitals
NHS Foundation Trust

Infection Prevention & Control
Annual Report 2018/19

Contents

Introduction & Foreword

This is my second annual report as Director of Infection Prevention and Control.

Infection prevention and control is a top priority for Gloucestershire Hospitals NHS Foundation Trust. Keeping our patients safe from avoidable harm is everyone's responsibility and as Director of Infection Prevention and Control I have a wide ranging programme of activity that focusses on continual improvement in order to deliver the best care for everyone and keeping our patients at the heart of everything we do.

This report provides details of the progress with infection prevention and control from April 2018 - March 2019.

2018/19 has been a challenging year with national objectives for meticillin resistant Staphylococcus aureus (MRSA) and Clostridium difficile infection aimed at delivering a zero tolerance approach to avoidable infections. Progress has been made throughout when compared to recent years, primarily due to the decrease in MRSA bacteraemias and other healthcare-associated infection seen within the Trust.

The Infection Prevention and Control Team work in line with national guidance on the prevention of infections in the healthcare setting. Adherence to policies and procedures based on national guidance and the evidence base supports the trust in continually reducing the risk from avoidable infection for our patients and staff. All the policies and procedures are readily available on the Trusts intranet page.

I and the Infection Prevention and Control Team work closely with external agencies. A strong working relationship is maintained with Gloucestershire Clinical Commissioning Group (GCCG), Public Health England (PHE) and NHS Improvement. The team meets monthly with GCCG; primarily to discuss *C. difficile* root cause analysis (RCA). During outbreaks of infections PHE are notified and invited to support outbreak meetings. NHS Improvement are kept up to date on the Trust's performance.

Despite the challenges we have faced I am pleased to report progress with Infection Prevention and Control and that we are moving in the right direction, during 2019/19 I appointed my Associate Chief Nurse and Deputy Director of Infection Prevention & Control to lead this strategy moving forwards.

Steve.

Steve Hams
Director of Quality, Chief Nurse and Director of Infection Prevention & Control

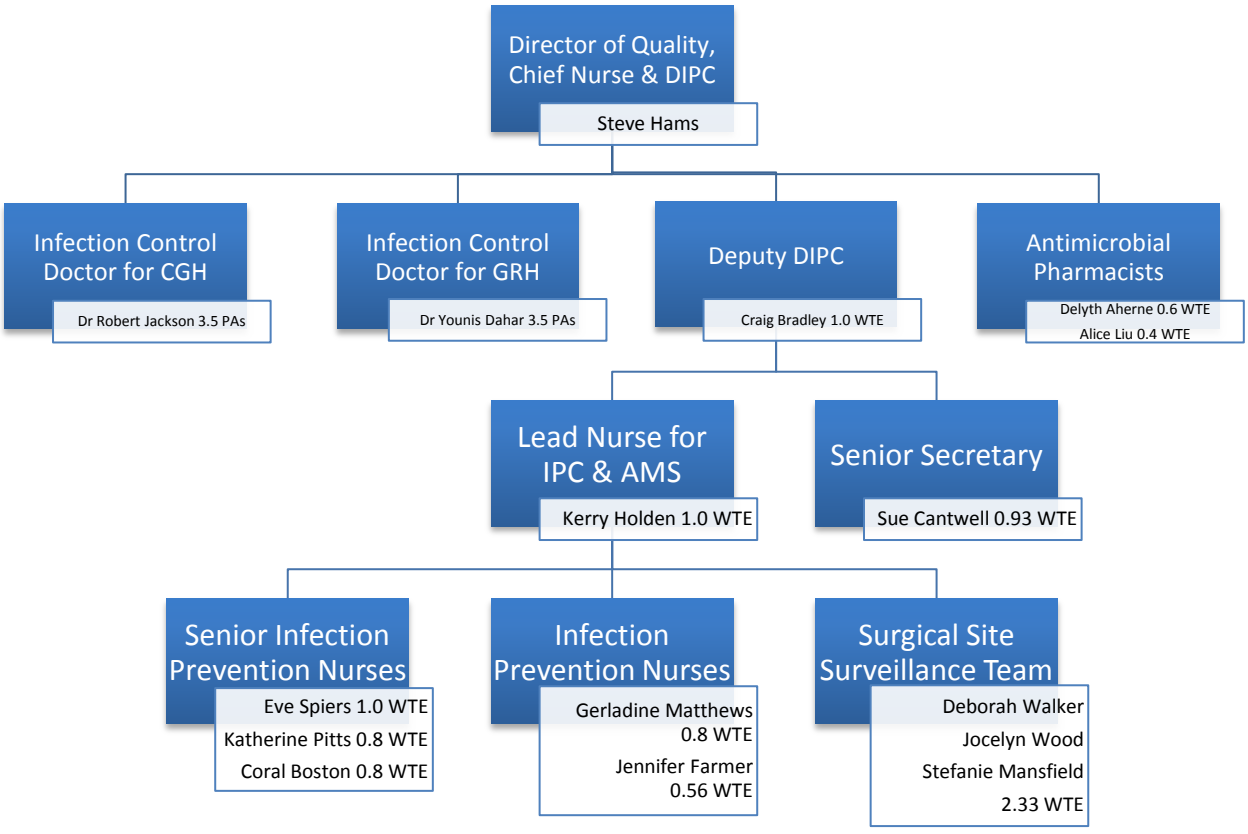
1.1 Where to find evidence of compliance with the code of practice (2015) on infection prevention and control from the Health and Social Care Act 2012

Criterion	What the registered provider will need to demonstrate	Location in annual report
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.	Section 2 and 4
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	Section 9 and 10
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.	Section 7
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.	Section 6 and 8
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.	Section 3, 4 and 6
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	Section 6 and 8
7	Provide or secure adequate isolation facilities.	Section 2
8	Secure adequate access to laboratory support as appropriate.	Section 2 and 7
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.	Section appendix 1
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.	Section 8

2.0 Infection Prevention and Control Team Structure 2018/19

During 2018/19 there were some staff changes within the Infection Prevention and Control team. Craig Bradley was appointed to the role of Deputy Director of Infection Prevention and Control (DIPC) and Associate Chief Nurse, reporting directly to the Director of Infection Prevention and Control and Director of Quality and Chief Nurse. Kerry Holden was appointed as the new Lead Nurse for Infection Prevention and Antimicrobial Stewardship.

Figure 1 Infection Prevention and Control Team Structure on 31st March 2019. Organisational lines do not represent line-management, for example the Antimicrobial Pharmacist is part of the Pharmacy Department and is represented here as an integral part of the IPC team's activity.



2.1 Infection Prevention Reporting Framework

In 2018/19 the Infection Control Committee (ICC) occurred monthly with a broad membership and an agenda that rotated from meeting to meeting. It included

representation from the Trust Board. The clinical divisions provided assurance of their management and ownership of infection control to the committee.

Membership:

Executive Chief Nurse/Director for Infection Prevention and Control (Chair)

- Infection Prevention and Control Doctors
- Lead Nurse Infection Prevention and Control
- Antimicrobial Pharmacist
- Divisional Chief Nurses
- Deputy Director of Facilities and Estates

The Director of Quality, Chief Nurse & DIPC reports on infection prevention and control to the trust Quality and Performance Committee quarterly. All members of the Board of Directors have access to information concerning the Trust's performance against the external and internal infection prevention targets and other infection related issues.

Monthly performance reports continue to be produced by the Infection Prevention and Control Team detailing incidences of meticillin resistant *Staphylococcus aureus* (MRSA) identifying both incidence of carriage and bacteraemia, meticillin sensitive *Staphylococcus aureus* (MSSA), *Escherichia coli* (*E.coli*), *Klebsiella sp.* and *Pseudomonas sp.* bacteraemia are also collated along with *Clostridioides difficile* infection (CDI) with an EIA toxin positive result. There is close monitoring for the identification of potential MRSA inpatient acquisitions and outbreaks.

The HCAI performance report highlights any possible clustering of patients with positive test results for *Clostridioides difficile* including both EIA toxin positive and PCR gene positive results – this gives an indication of areas that have possible Periods of Increased Incidence (PIIs) that require monitoring, further investigation and enhanced cleaning.

The HCAI performance report includes a summary of ward or bay closures in the previous month that are categorized as suspected (or confirmed) outbreaks of viral gastroenteritis (usually norovirus).

A monthly surveillance report is also produced by PHE for the South West and is sent to each hospital which allows bench marking for all the reportable organisms.

2.2 Microbiology and Laboratory Support

The Infection Prevention and Control Team work closely with the clinical microbiology department which provides comprehensive bacteriology, virology, parasitology, and mycology services. The department is UKAS accredited and participates fully in external quality assurance schemes for the full repertoire of tests. The department is based at Gloucestershire Royal Hospital. Staff offer a 24-hour diagnostic and monitoring service for routine and urgent detection of patient infection, e.g. meningitis, hepatitis and MRSA infections caused by bacterial, viral and fungal agents, using specialised automated and manual techniques. The clinical microbiology department provides support to the Infection Prevention and Control

Team through reporting of results and processing of clinical samples. Out of hours the on-call consultant microbiologist currently provide urgent infection prevention and control advice for the Trust.

Laboratory testing locally for CDI currently uses a two stage test looking both for GDHSC antigen and *C. difficile* toxin. As per national reporting requirements, both tests need to be positive for the infection episode to be reported on HCAI DCS. The laboratory also conducts an additional test on toxin negative, GDHSC antigen positive specimens to look for toxin genes (by PCR) which can be helpful in identifying patients who may have already developed CDI or who may just be *C. difficile* carriers/excretors.

2.3 Isolation facilities

There are 1075 beds across the trust's sites. Side room isolation facilities are available in all wards. The amount of side rooms provides challenges for the Infection Prevention and Control Team, however close working with the clinical site managers is required to reduce the risk of infected patients if no isolation facilities are available.

3.0 Performance

Explanatory note

The assignation of bacteraemia cases to the trust is based on time of collection and admission. Day one is the day of admission and cases are assigned as trust-apportioned when they are collected after day 2 or for *C. difficile* this is after day 3. This has previously been referred to post-48 hour cases, in this report it is referred to as trust-apportioned.

3.1 MRSA bacteraemia

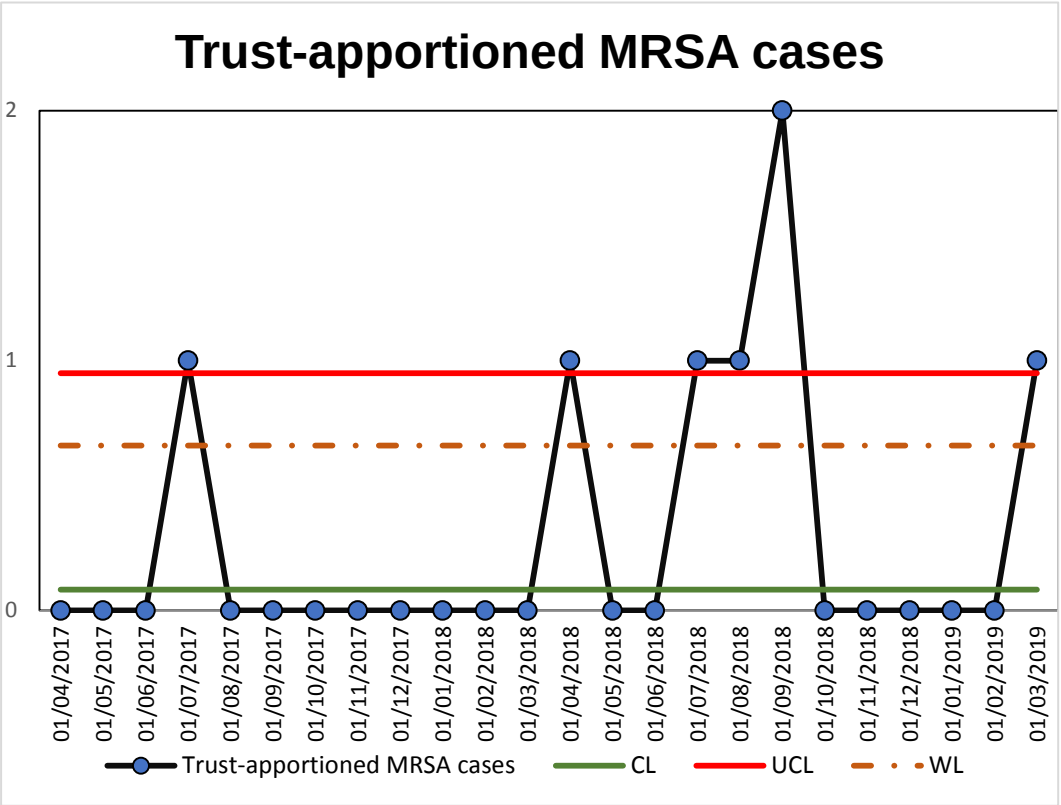
NHS Improvement published guidance on the reporting and monitoring arrangements, post infection review process for MRSA bloodstream infections, and made it a requirement in April 2014 to institute a Post Infection Review in all cases of MRSA bloodstream infection. For 2018/19 this requirement ceased and was referred to local health communities to decide how to manage and monitor cases. Within Gloucestershire it was decided to continue the current reporting framework.

The outcome of the Post Infection Review assists in attributing responsibility for learning actions from MRSA bloodstream infections. All cases reported are assigned either to an acute Trust or Clinical Commissioning Group, the option to assign to a third party was discontinued. This process relies on strong partnership working by all organisations involved in the patient's care pathway, to jointly identify and agree the possible causes of, or factors that contributed to, the patient's MRSA bloodstream infection.

MRSA bacteraemias continued to be reported to Public Health England (PHE) via the HCAI DCS as part of Department of Health mandatory HCAI surveillance.

In 2018-2019 there were 15 MRSA bacteraemias for the whole of the Gloucestershire healthcare community with 5 trust apportioned bacteraemia cases. The annual target (objective) for MRSA bacteraemia for the trust was 0 (which was a national zero tolerance target) and unfortunately this was not achieved.

Figure 2: Number of Trust apportioned MRSA bacteraemia cases since April 2017



CL – control line, UCL – upper control limit, WL – warning line

Table 1: Monthly number of MRSA bacteraemias

Month	Total bacteraemia	Time of bacteraemia acquisition?	
		Non Trust apportioned	Trust apportioned
April 2018	2	1	1
May 2018	0	0	0
June 2018	1	1	0
July 2018	2	1	1
August 2018	1	0	1
September 2018	4	2	2
October 2018	1	1	0
November 2018	1	1	0
December 2018	0	0	0
January 2019	1	1	0
February 2019	0	0	0
March 2019	2	1	1
Total	**15**	**9**	**6**

3.1.2 Learning from incidence of MRSA bacteraemia

The trust continue to carry out post infection reviews which are led by the clinical team responsible for the patient's care and reviewed jointly with the Clinical Commissioning Group.

Cases have been reviewed thoroughly; reviews are led by clinical teams that were responsible for the patients care.

Themes emerging from reviews were:

- MRSA screening not always being undertaken
- Invasive device care not adequately documented
- Decolonisation therapy not commenced
- MRSA colonisation of intravenous drug user

Improvement actions

The Infection Prevention and Control Team (IPCT) have established an MRSA screening and decolonisation short-life working group to review latest evidence and develop a new strategy.

Implemented actions:

- A successful trial of screening long stay patients every 28 days was completed in 2 pilot areas. This will be rolled out across the trust.
- A patient group directive established for the administration of decolonisation therapy. Nurses that have completed the competency can administer the therapy without the need for as doctor's prescription.
- Implementing universal decolonisation in critical care
- MRSA screening for elective surgical patients during outpatient appointments

3.2 MRSA acquisition

Surveillance is carried out on patients that test positive for MRSA on admission and during an in-patient episode. If the MRSA is found more than two days following admission, in a patient not known to have been MRSA positive before, it is recorded as an acquisition. Table 2 details the incidence of MRSA with the majority of cases from the community.

Table 2: Monthly number of MRSA (MRSA incidence – new first detections of MRSA)

Month	Total MRSA	Time of positive test	
		On admission	In-patient episode
April 2018	21	20	1
May 2018	25	23	2
June 2018	33	30	3
July 2018	36	34	2
August 2018	29	27	2

September 2018	29	25	4
October 2018	33	28	5
November 2018	25	24	1
December 2018	20	18	2
January 2019	40	37	3
February 2019	39	37	2
March 2019	49	47	2
Total	**379**	**350**	**27**

Note: these cases do not represent bacteraemia. Most of the new MRSA detections are from MRSA screening samples. Some of the detections are from diagnostic microbiology samples sent for culture and sensitivity testing taken to investigate suspected clinical infection. It is not possible to say how many clinical MRSA infections there are from these figures.

3.3 *Clostridioides difficile* infection

The objective for *C. difficile* infection (CDI) for 2018/19 was set at no more than 36 cases by NHS Improvement. The trust recorded 56 cases of CDI during a challenging year, although the trust have achieved a 22% decrease compared to the previous year. Table 3 gives an overview of rates of CDI by year.

Table 3: Annual CDI rate

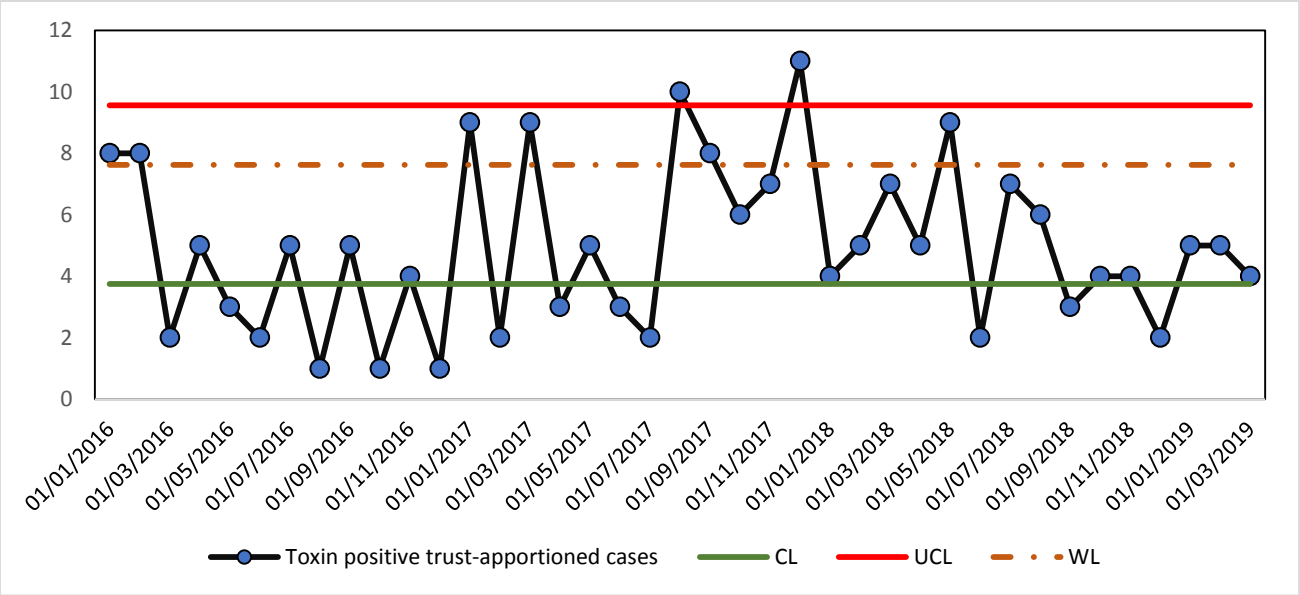
Year	CDI Cases
2014/15	49
2015/16	54
2016/17	47
2017/18	72
2018/19	56

During the year the infection prevention and control team continued to work on the CDI Improvement Plan that was implemented in January 2018 and have seen significant improvements.

The unexpected rise in CDI cases during 2017 led to the establishment of a new oversight group led by the CCG called the *C. difficile* Assurance Panel. The panel is made up of the three provider NHS trusts in Gloucestershire, Gloucestershire County Council and the CCG and meets monthly to discuss the

The mandatory reporting requirements from Public Health England and NHS England has been established for a number of years, all toxin positive *C. difficile* cases must be reported.

Figure 3: Number of Trust apportioned *C. difficile* cases since January 2016



Implementation of the trust wide *C. difficile* reduction plan developed in 2017/18 continued into 2018/19.

The action plan has focused on 5 key areas;

- Environmental decontamination
- Clinical practice –prevention and management
- *C. difficile* education and training
- Buildings and environment
- Antimicrobial stewardship

A huge amount of work was undertaken not only by all members of the team, but also the antimicrobial pharmacist and communications department, who assisted in the design of education resources. The reduction plan was also enhanced further following an external review by NHS Improvement.

