GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

The next meeting of the Gloucestershire Hospitals NHS Foundation Trust Main Board will be held on **Wednesday 13 September 2017** in the **Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital** commencing at 9.00 a.m. with tea and coffee from 8.45 a.m. **(PLEASE NOTE DATE AND VENUE FOR THIS MEETING)**

Peter Lachecki
Chair

23 August 2017

AGENDA

				Approximate Timings
	Patient Story			09:00
1.	Welcome and Apologies			09:30
2.	Declarations of Interest			
3.	Minutes of the meeting held on 12 July 2017	**PAPER**	**To approve**	09:32
4.	Matters Arising	**PAPER**	**To note**	09:35
5.	Chief Executive's Report September 2017	**PAPER** (Deborah Lee)	**To note**	09:40
6.	Quality and Performance:		**For Assurance**	09:50
	• Quality and Performance Report - Update of the Chief Operating Officer	**PAPER** (Arshiya Khan)		
	• Assurance Report of the Chair of Quality and Performance Committee meeting held on 22 August 2017	**PAPER** (Tracey Barber)		
	• Trust Risk Register	**PAPER** (Deborah Lee)		
	• Patient Experience Improvement in Response to Board Stories	**PAPER** (Maggie Arnold)		
	• Mortality Review	**PAPER** (Sean Elyan)		
7.	Financial Performance:		**For Assurance**	10:30
	• Report of the Finance Director	**PAPER** (Steve Webster)		
	• Assurance Report of the Chair of the Finance Committee meeting held on 30 August 2017	**PAPER** (Keith Norton)		
8.	Workforce:		**For Assurance**	10:50
	• Report of the Director of Human Resources and Organisations Development	**PAPER** (Dave Smith)		
	• Assurance Report of the Chair of the Workforce Committee on the meeting held on 24 August 2017	**PAPER** (Tracey Barber)		
	• Workforce Race Equality Standard	**PAPER** (Dave Smith)		
	Break			**11:10 - 11:20**

9.	Audit and Assurance:		**For Assurance**	11:20
	• Report of the Chair of the Audit and Assurance Committee meeting held on 11 July 2017	**PAPER** (Rob Graves)		
10.	Smartcare Progress Report	**PAPER** (Sally Pearson)	To Note	11:30
11.	Risk Management Strategy	**PAPER** (Deborah Lee)	**For Approval**	11:40
12.	Guardian Report on Safe Working Hours for Doctors and Dentists in Training	**PAPER** (Sean Elyan)	**For Assurance**	11:55
13.	Items for the Next Meeting and Any Other Business	**DISCUSSION** (All)	**To Note**	12:05
	Governor Questions			
14.	Governors Questions – A period of 10 minutes will be permitted for Governors to ask questions		**To Discuss**	12:10
	Staff Questions			
15.	A period of 10 minutes will be provided to respond to questions submitted by members of staff		**To Discuss**	12:20
	Public Questions			
16.	A period of 10 minutes will be provided for members of the public to ask questions submitted in accordance with the Board's procedure.		**Close**	12:30
	Lunch			**12.40 – 13.00**

COMPLETED PAPERS FOR THE BOARD ARE TO BE SENT TO THE BOARD ADMINISTRATOR NO LATER THAN 3.00PM ON THURSDAY 31ST AUGUST

Date of the next meeting: The next meeting of the Main Board will take place at on **Wednesday 11 October 2017** in the **Lecture Hall, Sandford Education Centre, Cheltenham** at **9.00 am.**

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

Tracey Barber
Dr Claire Feehily
Tony Foster
Rob Graves
Keith Norton
Alison Moon

Executive Directors

Deborah Lee, Chief Executive
Maggie Arnold, Nursing Director
Steve Webster, Finance Director
Dr Sean Elyan, Medical Director
Dr Sally Pearson, Director of Clinical Strategy
Dave Smith, Director of Human Resources and Organisational Development
Arshiya Khan, Interim Chief Operating Officer

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE TRUST BOARD HELD IN THE LECTURE HALL, REDWOOD EDUCATION CENTRE, GLOUCESTERSHIRE ROYAL HOSPITAL ON WEDNESDAY 12 JULY 2017 AT 9AM

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	Chair
	Deborah Lee	Chief Executive
	Dr Sean Elyan	Medical Director
	Maggie Arnold	Director of Nursing
	Dr Sally Pearson	Director of Clinical Strategy
	Felicity Taylor-Drewe	Associate Director of Planning and Performance
	Dave Smith	Director of Human Resources and Organisational Development
	Steve Webster	Director of Finance
	Dr Claire Feehily	Non-Executive Director
	Tony Foster	Non-Executive Director
	Rob Graves	Non-Executive Director
	Keith Norton	Non-Executive Director
APOLOGIES	Tracey Barber	Non-Executive Director
	Arshiya Khan	Interim Chief Operating Officer
IN ATTENDANCE	Natashia Judge	Board Administrator
PUBLIC/PRESS	Craig Macfarlane	Head of Communications
	Three Governors, three members of the public, one member of the press and two members of staff.	

The Chair welcomed Governors, the public and staff to the meeting and apologised that there would be no Patient Story but assured the Board that this would resume at the September Board meeting.

155/17 DECLARATIONS OF INTEREST **ACTIONS**

The Medical Director declared an interest in the SmartCare Programme Board report given that the proposed changes affect the Oncology department and that he is an Oncologist.

156/17 MINUTES OF THE MEETING HELD ON 7 JUNE 2017

RESOLVED: That the minutes of the meeting held on 7 June 2017 were agreed as a correct record and signed by the Chair.

157/17 MATTERS ARISING

MAY 2017 120/17 PATIENT STORY - AUDIOLOGY DEPARTMENT AND THE CALLING OF PATIENT NAMES

The Disability Equality Manager to contact the Charitable Funds Committee regarding resources to purchase visual electronic signage. Mr Foster explained that he would raise this with the charity team. *Completed.*

MAY 2017 120/17 PATIENT STORY - COMMUNICATION BETWEEN DOCTORS AND DEAF PATIENTS
The Medical director asked that Kim Fletcher think about what three key signing messages should be taught to all doctors so that these could be introduced. *Completed.*

MAY 2017 120/17 PATIENT STORY - COMMUNICATION BETWEEN DOCTORS AND DEAF PATIENTS
Disability Equality Manager to liaise with Jo Dutton (Advanced Hearing Therapist) to arrange to attend the Education and Early Development sub group to investigate how training could be developed. *Completed.*

MAY 2017 120/17 PATIENT STORY - COMMUNICATION BETWEEN NURSES AND DEAF PATIENTS
The Director of Nursing asked that Kim Fletcher and Victoria Banks attend an upcoming strategy day. The Head of Patient experience will link in with Fran Wilson (Matron for Outpatients) to discuss the outpatient forum. *Completed as a Matter Arising.*

MAY 2017 124/17 ANNUAL ACCOUNTS - COMMUNICATIONS REGARDING THE DEFICIT
Head of Communications to develop clear and understandable communications regarding the deficit focusing on the £18m operational figure. *Completed.*

MAY 2017 125/17 QUALITY REPORT - STAKEHOLDER FEEDBACK - TRUST HAS NOT QUITE MET EXPECTATIONS ON REPORTING PATIENT EXPERIENCE AND DATA REGARDING TYPE OF ENGAGEMENT
The Director of Clinical Strategy to work with the Head of Patient Experience to strengthen the information taken and had discussed in Quality and Performance Committee looking at a more robust set of indices to give assurance on safety in the Emergency Department. *Completed.*

MAY 2017 125/17 QUALITY REPORT - POOR CCG INFORMATION CASCADE FROM QUALITY COMMITTEE.
The Chief Executive will investigate this. *Completed.*

MAY 2017 129/17 ANY OTHER BUSINESS - TRENDS AND ISSUES RAISED DURING SAFETY WALKABOUTS
Head of Patient Experience to liaise with the Director of Safety and look at collating information. Director of Safety to bring issues regarding safety to the Quality and Performance Committee. *Completed.*

MAY 2017 129/17 ITEMS FOR THE NEXT MEETING - STAFF STORIES AT BOARD AS WELL AS PATIENT STORIES
The Chair agreed this was a good suggestion and would investigate having one staff story a year. The Medical Director noted that stories of staff experiences whilst patients themselves were also very helpful. *Completed.*

MAY 2017 129/17 ITEMS FOR THE NEXT MEETING – WORKPLAN
Board Secretary to include Work Plan in next month's papers. *Completed.*

JUNE 2017 133/17 PATIENT STORY/ NATIONAL INPATIENT SURVEY - GOVERNORS HAD INDICATED A WISH TO HAVE A FOCUS ON IMPROVING PATIENT EXPERIENCE IN OUT-PATIENTS
The Director of Clinical Strategy and the Head of Patient Experience to work together to agree an objective which addressed these concerns. *Completed.*

JUNE 2017 133/17 PATIENT STORY/ NATIONAL INPATIENT SURVEY - EVEN DISTRIBUTION OF AGENCY AND SUBSTANTIVE NURSING STAFF
The Chief Executive proposed that consideration be given to reviewing the allocation of substantive posts to ensure no clinical area was left with excessive reliance on agency staff. *Completed.*

JUNE 2017 135/17 MINUTES OF THE MEETING HELD ON 26 MAY 2017
A number of minor points were highlighted. *Completed.*

JUNE 2017 136/17 MATTERS ARISING - Agreed that the format of the "tracker" should be reviewed, recognising that this reflected more the detail of the minute, rather than the action undertaken. *Completed.*