Post infection Review

As of April 2018 all trust apportioned cases were investigated by post infection review (PIR). A multidisciplinary review meeting is held to investigate the case to identify if any lapses in care as per NHS England requirements (2016) have likely attributed to the acquisition of CDI. Lapses in care refer to issues that may have contributed to the development of a patient's *C. difficile* infection. The PIR meetings also determine if there are lapses in care that requires redress by the clinical area. This enables the formation of an action plan to assist in praise of good practice and drive forward change for elements of practice that may need developing in order to

improve patient safety. Lapses in quality are also reviewed and actioned and these refer to issues relating to the management of the patient with confirmed *C. difficile*

Outcomes of PIR's are then jointly reviewed by the commissioners on a monthly basis. In 2018/19 it was agree through joint review that 33 of the 56 cases had identified lapses in care.

3.4 Gram negative bacteraemias

The Department of Health and Social Care (DHSC) has required Trusts to submit mandatory surveillance data on *Escherichia coli* bloodstream infections since June 1st 2011. *E.coli* constitutes the most common Gram-negative bacterium detected from clinical microbiology samples; in Gloucestershire there are on average 22 *E.coli* bacteraemias each month.

Most *E.coli* bacteraemias are not a reflection of HCAI; most occur in patients due to underlying disease and are related to common infections such as urinary tract infection, intra-abdominal sepsis and biliary tract infection. Most of these infections commence in the community (but being detected when patients are admitted for investigation and treatment). A proportion of the *E.coli* bacteraemias are healthcare-associated and are related to recent previous hospitalisations and invasive interventions performed on patients, the most important of which is urinary catheterisation. From April 2017 Mandatory Surveillance was extended by DHSC /PHE to include bacteraemias caused by other aerobic Gram negative bacillary bacteria. In addition to *E. coli*, it is now necessary to report patient episodes where blood cultures have yielded *Klebsiella* species and *Pseudomonas aeruginosa.* Systems were put in place within GHNHSFT to collect data and report such bacteraemias on the HCAI DCS. This data collection is coordinated by the GHNHSFT Microbiology Department Information Officer and Medical Secretaries.

During 2018/19 there were 44 trust apportioned cases of *E. coli* bacteraemia; cases identified after day 0+1 (day 0 is taken as day of admission). There were 225 cases of *E.coli* bacteraemia identified before day 0+1; this represents cases that were detected on admission to GHNHSFT. A full break down on monthly *E.coli* bacteraemia cases can be seen in the below table.

Table 4: Monthly numbers of *E.coli* bacteraemia

Month	**Time of *E. coli* bacteraemia acquisition**	
	Day 0+1 case	**After day 0+1 case**
April 2018	13	4
May 2018	12	3
June 2018	21	3
July 2018	19	4
August 2018	20	7
September 2018	28	4
October 2018	21	4
November 2018	13	4

December 2018	17	3
January 2019	31	3
February 2019	15	2
March 2019	15	3
Total	**225**	**44**

During 2018/19 there were 31 trust apportioned cases of *Klebsiella sp.* bacteraemia; cases identified after day 0+1 (day 0 is taken as day of admission). There were 52 cases of *E.coli* bacteraemia identified before day 0+1; this represents cases that were detected on admission to GHNHSFT. A full break down on monthly *Klebsiella sp*. bacteraemia cases can be seen in the below table.

Table 5: Monthly numbers *Klebsiella sp*. of bacteraemia

Month	**Time of *Klebsiella* bacteraemia acquisition**	
	Day 0+1 case	**After day 0+1 case**
April 2018	5	1
May 2018	5	1
June 2018	3	4
July 2018	7	2
August 2018	5	2
September 2018	4	6
October 2018	5	2
November 2018	7	3
December 2018	3	2
January 2019	4	2
February 2019	3	3
March 2019	1	3
Total	**52**	**31**

During 2018/19 there were 12 trust apportioned cases of *Pseudomonas aeruginosa* bacteraemia; cases identified after day 0+1 (day 0 is taken as day of admission). There were 19 cases of *P. aeruginosa* bacteraemia identified before day 0+1; this represents cases that were detected on admission to GHNHSFT. A full break down on monthly *P. aeruginosa* bacteraemia cases can be seen in the below table.

Table 6: Monthly numbers *P. aeruginosa* of bacteraemia

Month	**Time of *Pseudomonas* bacteraemia acquisition**	
	Day 0+1 case	**After day 0+1 case**
April 2018	1	1
May 2018	0	1
June 2018	1	2
July 2018	5	3

August 2018	2	1
September 2018	2	1
October 2018	2	1
November 2018	2	1
December 2018	1	0
January 2019	0	0
February 2019	2	1
March 2019	1	0
Total	**19**	**12**

3.5 Meticillin Sensitive *Staphyloccous aureus* (MSSA) bacteraemias

Since January 2011 all acute NHS Trusts have been mandated to report all Meticillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemias to the DHSC via the HCAI data capture system as part of mandatory surveillance of HCAI. GHNHSFT has had systems in place for this data collection and reporting. The current system entails the Microbiology Department recording these infections and manually entering the infection episodes onto Public Health England (PHE) HCAI Data Capture System. The episode data includes date sample taken and date of admission so an assessment of whether the infection is pre- or post-day 0+1 of admission can be made. There is no nationally set or locally agreed target for post-day 0+1 (trust attributable) MSSA bacteraemia. GHNHSFT is however keen to keep the numbers of these infections to an absolute minimum.

In the county there are approximately 9 MSSA bacteraemias per month. In the last 12 months of the surveillance there were 115 MSSA bacteraemias. 73% (84) of episodes were in patients in the first 48 hours of their admission. 27% (31) were post day 0+1 episodes. A full break down on monthly MSSA bacteraemia cases can be seen in the below table 7.

Table 7: Monthly numbers of MSSA bacteraemia

Month	**Time of MSSA bacteraemia acquisition**	
	Day 0+1 case	**After day 0+1 case**
April 2018	4	5
May 2018	5	4
June 2018	8	2
July 2018	11	2
August 2018	4	4
September 2018	10	4
October 2018	7	2
November 2018	9	4
December 2018	9	2
January 2019	6	1
February 2019	7	0
March 2019	4	1
Total	**84**	**31**

3.6 Carbapenemase Producing Enterobacteriaceae (CPE)

Screening of patients for CPE was introduced in Gloucestershire in September 2014 to comply with a requirement to implement the national CPE toolkit for Acute Trusts This guidance was intended to assist in preventing any outbreaks and reducing the spread of these resistant organisms within health care settings.

The monthly surveillance report presented monthly data on CPE testing undertaken in GHNHSFT Microbiology for the laboratory catchment area in Gloucestershire. The total numbers of specimens (screens) sent specifically for screening for carriage of CPE is presented. The numbers of specimens that have grown Enterobacteriaceae that are suspected to be CPE on the basis of local testing are also presented (possible CPE). Any samples with possible CPE are sent to a reference lab for confirmation. The number of samples shown to have confirmed CPE (on the basis of reference laboratory results) is also presented.

CPE isolates can potentially be yielded from any diagnostic microbiology specimen (e.g. sputum, blood cultures, and urine) as well as from samples sent specifically for CPE screening. CPE screening samples are mainly rectal swabs and stool samples, but with a few other selected superficial (‘manipulated’) sites being investigated for carriage as clinically indicated. Most detections of CPE will reflect asymptomatic carriage, but these organisms do have the potential to cause clinical infections and when detected from sites other than CPE screening samples might be causing clinical infection.

GHNHSFT identifies how many CPE screens have been taken monthly within the healthcare community and identifies the location of any confirmed cases. This information was reported in the monthly surveillance report. CPE incidence is presented as numbers of “detections” rather than as a rate of infection (true incidence).

In 2017/18 there were 0 confirmed cases of CPE. Currently our patient population appears to have a low rate of CPE carriage.

4. Outbreaks and learning from incidents

The infection prevention and control team have a comprehensive surveillance programme that allows early detection of emerging incidents. The Trust investigates incidents to extract learning points in order to continually improve the quality of our services.

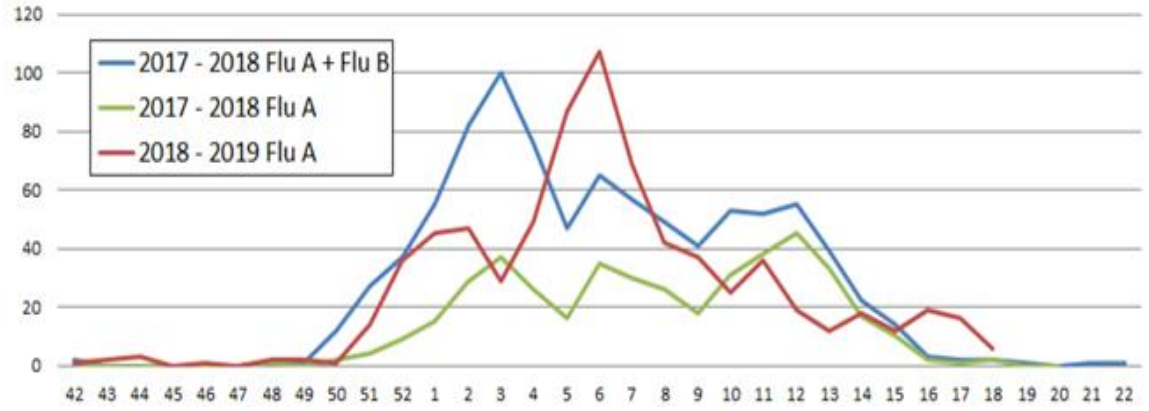
4.1 Norovirus

From April 2018 - March 2019 there was a total of 2 ward closures due to outbreaks of diarrhoea and vomiting; both at GRH of which Norovirus was identified as the causative organism. The organization appears to have not been too badly affected by norovirus this financial year with rapid detection and control of outbreaks when these did occur. During October 2018 to May 2019 the Infection Prevention and Control Nurses (IPCN) provided a service to review outbreaks of diarrhoea and vomiting and influenza at weekends and bank holidays. Also, daily outbreak update meetings were held with the site team and the IPCN's to support the management of both Norovirus and Influenza outbreaks.

4.2 Seasonal Influenza and staff vaccination campaign

Influenza activity has been high this season 2018-19. As of May 2019 we have had 737 cases of Influenza A compared to 430 cases in the previous season and one case of Influenza B compared to 467 cases last season. See figure 4 below for details of the Influenza cases during the 2018/19 season compared to 2017/18.

Figure 4: Influenza cases during the 2018/19 season compared to 2017/18



In addition, there have been significant numbers of patients admitted to hospital with influenza or illnesses arising as a complication of influenza (e.g. secondary bacterial pneumonia). The increased numbers of patient admissions with active current influenza infection proved challenging to the organisation during our period of Winter Pressures. As in previous seasons it was not possible to isolate, in single rooms, all patients whilst they were infected and there was not 100% compliance with all elements of the "Flu Bundle". The inability to isolate all infectious patients resulted in a number of transmissions of infection to existing inpatients. Also, in a number of cases patients were only being isolated in response to positive Flu results and not

based on clinical symptoms; this also exposed further patients to Influenza. In a number of cases this resulted in short periods of bed closures. A consequence of inpatient exposure to un-isolated infectious patients was a need to assess exposed contacts for the need for them to receive antiviral chemoprophylaxis as “post-exposure prophylaxis” and in some cases this needed to be converted to a treatment course.

Influenza point of care testing (POCT) at GRH continued. The overwhelming opinions from staff, was that this was a very valuable addition to the need for rapid diagnosis of influenza. It was also felt to be vital to patient bed allocation from ED and AMU. However, there were occasions when patients were not tested on admission and were admitted to bays subsequently exposing other patients and were implicated as the source of outbreaks.

From April 2018 - March 2019 there was a total of 9 outbreaks of Influenza; resulting in one total ward closure for a period of 7 days and 4 outbreaks resulting in one to two bay closures for a small number of days (7 outbreaks occurring at GRH and 2 outbreaks occurring at CGH).

It is likely that the scope of the Seasonal Influenza Meetings will need to be expanded to include not just an ongoing focus on staff vaccination, but also service delivery considerations during periods of increased activity, and development of an Influenza pathway and an escalation policy for Influenza that indicates trigger points for when affected wards should institute cohort nursing when single room isolation capacity is exceeded. Cross site use of POCT machines should also be considered.

The Trust was also required to report Influenza figures daily to NHS England. This required the team to report all new cases of:

- Laboratory confirmed cases of Influenza in High Dependency and Intensive care units, and of those how many in the last 24hrs
- Laboratory confirmed cases of Influenza in all other inpatient beds

Total patients tested positive in the last 24hrs, and of those how many were discharged.

Immunization of frontline healthcare workers in the NHS reduces staff sickness absences and protects our patients. Each year Public Health England launches their annual campaign in late autumn to help reduce influenza transmission by reinforcing the message that it is vital that frontline staff to get vaccinated. The 2018/19 target was to have 75% of frontline healthcare workers vaccinated, we exceeded this with an uptake of 79.2% with more than 4000 frontline staff having their jab. Our campaign was led by peer vaccinators and matrons delivering vaccinations in clinical areas. We were unable to collect reasons for opting out of the programme and this will therefore be an ambition for the 2019/20 campaign in which we also aim to achieve 80% uptake.

The campaign focussed on frontline healthcare workers working in high risk areas such as unscheduled care, respiratory wards, critical care including the neonatal unit and oncology wards. This is due to our most vulnerable patients being housed here,

in terms of immunosuppression and the increased likelihood of seeing patients with influenza in the unscheduled care areas.

4.3 Infection prevention and control incidents recorded on Datix

Confirmed serious incidents

Four serious incidents (SI) confirmed during the period 2018/19 two of which included *C. difficile* outbreaks on ward 4B at GRH. Another SI was related to a *C. difficile* case that resulted in death (Part 1 of the death certificate) associated with one of the ward 4B *C. difficile* outbreaks and another SI was related to an Influenza case that resulted in death during an Influenza outbreak on Ward 9B.

Serious incidents are investigated by the Patient Safety Investigation Team who carry out a comprehensive assessment of the incident and produce a detailed report with recommendations and learning points. These learning points included organising a deep clean of Ward 4B, which was completed. Other points identified reinforced sending stool samples promptly when patients experience new onset of diarrhea and communicating when samples have been sent to multidisciplinary team colleagues. Subsequently, ward staff were supported with training on appropriately sending stools samples and have available a diarrhoea/ stool sampling sticker which is put in the notes to inform the team that a sample has been sent and that the patient should be reviewed for CDI treatment. Staff were also supported with training on the importance of cleaning and how to effectively decontaminate equipment after use.The investigation on Ward 9B identified the importance of ensuring point of care Influenza testing is utilised by Emergency Department when patients present with Influenza-like symptoms. Early detection of Influenza in patients would then enable adequate provision of isolation single room facilities and prevent ongoing transmission.

4.4 National Inpatient Survey

The Trust participated in the National Inpatient Survey in 2018 and in 2019 as required by the Care Quality Commission for all NHS Trusts in England. These results are benchmarked and compared against the range of results from all other trusts that take part in national surveys.

The results from the following surveys have been published or carried out during 2018-2019 and contained questions relating to Infection Prevention and Control.

- National Inpatient Survey 2018 and 2019
- National Maternity Survey 2019

See the table 8 for the results of surveys participated in which contain questions relating to infection prevention and control.

Table 8: Survey results relating to Infection Prevention and Control

Survey	Question	Result /national benchmarking
Maternity Survey 2019	**Cleanliness of room or ward** Thinking the hospital room or ward was **clean**	**9.2/10** **About the same**
Adult Inpatient 2018	**Cleanliness of rooms or wards** for the **hospital room or ward being clean**	**8.4/10** **Worse**
Adult Inpatient 2019	**Awaiting results**	
Children and Young People 2017	**Cleanliness** for parents and carers saying the room or ward their child stayed on was clean	**8.7/10** **About the same**
Children and Young People 2019	**Awaiting results**	
ED 2017	**Cleanliness** for describing the **emergency department as clean**	**8.5/10** **About the same**
ED 2019	**Awaiting results**	

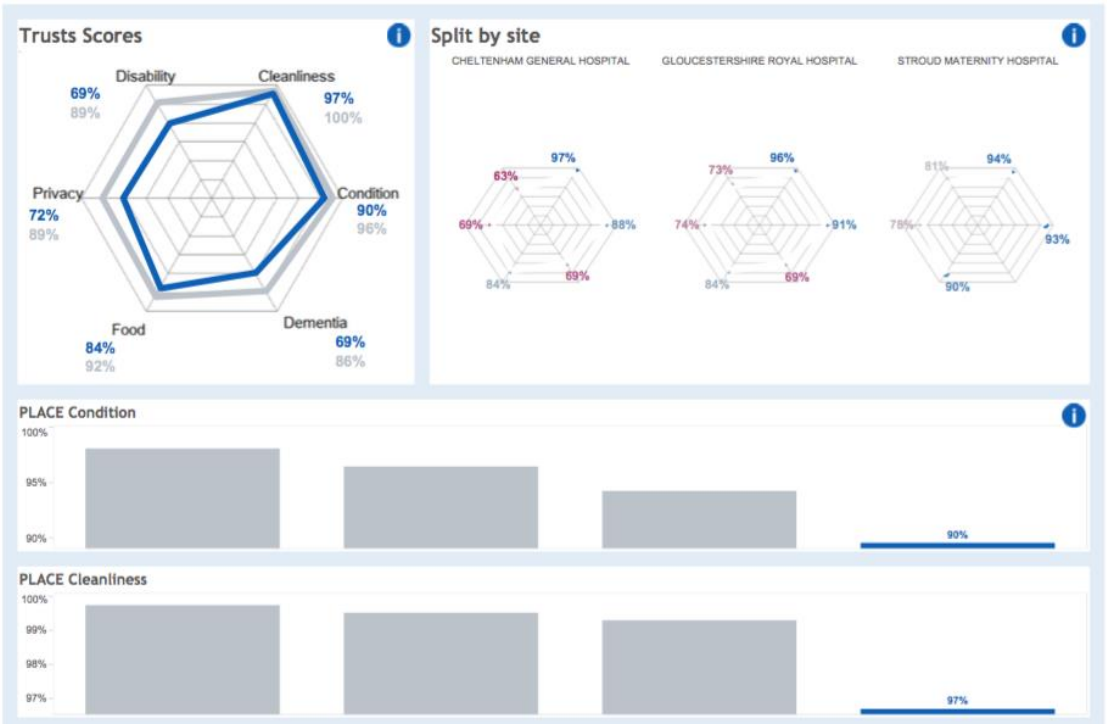
Each trust also received a rating of 'About the same', 'Better' or 'Worse'. These are defined as;

- Better: the trust is better for that particular question compared to most other trusts that took part in the survey.
- About the same: the trust is performing about the same for that particular question as most other trusts that took part in the survey.
- Worse: the trust did not perform as well for that particular question compared to most other trusts that took part in the survey.

Patient-led Assessments of the Care Environment (PLACE) audit

April 2013 saw the introduction of PLACE, which is the system for assessing the quality of the patient environment, replacing the old Patient Environment Action Team (PEAT) inspections. The assessments involve patient assessors coming into both hospital sites as part of teams to assess how the environment supports the provision of clinical care assessing in particular cleanliness and general building maintenance. Results from the IPC aspects of the PLACE assessment completed in 2018 are displayed in figure 5.

Figure 5: PLACE assessment results



There is no specific question about the bathroom or toilets as part of the National Inpatient Survey, but we will continue to monitor this across our wards.

4.5 Complaints and Concerns

The Patient Experience Department recorded 9 issues between April 2018 and March 2019 reported via the Patient Advisory Liaison Service (PALS).Themes arising from concerns and complaints during this period related to infection control were:

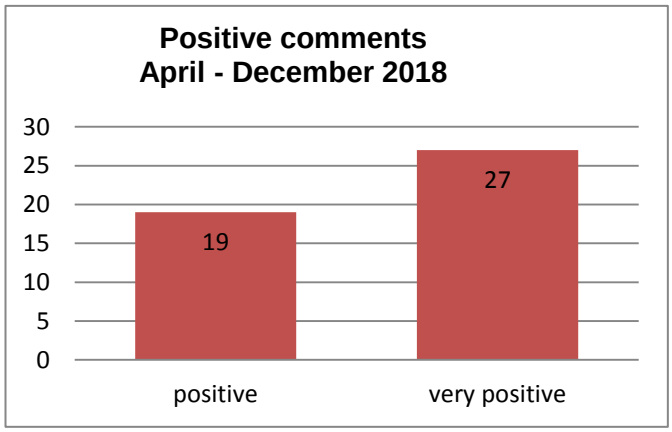
- Cleanliness of the environment; specific example of concern identified blood on curtains
- Ambulant patient with Influenza not remaining in isolation
- Patient's being sent home with soiled clothes within belongings and property
- Maternity- sheets not changed and inadequate cleaning
- Possible acquisition of infection from other patients with MRSA
- Clutter and litter around bed spaces
- IV fluids disconnected from patient left hanging on drip stand and leaking on the floor.

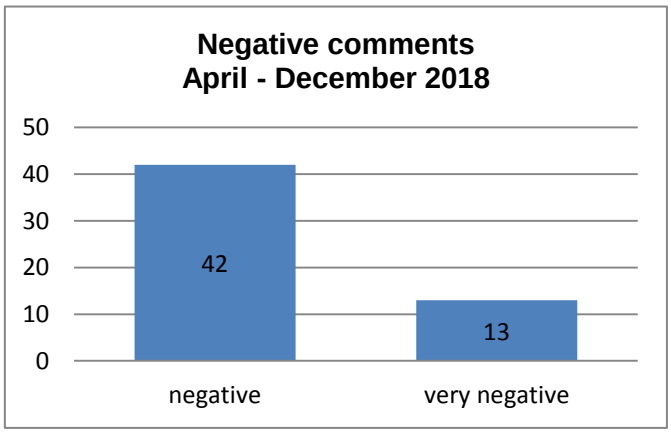
Friends and Family Test data – Infection control / Cleanliness

The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether their patients are happy with the service provided, or where improvements are needed. It is a quick and anonymous way for patients to give their views after receiving care or treatment across the NHS. FFT comments left in the period from April – December 2018 searching for the key words

clean/cleaned/cleanliness. See figure 6 for results based on those search terms.

Figure 8: FFT results for IPC related questions





The Patient Experience Department recorded 23 complaints between April 2018 and March 2019 related to infection control and cleanliness. These complaints included a sub-subject specifically related to:

- Failure to adopt infection control measures
- Cleanliness (clinical)
- Cleanliness (non-clinical)
- Acquired infection
- Laundry/Linen – cleanliness

Of the above complaints the most commonly raised issues were (note that some complaints may feature more than one sub-subject):

- Failure to adopt infection control measures (20)
- Cleanliness Clinical (all aspects, all areas) (16)
- Cleanliness Non Clinical (all aspects, all areas) (6)

5.0 Surgical Site Infections

Surgical site infection is a type of healthcare-associated infection in which a wound infection occurs after an invasive (surgical) procedure. Surgical site infections have been shown to compose up to 16% of all of healthcare associated infections. Around 5% of patients undergoing a surgical procedure develop a surgical site infection.

A surgical site infection may range from a spontaneously limited wound discharge within 7–10 days of an operation to a more serious postoperative complication, such as a sternal infection after open heart surgery. Most surgical site infections are caused by contamination of an incision with microorganisms from the patient's own body during surgery. Infection caused by microorganisms from an outside source following surgery is less common. Measures can be taken in the pre-, intra- and postoperative phases of care to reduce risk of infection.

Surgical site infections can have a significant effect on quality of life for the patient. They can be associated with increased morbidity and extended hospital stay. In addition, surgical site infections result in increased financial costs to healthcare providers. Advances in surgery and anaesthesia have resulted in patients who are at greater risk of surgical site infections being considered for surgery. In addition, increased numbers of infections are now being seen in the community as patients are allowed home earlier following day case and fast-track surgery.

In May 2018, control of the SSI team and process was transferred from the Surgical Division (and the Practice Development Nurse) to the Infection Prevention and Control Nursing team. The team is established to 2.33 whole time equivalents (WTE) as detailed in table 9

Table 9: SSI team

Band 3	SSISS Coordinator	1.0 WTE
Band 2	SSISS Data Collector	0.8 WTE
Band 2	SSISS Data Collector	0.53 WTE

During the period of April 2018 to Dec 2018 SSI Categories covered by the SSI team are as follows: Gastric, Large Bowel, Small Bowel, Breast, Hip and Knee arthroplasty, neck of femur, Long Bone Reduction and Spinal surgery. With surveillance data being reported to Public Health England (PHE) in Quarter 1 for all specialities and for Hip and Knee arthroplasty and Spinal surgery in Quarter 2.

Spinal surgery saw us being assigned as high outliers at GRH in the July to September quarter 2 (3.7% against a national average of 1.1%, representing 3

cases). As a result a control group with stake holders from the surgical division, Infection Prevention and control, Risk department was formed to implement an action plan to address the high incidence of SSI in spinal surgery. Spinal surgery surveillance recommenced in April 2019 utilising active surveillance and PHE prescribed methodology.

For quarter 1 knee arthroplasty at CGH was also identified as an outlier (for April-June total SSI prevalence was at 1.2% against a national average of 0.4%, representing 3 cases). Also, Hip arthroplasty at GRH saw us be assigned high outliers in April to June (for the four periods combined there was a SSI prevalence rate of 2.6% against a national average of 0.4%, representing 6 cases). Outlier status continued into quarter 2 July- September (for the four periods combined there was a SSI rate of 2.2% against a national average of 0.4%, representing 3 cases). Also for quarter 1 repair of neck of femur surgery at GRH was identified as an outlier (for the quarter there was a SSI prevalence rate of 2.1% against a national average of 1.2%, representing 4 cases). Since 2016 a multi-disciplinary 'orthopaedic infection control group' has been in place to review and improve practices. This group continues to meet regularly and has recently revised the action plan.

In November 2018 a review of the service provision was undertaken as the surveillance methodology being utilised was not in accordance with the Public Health England (PHE) nationally prescribed requirement. As of January, surveillance of all specialities was suspended following consultation with the national surveillance lead at PHE. PHE further advised that the trust do not submit any data during quarter 3 onwards as the programme is not compliant with the required methodology. The Trust had already complied with mandatory elements of the national surveillance programme by submitting at least one orthopaedic category during one quarter of 2018/19.

As of January 2019 PHE methodology of active surveillance was applied to Caesarean section surgery at GRH and Large and Small bowel surgery at GRH. Appendix 1 describes the methodology implemented by the SSIS team to identify SSI cases. PHE were invited to the Trust in April 2019 to undertake an appreciative inquiry of the Trust's SSIS provision and the methodology described in appendix 1 was agreed to be in line with the PHE methodology.

From January to March total SSI prevalence for Caesarean section was 12.14%; with 5 cases being reported as inpatient or readmission and 33 cases identified via ad hoc clinic review or patient self –reported classified through 30 day post-operative phone calls (validated by the patient's GP). There is no nationally recognised benchmark for C-section SSI surveillance and therefore cannot be compared against national SSI rates.

From January to March total SSI prevalence for large bowel surgery was 14.4%; representing 10 cases (including patient reported cases). From January to March total SSI prevalence for small bowel surgery was 20%; representing 4 cases (including patient reported cases, to also note only 20 operations were performed during this quarter and PHE protocols suggest at least 50 procedures should be performed to enable confidence in the SSI data outcomes, therefore surveillance for small bowel surgery continues in to quarter 1 2019/20). For both large and small

bowel surgery we have identified a higher prevalence of SSI utilising the new active methodology compared to quarter 1 in which passive data collection and discharge letter review was implemented (with total SSI prevalence of 6.5% being reported for small bowel and 9.9% being reported for large bowel surgery in quarter 1 2018/19).

Also, completed in January was a point prevalence survey for SSI's across all surgical wards. Utilising the methodology the European Centre for Disease Prevention and Control (ECDC) definition for SSI and PHE protocol described in the European point prevalence survey as detailed in appendix 2. Please find the results of the PPS in table 10 below.

Table 10: SSI point prevalence survey

Date	Ward	Number of patients on ward	Number of patients who underwent surgery	Number of surgical site infections
14/01/19	5B GRH	32	18	2 x Superficial
15/01/19	5A GRH	16	2	1 x Organ Space
16/01/19	2A GRH	20	3	1 x Organ Space
17/01/19	2B GRH	20	4	0
17/01/19	Maternity GRH	25	8	1 x Superficial
21/01/19	Prescott CGH	24	12	1 x Superficial
22/01/19	Bibury CGH	21	11	2 x Superficial
23/01/19	Guiting CGH	31	12	2 x Superficial
04/03/19	Dixton CGH	6	6	0
05/03/19	3A GRH	30	26	0
06/03/19	AlstoneE CGH	20	20	0
11/03/19	3B GRH	29	7	Spinal- 1 x Deep Trauma- 1 x Superficial
12/03/19	5B GRH	37	16	2 queries (collections)
13/03/19	5A GRH	13	1	0
18/03/19	2A GRH	21	9	1 x Deep
19/03/19	2B GRH	20	0	0
19/03/19	Maternity GRH	28	6	0
25/03/19	Prescott CGH	32	11	0
26/03/19	Guiting CGH	27	12	1 x Superficial
17/04/19	3A GRH	27	26	0
23/04/19	3B GRH	29	10	1 x Organ Space
24/04/19	Alstone CGH	15	13	1 Organ Space

In March 2019 a trust wide OneTogether assessment was completed across the surgical pathway at both GRH and CGH. The assessment tool supports close collaboration between infection prevention and control teams and surgical teams and

supports addressing challenges identified throughout the pre, intra and postoperative stages of surgery. The standards included in the assessment tool have been derived from national evidence-based guidelines or expert recommendations from professional bodies and reflects NICE guidance. Results from the assessment tool will support identification of areas for improvement, and in conjunction with a risk assessment, ensure resources are appropriately allocated.

In July 2019 SSI surveillance will be reported through a trust wide SSI surveillance steering group and a Trust wide SSI prevention plan will be implemented.

Chief Nurse Junior Fellows are band 5 nurses, midwives or AHPs that are part of a leadership training programme with mentorship directly from the Chief Nurse and his team. Each Chief Nurse Junior Fellow carries out a quality improvement project in their clinical area. Nur-in Jamaica, a staff nurse in surgery is leading a project to support identification of patients who are at risk of inadvertent perioperative hypothermia (IPH) a risk associated with a number of adverse outcomes including increased risk of surgical site infection. Alerting patients at risk of IPH enables appropriate perioperative warming to be implemented which subsequently reduces their SSI risk.

6.0 Audit

The Infection Prevention and Control Team have a comprehensive audit programme for assurance purposes that has been successfully delivered during 2018/19.

Cleaning hands is one of the most important actions anyone can carry out to prevent infection. Hand hygiene audits are undertaken by the clinical area and are reported every month at the ICC. Audits are undertaken monthly by the clinical areas. Regular hand hygiene audits are performed by the Infection Prevention and Control Team and Gojo (providers of alcohol hand foam to the Trust) clinical support team to further validate the results.

Saving Lives 'high-impact interventions' are evidence based tools that allow staff to monitor compliance with clinical guidance and provide feedback so that compliance can improve consistently. High impact interventions provide the means to ensure that staff undertake clinical procedures correctly every time they are needed. The high impact interventions include guidance and tools for: central venous catheter care, peripheral venous catheter care, renal dialysis catheter care, prevention of surgical site infection, care for ventilated patients, urinary catheter care and reducing the risk of *C. difficile*. Saving lives audits are regularly undertaken by clinical areas every month. In 2019 the updated high impact interventions will replace the Saving Lives audits.

A regular infection control audit of clinical areas is carried out by an Infection Prevention Nurse. The audit consists of: observation of practice, review of care and management of patients with infections, observations on correct use of personal protective equipment, observations of environmental cleanliness and review of patient indwelling devices. The results of the audit are fed back to the clinical area and Matron.

A rolling programme of monthly independent environmental audits, led by the Estates Team, are in place to monitor the compliance of clinical and non-clinical areas against the national cleaning standards framework. Audit results are made available to areas and reported to ICC.

The planned audit programme for 2018/19 is detailed below:

- *Saving Lives* programme's high impact interventions (HIIs) care bundles – undertaken monthly by nursing staff
- Hand hygiene-undertaken monthly
- Bare below elbow- undertaken monthly
- Environmental audits-Monthly programme
- MRSA screening compliance with policy
- Hand hygiene reliability audits of inpatient areas by Gojo
- Hospital Antibiotic Prudent Prescribing Indicators (HAPPI) – monthly by pharmacists (not all areas completed monthly)
- Trust wide urinary catheter prevalence audit (in support with BD)

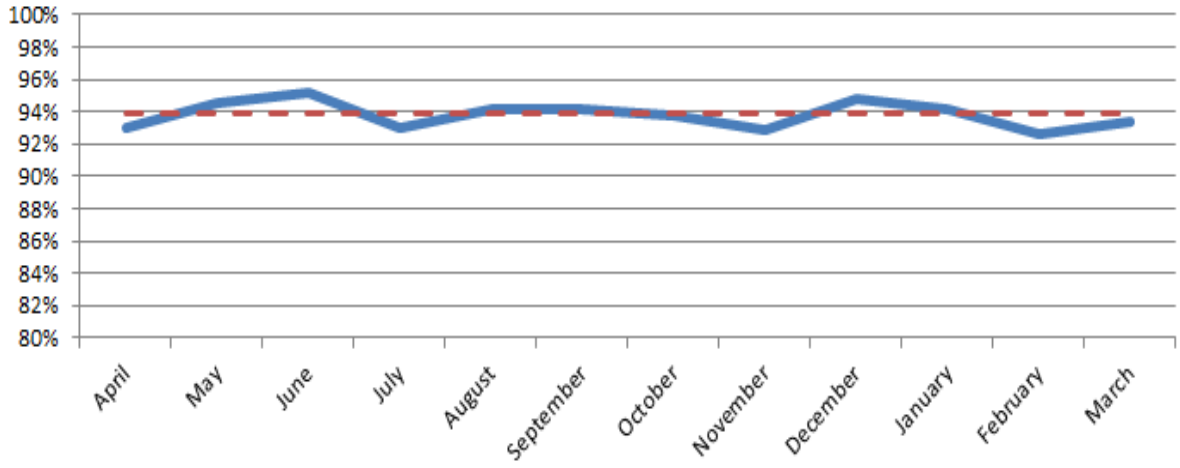
The planned audit of compliance with the MRSA policy was not undertaken but a snap shot audit of MRSA screening compliance was completed and only 3 out of 50 patients did not have an MRSA screen completed on admission. Also a 4 week pilot of screening patients for MRSA at 28 days (long stay admissions) was performed across a medical and surgical ward and no MRSA acquisitions identified (MRSA found more than two days following admission, in a patient not known to have been MRSA positive before is recorded as an acquisition).

Gojo continued to provide reliability audits. These continued to show disparity between Trust scores and reliability scores. These results are circulated to ward managers, Matrons and divisional leads. The ICNs undertook planned monthly programme of environmental audits as workload prioritisation allowed. The trust wide catheter prevalence audit validated the findings from monthly safety thermometer audits with 21% of inpatients

Hand Hygiene

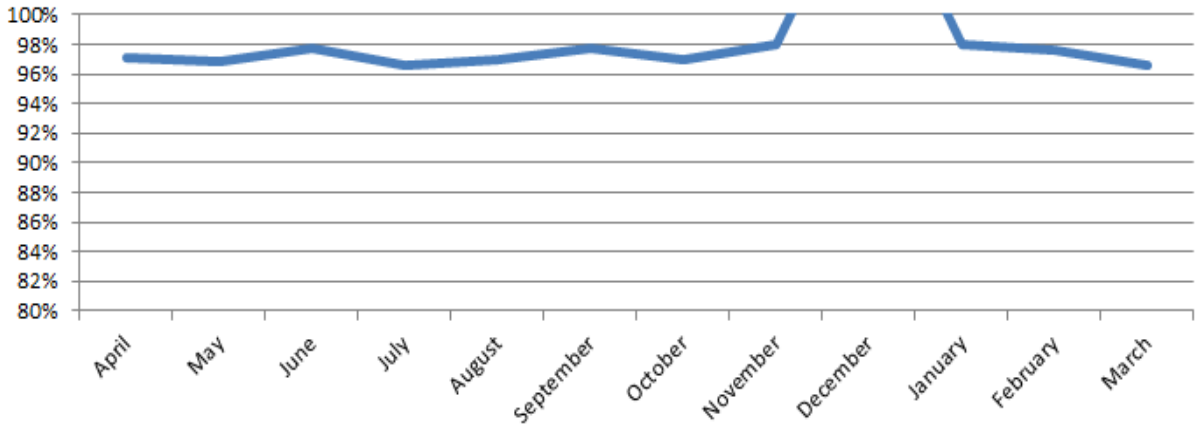
Hand hygiene (HH) audits continued to be undertaken monthly by the ward based hygiene Champions. The results are displayed locally and reported to each Division and to the Trust Board. In 2018/19 the average overall Trust-wide hand hygiene compliance score was 93.8%.

Figure 9: Trust-wide- Hand hygiene compliance



Bare below the elbow results are also recorded as part of the HH audit monthly, the average Trust-wide compliance score was 96.8%.

Figure 10: Trust-wide- Bare below the elbow audit



As part of the service level agreement with the suppliers of the alcohol hand foam used within the Trust, on average five reliability audits were also undertaken across sites every 2 months by the Education Practitioner. Reliability Hand Hygiene scores varied from 33% to 93.3%, feedback given to Matrons /Charge Nurses within Division.

The Trust participated in a *Glove awareness week* and *Hand Hygiene Awareness day* in April 2018 and May 2018. As part of this an educational roadshow was provided by the IPCN's with the support of the domestic supervisors to update staff on appropriate glove use and the importance of hand hygiene. All wards were visited and staff were also provided with information on skin health to prevent contact dermatitis. A social media campaign 'Glove songs' to engage staff was also implemented to reduce inappropriate glove use in a fun and interactive manner. There was particularly great participation from staff in this campaign and was well received on the social media site Twitter (a ward who submitted a 'glove song' video for the campaign had 2,770 views on Twitter)

As part of the World Health Organisation's Global hand hygiene awareness day, members of the staff and members of the public were educated and updated on the importance of hand hygiene in stands at GRH. A hand hygiene pledge board was also signed by staff across the Trust to support preventing infection by delivering safe and clean care for all. Images from staff interactions were uploaded onto the IPC Twitter account generating 4,086 impressions. The national hand hygiene policy was also adopted by the Trust.

During 2019 hand hygiene products were be provided by an alternative supplier and will be in manual push bottles given the challenges we have had with automated alcohol hand rub dispensers. Also, in 2019 new metrics for hand hygiene compliance will be launched.

7.0 Antimicrobial Stewardship

Antimicrobial stewardship refers to coordinated interventions designed to improve and measure the appropriate use of antimicrobials by promoting the selection of the optimal antimicrobial drug regimen, dose, duration of therapy, and route of administration.

An antimicrobial is defined as “a drug that selectively destroys or inhibits the growth of microorganisms. Sometimes referred to as an ‘antimicrobial agent’. Examples include antibiotics (also known as antibacterials) antiviral and antifungal agents.”

Antimicrobials have a vital role in the treatment and prevention of infection. Antimicrobial resistance (AMR) is linked to antibiotic usage and renders antibiotics ineffective. Increasing bacterial resistance to antibiotics is a major concern.

Effective AMS is therefore essential for patient safety but also relevant to clinical effectiveness and patient experience. The importance of antimicrobial resistance is widely recognised and there is an integrated UK five-year national action plan, Tackling antimicrobial resistance 2019–2024.

This document defines AMS as:

“A key component of a multifaceted approach to improve the safety and quality of patient care whilst preventing the emergence of AMR. Good antimicrobial stewardship involves selecting an appropriate drug and optimising its dose and duration to cure an infection while minimising toxicity and conditions for selection of resistant microbes. Good AMS includes a review of the continuing need for antibiotics following clinical diagnosis and documented actions to stop, continue or change antimicrobial treatment.”

This national action plan contains targets including:

- *“halve healthcare associated Gram-negative blood stream infections;*
- *reduce the number of specific drug-resistant infections in people by 10% by 2025;*
- *reduce UK antimicrobial use in humans by 15% by 2024;*
- *reduce UK antibiotic use in food-producing animals by 25% between 2016 and 2020 and define new objectives by 2021 for 2025; and*
- *be able to report on the percentage of prescriptions supported by a diagnostic test or decision support tool by 2024.”*

The fifth annual report from the English Surveillance Programme for Antimicrobial Utilisation and Resistance (ESPAUR) was published in October 2018.[3] Key points from this report include:

- *"The proportions of bacterial species causing BSIs that are resistant to key antibiotics have remained stable over the last 5 years. This likely reflects the importance of stewardship activities that have reduced levels of antibiotic prescribing, which in turn reduced selective pressure for spread of resistant strains. However the burden of resistance as measured in terms of total numbers of antibiotic-resistant BSIs has increased by 35% from 2013 to 2017, driven predominantly by the year-on-year increased incidence of BSI."* Note: BSI = bloodstream infection

- *"Overall antibiotic consumption in secondary care in England increased by 7.7% between 2013 and 2017. Prescribing for hospital inpatients increased by only 2% but increased by 21% in hospital outpatient settings over the five-year period. This is an improvement compared to the data presented in the first ESPAUR report, where from 2010 to 2013, prescribing to hospital inpatients increased by 11.9%. This potentially reflects improved focus on antibiotic stewardship for hospital inpatients."*

- *"In 2017/18, 23%, 75% and 45% of 152 NHS acute Trusts met their objectives to reduce total antibiotic, piperacillin/tazobactam and carbapenem consumption, respectively, as measured through the national Commissioning for Quality and Innovation (CQUIN)."* – Local CQUIN data is presented below.