JUNE 2017 137/17 CHIEF EXECUTIVE'S REPORT – SMOKE FREE NHS LETTER
A positive response letter on a smoke free NHS from Duncan Selbie to be circulated. *Completed.*

JUNE 2017 137/17 CHIEF EXECUTIVE'S REPORT - DEVELOPMENT OF TRUST'S DIGITAL STRATEGY
Develop the Trust's Digital Strategy in the context of the countywide Digital Strategy which had been presented recently. This was identified as a potential subject for a Board Seminar. *Completed.*

JUNE 2017 138/17 REPORT OF THE INTERIM CHIEF OPERATING OFFICER - REPORTS AND THE INCLUSION OF HISTORIC DATA
Greater clarity of the enablers which could be instrumental in making progress, recognising that there were also constraining factors to be included in the report in future. *Completed.*

JUNE 2017 139/17 TRUST RISK REGISTER - UPDATE OF FY18 ON TRUST RISK REGISTER
F2515 Risk that the Trust does not agree a FY18 Control Total accepted on to the risk register as a finance risk (15 and above). *Completed.*

JUNE 2017 146/17 GOVERNOR QUESTIONS - CAPACITY ISSUES AND EXTENDED WAITING TIMES

The Interim Chief Operating Officer to review the content of letters, and share information more widely with staff about extended waiting times. To also explore the possibility of providing generic information in out-patient areas. The Chief Executive suggested that receptionists and volunteers might also be well placed to advise patients about likely waiting times. *Ongoing.*

JUNE 2017 148/17 PUBLIC QUESTIONS - CONTACT DETAILS WITHIN GUIDANCE FOR SUBMITTING QUESTIONS
Board Administrator to update. *Completed.*

158/17 CHIEF EXECUTIVE'S REPORT

[Mr Graves joined the Board]

The Chief Executive presented her report highlighting the following points:

- Operational pressures had been challenging, assumed to be because of the recent good weather. Within the final two weeks of June an additional 500 patients attended the Accident & Emergency (A&E) departments which inevitably affected patient experience. As a consequence of this the Trust was noted to be performing in the lower decile for performance of A&E which is attracting negative attention. The Chief Executive felt it was important to recognise that great unprecedented demand was impacting on performance.

- The Chief Executive noted the recent tragic fire at Grenfell Tower and shared that as a result it was imperative the Trust was assured regarding the safety of Gloucester Royal Hospital Tower Block. She commended the Director of Estates and Facilities and Director of Clinical Strategy for undertaking additional, unplanned weekend assessments so efficiently as a requirement of instructions fromthe Secretary of State and assured the Board that no shortcomings had been identified.

- The Care Quality Commission (CQC) report was recently published and the Chief Executive felt it was important to recognise the improvement noted within this. While the Trust was not yet at the right point she felt the report was a positive milestone in the journey to be a Good and eventually Outstanding Trust. 73% of ratings were noted to be Good or Outstanding with nine areas having improved since the last inspection including End of Life Care being rated good overall.

- The Director of Nursing recently hosted a visit from the Powys Community Health Council (CHC) who requested a visit to Oncology at Cheltenham General Hospital. The group viewed presentations regarding services and were then taken on a walkabout. Feedback from the visit was very positive with the inspector of Powys CHC remarking that the people of Powys were very fortunate to be able to be treated there.

- The Chief Executive noted new substantive appointments within the Board with Caroline Langdon due to begin on 9th October as Chief Operating Officer and Steve Hams to begin as Director of Quality and Chief Nurse on 19th September. A replacement for the Director of Human Resources and Organisational Development has also been appointed with Emma Wood (currently Human Resources Director at the South West Ambulance Trust) due to begin around November. The Chief Executive thanked the current Director of Human Resources and Organisational Development reflecting that the recent 100 Leaders session had illustrated how difficult he would be to replace.

- The importance of taking the opportunity to recognise and celebrate success was discussed and within this context the upcoming Staff Awards was mentioned with 400 nominations having been received – twice as many as in previous years. The Chief Executive hoped this reflected increased engagement from staff in the Trust. Shortlisting was difficult however this is now completed with the awards planned for 21st September.

The Chief Executive then invited questions from the Board and a number of points were made:

- The Medical Director felt it was important to acknowledge the toll that operational pressures had on staff. The Chief Executive echoed this and also reflected on an incident which happened on 10 July where a patient was found deceased in a public toilet. She praised the staff response as exemplary and thanked in particular the Porters, Infection Control Team and the Site Team for their dignity in approaching the situation. She also thanked the Director of Nursing for taking executive leadership.

- Dr Feehily shared that she was seeking to understand the surge in demand and the instability of the Minor Injury Units and Out of Hours and queried what could be done differently in the short term? The Chief Executive noted that Minor Injury Units were busier than ever and that more people were accessing urgent care than ever before but suspected that uncertainty around opening hours of some community services, led patients to attend the Emergency Department as this was a twenty four hour service. She felt the solution was not straight forward but that Sustainability and Transformation (STP) work that the Director of Clinical strategy was involved in regarding redesigning pathways to include Urgent Treatment Centres was the correct direction of travel to addressing the issue. These Urgent Treatment Centres would be more comprehensive than a Minor Injury Unit and would have the same consistent hours of operation across the county.

- The Director of Clinical Strategy noted that General Practice Surgeries were more in demand and changes in the

environment magnified this. This was noted to particularly affect patients with chronic conditions and that currently the pathways for advanced support were not clear. She reinforced that STP work around 'One Place' models was underway investigating how patients should be supported in their own home.

- The Director of Finance queried whether the rise in demand was related to the warm weather and wondered if a similar trend had been identified elsewhere. The Chief Executive remarked that this needed to be investigated and the Associate Director of Planning and Performance resolved to investigate this as reviewing the data for June demand has increased by 3.6% with an increase in minor injuries after 8-10pm. **FTD/AK**

- The Medical Director shared that he had attended a Quarterly Review alongside NHSI investigating what factors were driving the peaks in use. He explained that an analysis would go to the next Quality and Performance Committee.

- The Chair noted that within the Staff Awards 74 recommendations were received from patients regarding staff and expressed that he was pleased with the great engagement from the community.

The Chair thanked the Chief Executive for her report.

RESOLVED: That the report be noted.

[09:32]

159/17 QUALITY AND PERFORMANCE REPORT

PERFORMANCE MANAGEMENT FRAMEWORK REPORT - UPDATE OF THE CHIEF OPERATING OFFICER

The Chair welcomed the Associate Director of Planning and Performance who deputised for the Interim Chief Operating Officer and presented the new style and format of the Performance Management Framework Report (PMF) which had been earlier approved by the Quality and Performance Committee. The Associate Director of Planning and Performance explained that the report should provide assurance to the Board (via Quality and Performance Committee) and identifies strengths, weaknesses and opportunities assigned with executive responsibility. She noted that Board may have noticed areas for improvement such as strength of narrative, forecasting and benchmarking, mitigating actions and escalating actions and reassured the Board that the report was in the development stage therefore it was important to note these within that context.

Within the PMF report the Associate Director of Planning and Performance drew the Board's attention to the main performance issues including:

- A&E Performance
- Diagnostics
- Cancer performance and RTT
- Urology was noted in particular to be impacting other areas and therefore they have been asked to attend the next Quality and Performance Committee to undertake a deep dive.
- Increase in attendances with A&E and in particular an increase in ambulances after 6pm.
- Increase in demand for cancer services within Colorectal which are impacting the Trust's position. It was noted that many patients were declining short notice appointments and therefore other areas are being investigated so that this can be relayed back to primary care.

Following the presentation of the new report a number of points were made by the Board:

- Mr Norton thanked the Associate Director of Planning and Performance and expressed that the report was a big step forward. He went on to query how the report would fit into future prioritising. The Associate Director of Planning and Performance explained that cultural and governance work was needed and that future reports should take into account quality issues such as patient experience and staff issues.

- The Director of Clinical Strategy shared that the agenda for Quality and Performance is structured so as to force prioritisation with the PMF report first followed by areas for further scrutiny. This addresses assurance whilst identifying areas where more detail is needed. Quality and Performance Committee conversations then require replication within specialities and divisions. Mr Norton agreed it was important that once a report is reviewed it feeds back into how staff work on a day to day basis and thanked both the Director of Clinical Strategy and Associate Director of Planning and Performance for their assurance.

- Mr Graves shared that he had sat in on the last Quality and Performance Committee and felt the new PMF report was a huge step forward in the way data is presented despite any refinements needed and thanked the Associate Director of Planning and Performance and the team for all their hard work. Mr Graves queried the Board's responsibility and how they would move items from orange to green and wondered what pace and objectives should be set for the Board? The Chief Executive answered that committees needed trajectories addressing the pace of recovery. She expressed that increasingly stronger forecasting was needed so that successes, failures and the future were clearer. The Chief Executive informed the Board that most performance reports are inherently backward looking but to set the Trust apart more forward looking reports were needed.

- Dr Feehily queried how the presentation would sit with a public audience and explained that the report had been shared with governors where useful feedback was received and that the Associate Director of Planning and Performance would be attending the next Governors Quality and Performance session to work through underlying principles. The Associate Director of Planning and Performance explained that a key objective was to make the report appropriate for a public audience.

- Dr Feehily also queried the relationship between the report and the Risk Register. The Chief Executive responded that she felt it imperative that performance issues were not included within the Risk Register as it was important it contained risks and not issues. She felt it was important to analyse performance and establish what risks this presented and what should be therefore added to the Risk Register. The Associate Director of Planning and Performance explained that more work was needed regarding making a distinction between risk and issues.