AMS Team Resource

AMS activity within our trust is led by the AMS team, consisting of a pharmacist and consultant medical microbiologists. There is currently 1.0 whole time equivalent antimicrobial pharmacist and a Lead Nurse for Infection Prevention & Antimicrobial Stewardship within the organisation. Increasing operational and governance requirements relating to AMS have been included in a risk assessment and a business case has been produced which proposes additional resource in order for our Trust to be able to meet current AMS requirements. Note that implementation of an electronic pharmacy would significantly increase the opportunity to collect, analyse and feedback antibiotic consumption data to prescribers.
Increased production and dissemination of local "drug bug" surveillance data should be undertaken in order to inform local antibiotic usage guidance.

Requirements

A number of national and local requirements and guidance documents relate to AMS and include:

- **The Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance**.
  https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance

This Code of Practice requires that providers of healthcare *"Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance."*

- **Antimicrobial stewardship: Start smart - then focus.** Includes, *"Implementation of this toolkit and the audit programme can be used as evidence of meeting criterion 9 of the Code of Practice on the prevention and control of infections when seeking registration with the Care Quality Commission."*

- **National Institute for Health and Care Excellence (NICE).** NICE continues to produce and develop a range of documents relating to antibiotic use

  This includes:
  - Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use
    NICE guideline [NG15]: August 2015:
    https://www.nice.org.uk/guidance/ng15/resources
    The associated baseline assessment tool was completed in 2016 and indicated that 4% (2 of 51) of the recommendations were currently met. Compliance is currently being reassessed. A business case has been produced so that AMS resource can be increased.

  - Antimicrobial stewardship. Quality standard [QS121]: April 2016:
    https://www.nice.org.uk/guidance/qs121
    Note that progressing compliance with relevant aspects of this quality standard is partially dependent on the implementation of an electronic pharmacy.

- **NHS Standard Contract 2019/20:** https://www.england.nhs.uk/nhs-standard-contract/19-20/
  Service condition 21 includes statements regarding reducing antibiotic usage.

- **Commissioning for Quality and Innovation (CQUIN) Guidance for 2019-2020** https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-19-20/ **are as follows:**

  - **CCG1a: Antimicrobial Resistance – Lower Urinary Tract Infections in Older People** - Achieving 90% of antibiotic prescriptions for lower UTI in older people meeting NICE guidance for lower UTI (NG109) and PHE Diagnosis of UTI guidance in terms of diagnosis and treatment.

  - **CCG1b: Antimicrobial Resistance – Antibiotic Prophylaxis in Colorectal Surgery** - Achieving 90% of antibiotic surgical prophylaxis prescriptions for elective colorectal surgery being a single dose and prescribed in accordance to local antibiotic guidelines.

  - **Improving Value in Specialised Services 2019/2020**

- **Antifungal Stewardship**
  https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-19-20/

This initiative is based around the following improvement principles:

1. Evidence based guidance within every NHS Trust, including a nationally standardised prophylaxis risk table

2. Antifungal Reviews by Stewardship Teams: Antifungal therapy (treatment – targeted/empiric) should be reviewed 48-72h after initiation and every 7 days thereafter by a specialist stewardship team

3. Regular audit of antifungal prescribing utilising a standardised audit proforma, with key metrics reported

4. Diagnostics Gap analysis against the British Society for Medical Mycology best practice recommendations for the diagnosis of serious fungal diseases

5. Introduce Blueteq prior-approval for the higher cost agent isavuconazole

- **Commissioning for Quality and Innovation (CQUIN) Guidance for 2017-2019 year 2 was as follows:**

  - Reducing the impact of serious infections CQUIN part 2c Antibiotic review

Table 11: CQUIN 2c data on antibiotic review

CQUIN 2c - Antibiotic review	**Target not achieved for the Q4 period of Jan-March 2019**
30 sets of notes assessed per quarter diagnosed with sepsis.	

Quarter	**Q1: Apr-Jun 18**	**Q2: Jul-Sep 18**	**Q3: Oct-Dec 18**	**Q4: Jan-Mar 19**
GHFT Result				
Percentage of antibiotic prescriptions reviewed between 24-72 hours as per criteria	**72%**	**60%**	**50%**	**59%**
Target	**≥25%**	**≥50%**	**≥75%**	**≥90%**

Reducing the impact of serious infections CQUIN part 2d had 3 components:

- Reduction in antibiotic consumption per 1,000 admissions by 3% from the actual total consumption in 17/18
- Reduction of carbapenem consumption per 1,000 admissions by 3% from the actual carbapenem consumption in 17/18
- Increase the proportion of total antibiotic prescribing from the 'Access' category of the WHO essential Medicines List AWaRe index by 3% from baseline 2016 calendar year.

Table 12: CQUIN 2d data on antibiotic consumption per 1,000 admissions

CQUIN 2d - Reduction in antibiotic consumption per 1,000 admissions	**Overall target for the Q4 period of Jan-March 2019**

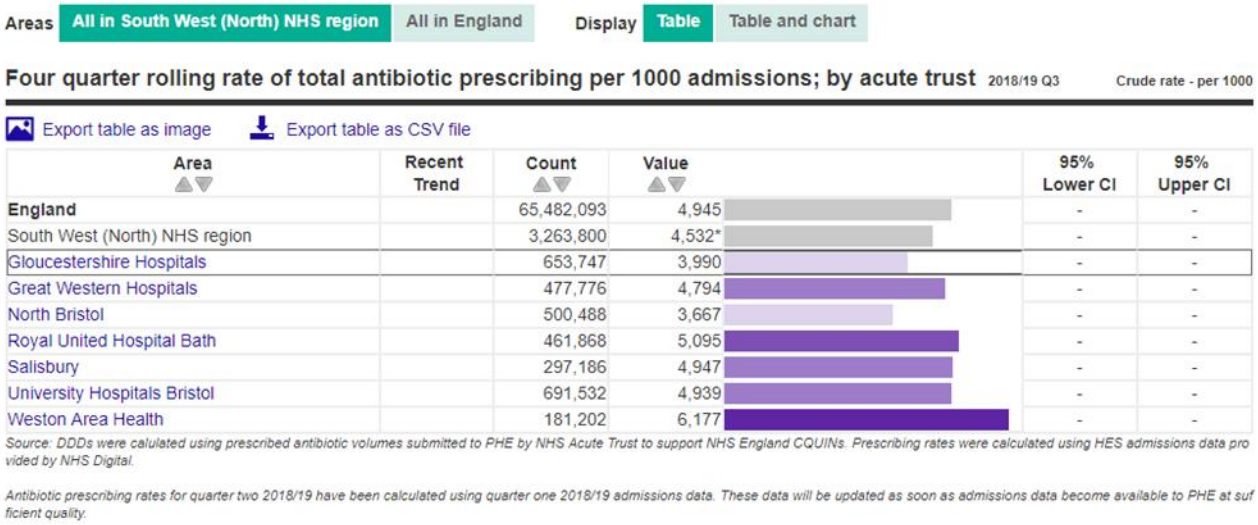
2017-18 antibiotic consumption (DDD/1000adm) (figures below from fingertips)		18/19 target antibiotic consumption (DDD/1000adm) (Total 3% ↓on 17/18 consumption: CPM 3% ↓ on 17/18 consumption**)	2018-19			
			Q1 DDD/ 1000 adm (rolling 12-month ave)	Q2 DDD/ 1000 adm (rolling 12-month ave)	Q3 DDD/ 1000 Adm (rolling 12-month ave)	Q4 DDD/ 1000 Adm (rolling 12-month ave)
Total	4058	3936	4151	3990	3990	*4061
CPM	88	85	77.5	71.3	69.9	*51.5

*Q4 is an estimate from Refine and admissions figures for 17/18. Fingertips confirmed figures will be published in early July 2019.

Total antibiotic usage (for both in-patients and out-patients) per 1,000 admissions achieved at Q3 but await final Fingertips figures for Q4 which I understand will be early July 2019 as the figure below is predicted
Total usage (for both in-patients and out-patients) of carbapenem per 1,000 admissions achieved at Q3 but await final Fingertips figures for Q4 which I understand will be early July 2019 as the figure above is predicted

See figure 11 for surveillance and audit data which includes PHE fingertips graphics by sub-region (SW north) for 4 quarter rolling average for total antibiotic consumption

Figure 11: PHE fingertips graphic- total antibiotic prescribing per 1,000 admissions by sub-region.



Areas: All in South West (North) NHS region | All in England Display: Table | Table and chart

Four quarter rolling rate of total antibiotic prescribing per 1000 admissions; by acute trust 2018/19 Q3

Crude rate - per 1000

Export table as image Export table as CSV file

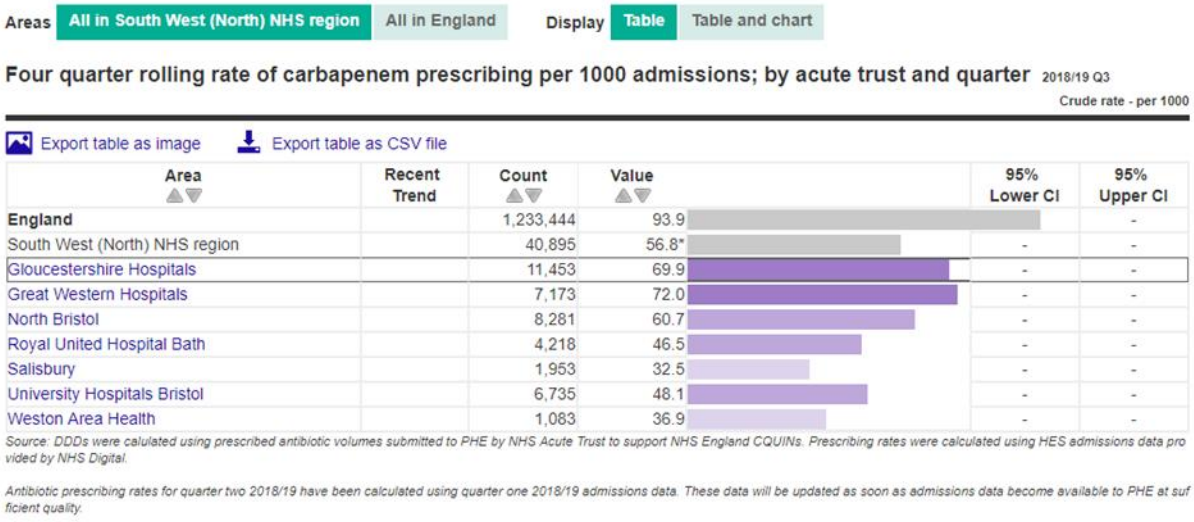
Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England		65,482,093	4,945	-	-
South West (North) NHS region		3,263,800	4,532*	-	-
Gloucestershire Hospitals		653,747	3,990	-	-
Great Western Hospitals		477,776	4,794	-	-
North Bristol		500,488	3,667	-	-
Royal United Hospital Bath		461,868	5,095	-	-
Salisbury		297,186	4,947	-	-
University Hospitals Bristol		691,532	4,939	-	-
Weston Area Health		181,202	6,177	-	-

Source: DDDs were calulated using prescribed antibiotic volumes submitted to PHE by NHS Acute Trust to support NHS England CQUINs. Prescribing rates were calculated using HES admissions data pro vided by NHS Digital.

Antibiotic prescribing rates for quarter two 2018/19 have been calculated using quarter one 2018/19 admissions data. These data will be updated as soon as admissions data become available to PHE at suf ficient quality.

See figure 12 for surveillance and audit data which includes PHE fingertips graphics by sub-region (SW north) for 4 quarter rolling average for carbapenem consumption.

Figure 12: PHE fingertips graphic- four quarter rolling rate of carbapenem prescribing per 1,000 admissions for acute trusts by sub-region.



Areas: All in South West (North) NHS region | All in England Display: Table | Table and chart

Four quarter rolling rate of carbapenem prescribing per 1000 admissions; by acute trust and quarter 2018/19 Q3

Crude rate - per 1000

Export table as image Export table as CSV file

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England		1,233,444	93.9	-	-
South West (North) NHS region		40,895	56.8*	-	-
Gloucestershire Hospitals		11,453	69.9	-	-
Great Western Hospitals		7,173	72.0	-	-
North Bristol		8,281	60.7	-	-
Royal United Hospital Bath		4,218	46.5	-	-
Salisbury		1,953	32.5	-	-
University Hospitals Bristol		6,735	48.1	-	-
Weston Area Health		1,083	36.9	-	-

Source: DDDs were calulated using prescribed antibiotic volumes submitted to PHE by NHS Acute Trust to support NHS England CQUINs. Prescribing rates were calculated using HES admissions data pro vided by NHS Digital.

Antibiotic prescribing rates for quarter two 2018/19 have been calculated using quarter one 2018/19 admissions data. These data will be updated as soon as admissions data become available to PHE at suf ficient quality.

CQUIN 2d - Reduction in antibiotic consumption per 1,000 admissions	Overall target for the Q4 period of Jan-March 2019

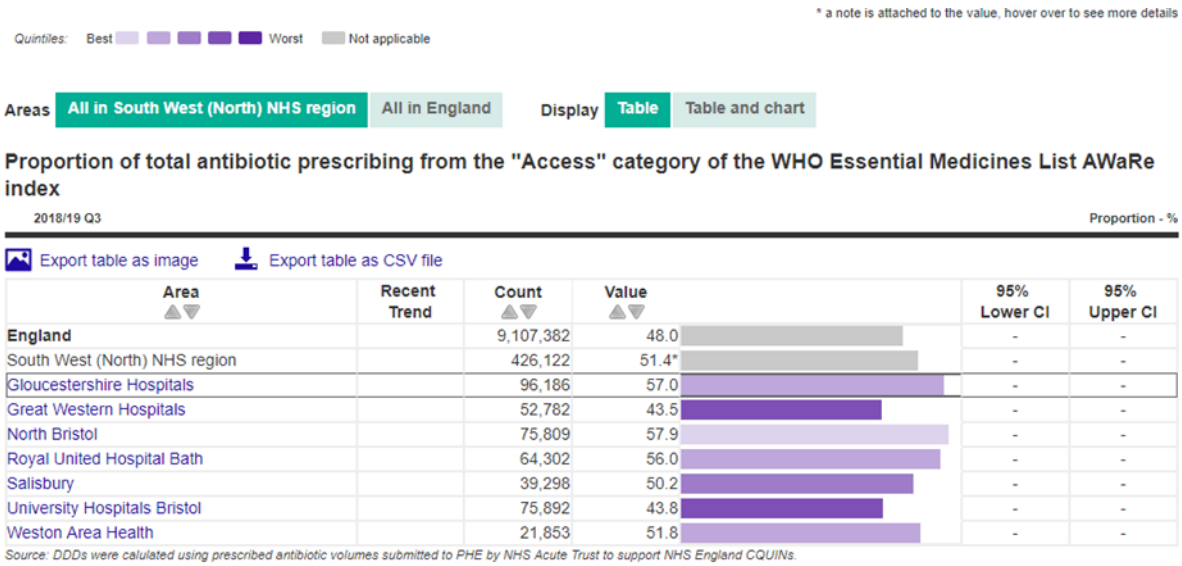
Table 13: Proportion of total antibiotic prescribing from the 'Access' category of the WHO essential Medicines List AWaRe index

	Baseline 2016	Q4 figure for 17/18 from fingertips	Target for 18/19 (increase by 3% from baseline 2016 calendar year	Q1 (12 month rolling ave)	Q2 (12 month rolling ave)	Q3 (12 month rolling ave)	Q4 (12 month rolling ave)
Proportion of total antibiotic prescribing from the 'Access' category of the WHO essential Medicines List AWaRe index	46.09%	43%	49.09%	44.4%	51.5%	57%	*53%

***Q4 is from Refine. Fingertips confirmed figures will be published in early July 2019**.

Proportion of total antibiotic prescribing from the 'Access' category of the WHO essential Medicines List AWaRe index - achieved at Q3 but await final Fingertips figures for Q4 which I understand will be early July 2019 as the figure below is predicted

Figure 13: Surveillance and audit data – PHE fingertips graphics by sub-region (SW north) for 4 quarter rolling average for Aware category



Hospital Antimicrobial Prudent Prescribing Indicator (HAPPI) audit.

In October 2018, a new HAPPI audit was undertaken which was slightly different from the previous one, but continued to look at **documentation** on the anti-infective pages on the current in-patient prescription chart, and whether it fulfilled the requirements of CQUIN 2c - Antibiotic Review set by the NHS Improvement. There were 170 patients seen in the audit with 339 of the antibiotic prescriptions. The results have shown that only 43% of the antibiotic prescriptions had evidence that the antibiotics had been reviewed within 72 hours. For those without a review date, only 17% had a clear "stop" date on the prescription.

Table 14: HAPPI audit results 2018

(N = 339)	CGH	GRH	GHNHSFT
(I) Allergy Box	100%	100%	100%
(II) Appropriate Ab choice	88%	94%	91%
(III) Appropriate Ab route	98%	100%	99%
(IV) Ab R/V within 72 hrs (%)	34%	51%	43%
Stopped date specified on the Ab Rx chart	14%	21%	17%

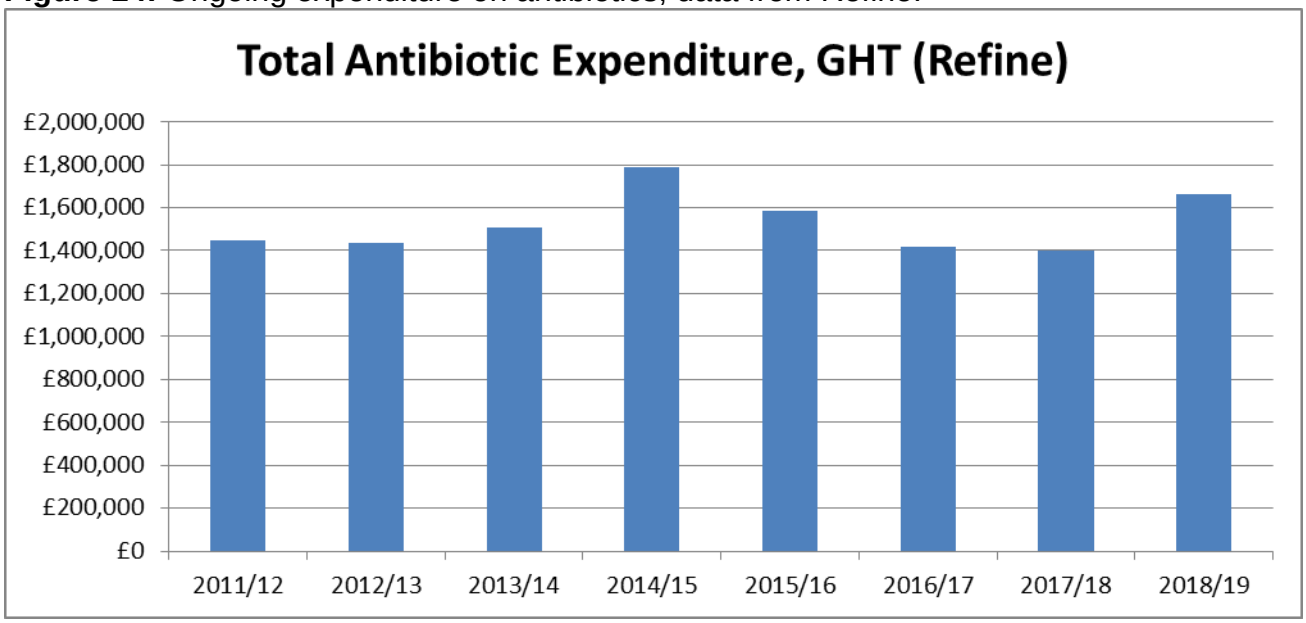
In January 2019 this revised audit was undertaken with a focus on documentation of antibiotic review and stop date on the in-patient prescription chart. Results can be seen below. Further work is now being undertaken by a group of junior doctor as an improvement project.

Table 15: HAPPI audit results 2019

Month/Year	Oct-18 (N=328)			**Jan-19 (N=326)**		
	CGH	GRH	GHNHSFT	**CGH**	**GRH**	**GHNHSFT**
Appropriate Ab choice	86%	94%	90%	**91%**	**89%**	**90% ↔**
Ab R/V within 72 hrs (%)	35%	51%	43%	**43%**	**34%**	**39% ↓**
Stopped date specified on the Ab Rx chart	13%	21%	17%	**18%**	**37%**	**28% ↑**

GHT antimicrobial expenditure

Figure 14: Ongoing expenditure on antibiotics, data from Refine:



Diagnostics

As mentioned above the national action plan[7] recognises the importance of diagnostics in AMS and the targets include*: "be able to report on the percentage of prescriptions supported by a diagnostic test or decision support tool by 2024."*

An example of local work relating to diagnostics includes the use of influenza point of care testing. Further work is planned in relation to blood cultures (see strategy at Appendix 3) and antifungal diagnostic gap analysis (Improving Value in Specialised Services 2019/2020: Antifungal Stewardship).

AMS team work summary 2018-19

Work area	Examples
CQUIN 2017/19 Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	See summary data above
Ongoing development and review of antibiotic guidelines	**Reviewed / updated guidance:** Prophylaxis against endocarditis Neutropenic sepsis antibiotic and antifungal guidelines Influenza related pneumonia Pelvic Inflammatory Disease

	Post-operative Gynaecological Sepsis
Audit / Quality improvement	HAPPI (ongoing) AFS CDI Gentamicin pilot
Multi-disciplinary team (MDT) meetings and ward rounds	Department of Critical Care Haematology Tuberculosis Prosthetic joint infection Uro-gynaecology MDTs
Countywide Antimicrobial Stewardship group and surveillance subgroup	AMS team members attendance at these meetings

Conclusions

Effective AMS activities are essential in combating related patient safety risks including those associated with antimicrobial resistance.

Trusts are therefore subject to increasing scrutiny and requirements in relation to AMS.

Whilst this report demonstrates that AMS activities do take place in our organisation it is clear that this is currently not sufficient.

Consideration should therefore be given to business case proposals which would increase the capacity of the AMS team.

A Trust Antimicrobial Stewardship Annual Strategy for 2019/20 has been produced, see Appendix 3.

8.0 Training and Education

In 2018/19 the Infection Prevention and Control Team have continued to deliver a wide variety of education within the Trust. It is mandatory for every member of staff to receive an annual infection prevention and control update.

The Infection Prevention and Control team continues to contribute to corporate induction training sessions run by the Training and Learning department. Infection Control Doctors delivered sessions for new junior medical staff. Infection Control training remains a mandatory requirement. See tables below outlining divisional and staff group compliance:

Table 16: GHT IPC mandatory training compliance

GHT Total compliance	**88%**
Corporate Division	86%
Diagnostics & Specialty Division	92%
Medicine Division	87%
Non-Division	71%
Surgery Division	89%
Women's & Children Division	87%

Gloucestershire Managed Services

Gloucestershire Managed Services	**69%**

Gloucestershire Hospitals

	Compliance
GHT Total	**88%**
Add Prof Scientific and Technic	91%
Additional Clinical Services	83%
Administrative and Clerical	91%
Allied Health Professionals	94%
Estates and Ancillary	91%
Healthcare Scientists	91%
Medical and Dental	79%
Nursing and Midwifery Registered	90%

Gloucestershire Managed Services

	Compliance
GMS Total	**69%**
Additional Clinical Services	93%
Administrative and Clerical	86%
Estates and Ancillary	63%
Healthcare Scientists	100%

There has been an overall slight increase in compliance with mandatory training from 86% March 2018 to 88% March 2019.

Ward-based education has been delivered by the Infection Control nurses supported by the Saving Lives/Infection control link nurses and Hand Hygiene champions covering:

- Hand Hygiene training
- Norovirus
- Influenza
- Local updates following learning from incidents

Other education/ training undertaken:

- Trust wide glove awareness educational roadshow
- *C. difficile* update- Bristol stool chart refresher 'poo buffet'
- Trust wide environmental cleaning roadshow- re-refresher on wipes training and launch of new spill wipe
- Hand hygiene awareness stands in GRH
- Volunteer training
- Hand hygiene training for medical students
- Annual Hand hygiene champions study afternoon
- Cross site quarterly Saving Lives /Infection control link practitioner study sessions

Team publications and invited lectures

11th October 2018
Hosted 'Jabathon'- national Influenza vaccination campaign
Craig Bradley

30th October 2018
IP2018, Glasgow
Craig Bradley
New to Infection Prevention and Control

10th December 2018
Unplanned Admissions Consensus Committee, Palace of Westminster, London
Craig Bradley
UTI collaborative and Gram negative reductions

4th February 2019
Annual IPC conference, Isle of Man
Craig Bradley
High Impact Interventions

20th March 2019
NHSI Infection Prevention and Control Study day- Care Homes, London
Kerry Holden
Preventing Pneumonia

Bradley, C., Burdett, H., Holden, K., Holden, E. and Garvey, M. (2019) **How do we define recurrence in Clostridium difficile infection?** *The Journal of Hospital Infection. 102, pp. 168-173.*

Garvey, M., Bradley, C., Wilkinson, M., Holden, K., Clewer, V., and Holden, E. (2019) **The value of the infection prevention and control nurse led MRSA ward round**. *Antimicrobial Resistance & Infection Control*. 8 (53).

Garvey, M., Bradley, C., Wilkinson, M., Holden, K., and Holden, E. (2018) **Wiping out MRSA: effect of introducing a universal disinfection wipe in a large UK teaching hospital**. *Antimicrobial Resistance & Infection Control.* 7(155)

9.0 Facilities

9.1 Environmental Cleaning

The Infection Control Committee continues to monitor cleanliness for the Trust as part of the compliance strategy. GMS report on a monthly basis to demonstrate compliance and that the results reflect the reality of what is the standard found on the wards.

The cleaning of premises within Gloucestershire Royal Hospital and the Cheltenham General Hospital are carried out by teams of cleaning staff who are managed by GMS.

The monitoring and supervisors team continue to audit cleanliness standards in line with the contractual standards. The Facilities Management service continues to monitor and audit the level of cleanliness throughout the Trust. Earlier in the year Issues had been raised about the audit process and recording of the GRH monitoring audits completed by the supervisors; this has now been reviewed and training given to supervisors to complete the audit to standard. Cleaning standards were reviewed and a step change was introduced last September across the service. This was to improve the standard of cleaning after criticism by the ICC. The management structure and frequencies in the clinical areas have been changed and the graphs show an improvement to date. A proposal to improve the cleaning levels to the national cleaning standards has been presented to the Trust in the GMS Year 2 Business Plan and engagement is due to start with the Stakeholders. Representatives from the ICC and GMS regularly meet to review compliance, actions are now agreed at department level to correct any changes in performance and reviewed by ICC the following month.

9.2 Auditing – Cleanliness

The cleanliness monitoring team and supervisors provide a balanced assessment of the effectiveness of cleanliness of the built environment, cleanliness of patient equipment, providing cleanliness reports to make sure that the contract delivers a service that is compliant with the contractual KPI's.

Technical cleaning audits are carried out against the criteria laid out in 'The National Specifications for Cleanliness in the NHS: a framework for setting and measuring performance outcomes' document using the National Cleaning Audit Tool using an electronic hand held monitoring system. An essential component of any monitoring framework is the fundamental principle of continuous improvement. Therefore, the Monitoring Framework not only provides a reporting mechanism, but a rectification process that can be used locally to identify, prioritise and address issues of non-compliance.

The principles of the audit are:

1. The audit clearly highlights the gap between current levels of cleanliness and the standards laid down in the national standards of cleanliness for the NHS.

2. All issues/items identified as part of the audit generate exception reports.*

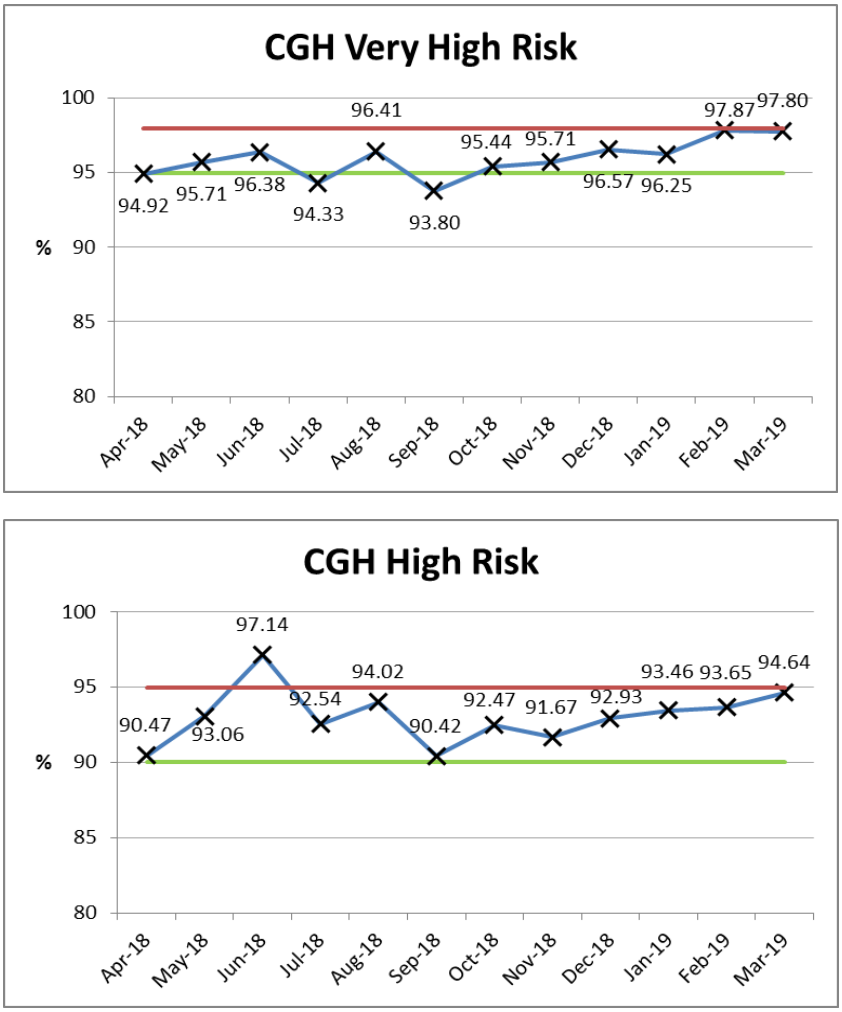
*****A report giving detail of failures or defects that require immediate inspection as they impact on the capability to clean. These reports are escalated to the relevant professional.

The Trust contract determines our cleaning KPI's, the following are provided as indicative aims for each of the four 'risk categories'

Risk Category	Frequency	Trust Target
Very High Risk	Weekly	95%
High Risk	Monthly	90%
Significant Risk	3 Monthly	85%
Low Risk	6 Monthly	78%

The following results have been demonstrated over this last year.

Figure 15: CGH Overall Results - Annual Cleaning Elements (Monitoring & Domestic Audits)



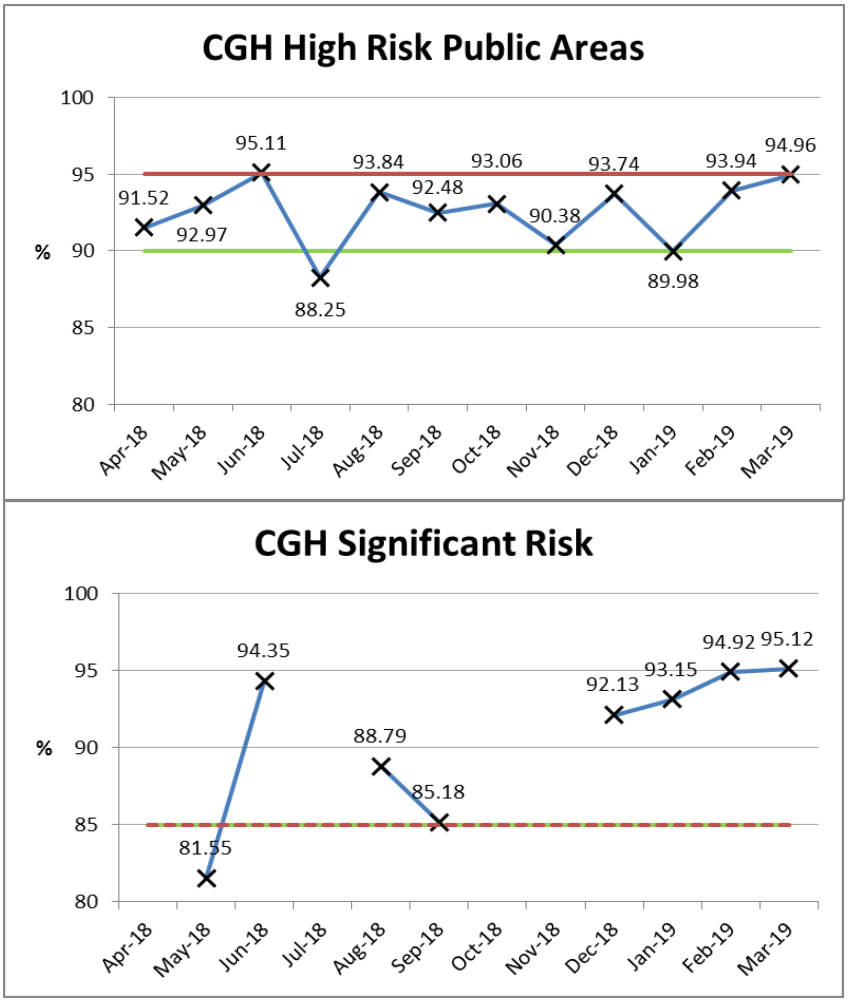
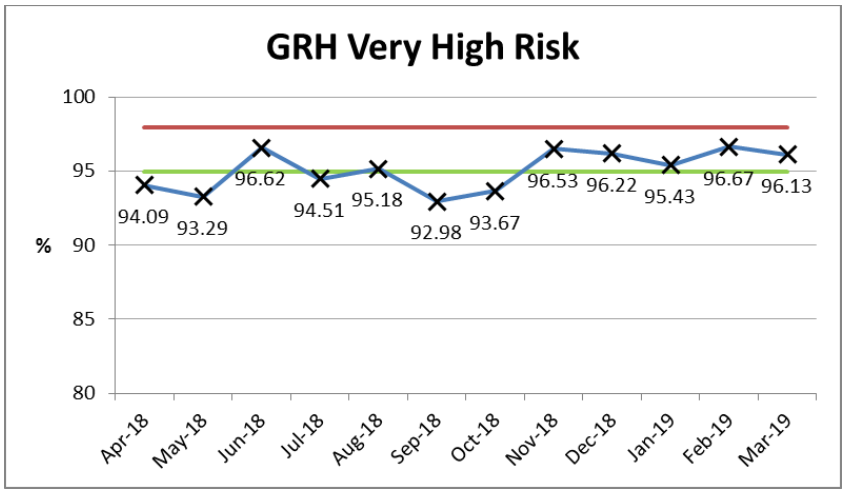
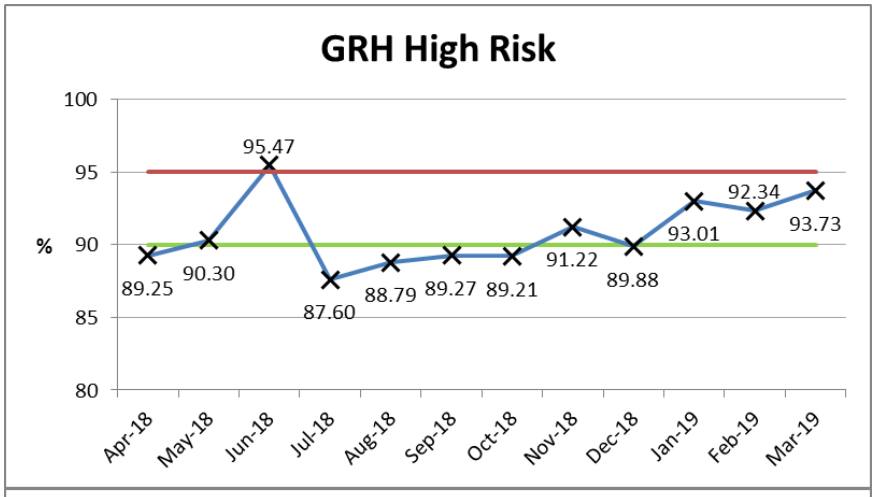
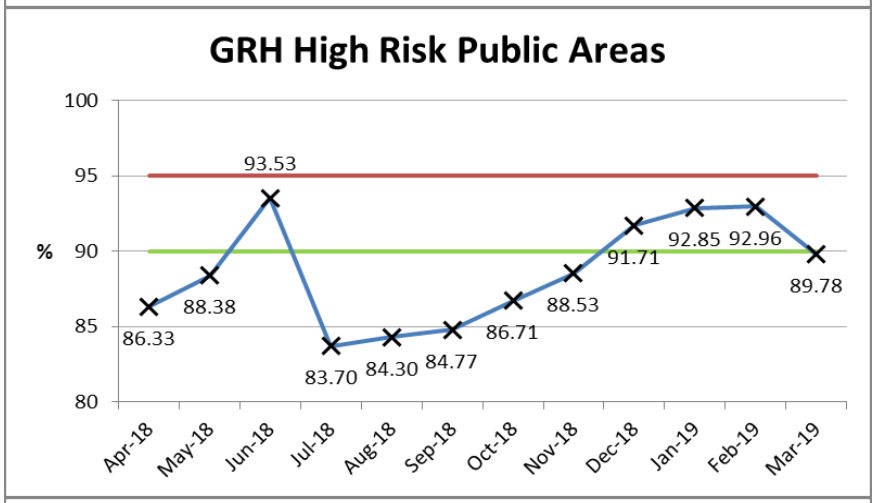


Figure 16: GRH Overall Results - Annual Cleaning Elements (Monitoring & Domestic Audits)




GRH High Risk
100
95
90
85
80
%
95.47
89.25
90.30
87.60
88.79
89.27
89.21
91.22
89.88
93.01
92.34
93.73
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19


GRH High Risk Public Areas
100
95
90
85
80
%
93.53
86.33
88.38
83.70
84.30
84.77
86.71
88.53
91.71
92.85
92.96
89.78
Apr-18
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Mar-19

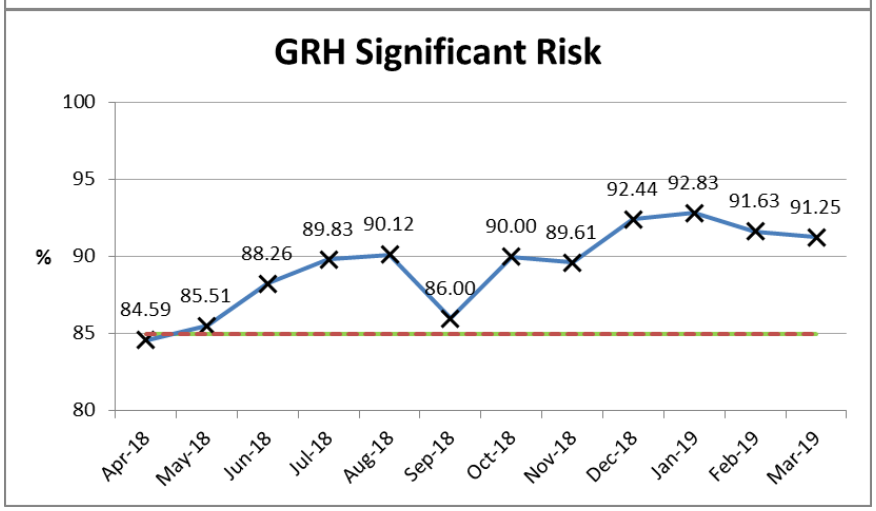

GRH Significant Risk
100
95
90
85
80
%
84.59
85.51
88.26
89.83
90.12
86.00
90.00
89.61
92.44
92.83
91.63
91.25
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19

Figure 17: Trust Overall Results – Annual Cleaning Elements (Monitoring & Domestic Audits)

Risk	CGH	GRH	Average Total
Very High Risk	96.09 %	94.79 %	95.44 %
High Risk	93.38 %	90.78 %	91.39 %
High Risk Public Areas	92.82 %	88.58 %	
Significant Risk	92.88 %	89.68 %	91.28 %
		Overall Trust Total	92.38 %

9.3 GMS Engineering Services

9.3.1 Water Management

Legionella and *Pseudomonas aeruginosa* sampling throughout the year suggests both remain under control. However there remain areas that have proven hard to control. These have had separate initiatives and are subject to regular testing until confidence in the control procedures is established.

The legionella risk to patients and staff has been significantly mitigated by control measures put into place. However, the nature of these bacteria is such that it can still be introduced into the hospital water systems from the mains water supply. Continued and ongoing control measures and monitoring are required to maintain low levels of risk of hospital-acquired legionellosis.

The Trust's Water Action Group continues to provide oversight of controls across the Trust, and the wider Hospitals, and complete actions in the action plan.
It was also discussed at the following governance committees:

- Water Action Group
- Estates and Facilities Health and Safety Forum
- Trust Health and Safety Forum
- Infection Control Committee

The GHT is the Duty Holder (Water) and Chair of the Water Action Group (WAG) is the GMS Service Lead and the Competent Responsible Person Water.

Deputy Responsible Persons GMS have also been appointed for each main GHNHSFT site to manage the day-to-day activity relating to water management. The Water Action Group (WAG) has representatives from across the Trust Divisions and Infection Control Doctors and Nurses

Tetra Consulting Ltd are the Trust's Water Management External Advisor. *Tetra* undertook a Water Management Audit in November 2018.
The initial observations are:

Of the 15 areas of water management audited, all 14 returned a rating of HIGH compliance and one area at medium. The key recommendations for improvement related to non-critical updates to the Water Policy, these are scheduled for inclusion within the next policy review in August 2018.

Notable actions and events within the reporting period:

The Action Plan shows 2 red actions, Water Management Policy and Written scheme and the Thermostatic mixing valves are both now completed.

The comprehensive testing of water outlets in the Tower is still on going all areas being completed and all positive outlets being remediated where results have demanded action.