- Mr Foster shared that he found the summary scorecard useful and expressed that though he did not wish to see the detail behind this did but did query the range used. The Chief Executive directed Mr Foster to the Quality Dashboard where this was visible and explained that as the report progressed this would be much more interactive.

The Chair thanked the Associate Director of Planning and Performance for the report and shared that he felt it was a leap forward in terms of reporting and demonstrated the culture that he and the Chief Executive wanted to bring to the Board.

RESOLVED: That the Board note the Integrated Performance Framework Report as assurance that the executive team are divisions fully understand the current levels of poor performance and have action plans to improve the position.

[09:46]

REPORT OF THE CHAIR OF QUALITY AND PERFORMANCE COMMITTEE MEETING HELD ON 28 JUNE 2017

In the absence of Dr Feehily the Quality and Performance Committee was chaired by Ms Barber. Ms Barber was unable to attend the Board meeting and therefore the Chair noted he would take the report as read.

Ms Barber had raised a point which she requested Mr Norton share with the Board in her absence concerning the telephony project. Ms Barber expressed the importance of learning from TrakCare and that this was a project about behavioural change with an Information Technology (IT) component rather than an IT project with a behaviour change component. Mr Norton acknowledged this and felt it was important that the IT did not completely take over. The

Director of Human Resources and Organisational Development shared that he would align with the Head of Leadership and Organisational Development and the project team. **DS**

RESOLVED: That the report of the of the Chair of the Quality and Performance Committee held on 28 June 2017 be noted.

[09:48]

TRUST RISK REGISTER

The Chief Executive presented the Risk Register and explained that this had continued to develop and the divisions had now reviewed all risks at a rating of 15+ as well as safety risks of 12 or above for future incorporation on to the Trust Risk Register. The Trust Risk Register was noted to be up-to-date and dynamic. A large amount of risks at a rating of 12 or above were noted and following review by the divisions many of these were found to be over-scored and therefore de-escalated. A small number of these risks have come through to the Trust Risk Register but not as many as were sitting on the Divisional Registers. One risk had been downgraded which was the risk that referred to Fractured Neck of Femur thanks to the focus work in this area. By utilising the ward team there has been a reduction in mortality of 29% of patients who present at Gloucester Royal Hospital. This risk has therefore been de-escalated and will eventually be closed. The Trust as a whole is now back within the expected range.

Following the presentation a few points were noted and raised by the Board:

- Mr Graves expressed that he found the detail noted very helpful and dynamic. He felt it would be useful to see a summary of the absolutes and their direction of travel and had further thoughts regarding what this would look like. The Chief Executive agreed and shared that this would be visible in future.

- Dr Feehily queried whether Divisions were dealing with risks in a consistent manner now that there was a level of confidence regarding how well the Risk Register is understood. The Chief Executive explained that she chaired a Risk Management Group which is attended by the divisional leads: the format of the group is that at each meeting two divisions attend to review their Risk Registers and this ensures that risks are scored consistently across divisions. She also explained that the Risk Register was a standing item on the agenda of all monthly executive management reviews and that if Dr Feehily wanted to attend the Risk Management Group for assurance she was most welcome.

- Mr Graves noted that Audit and Assurance committee were looking at work done on risk management within the Trust and how internal systems of control work. He noted this to be an evolving process but progress is being made.

The Chair noted that excellent progress was being made in this area and thanked Mr Graves for his support.

RESOLVED: That the Board 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.

[09:55]

160/17 FINANCIAL PERFORMANCE REPORT

REPORT OF THE FINANCE DIRECTOR:

The Director of Finance presented the Financial Performance Report to the Board and gave a summary of the key points covered with this. Particular points of note were:

- The Trust is cumulatively slightly ahead of the budget for the end of May and is essentially break even to budget with an improvement on the position at the end of April. The Trust was reporting a £1m deficit in April and this now been turned into a £1m surplus in May resulting in a cumulative break even. The Director of Finance therefore noted a big improvement between the months of April and May and attributed this to two key areas: the first being income with a £1.8m improvement and the second being pay. He noted a bigger pay underspend in May than April and expressed that it was not as simple as gradually filling vacancies because the underspend actually increased.

- Cost Improvement Programme (CIP) delivery was noted to be ahead of plan by £1.9m and the Director of Finance felt this was part of the same story with two factors driving this: the first being short term vacancies and the being second lower financing costs.

- It was noted that the Trust is £2.3m adverse to the NHSI plan but a revised plan has been submitted to NHSI which proposes to align the NHSI plan to our internal budget. No response has been received as yet but the Director of Finance felt it was clearly more helpful to be working to a similar plan.

- The data shared within the report was noted to be from month 2. The Director of Finance shared that he had had early sight of the figures for month 3 and though these were not yet finalised they were broadly in line with the budget for month 3.

- The overall position was noted with income shortfalls of £2.3m covered by a combination of pay underspend which has been through CIP and lower financing costs. Income shortfall was noted to be part of this equation and the Director

of Finance queried how much was down to problems with TrakCare and counting and coding. As a consequence the Finance Committee report is investigating reaching agreement on a block for a period of time. This would improve the position in the short term and would change the break even picture and provide a small surplus.

- The Director of finance felt that overall the picture was a positive story however did express concern over the phasing of the plan illustrated in the report with a £67k cumulative surplus in month 1 against a £10m deficit plan. This is a £10m deficit in two months and if the Trust is aiming for £14.6m this is a 4m deficit in the next ten months. He agreed that though this was the right thing to do it did display how much the Trust has back phased the plan. He noted two key elements of this which are the CIPs and income budget because of TrakCare problems and felt the scale of this was clearly visible.

- Overall the Director of Finance noted that the Trust was on plan but could be ahead of this if an agreement could be reached on block contract. He noted that this plan was stepping up incrementally in future months and that the big challenge would be stepping up financial performance and that it was important to recognise the scale of the challenge in the remaining months. This discussion was had at Finance Committee where it was agreed that the key was to get a more granular focus of the remaining months and ensure that all actions were being taken to achieve the challenge alongside identifying any further actions. While a forecast of achieving the plan is available it is not supported by adequate detail of what needs to be done and the Director of Finance felt this was the most important thing ahead of the Trust. He identified three key elements to this which were:
    1. Stepping up CIPs
    2. Counting and coding issues around TrakCare and the delivery aspects
    3. Pay underspend

  It was reinforced that tackling pay underspend was not as simple as gradually filling vacancies. £0.7m was noted in month 1, £1.2m in month and the around a million estimated for month 3. This is not gradually reducing and therefore the Director of Finance felt this needed addressing as it could be a positive contributor to short falls elsewhere

Following the presentation a few points were noted and raised by the Board:

- The Chair thanked the Director of Finance for his helpful clear overview of what levers the Trust needed to pull and where we are with this and the risks identified.

- Mr Graves reinforced that it was encouraging to hear the challenges stated so clearly and felt the magnitude was a significant requirement. He expressed that it was vital that the

Board was appraised of the Director of Finance's views once he had investigated the detail of achieving the forecast as he felt it was difficult to understand how reasonable this was without seeing the detail.

- The Chief Executive wished to express that while she did not want to take away from the Director of Finance it was important to acknowledge that this was the plan previously developed and was not a consequence of the Director of Finance coming in with fresh eyes. She reinforced the regulator understood the scale of risk in the second half of the plan and the reason this was so challenging is because the regulator would not accept a deficit larger than £14.6m. The Trust were clear that this would be challenging and that we would have been more comfortable with a greater deficit and distributed recovery over a longer period of time but this was not something the regulator would afford.

- Mr Graves highlighted that the cash position had changed and wondered if there were any issues behind this pinpoint movement in trade payables. The Director of Finance explained that the Trust borrowed less than planned which is part of the positive position of financing. He noted that debtors have been higher and there were areas where commissioners hadn't paid on due dates. This has now been resolved. Mr Graves followed up whether as a result the picture would be more positive in upcoming months. The Director of Finance expressed that the cash position would be affected by I & E and therefore depends on our performance and this would impact month 4 in particular, with the cash plan assuming this. Mr Graves finally queried whether the Finance Committee reviewed the cash flow forecast and the Director of Finance confirmed that they did.

- The Chief Executive felt it was important to note that because of the cost of borrowing to the Trust being so high it was important to keep cash balances low but enough to trade and that this was the goal but that it was a fine balance. Currently the levels were not where she would like them to be at in the future.

- Mr Foster queries whether a month by month forecast of all major parameters to be reviewed (such as CIP, Income, Pay and Cash) would be created and the Director of Finance answered yes.

RESOLVED: That the Board receive the report for assurance in respect of the Trust's Financial Position.

[10:07]

REPORT OF THE CHAIR OF THE FINANCE COMMITTEE MEETING HELD ON 29 JUNE 2017

Mr Norton presented the report from the Finance Committee on 29

June and gave a summary of the key points from the meeting:

- £12.8m of the CIP target was noted to be in red category and this amounted to around a third. Mr Norton acknowledged that it was positive that there was definition between the red but nonetheless it should be recognised that one third is still to be properly planned out before the Board can be reassured. Questions had been posed previously around how this would be achieved and in particular whether there was leadership to implement the changes. The Finance Committee have planned to investigate the medical productivity CIP in July so that further judgements can be made about the plans for other CIPs. Mr Norton emphasised that while he felt it was important to be careful there was no duplication with other committees the Finance Committee did need to seek reassurance regarding this.

- Some items within the Capital programme may potentially be different in 2017/2018 and Mr Norton explained that this was around issues with funding. This will be investigated and the team will investigate dual sources to ensure resources are in place.

- Medical agency spend was noted to be a concern. In order to seek reassurance medical agency spend will come under further scrutiny at the next committee. Mr Norton noted that in other areas agency spend had been gripped very clearly with visible improvements in performance as a consequence. Therefore, he felt this needed more scrutiny and that the first part of the year was the optimum time to establish issues and investigate them.

In response to the report the Board had further questions and points they wished to discuss:

- The Chair asked the Director of Finance to share his thoughts regarding leadership and ownership and how this was embedded within the organisation with new structures and project management office. The Director of Finance responded that he did not wish to go into detail as yet as he wanted to discuss this with colleagues but he did note that he was liaising with the PMO team and focusing on approach and organisation and how this could change slightly with more focus on what will be delivered. He felt a better balance was needed between actions and meetings but noted he had not brought this together yet.

- The Chief Executive asked the Medical Director and Director of Nursing for their thoughts on the strength of clinical engagement.

- The Director of Nursing felt that nurses were very engaged as they knew lack of nurses would mean they may be relocated to another area and knew what it was like to work alongside agency nurses. She noted that CIP was a topic at Strategy

Days and a recent ward clerk strategy day saw follow up communication from ward clerks with suggestions for cost improvement. She shared that the Nursing Agency meeting was progressing well under new PMO leadership.

- The Medical Director felt that agency spend was a topic that doctors engaged well with and understood that agency is not desirable as the quality is not as consistent and therefore substantive staff are preferable. He felt that good engagement was reflected in the reduction in agency spend. Much work had been done regarding recruiting substantive staff in hard to recruit areas, in general in Acute Medicine, but as yet this has not yielded as much as hoped and further gains are still to be had. Medical Productivity was noted to be much harder to inspire and the Medical Director welcomed any ideas or approaches. The Director of Finance felt it was important to approach medical productivity by asking clinicians what ideas and thoughts they had and harnessing these. She expressed that clinicians were the best innovators at thinking outside of the box and this needed to be harnessed with the help of the Finance Director. The Chief Executive then went on to recount a story shared at 100 Leaders by Professor Scanlon who focused on innovative income recovery as opposed to cost savings and delivered his CIP target through this, enabling him to invest back into the service. She felt that lessons could be learnt from this and options presented to clinicians where if they made savings or generated income they could utilise a portion of this to develop their service. The Director of Human Resources and Organisational Development noted that at a recent Local Negotiating Committee (LNC) Doctors confessed to a lack of understanding of CIP. The Director of Human Resources and Organisational Development suggested the Director of Finance attend this committee in order to explain and engage staff further. **SW**

RESOLVED: That the report of the Chair of the Finance Committee held on 29 June 2017 be noted.

[10:22]

161/17 WORKFORCE REPORT

REPORT OF THE DIRECTOR OF HUMAN RESOURCES AND ORGANISATOINAL DEVELOPMENT:

The Director of Human Resources and Organisational Development presented the Workforce Report. The report included the progress on control of pay spend and agency expenditure and updated the Board on the progress of the Workforce Committee. There is recognition of pay and the alignment of this with reporting and this will be discussed at the September Workforce Committee.

The Director of Human Resources and Organisational Development noted three factors which were contributing to the current picture

regarding pay.

1. The establishment of realistic budgets for the first time in several years. This year's budget was based on last year's run rate plus built into this were positions to be recruited to and offer one off adjustments.
2. A greater sense of grip
3. Current under-recruitment to existing vacancies, many of which are in the medical field though not exclusively. The Director of Human Resources and Organisational Development noted that at a previous Vacancy Control Panel (VCP) 90 requests were reviewed and that the team were recruiting as fast as possible. He explained that if the Board looked at the previous year's; full time equivalent (FTE) numbers increased in the Autumn as most recruitment takes place during this season and therefore the Trust may well see a future increase in FTE. He noted that having said this grip has improved.

The Director of Human Resources and Organisational Development informed the Board that the Trust was £900,000 better off in terms of agency expenditure, the bulk of which was in nursing. Medical expenditure was noted to have reduced but was on a par with last year and it was hoped that there would not be a late summer surge (similar to the previous year) thanks to earlier review of the rotas. The Director of Human Resources and Organisational Development noted that in July 2016 nursing agency costs spiralled therefore rotas were being reviewed much earlier to avoid this. He noted that the Trust was better recruited than this period last year but this would need constant scrutiny. It was broached that medical recruitment needed to be reviewed in a more holistic way and therefore a special VCP would be held to review historical gaps. Overall the Director of Human Resources and Organisational Development expressed that he was pleased with the figures but cautious about maintaining these over the summer months.

The Director of Human Resources and Organisational Development shared that he was in the process of undertaking detailed conversations with the leaders of work streams and the structure around driving Cost Improvement Programmes (CIPs) was helpful. He shared the focus on fewer meetings with greater content and expressed dissatisfaction with too many meetings being held with little progress.

Following the presentation a few points were noted and raised by the Board:

- The Chair expressed his reinforcement of fewer meetings with these being more incisive, a topic discussed at the last Audit and Assurance Committee.

- Dr Feehily queried how financial targets were balanced against service requirements at the moment and wondered how the Trust could guarantee savings without compromising staffing. The Director of Human Resources and Organisational Development responded that he had worked through processes and that additional money could be

deployed to keep levels as they should be.

- The Director of Nursing explained that a lot of engagement work had been undertaken to ensure newly qualified nurses would join the Trust in the autumn and currently it was hoped that this would be around 80 nurses. She also explained that some nurses who had passed their IELTS were interviewing nurse candidates abroad via skype creating a positive atmosphere for nurses to showcase their departments.

- The Chair shared that he almost wished he was a student investigating a career in nursing as the current staff passion he had seen at a recruitment event was outstanding and inspiring.

- The Chief Executive recently met the University of West England regarding nursing recruitment and shared that the lack of bursary was having quite a considerable effect, particularly in mature students. The effect on mental health nursing was noted to be even worse, a concerning point considering the support that mental health offer our services. She noted less nurse recruits for September and was investigating what could be done to recruit more through clearing and would discuss this further with the Director of Nursing and Director of Human Resources. **DL/ MA/ DS**

[10:33]

RESOLVED: That the Board note the early positive variance to budget recognising that firmer conclusions maybe drawn after month 2.

REPORT OF THE CHAIR OF THE WORKFORCE COMMITTEE OF THE MEETING HELD ON 9 JUNE 2017

In the absence of Ms Barber the Chair explained that he would take the report as read but noted comments at the end of the report which discussed evaluating the VCP process and queried how long this had been running for. The Director of Human Resources and Organisational Development shared that it had been running for nine months and that at the next Workforce Committee the group would review this and debate whether this was the best way of conducting the process.

RESOLVED: That the report of the Chair of the Workforce Committee held on 9 June 2017 be noted.

(The Board adjourned from 10:35am to 10:45am)

162/17 BOARD ASSURANCE FRAMEWORK

The Chief Executive presented the Board Assurance Framework (BAF) and thanked the Director of Clinical Strategy for creating a comprehensive set of objectives which helped guide the framework into place. She explained that the first, traditional purpose of the BAF

was to describe the major risks which could lead to the Trust not delivering the strategic objectives and the second purpose was to serve as an update on progress. It was reinforced that the BAF was currently a work in progress and further updates would be completed for example a few strategic objectives were yet to be included.

The Chair commended the Chief Executive on her progress with the BAF and thanked the Director of Clinical Strategy for the excellent strategic objectives work.

Mr Graves expressed how pleased he was to see the BAF taking shape and raised that within previous discussions there have been conversations regarding enablers and leading indicators which he felt should be linked together in order to track what progress is being made against these. The Chief Executive felt the enabling strategies section could be looked at and developed further to think about key enablers and activities as opposed to strategies. Mr Graves agreed that this would note tangible things that have happened within the organisation in order to plan what should follow. The Chief Executive pondered that it may be helpful to think about the quarterly progress report and pinpoint key activities within a period that have been completed which contribute to delivery whilst also considering key activities in the future period to establish what should be done. BAF template to be developed to include. **DL / NJ**

The Chief Executive posed a question for the Chair regarding how Committee Chairs should use the BAF in order to have the correct oversight of the objectives they're responsible for and noted that she had interpreted this in different ways. Mr Graves agreed noting that there is a formal commitment for the Audit and Assurance Committee to review the BAF. In response the Chair confirmed that he felt it was good practice for Board Committees to review objectives relating to their Committee within the BAF as it would provide a tight link between them and the Board.

The Chief Executive noted that a final piece of work was to be done once a senior post in Corporate Governance was established to ensure that the Trust had the taxonomy right in regards to committees and groups as there were a lot of mixed dynamics regarding committees and groups and further thought would be given to this.

RESOLVED: That the Board receive the report for assurance that the Executive is sighted on and actively controlling the potential risks to achievement of the Trust's objectives.

[10:53]

163/17 SMARTCARE PROGRAMME BOARD REPORT

The Director of Clinical Strategy presented the SmartCare Progress Report to the Board to provide assurance from the SmartCare Programme Board, on progress within the continued operation of

TrakCare and planned implementation of Phases 1.5 and 2. The report set out the proposed timeline for the deployment of further functionality of TrakCare and the Director of Clinical Strategy wished to highlight specific points:

- Radiology order communications: the ability for clinical staff to order diagnostics tests and imaging through the system by the end of September. A high level of engagement from the Radiology teams was noted with staff confident they could complete all tasks required of them but identifying 'to be' processes and the impact on those people who would be end users of the system was noted to be less robust. Learning from the previous deployment this would not go live until all user acceptance tests had been satisfactorily completed. This could impact on the proposed timeline.