The Seven Dialysis Unit has had extensive modifications in the last 12 months to work towards good control due to high readings suddenly occurring and had become a regular feature. The boiler was changed for the building along with the buffer vessel and pump. Sinks have been removed when considered to be under used in partnership with the Unit management, ICC and GMS engineering. The pipe work has been traced for likely areas of contamination which resulted in redirecting the pipework from the plant room to high level and out of the ground. Regular testing is still in place and analysis will be done at the WAG meetings.

Under the ongoing water improvement program, GRH Tower Block a number of new sinks and taps to current HTM standards were installed to replace less complaint versions and the TMV maintenance program is on target.

There has been an ongoing issue with positive pseudomonas results being experienced in the Cotswold Dialysis units for a number of months. Patient safety is being assured through the use of point of use filters however the positive counts have proven resistant to repeated attempts at disinfection. Authorising Engineer advice has been sought and implemented and we continue to undertake remedial measures together with further investigation into possible causes This Unit is the next area of concentration for the next year.
Levels of Pseudomonas in the CGH and GRH in other areas have remained low and continued analysis and remedial actions continue.

Table 17: Review of Legionella Samples taken at Cheltenham General Hospital over the previous 12 months up to 31st Mar 2019.

(Does not include re-samples)

Month	No of Samples	No of Detections	Ave cfu/l per Detection	Area Sampled
Apr	30	0	0	Week 7 (EB/SL/Thirl)
May	25	0	0	Week 8 (LEN/ON/TB)
Jun	25	6	1616	Week 1 (SB/CB/WB)
Jul	27	0	0	Week 2 (CRW/SP)
Aug	30	0	0	Week 3 (EB/SL/Thirl)
Sep	25	2	1050	Week 4 (LEN/ON/TB)
Oct	24	2	650	Week 5 (SB/CB/WB)
Nov	27	0	0	Week 6 (CRW/SP)
Dec	30	2	100	Week 7 (EB/SL/Thirl)
Jan	25	1	200	Week 8 (LEN/ON/TB)
Feb	23	8	1537	Week 1 (SB/CB/WB)
Mar	26	0	0	Week 2 (CRW/SP)

Table 18: Review of *Legionella sp.* samples taken at Gloucestershire Royal Hospital over the previous 12 months up to 31st Mar 2019.

Month	No. of Samples per month	No. of Detections per month	Total cfu/l Detected	Ave cfu/l per Detection
Apr	82	4	12100	3025
May	82	1	600	600
Jun	83	6	113900	18983
Jul	90	3	3500	1166
Aug	88	5	1400	280
Sep	105	15	50900	3393
Oct	116	11	156900	14263
Nov	113	10	15600	1560
Dec	114	11	14700	1336
Jan	101	17	25000	1470
Feb	101	12	114300	9525
Mar	101	4	26800	6700

Levels of *Pseudomonas sp.* in the CGH and GRH have remained low and continued analysis and remedial actions continue

10.0 Decontamination

The Decontamination Lead role for the trust is currently undertaken by the Director of Quality and Chief Nurse and the General Manager for Trust Decontamination and Sterile Services responsibilities is held by Debbie Lewis.

The Trust's Authorised Person for Decontamination is Dave O'Brien (Estates), who provides the engineering technical aspects of the service and the AE(d) provision is supplied for the Trust by Mark Walker (External Impartial company DeconCidal Ltd) Mark provides decontamination advice for the Trust and conducts independent annual decontamination audits to confirm compliance. The annual audit in October 2018 raised a few minor issues which have been addressed and this is shared with the Governance Group.

These roles are consistent with the guidance in the HTM 01-01 (Health Technical Memorandum – Management and Decontamination of Surgical Instruments in acute care). The Sterile Services Departments are also compliant to the requirements of HTM 01-01 and this is monitored through the Trust Decontamination Group which holds bi monthly meetings.

Sterile Services Department (SSD)

In May 2018 the Sterile Services Departments novated across to Gloucestershire Managed Services, (GMS) which is a subsidiary company wholly owned by the Trust. There are agreed Service Level Agreements between the Trust and GMS with the service provision and non-conformances a monitored through reported datix, KPI's, trend analysis and action plans which are reviewed monthly to ensure continuous improvement and the requirements of the SLA are consistent.

The department provides a full decontamination service for external customers including GP surgeries, Health Centres and Podiatry Clinics; this service generates income for the Trust.

In August 2018 both departments were audited by British Standards Institute (BSI) notified body and maintained the accreditation ISO 13485:2016 Quality Management System for the reprocessing of reusable Medical Devices and the relevant clauses of the Medical Devices Directive 93/42/EEC. The departments are annually audited by BSI (British Standards Institute).

A complaint tracking system (*Health Edge HESSDA*) was installed in the two departments in 2017 and provides a compliant track and trace system able to locate instrument sets and supplementary items. To guarantee staff competence. The staff in the departments have received formal training with extra training sessions organised when required. Production figures are produced monthly and In 2018 the departments processed a total of 300,548 items.

10.1 Trust Decontamination Group

The Trust Decontamination Group meets bi-monthly and discuss all aspects of decontamination to ensure optimal standards are achieved throughout the organisation. The group is chaired by the Decontamination Lead and is an opportunity to review policies and procedures to confirm that best practice is being aDHSCered against guidance and legislation.

The group is represented by a range of services including Endoscopy, Sterile Services, Estates and facilities, with advice from the Infection Prevention & Control teams. The main purpose is to review and work to improve the quality of performance delivery. Action plans strengthen the commitment to promoting a safe environment for staff and patients and that ensure patients are treated using safe and appropriately decontaminated medical devices.

Any areas for concern are escalated to the Infection Control Committee for further review and discussion in line with the Trust aims and objectives. Minutes and action plans from this group are held by the group secretary and are available for review.

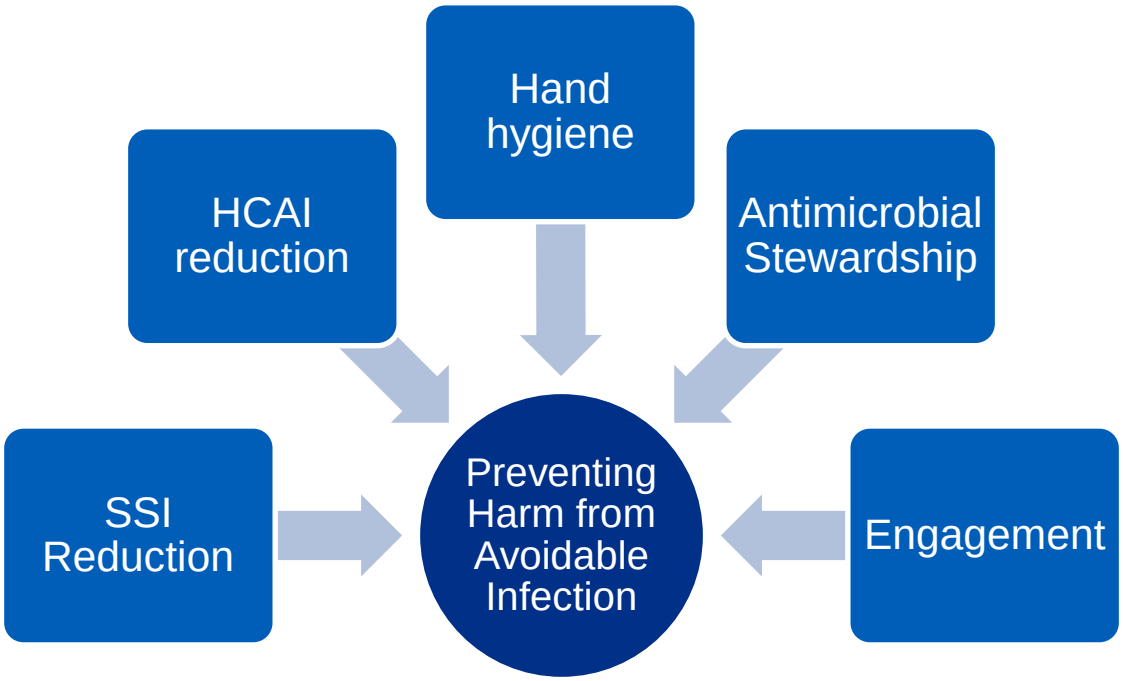
11.0 Overview of 2019/20 Objectives

Infection prevention and control remains a top priority for the trust. During 2019/20 we will set out our programme for the year to keep our patients, staff and the public informed of our planned activity across our hospitals.

This year we will undertake a review of the Trust's compliance with the Health & Social Care Act 2008 Code of Practice on the Prevention and Control of Infections (2015). The team's aim is to provide an infection prevention & control service that supports our clinical teams to deliver the best care for everyone. Our annual plan will cover 5 strategic themes we have identified as areas of focus for the financial year 2019/20.

Strategic themes

Our strategic themes in 2019/20 focus on improving outcomes for our patients and provide a framework for our operational work plan.



SSI Reduction
The Surgical site infection surveillance programme will continue to be enhanced with the implementation of new ICNet software to support patient re-admission SSI monitoring. SSI reporting processes will be strengthened and trust wide engagement in the SSI programme will be fostered through the development of a Trust SSI prevention steering group with stakeholders from across the surgical pathway.

Antimicrobial Stewardship

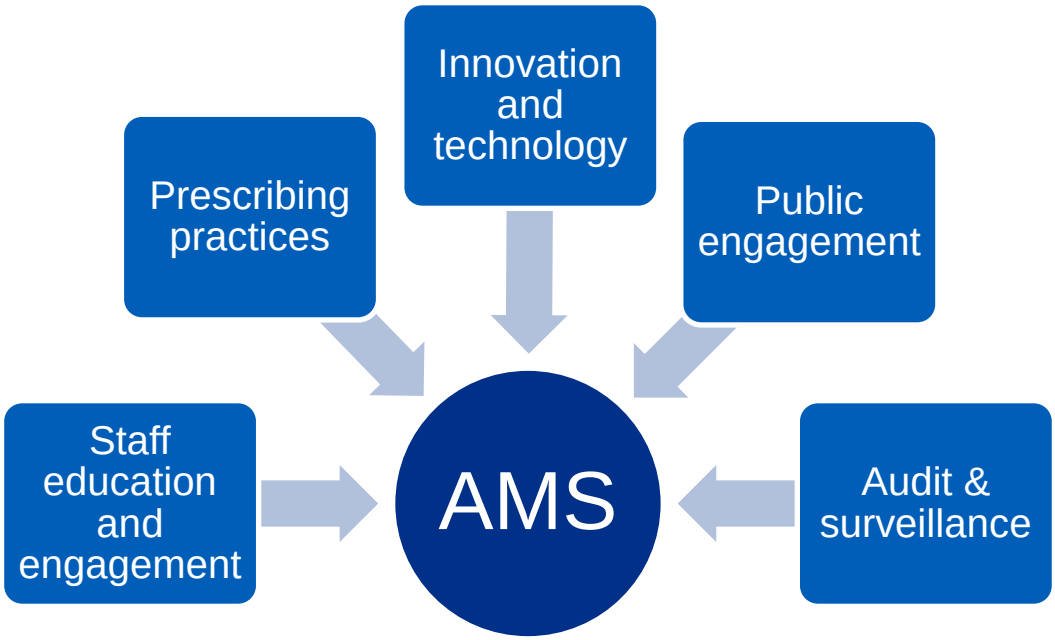
The scale of the threat of antimicrobial resistance (AMR) and the case for action was set out in the 'Annual Report of the Chief Medical Officer, 2011', published in March 2013 and followed by the 'UK Five Year Antimicrobial Resistance Strategy 2013 to 2018'. and ' Contained and controlled- the UK's 20 year vision for antimicrobial resistance' and "Tackling antimicrobial resistance 2019-2024 The UK's five-year national action plan" was were subsequently published by the Department of Health in January 2019 and sets out actions to address the key challenges to antimicrobial resistance (AMR).

Developed by the Lead Nurse for AMS, trust's antimicrobial pharmacists, designated AMS medical lead the strategy has been linked to the Code of Practice compliance criterion 3; ensuring appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.

The overarching goal of the strategy is to slow the development and spread of AMR. It focusses activities around 3 strategic aims:

- improve the knowledge and understanding of AMR and AMS
- develop and implement innovations and new technologies to support AMS
- conserve and steward the effectiveness of existing treatments

Our strategic themes in 2018/19 focus on improving outcomes for our patients and provide a framework for our operational work plan



Making improvements to the trusts antimicrobial stewardship programme is a key component of HCAI prevention, particularly for *C. difficile* and SSI reductions.

HCAI reduction

Our HCAI reduction strategy will see us delivering actions to support further *C. difficile* reductions. The *C. difficile* objective for 2019/20 is 114 cases, we are aiming to finish the year 10% below this on 103 cases.

This will include the development of a faecal microbiota transplant service for patients with recurrent *C. difficile,* review of treatment protocols to reflect new evidence and best practice recommendations and ongoing one system learning from cases of *C. difficile.*

We will also aim to reduce healthcare associated Gram negative bacteraemias by 10% to support the national ambition to reduce these bloodstream infection by 50% by 2022. We will be implementing actions to prevent hospital acquired pneumonia through improvements in oral health, appropriate diagnosis and management of UTIs and reducing inappropriate indwelling urinary catheter use across the Trust. We will also continue to work closely with Gloucestershire Managed Services to see increased investment, leadership and improvements in standards to maintain a clean, safe environment for our patients.

Our ambition is to eliminate healthcare associated MRSA bacteraemia by strengthening our screening and decolonisation protocols.

Hand hygiene

The 2019/20 strategy will see the re-launch our multi-modal hand hygiene programme with some new key changes to support successful and sustained hand hygiene improvement. This includes launch of a new supplier for hand hygiene products, updates to work place reminders and staff and patient engagement in hand hygiene education. Critical to this programme will be an effectual monitoring process to ascertain productivity against hand hygiene compliance to keep our patients safe from avoidable healthcare associated infections.

Engagement

The 2019/20 strategy will include actions to support patient engagement in the IPC programme. Particularly, learning from patient experiences and utilising feedback from patient surveys to drive IPC improvements. IPCNs will also look to participate in patient and governor forums.

Appendix 1: SSIS data collection methodology

Inclusion of categories of surgical procedures

Surgical site infection surveillance will include identified knife to skin procedures, including laparoscopic procedures carried out at Gloucestershire NHS Foundation Trust. The surgical procedures will be identified by the OPCS Codes.

Categories that will be considered for surveillance will include:

- Abdominal Hysterectomy and other Gynaecological procedures performed through a Laparotomy including laparoscopic procedures
- Caesarean Section
- General Surgical procedures including Laparoscopic procedures
- Vascular Surgery
- Thoracic Surgery
- Elective and Trauma Orthopaedic Surgery
- ENT and Maxillo-Facial surgery (if knife to skin)
- Laparoscopic assisted surgeries

Given the work load attributed to active surveillance and present team resources, surveillance of all categories of surgery will not be performed GHNHSFT across an annual basis. The SSIS team with the SSIS steering group will decide which surgical procedures will have surveillance completed for each quarter period. This will based on assessment of need based on increased prevalence rates, raised concerns, number of procedures required to have confidence in results of surveillance, assessment of SSI prevention interventions etc.

Exclusions are:

- Any surgery which involves mucous membranes
- Any surgery which includes debridement or drainage of haematoma or abscess
- Trans-urethral procedures
- Trans-vaginal procedures
- Trans-anal surgery
- ENT and Maxillo-Facial surgery (Mucus membrane)
- Procedures performed by Endoscopy
- Diagnostic procedures
- Trans- oesophageal procedures e.g. TOE
- Cardiac Catheter

Data collection on each eligible procedure must be commenced as soon after surgery as possible to ensure active follow up of these patients. More than one source of data may need to be reviewed on a daily basis to ensure that all eligible procedures are captured and included in the surveillance. This may include emergency theatres lists, operating theatre records and admission lists.

Surveillance periods

Period start* (start including all eligible operations)	Period ends* (stop including all eligible operations)	Data must have been submitted and reconciled if submitted to PHE if mandatory surveillance
1st April	30th June	30th June
1st July	30th September	31st December
1st October	31st December	31st March
1st January	31st March	30th June

*Surveillance based on date of surgery

Proposed Surveillance programme

Presently only quarter 1 2019/20 surveillance programme has been agreed and this will include:

- Gastric Surgery
- Small bowel surgery
- Large bowel surgery
- Spinal surgery

Further proposals for surveillance programme will be discussed and agreed by the SSI committee.

Collecting the surveillance dataset

The standard set of demographic and operation data must be completed for each procedure in the surveillance. Every patient should be actively and systematically followed up from the time of surgery to establish whether they develop signs and symptoms that meet the definition of an SSI. This will include monitoring during the post-operative hospital stay, on readmission, return to any outpatients or wound clinic and post discharge by telephone call at 30 days and if an implant is inserted then a deep incisional or organ space SSI can be detected up to 1 year post op so a further telephone call at 3 months, 6 months and 12 months will take place.

The identification of SSI's that meet the definitions of infection can be facilitated by the following measures:

- Encourage all members of the multidisciplinary team to clearly document the clinical symptoms of SSI they observe in case notes and on laboratory request forms
- Encourage medical staff to write diagnosis of SSI in the case notes
- Develop clear guidance for staff on when a wound swab should be taken – there should be some clinical signs of infection, e.g. discharging pus, redness, swelling, heat, pain
- Microbiology results should be interpreted in conjunction with clinical information. Advice from a Microbiologist should be sought if there is any doubt about the result

Inpatient surveillance programme

From day of surgery until the patient is discharged from hospital a member of the SSI Team will actively monitor each patient for signs of infection. Daily (Mon – Fri) visits to the identified wards by the Surveillance Team to discuss patients with potentially infected wounds with the Clinical Team. The following procedure will be completed:

1. Daily using the theatre list the SSIS team will identify which patients are having procedures in the included surveillance categories and commence the patient on the appropriate yellow surveillance data sheet (see embedded) A master copy will remain with the SSIS team and a secondary copy will be left in the patients' medical notes to follow the patient pre-operatively and post operatively during the inpatient episode.

2. It will be expected that the surgical team document information with regards to procedure details; operation duration- incision and closure times, procedure description, ASA scores and performing surgeon details. This information must be on either the yellow surveillance form or as part of the operation notes. GMC registration code will be used as surgeon codes on surveillance sheets. GMC registration codes can be identified on https://www.gmc-uk.org/registration-and-licensing/the-medical-register/a-guide-to-the-medical-register/find-a-doctors-record.

3. The SSIS team will attend the wards and introduce themselves to identified patients providing verbal and written information about their role and explaining surgical wound infection and what our surveillance programme is and how they will be engaged in that (the PHE monitoring surgical wounds for infection patient information leaflet (PIL) will be provided at that time). The SSIS team will also confirm whether the patient is happy to be contacted via telephone for post discharge surveillance and conform contact details are correct. The patient will also be provided with a wallet sized contact card/ sticker will be attached to PIL which is to be given to health care professional to prompt them to contact the SSIS team if the patient is re-admitted for concerns with wound infection (this will be an interim measure to support re-admission surveillance whilst we await ICNet).

4. The team will liaise with ward staff, review medical and nursing records, patients temperature and treatment sheet to identify signs and symptoms that may indicate an SSI (only patients who have had a surgical procedure within the included categories will be reviewed). The SSIS team will monitor each patient at least thrice weekly to see whether:

    - The multidisciplinary team have documented the clinical symptoms an SSI they observed in case notes or on laboratory request forms
    - Medical staff have documented a diagnosis of SSI in the case notes
    - Liaise with the ward/ surgical team to identify clinical signs of infection e.g. discharging pus, redness, swelling, warm to touch, wound has broken down/ intentionally or unintentionally opened up (dehisced) pain

at surgical site, signs of sepsis- pyrexia or hypothermia, hypotensive, tachycardia and tachypnoeic.
    - Commencement of on new antimicrobial therapy for treatment of SSI
    - Review microbiology reports to find any positive surgical site cultures from patients and checking why the cultures were taken and if there are any signs of infection. It is noted that as we do not check for the presence of pus cells for wound or tissue cultures the receipt of positive microbiology from cultures alone will not meet the criteria for an SSI.

5. The SSIS team will record outcomes of review onto yellow surveillance sheet (continuation sheets for patient reviews will be available and should be attached to yellow surveillance sheets; see embedded)

6. Information from this review will be used to determine whether any of the criteria defining a surgical site infection have been met. Only staff that have completed the PHE Surgical site infection surveillance training day can determine whether SSI criteria has been met and enter this data onto the PHE SSISS data capture system if mandatory surveillance.

Identification of SSI in patients readmitted to hospital

Follow up period

The maximum period for follow up depends on whether the surgical procedure involves the insertion of an implant. An implant is defined as a non-human foreign body that is placed permanently in the patient during an operation, e.g. Joint prosthesis, screws, wires, mesh or prosthetic heart valves.