- Pharmacy stock control potentially in place by November. Technical issues had been noted that may compromise the timeline and should these occur this would need to be deferred until January due to increased performance over the Christmas period.

- Oncology proposal: the clinical aspects of oncology could be in place by the beginning of April 2018. This was noted to be quite a complicated deployment in terms of functionality however there was an operational driver to proceed within the timetable as the existing Oncology system, OPMAS, had previously been on the Risk Register as it is an unsupported system and therefore carries an inherited risk as it requires maintenance and cannot be updated to follow reporting requirements. If the deadline of 1st April 2018 to establish reporting could not be met then further negotiations would be needed with the commissioners regarding what the impact would be. The Director of Clinical Strategy explained that Oncology could not be deployed until the pharmacy elements were clear however she noted a high level of engagement from Oncology and praised the Specialty Director for taking a leadership role and noted that they had project governance arrangements within the speciality. Complexity was noted to be significant from the side of supplier however as though it is felt that the project has good characteristics for deployment Intersystems were unsure if Oncology should be the first area where the Trust goes live with some of the functionality. This would be reviewed through the project board.

- At the last Board it was agreed that the Resource Plan needed to be reviewed given that the timelines were different to what the Board agreed. The Director of Clinical Strategy noted that there was recognition from the learning of the last deployment that resources needed to be used differently and focus put on utilising the resources that were available to strengthen operational aspects rather than investing in a project team which had the risk of being marginal to the delivery of the business.

- The Director of Clinical Strategy also wished to note that recently a progressive conversation was had with the training team, clinical leads, project team and education and learning team where the areas worked together to establish where resources could best be utilised.

The project was noted to be progressing and the Director of Clinical Strategy would update the Board further in September. Following the presentation a few points were noted and raised by the Board:

- Mr Norton queried where benefits were tracked and the Director of Clinical Strategy responded that she would further investigate this as a specific portion of the funding had been allocated to this and explained that she was currently investigating working alongside the Department of Health to develop benefits tracking. Further information would be provided in the next report. **SP**

- Dr Feehily questioned how learning from the previous deployment had been built into planning. The Director of Clinical Strategy explained that there was forensic attention to what current processes were to capture "what is" and "what should be". There is also a live system where testing can occur without interfering with the clinical interface. Dr Feehily requested that future system deployments prioritise identifying impact for patients ensuring they are communicated effectively.

- The Chief Executive noted that she saw the successes and problems with TrakCare and felt that engagement of staff was crucial and wondered how some disenfranchised staff would be re-engaged? The Director of Clinical Strategy explained that consolidated training would be offered to cover both phase 1 and future phases for clinical staff. She noted that she had recently received a letter from senior clinicians raising concerns with TrakCare and felt this was an opportunity to consider how the interest of staff who recognise challenges can be built upon to include them as part of the solution. The Chair agreed it was important to embrace these individuals. The Medical Director noted that he would be utilising iLead to begin these conversations.

RESOLVED: That the Board note the report as a source of assurance that the programme to identify issues within the respective operational and support areas to achieve a satisfactory recovery for Phase 1 and planning for subsequent phases is robust.

[11:09]

164/17 RESEARCH UPDATE

The Director of Clinical Strategy presented the Research Update Report and explained that within the Quality and Performance Committee there had always been measures of research performance but that this was an opportunity for the team to

showcase some of their achievements and pose the question of what would the Board like to see regarding this in the future. She noted that the Trust compared favourably in comparison to others in regards to what is done and the related costs in terms of the amount that was invested and the number of patients recruited to trials. A less impressive point noted was the performance against metrics and there was recognition amongst the team that this was not as good as it should be, in particular the time to first recruitment of a trial participant into a trial. This was noted to be often out of the control of the researchers as trials are often closed early by sponsors. The income stream was noted to be fragile for research as activity was non-recurring and therefore infrastructure was difficult to manage in a consistent way. Due to a decrease in income previous incentivisation schemes where income was shared with the clinician are no longer run but this was noted to be an issue nationally.

The Director of Finance requested to meet with the Director of Clinical Strategy outside the meeting to further discuss the topic. He queried the targets noted in Figure 1 and the Director of Clinical Strategy explained that these were set by the Regional Research Network. The Finance Director queried how the Trust compared against other hospitals and the Director of Clinical Strategy discussed other Trusts and stressed it was important to recognise that the Trust was at a disadvantage as it was not aligned with a medical school. The Chief Executive suggested this was reflected on further and the options of going further afield considered. **SW/SP**

Mr Graves suggested asking the team their thoughts on what would increase activity and the Director of Clinical Strategy agreed to progress this.

The Chair thanked the Director of Clinical Strategy for presenting this important topic and requested that the report is reviewed six monthly and felt a patient story around being involved in a trial would be interesting. **(NJ to add to work plan)**

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

[11:20]

165/17 ORGAN DONATION EXECUTIVE SUMMARY REPORTS

Dr Mark Haslam (Anaesthetic Consultant and Clinical Lead for Organ Donation) shared a presentation to support the Organ Donation Report. The key points noted within this presentation were:

- The background around donation: Dr Haslam noted that this was a large public health issue with 7,000 people currently waiting on a transplant list, 91 of these people within Gloucestershire County, with three people in the country dying each day awaiting a transplant and six people in Gloucestershire dying in the last year.

- The Trust's Organ Donation Committee: the team is made up of a variety of people including nurses, clinicians, and volunteers who have been touched by donation and transplant and who want to share their experience in a positive way. Representatives from departments involved in the donation pathway (the Emergency Department, Critical Care, Theatres, Bed Services and the mortuary) also attend.

- The community was noted to be tremendously supportive with 50% of residents signed up to the Organ Donation Register which is far in excess of the national average of 38%. Dr Haslam also noted excellent support over the years from the Board.

- Identification of patients who are potential donors was noted to be key as out of the half a million people who die in the country each year only 5,000 die in the exact circumstances that allow donation to happen. Therefore identifying patients through the committee is key so that they can be referred on to the specialist nurses. Dr Haslam stressed the importance of ensuring that the processes around this were in place to promote donation within the Trust.

- All figures and deaths are audited.

- The testing rate for last year was noted to be 100%. Referral rate was noted to also be 100% as was Specialist Nurse involvement. Ten patients were identified with one patient subsequently noted as unsuitable therefore nine families were approached. Of these six families gave consent and five patients went on to become donors. Dr Haslam reinforced that though the numbers were small they were key to allowing transplant to having.

- Donation After Circulatory Death (DCD) (expand) numbers were noted to be higher with a larger number of patients identified as potential donors. The outcome is lower and 37 patients were triggered via audit last year. Dr Haslam explained that these numbers have improved and continue to improve. Of these patients nine families were approached by the specialist nurse and Dr Haslam stressed the importance of families being given time and information sensitively and at the right moment as many families who decline go on to regret this decision. One organ donation went ahead.

- Overall six donations went on to facilitate fourteen transplants.

- The two challenges noted were the need to keep Donation after Brain Stem Death DBD (expand) at 100% while increasing the referral rates for DCD. Dr Haslam noted this could be achieved by looking at consent rates and providing education through the Emergency Department, Critical Care and Study days. A recent study day involved families who had said yes to organ donation and what it meant to them

alongside people who had had a transplant themselves. Simulation days had also taken place with a mannequin rigged up as a normal patient where model care is discussed, engaging staff in conversations around how to discuss death and donation to normalise this.

- Within the community consent rates need to be discussed and organ donation needs to be discussed amongst loved ones as without conversations this can become a terrible burden on family. Dr Haslam shared that the team was engaging communities from the young to the old and across all faiths with an upcoming event arranged at the Friendship Cafe in Gloucester in October. As a point of interest, Dr Haslam noted that our consent rates were poor in comparison to European neighbours.

In conclusion Dr Haslam stressed the importance of normalising organ donation in a clinical environment and within the community and focusing on what a gift this can be.

The Medical Director noted that patients do not have to be ventilated for cornea donation and queried whether there was a shortage of corneas? Dr Haslam agreed that tissue donation is often forgotten about, with most patients able to donate tissue, and remarked that there was a shortage of corneas, heart valves and skin tissue. He shared that information regarding tissue donation was being incorporated within leaflets in the Emergency Department and End of Life Care.

The Chair queried what the Board could do to support this issue and Dr Haslam requested the opportunity to present each year and asked that the Board support the team with communication. The Chair thanked Dr Haslam for the presentation and report.

RESOLVED: That the board receive the report as a source of assurance regarding the quality of organ donation activities in the Trust.

[11:39]

166/17 MINUTES OF THE MEETING OF THE COUNCIL OF GOVERNORS HELD ON 19 JUNE 2017

The Chair indicated that these minutes were for information and would take them as read.

Dr Feehily noted that within page 7, bullet point 2 the minutes referred to morality as opposed to mortality. The Board Administrator would correct this. **NJ**

RESOLVED: That the minutes be noted.

[11:40]

167/17 GOVERNOR QUESTIONS

The Lead Governor thanked the Board and expressed that he was pleased with openness of debate in particular with regards to the Finance report remarking that this was in contrast to Board meetings of the past. He noted that he was pleased to see the progress made in Quality and Performance Committee as well as the progress with the Risk Register and Board Assurance Framework. He found the public reports on performance within the Trust useful.

Within the Quality and Performance Committee minutes the Lead Governor made reference to the phrase 'Elective Deaths' and felt this phrase should not be used in future. He thanked the Board for the debate around TrakCare and noted the comment regarding benefits realisation a point also raised within a Governors meeting. He requested a reminder of the benefits of TrakCare be shared with the governors and this is to be progressed by the Director of Clinical Strategy. **SP**

[11:44]

168/17 STAFF QUESTIONS

There were none.

169/17 PUBLIC QUESTIONS

There were none.

[11:44]

170/17 ANY OTHER BUSINESS:

Dr Feehily queried how the Trust would be impacted or involved by the overnight public interest circulating historic matters regarding blood donation. The Chief Executive felt that she could not answer at this point and would need to await national guidance.

The Chair thanked the Board for their contributions.

[11:45]

ITEMS FOR THE NEXT MEETING:

The Director of Human Resources and Organisational Development shared that he would update the Board on Workforce and Quality Systems.

171/17 DATE OF NEXT MEETING

The next **Public** meeting of the **Main Board** will take place at **9am** on **Wednesday 13 September 2017** in the **Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital**

173/17 EXCLUSION OF THE PUBLIC

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

The meeting ended at 11.45 am.

Chair
13 September 2017

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD –SEPTEMBER 2017

MATTERS ARISING

CURRENT TARGETS

Target Date	Month/Minute/Item	Action with	Issue	Action	Update
July 2017	June 2017 146/17 Governor Questions	**AK**	Capacity issues and extended waiting times	The Interim Chief Operating Officer to review the content of letters, and share information more widely with staff about extended waiting times. To also explore the possibility of providing generic information in out-patient areas. The Chief Executive suggested that receptionists and volunteers might also be well placed to advise patients about likely waiting times.	*Nursing staff and receptionists communicate to the patients when a clinic is running more than 30 minutes late. The same information is displayed on the white boards and electronic boards. As a result of the query we have asked for a quick audit to see compliance in all areas. We have also asked for facility for this information on self-check in desks when these are released.*
September 2017	July 2017 158/17 Chief Executive's Report	**AK**	Whether rise in demand was related to the warm weather and if a similar trend had been identified elsewhere	The Associate Director of Planning and Performance resolved to investigate this as reviewing the data for June demand has increased by 3.6% with an increase in minor injuries after 8-10pm.	*June was a high demand month across the NHS which in our local health economy was related to the staffing shortages in MIUs and out of hours GP cover.*
September 2017	July 2017 159/17 Quality and Performance Report – Report of the Chair of Quality and Performance Committee Meeting held on 28 June 2017	**DS**	The importance of learning from TrakCare and that this was a project about behavioural change with an Information Technology (IT) component rather than an IT project with a behaviour change component. Important that the IT did not completely take over.	The Director of Human Resources and Organisational Development shared that he would align with the Head of Leadership and Organisational Development and the project team.	*Completed: The Head of Leadership and Organisational Development has joined the SmartCare Programme Board with a view to assisting with 'lessons learned' and considering OD support for future phases.*

September 2017	July 2017 160/17 Financial Performance Report – Report of the Chair of the Finance Committee meeting held on 29 June 2017	**SW**	At a recent Local Negotiating Committee (LNC) Doctors confessed to a lack of understanding of CIP.	The Director of Human Resources and Organisational Development suggested the Director of Finance attend this committee in order to explain and engage staff further.	*Completed: The Director of Finance and Director of Programme Management will attend the October Committee.*
September 2017	July 2017 161/17 Workforce Report – Report of the Director of Human Resources and Organisational Development	**DL/MA/DS**	Less nurse recruits for September were noted and further investigation is needed around what could be done to recruit more through clearing.	Chief Executive to discuss further with the Director of Nursing and Director of Human Resources.	*Completed: Incentives agreed for students applying to UWE and Gloucestershire University resulting in target recruitment numbers being achieved by both institutions*
September 2017	July 2017 162/17 Board Assurance Framework	**DL/NJ**	Quarterly progressing of the report, pinpointing key activities within a period that have been completed which contribute to delivery whilst also considering key activities in the future period to establish what should be done.	BAF template to be developed to include	*Completed: Added to Work Plan for October 2017.*
September 2017	July 2017 163/17 Smartcare Programme Board	**SP**	Benefits Tracking	Director of Clinical Strategy responded that she would further investigate this as a specific portion of the funding had been allocated to this and explained that she was currently investigating working alongside the Department of Health to develop benefits tracking. Further information would be provided in the next report.	*Closed: Central funding for Benefit Realisation support agreed to enable the creation of benefit dashboards, benefit realisation consultancy support and a longer term clinical impact analysis on a set of defined areas to be agreed across the three Trusts in the SmartCare collaborative group. This equates to a total of £199,625 over the contracted period.*

					Future report will include a section on progress with benefits realisation.
September 2017	July 2017 164/17 Research Update	**SW/SP**	Research	The Director of Finance requested to meet with the Director of Clinical Strategy outside the meeting to further discuss the topic.	*Completed: finance support for research activity clarified.*
September 2017	July 2017 166/17 Minutes of the Meeting of the Council of Governors held on 19 June 2017	**NJ**	Minute amendments	Dr Feehily noted that within page 7, bullet point 2 the minutes referred to morality as opposed to mortality. The Board Administrator would correct this.	*Completed: Minutes amended.*
September 2017	July 2017 167/17 Governor Questions	**SP**	Benefits realisation: the benefits of Trakcare to be shared with Governors	To be progressed by the Director of Clinical Strategy.	*Linked to 163/17.* *Presentation to a future CoG when first benefits dashboards are available.*

FUTURE TARGETS

Target Date	Month/Minute/Item	Action with	Detail & Response
August 2017	May 2017 101/17 Patient Story	**SC**	In response to questions from Ms Barber and Mr Foster about learning for the Board, the Chief Executive said that a quarterly review after the patient story will be presented to the Board. *Ongoing.*

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – SEPTEMBER 2017

REPORT OF THE CHIEF EXECUTIVE

1. Current Context

1.1 Operational pressures have eased over the summer weeks and this has been reflected in some of the strongest A&E performance we have seen for some time – particularly in respect of performance on the Gloucestershire Royal site. This is especially worthy of note as this relationship between improved performance and reduced operational pressures has not been consistently demonstrated in the past.

1.2 In respect of other operational areas, the Trust is broadly on plan with the levels of activity it is expected to do for both elective and non-elective surgery and inpatient care which is positive for patients and importantly in respect of our performance recovery in relation to the referral to treatment time standard (RTT). Outpatients and diagnostics however, continue to underperform both in respect of activity levels and performance and this is a significant focus for the leadership and operational teams.

2. National

2.1 Nationally, despite still being at the height of summer, attention has turned to preparation for Winter and Pauline Philip, National Director for Urgent and Emergency Care has begun to set out the priorities for the coming months. As ever the priority is to ensure that hospital services remain safe during the predicted peaks in activity and notably that A&E performance does not decline. In addition, the aim is to ensure that wherever possible, as many planned services continue to operate during these times of peak activity. A small number of Trusts are perceived to be at particular risk of reduced performance and as such additional support will be offered to these Trusts in the run up to Winter. Gloucestershire Hospitals is one of these Trusts reflecting our historical poor performance and the deterioration in performance observed last Winter.

3. Our System and Community

3.1 System partners continue to work constructively on the implementation of our Sustainability and Transformation Plan (STP). Of note, in this reporting period the STP partners have been working together to develop and finalise the *Gloucestershire One System Business Case* which is the case required to be approved in advance of the commencement of public consultation on our vision for elective and emergency services across the County. The case will set out the proposals for consultation and the risks and benefits associated with the different options which will include the development of Urgent Care Centres across Gloucestershire and the reconfiguration of elements of the Trust's service portfolio – all with the aim of improving the quality of care for patients throughout the County and reducing the reliance of patients on hospital based care.

3.2 In addition to the above work, partners have also been working closely to develop a bid against a national capital fund which will be made available to NHS England in the autumn of this year against which STP systems can bid to secure capital which supports delivery of their vision and strategic goals. The STP will be submitting a bid in the region of c£35m which will largely support development of the estate on the Gloucestershire Royal and Cheltenham General Hospital sites. Bids are expected to significantly exceed the capital available and teams across the STP partner organisations are working hard to ensure a strong bid from Gloucestershire. The deadline for bids is 1st September and announcements regarding the successful bidders are expected in the late autumn.

3.3 On August 15th Mr Keith Willett, National Director for Acute Care visited the community, at the request of Mr Bren McInerney. One of the Trust's Health Care Assistants, Angela McFarlane joined the day to share her perspectives from the 'front line' with Mr Willett and other participants. Angela has been instrumental in improving care for elderly patients, particularly those with dementia, in our Trust and her contribution was hugely valued by all those involved. The day was a huge success and I am personally very grateful to Bren for continuing to show case the great things we do in Gloucestershire, that all too often are not celebrated as they should be, with leaders outside the County.

4. Our Trust

4.1 Last month, my report updated the Board on the final inspection report from the Care Quality Commission which resulted in the Trust retaining its overall *Requires Improvement* rating though importantly, reflecting progress whereby 73% of the Trusts services are now rated *good* or *outstanding*

The focus since my last report has been the development of plans and actions to address the feedback from the inspection where opportunities for improvement were identified. The report identified 55 'must do' actions which teams across the Trust are now addressing in order that our goal of becoming a *good* or *outstanding* Trust at our next inspection is realised. The plan is overseen by the Board's Quality & Performance Committee.