- No implant inserted – surveillance should stop on day 30 after the operation
- Implant inserted – a deep incisional or organ/space SSI may develop for up to 1 year post surgery

When the updated version of ICNet is in place all patients that are re-admitted with a previous history of a surgical procedure within the identified follow up period will be flagged and reviewed to identify signs and symptoms that may indicate an SSI.

Methodology

In the interim before ICNet is implemented the following measures will be used to ensure that patients that are readmitted who are included in the surveillance are identified:

- Wards most likely to receive patients readmitted with SSI; patients with SSI's may not be readmitted to the same ward they were discharged from. Wards that could accept such readmissions should be identified and contacted daily to ask about patients readmitted with SSI. The staff working on them should be made aware of the surveillance, and asked to document clinical signs of SSI and report them to designated surveillance personnel.
- Check on TrakCare to see if any patients still within the follow up period have been re-admitted and review patient on ward they are on.

- Check TrakCare to see if any patients have attended outpatient/ wound clinic appointments have been attended- identifying whether a SSI has been diagnosed in letters/ notes/ conversation with wound clinic teams.
- Monitoring of patients for SSI can be stopped after the follow up period of surveillance has ended.

Post-discharge Surveillance

Patients will be contacted at 30 days post-surgical procedure to discuss their wound healing and they must be encouraged to contact the SSI Team if they have concerns with their wound.

Length of stay has reduced over the years due to advances in surgical procedures therefore most patients will have been discharged before any inpatient surveillance has occurred. These patients need to be followed up accordingly.

The process for post discharge surveillance is:

1. Engage the patient by explaining surveillance and give copy of SSI patient information leaflet during initial ward contact.
2. Ask patient for their latest contact number.
3. Phone all patients at 30 days post-operation and ask post discharge questionnaire (PDQ; see embedded) over the phone; discussing symptoms. The telephone post discharge surveillance will occur for:
    - All patients at 30 days post procedure
    - Patients who have had an implant of any description at 3 months
    - Patients who have had an implant of any description at 6 months
    - Patients who have had an implant of any description at 12 months
4. Phone non-responders at 3 different times to make contact.
5. Contact GP surgery (confirm any antimicrobials prescribed was for SSI)
6. Follow up wound swabs on PAS (identify any organisms grown)
7. Check symptoms meet criteria for patient reported SSI
8. Complete Part 2 SDS (detection: patient reported only) on the yellow surveillance report
9. Enter data into web-link if mandatory surveillance

Post discharge reporting by Health care professional (HCP) in outpatient clinics

Ad hoc reporting of SSI by hospital HCP

Patients may return to clinics around the Trust therefore hospital healthcare workers can notify SSIS staff who can then follow up and apply standard definitions. This will be reported as ‘other post discharge’; unless the patient is re-admitted and then they will be reviewed as part of re-admission surveillance. It is recognised that this is a passive method of SSIS and will rely upon staff remembering to contact the SSIS team. As a result it will be a requirement before starting a surveillance period that

those HCP's who will see patients post operatively in clinic are engaged in the process and will be given SSIS team contact details.

Surgical site infection surveillance steering group

It is the responsibility of GHNHSFT to comply with the standardised methodology set out in this protocol. This will be achieved by planning and co-ordinating the data collection and ensuring that governance systems are in place. This will be managed by the formation a Surgical Site Infection Surveillance steering group to support and direct the surveillance and to establish systems for collecting the data that conform to the methodology described in this protocol.

Key responsibilities of this steering group are:

- Developing a planned programme of surveillance
- Ensuring adequate resources have been identified to implement the planned programme of surveillance
- Promote the surveillance within the Trust
- Plan and oversee the collection and submission of data, including that required for post-discharge surveillance, and ensure effective arrangements are made to cover absence due to annual leave or sickness
- Identify and address training needs
- Monitor the accuracy and completeness of data collected
- Review, interpret and distribute reports and results of the surveillance
- Contribute to the development and monitoring of action plans for improving practice when the results of the surveillance suggest this is required

Membership of the surveillance steering group will include representatives of the following key stakeholders:

- Surveillance Coordinator/Administrator
- Associate Chief Nurse
- Infection Prevention & Control team- Lead Nurse for IPC and AMS and Senior IPCN within the surgical division
- Consultant Microbiologists and Infection Control Doctors
- Clinical governance
- Surgical teams (surgeons and anaesthetists)
- Theatre staff (theatre manager)
- Relevant hospital directorates
- Director of Infection Prevention (DIPC) and Control or Deputy DIPC

The SSIS steering group will look to meet monthly and will report into the Infection Control Committee (ICC).

Analysis and feedback of data

Reporting

The analysis and dissemination of results to relevant clinical and other staff is essential if surveillance is to be part of an effective infection prevention and control tool. At the end of a surveillance period an individual summary report of the results of surveillance for each of the chosen category of surgical procedures.

A clear strategy will be developed for actively disseminating the SSI surveillance reports so that results can be acted on. This reporting strategy will be developed by the SSIS committee.

Where the rates indicate a potential cause for concern, local practice will need to be reviewed to ensure that it complies with best practice

The summary report will present data on:

- Total number of operations and total number of SSIs for the selected surveillance period
- SSI type
- Causative micro-organisms
- SSI by risk factor (full list including ASA score, wound class, duration of operation, age group, body mass index, gender, type of surgery (admission type)).
- Operations/SSI by surgeon code (GMC number)

Incidence of surgical site infection

The cumulative incidence of infection is the number of new infections that occur in a defined population during a given period of time. This is most accurately described as the risk of SSI but this term tends to be used interchangeably with rate. This measure is reported as the number of SSIs per 100 operations. It takes account of the fact that the same patient can develop more than one SSI related to the same procedure.

$$\frac{\text{No. SSIs in a specific category}}{\text{No. operations in the specific category}} \times 100$$

Since SSIs reported by patients cannot be verified in the same way as those detected by active surveillance in hospital, rates based on patient reported SSI will be calculated separately to those based on SSI detected in inpatients. Thus two rates of SSI will be reported:

a. Cumulative incidence of SSIs detected during the inpatient stay and in patients readmitted with SSI.

b. Cumulative incidence of SSI based on all SSIs detected by inpatient and post-discharge surveillance including those reported by the patient at 30 days post-operation

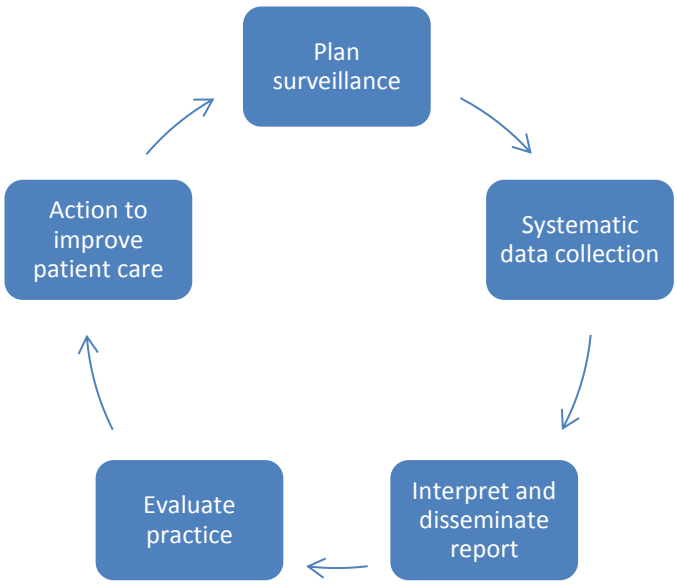
The number of surgical procedures undertaken in one surveillance period may be small and the reported incidence of SSI for a single period may therefore be imprecise. To address this problem data will be combined over several periods to calculate the incidence of SSI.

Reports will be produced and sent for distribution to the surgical speciality main contact, Speciality Director for Surgery, Divisional Chief Nurse for Surgery, Ward Matron and Ward Senior Sister/ Charge Nurse within 6 weeks of a surveillance period ending. Reports completed will also be sent to the SSIS committee which will form part of a standing agenda item.

Surgical engagement

Before a SSI surveillance period begins to ensure the surgical speciality and directorate fully understand and are engaged in the surveillance process, the SSIS team will support delivery of training on SSIS methodology and definitions of an SSI. This will facilitate introduction of the SSIS team to the surgical team (ward and theatre based), allow for the SSIS team to discuss what input/ details they require to assist in the identification of an SSI and open communication channels between all teams. The Surgical speciality and surgical ward staff will need to provide an opportunity for this training to be delivered. The surgical speciality which is having active surveillance performed will also need to nominate an SSIS champion and main surveillance contact; this person will need to attend the SSIS steering group. SSIS reports will also be sent to the main contact for circulation to colleagues and updates with regards to action plans will be need to be provided by this person at the SSI steering group. These individuals will also be provided with the opportunity to attend the SSIS training day held by PHE.

Making surveillance work and count towards improving patient care and safety to ultimately reduce the prevalence of surgical site infection at GHNHSFT is essential; the below process will need to be followed to enable that to happen.



Appendix 2: Point prevalence survey (PPS) for SSI

Methodology

1.Inclusion criteria

- All surgical wards will be included in the point prevalence survey (Ward 5b, Ward 5a, Prescott, Bibury, Guiting, Maternity unit, Dixton, Alstone, 2a, 2b, 3a, and 3b)
- The data will be collected in a single day for each surgical ward/unit. The SSS data collector will be expected to start work at 07:30am on the site the PPS audit is being completed on that day.
- Each ward will have data collected on three separate occasions (this will not be consecutive days as to not capture the same patients from the previous day)
- Patient admitted after 8am will be excluded from further data collection

2. Case finding algorithm

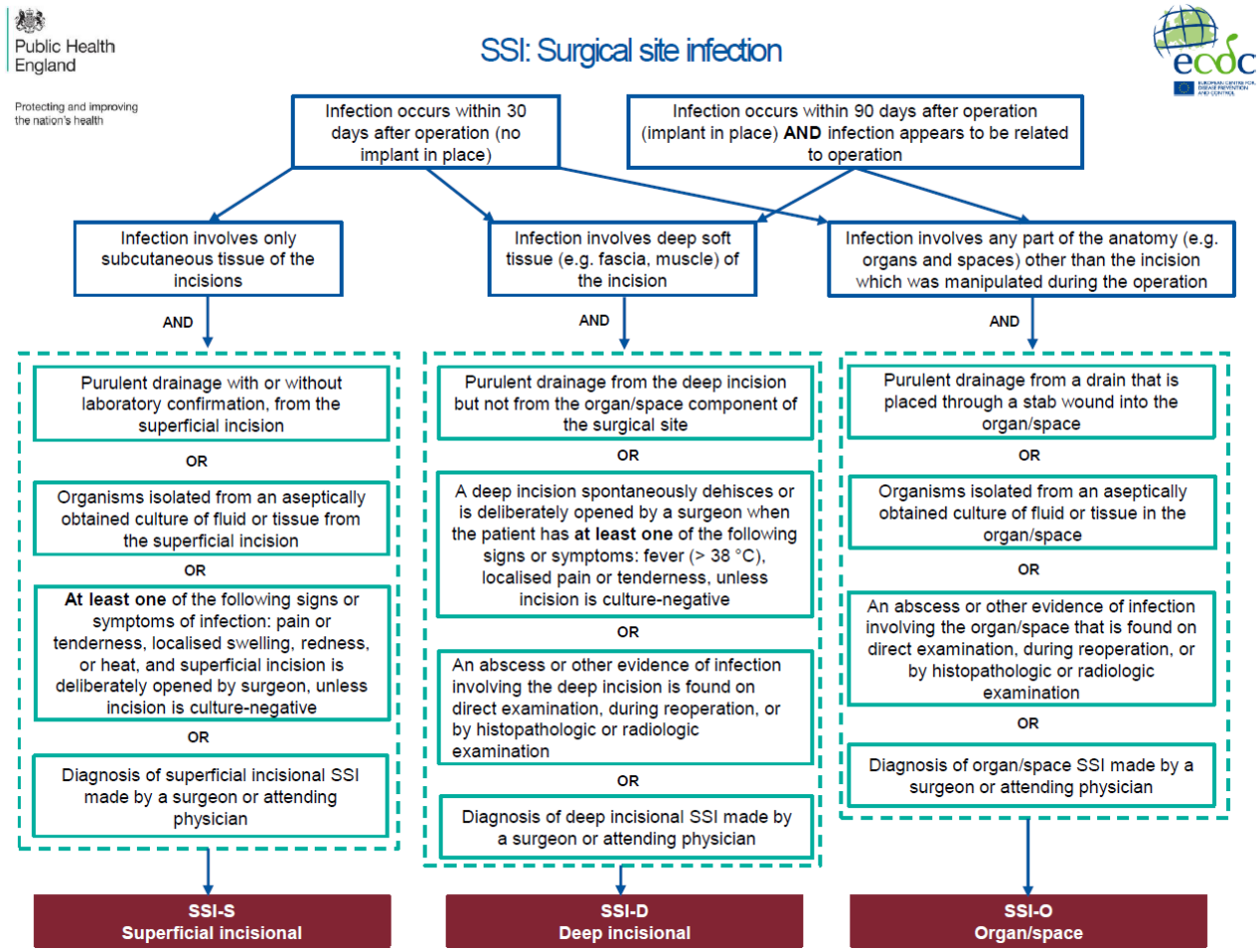
1. Surveillance data collector arrives on the ward
    a. Introduce yourself to the ward manager and explain
    b. Record start date and time
    c. Collect ward speciality type, number of beds
    d. Ask for patient list (handover)

2. Collect one set of patient notes (medical, nursing, observation, wound charts).

3. Record patient details and complete fields ‘A-H’ in PPS data collection form

4. Identify if the patient meets the ECDC and PHE SSI PPS standard definition as per flow sheet A.

Flowsheet A:



5. If patient meets criteria for SSI-S, SSI-D or SSI-O then complete all fields (including field's I-P) in the SSI PPS Excel spread sheet.

6. Repeat steps 3-5 for all patients on the ward

7. Once completed, record end time on forms

Appendix 3: AMS strategy

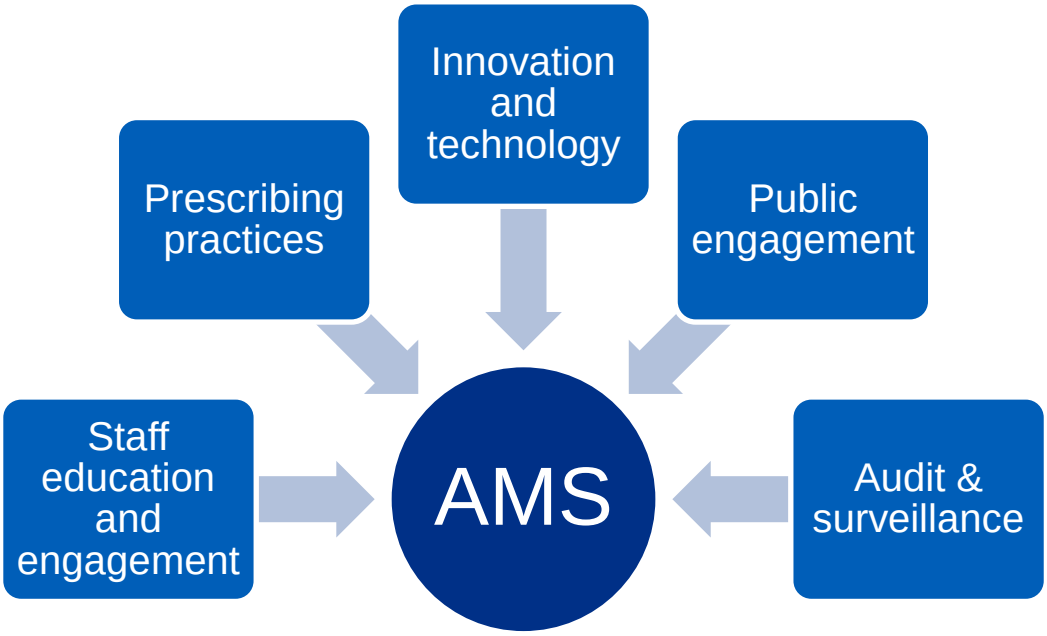
Antimicrobial Stewardship Annual Strategy 2019/20

Introduction

The scale of the threat of antimicrobial resistance (AMR) and the case for action was set out in the 'Annual Report of the Chief Medical Officer, 2011', published in March 2013 and followed by the 'UK Five Year Antimicrobial Resistance Strategy 2013 to 2018'. and ' Contained and controlled- the UK's 20 year vision for antimicrobial resistance' and "Tackling antimicrobial resistance 2019-2024 The UK's five-year national action plan" was were subsequently published by the Department of Health in January 2019 and sets out actions to address the key challenges to antimicrobial resistance (AMR).

Strategic themes

Our strategic themes in 2018/19 focus on improving outcomes for our patients and provide a framework for our operational work plan.



AMS Strategy

The AMS strategy provides an operational framework for achieving progress with our strategic themes across the trust. Progress against this plan is reported on a monthly basis at the Infection Prevention & Control Team at Infection Control Committee (ICC) and bimonthly at the Antimicrobial Stewardship committee. The plan has been linked to the Code of Practice compliance criterion 3; ensuring appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.

The overarching goal of the strategy is to slow the development and spread of AMR. It focusses activities around 3 strategic aims:

- improve the knowledge and understanding of AMR and AMS
- develop and implement innovations and new technologies to support AMS
- conserve and steward the effectiveness of existing treatments

Strategic Theme	Operational Objective	Action	Operational Lead(s)
Staff education and engagement	Produce and implement an antimicrobial stewardship educational programme to engage the workforce in AMS	Create an educational programme for Nurses and Midwives Antimicrobial Stewards highlighting their role and influence in antimicrobial prescribing and management	Kerry Holden
		Complete gap analysis of AMR and AMS education/ training provided for prescribers at GHT. Implementing actions to address identified gaps	
		Update AMS e-learning package and provide other accessible educational resources and scenario training materials on antibiotic prescribing on the intranet page (see appendix 1)	
	Develop communication/ engagement strategy for antimicrobial resistance and stewardship targeted to staff	Organise engagement activities for World antimicrobial awareness week (WAAW) in November 2019 for staff, utilising social media to publicise key messages	Alan Lees Kerry Holden
		Develop an annual AMR/ AMS communication strategy with the Trust communication department.	Delyth Ahearne

		Lead Doctor and Lead Nurse for AMS and Antimicrobial pharmacist to discuss AMR and AMS at Nursing, Midwifery, medical and AHP forums across the Trust	

Strategic Theme	Operational Objective	Action	Operational Lead
Prescribing practices	Implement multidisciplinary antimicrobial stewardship ward rounds	Develop inpatient antimicrobial pharmacist led antimicrobial polypharmacy ward rounds, Commence inpatient AMS ward rounds on an inpatient area- to include AMU	**Delyth Ahearne** **Kerry Holden**
	Ensure prescribers have access to user friendly up to date Trust antimicrobial guidelines	Ensure review of antimicrobial guidelines to ensure up to date and in line with national guidance and updated evidence base Explore use of other methods/ technologies for staff to access antimicrobial guidance at point of use	**Alan Lees** **Delyth Ahearne**

	Explore the implementation of antimicrobial prescribing competencies for medical and non-medical prescribers	Scope the inclusion of PHE antimicrobial prescribing and stewardship competencies in continuing professional development and appraisals of prescribers	**Alan Lees**

Strategic Theme	Operational Objective	Action	Operational Lead
Public engagement	Develop communication strategy for antimicrobial stewardship to educate patients and the public	Develop new and utilise existing educational materials and activities for public and patient awareness of AMR and AMS	**Kerry Holden**
	Engage in publically attended events on AMR and AMS awareness delivered to in the local community	Deliver an AMS engagement session at a 'Let's talk' in partnership with the University of Gloucestershire	**Kerry Holden**

	Engage in public awareness campaigns delivered as part of AMS countywide group	Ensure trust representation and engagement at quarterly monthly county wide AMS meetings Collaborate to support the delivery public awareness initiatives for AMS as part of the AMS countywide group	**Alan Lees** **Kerry Holden** **Delyth Ahearne**

Strategic Theme	Operational Objective	Action	Operational Lead
Innovation and technolo…	Optimise prescribing practices through better use of existing and new rapid diagnostics	Optimise blood culture pathway for improved Sepsis management and diagnostic antimicrobial stewardship	**John Boyes** **Jon Lewis** **Katie Howard**

	Infection prevention and control team (IPCT) to engage in research and development opportunities to prevent the spread of AMR and promote stewardship	The IPCT are to engage with industry partners to explore research opportunities and pilot new technologies to prevent spread of AMR and prevent the need for antimicrobials	**Kerry Holden**

Strategic Theme	Operational Objective	Action	Operational Lead
Audit and Surveillance	Provide prompt feedback on prescribing outcomes/ antimicrobial usage to medical and nursing stakeholders	Commence quarterly antibiotic audit feedback to divisional leadership teams delivered by divisional lead pharmacists	**Delyth Ahearne**
	Implement robust process of audit and surveillance related to antimicrobial usage and AMS.	Launch and implement new HAPPI audit tool completed by ward pharmacists Launch and implement use of the high impact interventions audit tools to promote stewardship in antimicrobial prescribing. Complete data collection for management of lower urinary tract infection as per CQUIN.	**Delyth Ahearne** **Kerry Holden** **Delyth Ahearne**
	Learn from investigation outcomes to understand trust wide practice related to prescribing and AMS	Post infection review findings related to AMS and prescribing practices to be fed into and discussed at AMS committee meetings for remedial intervention and celebration of good practice	**Kerry Holden**

A key feature of the strategy will be ensuring it is impact focused. Understanding the effectiveness of intervention and focusing on areas that offer a real opportunity to make a difference whilst being cost effective. Fundamental to this will be to utilise surveillance data and research to evaluate risks, monitor trends and understand what works to prevent and slow the spread of AMR and promote AMS.