4.2 One of the most concerning issues affecting the Trust is the ongoing impact arising from the deployment of the Trust's new electronic patient record, TrakCare. Operational impacts continue to be felt by both staff and patients, particularly in respect of outpatient services. The Trust has now been working with its recovery partner Cymbio for approximately four weeks and is on plan to achieve the actions and milestones agreed as part of the contract for services. Alongside this work, the Trust is embarking upon a 'deep dive' into four outpatient specialities with the aim of getting these specialties 'TrakFit' and in doing so develop an approach that can then be rolled out across all outpatient specialities in the Trust. The specialities in question are paediatrics, ophthalmology, cardiology and rheumatology. In addition, the Board will be spending time at its September Development Seminar discussing our challenges and next steps in respect of the SmartCare programme.

In the interim, work is underway between the Central Booking Office and the Patient Advice and Liaison Service (PALS) to look at how the Trust can better support patients and GPs who continue to experience problems with accessing outpatient services or have outpatient booking enquiries they wish to make.

4.3 I was delighted to have the opportunity to celebrate through my weekly message, the Trust's excellence in teaching which has been recently recognised by our junior doctors. The Trust's cardiology service was rated best in the country, by trainees working in the service for *Overall Satisfaction;* this is a huge achievement and even more impressive when considered in the context of the operational pressures facing the service and the relative position just two years ago when the service was ranked 13th nationally. I am very grateful to Dr Tushar Raina and the team of tutors and supervisors that have delivered this outstanding achievement.

4.4 On this note, the Trust continues to take every opportunity to recognise and celebrate success and with this context I am thrilled to have had such a positive response to this year's Staff Awards. Around 400 nominations were received from staff and patients wanting to recognise the extraordinary efforts of a colleague or member of our staff. This is almost twice as many as last year and 140 more than we have received since we established the awards five years ago - hopefully a positive sign that staff are re-engaging with the Trust after a difficult year. Shortlisting has taken place and we are set for a very exciting evening on the 21st September when we come together to celebrate the efforts of all those shortlisted as well as the winners.

4.5 Completion of recruitment to the Board is almost complete and start dates for the three incoming executive directors are now agreed; all directors will have commenced by the 1st November. Our final non-executive director (NED) vacancy has also been recently ratified by the Council of Governors and Alison Moon joins the Trust as our clinic NED on the 4th September 2017. I am very much looking forward to working with these new colleagues. Arrangements to say goodbye to those long serving and valued colleagues that we are losing in comings months are in hand and being communicated widely. It is with huge regret that I inform you that Dr Sally Pearson has taken the decision to retire early next year and will be leaving the Trust at the end of January 2018. Following an early rise to the role of Director of Public Health, Sally has enjoyed a hugely successful career in Gloucestershire, firstly in the Health Authority pursuing her first passion of public health and for the last 15 years as Director of Clinical Strategy for the Trust. Plans to replace Sally are in hand and as you'd expect arrangements to acknowledge her huge contribution to the County will commence in due course.

4.6 Finally, since my last report, the Trust has received and published the findings and recommendations of the Financial Governance Review. The Chair and Chief Executive briefed staff, partners and stakeholders following publication of the findings and answered questions that were posed. The Review will be received into the September meeting of the Health and Care Overview & Scrutiny Committee (HCOSC).

Deborah Lee

Chief Executive Officer

September 2017

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD MEETING – September 2017

Report Title
Quality and Performance Report
Sponsor and Author(s)
Authors: Felicity Taylor Drewe, Assistant Director Planning & Performance and Arshiya Khan, Interim Chief Operating Officer Sponsor: Arshiya Khan, Interim Chief Operating Officer

Audience(s)									
Board members	✓	Regulators	✓	Governors	✓	Staff	✓	Public	✓

Executive Summary

Purpose

This report summarises the key highlights and exceptions in Trust performance for July 2017.

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

Key Issues to note

During July, the Trust did not meet the national standards or Trust trajectories for A&E 4 hour wait; 2 week wait, 31 day and 62 day cancer standard; 18 week referral to treatment (RTT) standard (shadow reporting); and 6 week diagnostic wait. There is significant focus and effort from operational teams to support performance recovery. There is clinical review and oversight of patients waiting care to ensure that patients do not come to harm due to delays in their treatment.

However, in July 2017, the trust performance against the 4 A&E standard showed an improvement of 4.1% compared to June 2017. Whist, this represents the best performance against the 4-hour standard since November 2016, the year to date performance and Q2 performance remains under the national standard and the NHSI trajectory.

A&E attendances followed a similar pattern to June with circa 700 more attendances than in July 2016. In July the trust recorded the highest number of attendances in a day at 498 which is 125 more than the trust average. The Minor Injuries & Illness Units continued to face staffing challenges which coupled with out of hour staffing gaps is impacting on our A&Es.

Within the trust the various work streams under the Emergency Care Programme have gained moment and good progress was noted for the numbers seen by GPs at the front end in Gloucester A&E, overall numbers going through our ambulatory care services, continued downward trend in the medically fit for discharge patient numbers, early Comprehensive Geriatric Assessment and discharge from A&E by our geriatricians were extended service is provided during the weekdays. These initiatives have improved the flow of patients on the emergency care pathways with fewer bed related breaches.

The main focus for the next quarter is improvement in the number of breaches due to late assessments in A&E through efficiencies within the A&E, the implementation of a Surgical Assessment Unit, extended opening hours for ambulatory care at Gloucester and establishment of medical HOT clinics.

In respect of RTT, we continue to monitor and address the data quality issues following the migration to TrakCare. We have started reporting the RTT position in shadow form and will return to full reporting for December 2017. Operational teams continue to monitor and manage the long waiting patients on the Referral to Treatment pathways, however, as reported previously to the Board we will continue to see 52 week breaches until full data cleansing exercise is completed. In July we reported 11,out of these there were three patient choices and carried forward from June.

All patients have been treated. No clinical harm has been reported, from the reviews undertaken to date.

Our performance against the cancer standard saw deterioration against the 2 week standard with performance at 79.6% and lower than recorded for June. The main tumour sites that were compromised on the 2 week pathway were colorectal that continues to see a very high demand resulting in capacity issues, breast and dermatology due to staffing issues. This shows the relatively low capacity resilience due to national staff shortages in some of our highly subscribed services. Waiting list initiatives are in place and performance for breast and dermatology is expected to deliver against the standard from September whilst work continues with our primary care colleagues for managing demand on our colorectal services. In, addition, to these three areas a higher than average of patient choices contributed to the breaches. This trend is expected to continue in August and will impact on the 31 day and 62 days performances in the coming months.

In, July the 31 days Diagnosis to Treatment performance was 95.8% against a target of 96.2%.
62 days Referral to Treatment performance was 74.7% which represents an improvement in performance compared to June, however, as noted above the pressures on the 2 week pathway will impact on this in later months.

The Trust did not meet the diagnostics target in July at 5.3%, mainly driven by underperformance in three areas; colonoscopy with 190 breaches; audiology with 72 (breaches and endoscopy with 295. Recovery plans are in place for these diagnostic areas, an assessment of performance of all the diagnostic areas, capacity and individual recovery plans is being undertaken for delivery against the standard by December 2017.

As requested during the May Trust Board members received in June the breakdown of the reporting regime against each of the targets, in particular those that are reported quarterly or in arrears and those that we cannot at present report because of data quality issues. We will start reporting on cancelled urgent operations from September. The Trak team is looking at solutions for easily capturing information regarding dementia and VTE whilst the informatics team work on stabilising the data underpinning the reporting information for length of stay, readmissions and occupancy rates. An update on these reports will be provided to the Quality and Performance Committee until full reporting is restored.

Conclusions

Cancer under-performance is significant this month and relates to the 2 week wand 62 day pathway. For the former, issues with capacity, some issues of referral increase (Dermatology and Colorectal) and patient choice (sometimes due to short notice appointments) have impacted delivery. For the latter capacity in Urology is a known factor which continues to impact the overall recovery plan, though the speciality delivered its recovery trajectory in July.
Diagnostic recovery and underlying issues with Endoscopy remains an area of focus as it impacts other pathway's delivery. Additional waiting lists undertaken by the Trust and through external parties will support recovery. Alongside this the Board level support for the Central Booking Office and RTT validation will significantly positively impact teams ability to manage breaches and forward plan the required capacity ahead of time.

Significant focus from operational teams continues in order to improve performance against the national standards. Clinical oversight of patients awaiting care continues to ensure that no patients come to harm due to delays in their treatment.

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 four national waiting time standards ensures the Trust remains under scrutiny by local commissioners and regulators
Regulatory and/or Legal Implications
The Trust remains under regulatory intervention for the A&E 4-hour standard.
Equality & Patient Impact
Failure to meet national access standards impacts on the quality of care experienced by patients. There is no evidence this impacts differentially on particular groups of patients.

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

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

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

Gloucestershire Hospitals NHS
NHS Foundation Trust

Quality and Performance Report

Reporting period July 2017

to be presented at August 2017 Quality and Performance Committee

Executive Summary

The following summarises the key successes in July 2017, along with the weaknesses, opportunities, risks and concerns for the Trust into August 2017.
Executive Summary:
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 or Trust trajectories for A&E 4 hour wait; 2 week wait, 31 day and 62 day cancer standard; 18 week referral to treatment (RTT) standard; and 6 week diagnostic wait. There is significant focus and effort from operational teams to support performance recovery. There is clinical review and oversight of patients awaiting care to ensure that patients do not come to harm due to delays in their treatment.
The Key areas of focus remain for delivery of Cancer quality and performance against speciality level trajectories. The trajectory for delivery of cancer performance of the 62 day pathway was set to deliver from July 2017, which has not been achieved. Alongside this there has been a failure to deliver in the 2 week wait pathway.