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE COUNCIL OF GOVERNORS HELD IN THE LECTURE HALL, REDWOOD EDUCATION CENTRE, GLOUCESTERSHIRE ROYAL HOSPITAL ON WEDNESDAY 19 JUNE 2019 AT 17:30

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

PRESENT	Sandra Attwood	SA	Staff, Nursing and Midwifery
	Geoff Cave	GCa	Public, Tewkesbury
	Graham Coughlin	GCo	Public, Gloucester
	Anne Davies	AD	Public, Cotswold
	Pat Eagle	PE	Public, Stroud
	Charlotte Glasspool	CGl	Staff, Allied Health Professionals
	Colin Greaves	CGr	Stakeholder Appointed, Clinical Commissioning Group
	Ann Lewis	AL	Public, Tewkesbury
	Marguerite Harris	MHa	Public, Out of County
	Jenny Hincks	JH	Public, Cotswold
	Nigel Johnson	NJo	Staff, Other and Non-Clinical
	Alison Jones	AJ	Public, Forest of Dean
	Tom Llewellyn	TL	Staff, Medical and Dental
	Jeremy Marchant	JeM	Public, Stroud
	Sarah Mather	SM	Staff, Nursing and Midwifery
	Maggie Powell	MPo	Stakeholder Appointed, Healthwatch
	Alan Thomas	AT	Public, Cheltenham (Lead Governor)
IN ATTENDANCE	Peter Lachecki	PL	Chair
Directors	Claire Feehily	CF	Non-Executive Director
	Rob Graves	RG	Non-Executive Director
	Alison Moon	AM	Non-Executive Director
	Mike Napier	MN	Non-Executive Director
	Marie-Annick Gournet	MAG	Associate Non-Executive Director
	Lukasz Bohdan	LB	Director of Corporate Governance
	Rachael De Caux	RD	Chief Operating Officer
	Deborah Lee	DL	Chief Executive
	Mel Murrell	MM	Temporary Staffing Manager
	Sarah Stansfield	SS	Director of Finance
	Emma Wood	EW	Director of People and Deputy Chief Executive
APOLOGIES	Liz Berragan	LBe	Public, Gloucester
	Tim Callaghan	TC	Public, Cheltenham
	Rachael De Caux	RD	Chief Operating Officer
	Marie-Annick Gournet	MAG	Associate Non-Executive Director
	Andrew Gravells	AG	Stakeholder Appointed, County Council
	Steve Hams	SH	Director of Quality and Chief Nurse
	Balvinder Heran	BH	Non-Executive Director
	Mark Pietroni	MPi	Director of Safety and Medical Director
	Valerie Wood	VW	Public, Forest of Dean
PRESS/PUBLIC	None		

161/19 DECLARATIONS OF INTEREST **ACTION**

There were none.

162/19 MINUTES OF THE MEETING HELD ON 17 APRIL 2019

RESOLVED: That the minutes of the meeting held on 17 April 2019 be agreed as an accurate record subject to the following corrections:

- Page 4, first bullet point, 'GC' be amended to 'CGr'
- Page 5 and 6, 'GC' be amended to 'GCa'

163/19 MATTERS ARISING

APRIL 2019 146/19 REPORT OF THE CHIEF EXECUTIVE - AT PRAISED A RECENT CENTRES OF EXCELLENCE EVENT AND SAID HE HOPED TO SEE FURTHER EVENTS OF THIS KIND. AT EXPRESSED CONCERN REGARDING THE ICS AND ITS PUBLIC ENGAGEMENT.
Completed: Broader point around governor engagement has been raised and the ICS team is developing this further. PL raised at both an ICS Board meeting and at an ICS stakeholder event in May.

AT asked for an update on ICS governance. PL responded that effort had been made to ensure that across the ICS all the stakeholders understood how to operate in a proper governance framework. PL noted there was currently a loose framework in existence which was being refined to be clear on how decisions would be made, on when the Board would make decisions and when the ICS Board would make decisions – remembering that the ICS Board was not a statutory body so would not have decision-making rights. PL added that he had asked Ellen Rule, the ICS Programme Director, to develop progress this; the work was ongoing. To ensure that the Trust was clear on how it would work and has an input into it, there would be a session before the Trust Board meeting on 11 July 2019. PL had shared this approach with other Trust Chairs, who would investigate doing something similar in their Trust. PL added that as part of this work, the role of the NED and lay network was being investigated as was the governors' involvement and their representation in governance structures. PL had raised the governors' involvement in ICS governance at various forums and informally with Becky Parish; he noted that there was a strategic stakeholder group, although he did not know its membership.

AT noted he would continue to ask the question regarding how governors, the only publicly elected representatives of the public in the ICS, would be represented in decision-making. AT noted that he had asked several times, with neither direct refusal of governor involvement nor a conclusive answer. PL recommended AT wrote to Mary Hutton, ICS Accountable Officer, or Nick Relph, the Interim ICS Chair. AT added that at the Governors Focus Conference the Chief Executive of NHS Providers stated his belief that governors should be part of the process. PL added that the NHS Providers had recently published an article on this subject and assured AT that he had forwarded it to Ellen Rule. **AT**

Regarding AT's query, CGr said having support from the governors from other providers in the ICS would add some weight to the letter. The Council agreed.

Referring to action regarding Carers Gloucestershire on page 2 of the April Council of Governors minutes, PL explained that Carers Gloucestershire no longer had a contract with the Council and the work was now being undertaken by People Plus. PL had met People Plus a month ago and they were keen to act as a stakeholder organisation and to provide a suggested governor to the Council of Governors to represent carers, as Jacky Martel had done previously. They had agreed that People Plus would provide a paper for the Council of Governors by the end of May.

DL noted that the Trust had not lost touch with Jacky Martel despite the changing formal relationships and that SL had agreed to consider how she could

be involved in the Centres of Excellence work, since Jacky was eager to be involved and the Trust was keen to benefit from her expertise.

MHa noted that PL had met with Worcestershire Acute Hospitals Trust on the 19th May and asked whether she could or should meet with Worcestershire's governor equivalent. PL agreed that MHa could do this and DL said that the Trust could brief MHa on the nature of issues discussed between trusts before any contact.

Citing page 5 of the April Council of Governors minutes, AT referenced the staff survey results concerning violence and aggression amongst staff and requested some comment on this to come to the Council. DL agreed and noted that work was being undertaken by the Head of Leadership and Organisational Development in relation to violence and aggression. EW said that violence and aggression from the staff perspective was a trend of bullying and harassment from patients, colleagues and managers and that this was one of the three main priorities stemming from the staff survey. She added that there was a violence and aggression working group that reported into People and OD committee and some equality groups; on Monday 17 June 2019 the People and OD Committee had received an update on the key themes of violence and aggression and an update on the terms of governance. EW noted that the Trust was not an outlier with respect to these staff survey results.

In relation to page 5 of the April minutes, MPo noted the GMS review was not on the agenda and asked when it would take place. PL explained that the item was postponed for two reasons: the major feature on Centres of Excellence was more pressing in terms of getting governors involved; and the managing director of Gloucestershire Managed Services (GMS) had resigned and it had been agreed that it would be better for a replacement to do a review. DL added that the primary reason for the papers delay was the pressing agenda item today and it was agreed that the GMS Chair would deliver the presentation at the next Council of Governors meeting.

LB
For work plan

APRIL 2019 148/19 2019/20 PLAN - AG REQUESTED A BREAKDOWN OF THE CONTROL TOTAL AND ITS IMPLICATIONS. SS AGREED TO BRING THIS TO THE UPCOMING GOVERNOR DEVELOPMENT SESSION AND WOULD CIRCULATE A 'BRIDGE' GRAPHIC EXPLAINING THE TRUST'S FINANCIAL POSITION AND HOW THIS WILL MOVE TOWARDS THE ACCEPTED CONTROL TOTAL.
Completed: Session held and due to be repeated over the summer to ensure greater attendance.

DL noted there were two components to the action and only one was addressed in the update; she asked whether the bridge graphic had been circulated. SS noted that it was in the presentation that she gave to the session but agreed to check it was circulated.

SS

164/19 CHAIR'S UPDATE

PL presented the paper describing his activities from the 2 April 2019 to 11 June 2019.

PL noted that he excluded board committees, governor meetings, group meetings and 1-2-1s with Executives. He commented that he was spending lots of time outside the Trust, which was something he committed to do when he took the post in order to help the Trust become more outward facing.

AD noted how useful and interesting the governors evening at the university was; it had been interesting to hear about the apprenticeship degrees, which

she thought was a good way of getting people into the Trust. PL noted that the evening had a good format and relevant presentations that demonstrated the close relationships between the Trust and the university.

AT asked who Roland Valori was. Pl responded that Roland was a gastroenterologist consultant from the Trust who was working nationally on a new standard for consultants.

165/19 REPORT OF THE CHIEF EXECUTIVE

DL presented the Chief Executive's report, highlighting the following points:

- Operational pressures had been challenging.
- The Board had reviewed the Centres of Excellence business case and given its support; the proposals are subject to engagement and consultation.
- DL noted the governor presence at the Discharge Summit with Professor Brian Dolan. DLL noted that it was an inspiring event, adding the challenge was what we do now and delivering the pledges that staff made. DL added that 10-12th July was the global End PJ Paralysis Summit and that Trust would be taking part. DL thanked SA for her organisation of the Discharge Summit.
- The arrival of Elizabeth O'Mahoney as the regional director of NHS Improvement/England. The regions would have more influence in shaping how the NHS is run in the regions and DL found EO's approach, what she committed to and the way she committed to work in partnership with the Trust going forward refreshing. EO had worked and was living in the South West and DL expressed confidence in the relationship that would develop.
- The Care Quality Commission's (CQC) Board joined the Trust yesterday to hear more about quality improvement. DL thanked colleagues, particularly SH, EW and CF for their contributions.

In response:

- AL commented on how excellent Professor Dolan's event was, noting how he delivered a serious message in a light-hearted way.
- SA added that there had been table top exercises following professor Dolan's talk and a lot of feedback/ideas had been received from staff.
- PL echoed DL's enthusiasm in relation to the CQC Board's visit. AT said that he was grateful to be present and noted former governor's poster on deaf awareness. LB added that CQC wanted to take away some of our good practice to share with other Trusts.
- GC was curious about how the Health and wellbeing Hub was developing. EW said that there had been 75 contacts in the first 3 weeks of the hub going live and surveys were being done to capture the data; so far half of the issues related to mental health. EW added that the Hub was co-ordinating pro-active campaigns such as healthy eating week and events including tai chi and salsa. The hub had been ringing people on very long term sick to check in on staff and feedback indicated that people appreciated the hub reaching out. The hub was also reaching out to people on short term sick to see what the Trust could offer them, such as occupational health or physiotherapy. The hub continued to be promoted on wards and also in administrative areas. EW noted that reports were presented to the People and OD Committee and that they could be passed onto governors. GC asked whether the hub was sourced in-house. EW replied that the hub was run by her team and that it had a number of partnerships with local community groups, approximately 27, including the Citizens Advice Bureau and domestic violence organisations. EW explained that these groups were part of the

hub's triage and she noted the growing directory of services. DL added that the focus was partly on signposting. AM noted that People and OD Committee had been tracking the hub from an assurance point of view and they were interested in how the creation of the hub would generate tangible effects.

- PE asked how veterans' awareness was being used, noting that her partner had not been asked whether he was a veteran during his 19 day stay. DL responded that she was disappointed to hear this. DL noted that SH was the Executive lead for veterans' awareness and that this was a new focus in the organisation; the Trust had now established a feature on Trak to flag, ask and record this question. DL said PE's partner's journey would be tracked to understand how this was missed. DL added that Picnic in the Park Armed Forces Day would be on 30 June 2019. **DL**
- NJ asked what the Consultation Institute was. DL responded that it was an external organisation, independent from the NHS, which advised predominantly NHS organisations on how to consult on service change. They had been brought in to advise the Trust on how to approach the engagement activities that would commence in July 2019 and the public consultation in December 2019. NJ asked whether there was a cost associated with their involvement. DL noted that the cost was being picked up by the health system, adding that they were a not-for-profit organisation.

166/19 TEMPORARY STAFFING REPORT

EW presented the report and thanked MM for her work in this area.

EW noted that the governors had been interested in understanding the Trust's new temporary staffing solutions and in the question around reducing agency spend. Through the assurance from Quality and Performance Committee, particularly thanks to CF, it was clear that if the Trust's own staff care for patients it tends to produce a better experience, which was a driver for making the bank a vibrant offer. When MM started 18 months ago, the agency spend was high and the bank was not an attractive offer.

EW outlined the three work streams of the challenge for MM and her team. The Trust needed to 1) manage demand by improving governance and assurance around requests for temporary staffing 2) ensure the systems were as efficient as they could be, which has led to the introduction of new technology and 3) manage supply.

EW noted the successes in the first year from having a fully functional temporary staffing team, including the following:

- The rollout of an online system for nursing and midwifery wards, which enabled more accurate determination of the wards' needs, acuity, determining how many staff were needed at what grade and skillset, and a clearer flow.
- New bank rates had been introduced.
- A year ago there were no health care assistants on the bank, so having 268 on the bank now was a huge improvement.
- Work had been done with NHS Improvement and the Trust had gone to collaborative events to show and tell what we are doing.
- The Trust had entered a Master Vendor Agreement to streamline processes by commissioning one agency, which gave the Trust greater control of agency staff pay.

MM noted that both money and the aesthetic were important to staff who were choosing whether to join banks or agencies, therefore the team had worked with a creative agency to come up with a concept for what the bank could look and feel like to position the Trust as a competitor to agencies. This generated

'flexibleOurs', which was having a positive impact through social media and correlated with the improved bank fill rate and reduced agency spend. MM noted positive feedback received on the new temporary staffing solutions.

MM listed a variety of challenges, including the rapid roll-out of the E-Rostering system, the vacancy rate and the buoyant agency market due to the lucrative nature of agency work. MM explained the future actions and aspirations of the team, including the roll-out of a rostering system for doctors and allied health professionals.

In response:

- AL, who had been on three wards recently, commented on how the attitude of staff had improved. EW said that she would relay this to SH.
- CF noted the recent publications concerning centralising NHS procurement and said it seemed important that the Trust tailored work in this area to the local workforce supply and health economy; she asked whether there was concern about the centralised approach. SS replied that she had not come across anything from a staffing point of view. DL agreed, noting that new rules concerned procuring goods and supplies rather than services. DL added that it was a two-sided coin: one challenge was that agency suppliers would breach agency caps by playing Trusts off each other and centralisation might avoid this. EW noted recent guidance from NHS Improvement on the local procurement of admin agency.
- AM noted the reports to the People and OD Committee were great and wondered how the ambitious aim could be achieved this year considering the ambitious targets and success of the previous year.
- TL asked whether the Trust could identify areas where substantive post holders could be put in place to reduce the locum spend. EW said that a piece of work was being undertaken to build the operational plan into a 5-year plan. As part of this, the locum and interim spend would be investigated to see whether substantive posts could be introduced or whether alternative roles could be introduced to make the workforce more sustainable. DL explained that the Chief Executive must sign off every locum and as a result there had been some reduction in volume but a more notable reduction in price. EW noted that medical temporary staffing responsibility is split between two teams and a new programme of work from a Cost Improvement Programme (CIP) point of view that would look at making this more efficient.
- PL noted the success of the team and was impressed at the scale of the ambition of the team going forward and he thanked the team for their contribution.

167/19 REPORTS FROM BOARD COMMITTEES

FINANCE AND DIGITAL COMMITTEE

- **CHAIR'S REPORTS FORM THE MEETINGS HELD ON 25 APRIL 2019 AND 30 MAY 2019**
- **JUNE BOARD REPORT**

The June Board report was noted.

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

In response:

- PL noted the potential for another development session on finance and capital, encouraging all governors no matter what competence level to attend.

- CF reported positive feedback from the CQC meeting the day before concerning the Finance Team's Improvement Journey.
- SS noted the launch of the 'Count Me In' programme in Finance: a quality improvement project around financial training. So far, the training had been delivered on a voluntary basis to around 120 people, 86% of who said their understanding of finance was better or significantly better. The programme would be rolled out to 100 Leaders in July. The team's aim was to improve budget holder engagement and awareness training. There would also be a Twitter round table using #GHFTCountMeIn.

PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE

- **CHAIR'S REPORT FORM THE MEETING HELD ON 15 APRIL 2019**
- **MAY BOARD REPORT**

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

In response:

- Concerning retention, GCa asked whether there were other factors that might require government intervention, i.e. factors outside the Trust's control. AM responded that it might be useful for the Council of Governors to have a specific presentation on retention. DL noted that staff leave for a myriad of reasons and there was no silver bullet to solve the retention issue. DL added that the team had a plethora of qualitative information about why people leave but this data was not collected systematically. DL would discuss with EW bringing this back to the Council. **DL/EW**
- GCa commented that a lot of the exit information was collected electronically, and asked how the Trust tried to understand it. DL replied that compliance was poor. AM commented that it was assuring to see this data for the first time and that we were on the right path though there was still room for improvement.
- SM asked whether the Trust was measuring when people decided not to leave; she noted staff she knew who had wanted to leave but because of reasonable adjustments or their concerns being addressed they stayed. DL said that it could be captured on Greatix.
- AM suggested looking into the reasons why some areas had huge waiting lists of people who wanted to work there.
- AT noted the Trust's turnover rate compared well to two outstanding trusts.
- Regarding the hard-to-fill posts, AT noted that the Care of the Elderly (COTE) posts seemed to be an issue. AT asked whether there was a potential solution to this. DL noted that there was a 63% vacancy rate in COTE nationally, so it wasn't just a problem for the Trust and linked back to the number of trainees choosing to enter the programme. DL noted the work done to create joint appointments with Gloucestershire Care Services, which meant individuals would work part time in hospital medicine and part time in community medicine. DL discussed the potential of nurse and therapy consultants in COTE, a piece of work SH was leading on. DL said this was not due to a poor culture or poor leadership but she was disappointed by the failure of the Trust to convert a COTE trainee to a consultant: there was a vicious circle as high vacancy rates made it harder for a specialty to recruit.

- TL noted that despite the vacancies COTE was a successful service, where the aim was to not medicalise an elderly person. TL mentioned that there were opportunities from other specialties to work with the team.

AUDIT AND ASSURANCE COMMITTEE

- **CHAIR'S REPORT FROM THE MEETINGS HELD ON 23 APRIL 2019 AND 21 MAY 2019**

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

In response

- CGr noted that the 2018/19 was the first year new internal auditors, BDO, were working for the Trust. The internal audit opinion a year ago was prepared by PWC, previous auditors.

QUALITY AND PERFORMANCE COMMITTEE

- **CHAIR'S REPORT FROM THE MEETING HELD ON 24 APRIL 2019 AND 29 MAY 2019**
- **JUNE BOARD REPORT**

The April Quality and Performance Report was noted.

AM reported the key messages from the May Quality and Performance Chair's report.

In response:

- Regarding the 65 day wait in some complaints cases, PL noted that complainants were kept updated and made aware of the response timescales. AT said that he had asked at Board about the complaints system and he was assured that complainants and the families were kept in the loop. AT noted that 1 or 2 complex complaints per week was a lot so he wanted more information on this.

168/19 GOVERNORS' LOG

The Governors' Log was noted.

169/19 ANY OTHER BUSINESS

PL said that JH had decided to step down as governor for personal reasons and he thanked JH for her contribution as a governor. AT reiterated his thanks, noting her contribution to the Governance and Nominations Committee.

170/19 DATE OF NEXT MEETING

The next meeting of the Council of Governors will be held on **Wednesday 21 August 2019** in the **Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital** commencing at **17:30**.

171/19 PUBLIC BODIES (ADMISSION TO MEETINGS ACT) 1960

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

The meeting ended at 20:00

Chair
21 August 2019

ITEM 17

GOVERNOR QUESTIONS

VERBAL

ALL

ITEM 18

STAFF QUESTIONS

VERBAL

ALL

ITEM 19

PUBLIC QUESTIONS

VERBAL

ALL

ITEM 20

NEW RISKS IDENTIFIED

VERBAL

ALL

ITEM 21

ITEMS FOR THE NEXT MEETING

VERBAL

ALL

ITEM 22

ANY OTHER BUSINESS

VERBAL

ALL