Cancer underperformance is significant this month and relates to both the 2 week wait and 62 day pathway. For the former, issues with capacity, some areas of referral increase and patient choice (sometimes due to short notice appointments) have impacted delivery. For the latter capacity in Urology is a known factor which continues to impact the overall recovery plan, though this speciality has met its speciality level July performance trajectory.
Diagnostic recovery and underlying issues with Endoscopy remains an area of focus as it impacts on other pathway's delivery. Additional waiting lists undertaken by the Trust and through external parties will continue to support the Trust's recovery. Alongside this the Board level support for Central Booking Office and RTT validation will significantly positively impact teams to manage breaches and forward plan the required capacity ahead of breaches.
Key areas where additional reports have been provided for the Quality and Performance Committee are:
• Emergency care
• Trakcare Operational Recovery (including Reporting Re-commencement template)
• Mortality

Strengths

• A&E 4 hour performance has delivered the best performance since November 2016 and is encouraging, however performance is below the trajectory set and agreed with NHS I. A full report has been provided with a detailed action plan to the committee.
• 104 days performance has stabilised and is a significant improvement in the catergory of patients who do not have a TCI (21 June to 8 in July), which is positive, this combined with our analsysis of 62 day pathway 'long wait category' indicates we are making progress for our longest waiting patient cohort.
• Medically fit at 63 and DTOC at 32 , remain relatively stable during this period as would be anticipated for the summer period.
• Further improvement in the length of stay (LOS) for elective (2.75%) and stabilisation of non-elective length of stay at(5.63%), is a positive position and to be anticipated during the summer months.
• Reporting of the number of patient discharge summaries sent to GPs within 24 hours externally has recommenced. Whilst the performance is not at the required level (61.7%), a daily report is now available to support management and external reporting will re-commence on a monthly basis.
• The engagement of Glanso will continue to support a number of RTT specialities and diagnostics areas.
• Overall clinic slot utilisation is positive, this is still an area for further development but good progress is being made.
• Performance in the majority of the additional quality measures has been good; the three exceptions remain the same this month as last.

Weaknesses

• Due to the implementation of the new EPR system we are shadow reporting the number of patients waiting 18 weeks from referral to treatment.

• Patient Treatment Lists (PTLs) have residual data quality issues which continues to impact management of patient journeys. This will be addressed through the deployment of additional clerical staff as approved at May Board. Despite this, teams are focused on reviewing patients >35 weeks and predicting potential breaches on a more routine basis.

• Achievement of the national standard for % of patients seen within 6 weeks for Diagnostic tests is not delivering against target at 5.3% for July.

• Achievement of the Cancer standards is a significant concern, whilst the 62 day performance was not expected to deliver in the earlier part of the year, performance will not meet the required recovery trajectory. 2 week wait cancer standard has been impacted by issues of demand in colorectal but other specialities have also not delivered which has impacted on the overall performance. 2 week wait performance was not anticipated to fail in 2017/18.

A number of statutory returns and reporting requirements are not able to be reported due to issues with TrakCare. Separate assurance through the Appendix detailing the reporting areas and the return to reporting due date will be provided on a monthly basis as part of the TrakCare recovery report, for Quality and Performance committee, August 2017.

Opportunities

• Development of Standard Operating Procedures (SOP) for key areas being developed across teams. This will provide action cards supporting staff to enter it right first time and to provide corporate guidance on operating procedures e.g. DNA's. There is some evidence that we are not operating our Access Policy in full and this has led to some breaches e.g. >52 week waits, which will be addressed through the development of SOPs. This will be managed through the Planned Care Programme Board.

The development of the Cymbio work to support the diagnostic and identification of the remaining issues to support operational recovery and the data quality issues raised through input of data into trak. These can then be addressed with targeted training support to prevent the issues re-occurring.

• The South West Cancer Alliance is providing some additional funding, £60k to support the delivery of the colorectal pathway. In addition, the IST (& NHS I) have offered a day's support on 1/09 to review the current Cancer Recovery Plan.

• Support from commissioners has been sought in relation to cancer across a number of areas:

- Referral rate increases (colorectal & dermatology) – CCG to support communication to targeted practices in the CGH area.
- Clinical support for triage of 2ww pathway patients in Lower GI supporting communication with Primary Care on appropriate pathway utilisation.

• Confirmation from local Commissioners that they will support escalation of late cancer referrals to neighbouring Trusts. It is recognised that these are small in number but have caused breaches in the 62 day pathway for patients.

• The speciality of Urology despite significant service re-configuration with the Multi- Assessment and Diagnostic clinic has surgical capacity barriers. This pathway impacts on a number of the Trusts key constitutional targets. The August Q&P committee are receiving a 'deep dive' and review of the recovery plan. Early indications are that the speciality is making improvement in the 'long-waiting' patients and that the MAD clinic configuration is having an impact to stabilise performance. A recent locum urologist appointment commencing in September represents a significant opportunity for this speciality to deliver.

Risks & Threats

• Cancer performance remains a significant risk for the Trust. 2 week wait analysis shows a combination of factors have led to a decline namely: capacity; clinic cancellations and patient choice. Patient choice levels are being benchmarked as the Trust needs to ensure we are offering reasonable notice of appointments. In relation to clinic cancellations the process is smoother, there have been some cancellations due to the normal seasonal pattern of leave and some that have been related to the operational practice to support trak. This combined with an increase in specific specialities has impacted the overall delivery of 2 week wait and is forecasted to continue to impact delivery to target for August & September. Key tumour sites are Breast; Lower GI and Skin which are impacted by Capacity related issues. 2 week wait for July is un-validated performance of 79.6%, representing a significant decline. This represents a Trust risk.

• For 62 day cancer, since last year there has been an increase in the number of breaches per month but a number of patients on the 62 day pathway has decreased. Capacity and backlog are the main reasons for breaches. Performance excluding Urology impacts of a range between 5 % to 9%. Performance of long-waiting patients overall is improving. Within March's reported position across England, GHFT was ranked 8th when reviewing the number patients in the 63 to 76 day category. This is being reviewed when the National data set is available to track and benchmark progress (recent data since March has been requested to provide benchmarking opportunity in relation to long wait patients). July performance is 74.7%.

• The Diagnostic target, is under-delivering at 5.3% (where we failed to deliver against the 1% of patients to wait over 6 weeks). This was mainly attributable to Colonoscopy (274 breaches; Audiology (72 breaches).Recovery plans for these areas are in place, delivery remains a risk across the summer period. Outsourcing and waiting list initiatives remain a component part of the recovery plan for Gastroscopy and Colonoscopy modalities.

Performance Against STP Trajectories

* = unvalidated data

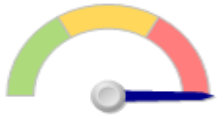
Indicator		Month											
		Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
ED Total Time in Department - Under 4 Hours	Trajectory	87.70%	89.50%	89.20%	88.30%	92.20%	91.00%	90.00%	88.10%	77.40%	80.00%	80.00%	83.50%
	Actual	82.85%	79.96%	79.90%	83.50%								
Referral To Treatment Ongoing Pathways Under 18 Weeks (%)	Trajectory	73.80%	75.00%	76.10%	77.20%	78.40%	79.50%	80.60%	81.80%	82.90%	84.00%	85.20%	86.30%
	Actual												
Diagnostics 6 Week Wait (15 Key Tests)	Trajectory	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%
	Actual	7.22%	5.30%	5.26%*	5.30%								
Cancer - Urgent referrals Seen in Under 2 Weeks	Trajectory	93.00%	93.00%	93.00%	93.10%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%
	Actual	91.40%	90.50%	85.90%	79.60%								
Max 2 Week Wait For Patients Referred With Non Cancer Breast Symptoms	Trajectory	93.40%	93.00%	93.10%	93.50%	93.00%	93.50%	93.10%	93.10%	93.30%	93.20%	93.20%	93.30%
	Actual	90.40%	94.00%	94.10%	57.30%								
Cancer - 31 Day Diagnosis To Treatment (First Treatments)	Trajectory	96.40%	96.20%	96.10%	96.20%	96.20%	96.10%	96.10%	96.20%	96.10%	96.30%	96.10%	96.30%
	Actual	94.90%	95.90%	95.40%	95.80%								
Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	Trajectory	98.40%	100.00%	98.30%	98.10%	100.00%	98.40%	98.00%	98.00%	100.00%	100.00%	100.00%	98.40%
	Actual	100.00%	100.00%	100.00%	100.00%								
Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	Trajectory	95.30%	95.70%	96.40%	94.90%	94.50%	94.90%	94.10%	94.60%	94.40%	94.40%	94.10%	94.20%
	Actual	98.50%	100.00%	100.00%	99.50%								
Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	Trajectory	94.90%	94.80%	94.00%	95.80%	94.50%	95.20%	94.10%	94.90%	94.70%	94.10%	94.50%	94.10%
	Actual	90.00%	97.50%	97.90%	93.60%								
Cancer 62 Day Referral To Treatment (Screenings)	Trajectory	92.00%	94.40%	90.00%	94.70%	91.20%	91.90%	92.90%	92.90%	90.50%	92.90%	92.90%	90.50%
	Actual	86.30%	91.80%	88.90%	89.10%								
Cancer 62 Day Referral To Treatment (Upgrades)	Trajectory	100.00%	80.00%	100.00%	87.50%	80.00%	91.70%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Actual	100.00%	100.00%	100.00%	57.10%								
Cancer 62 Day Referral To Treatment (Urgent GP Referral)	Trajectory	77.70%	79.40%	80.10%	85.40%	85.20%	85.20%	85.30%	85.50%	85.30%	85.40%	85.40%	85.20%
	Actual	78.30%	75.90%	71.20%	74.70%								

Summary Scorecard

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

QUALITY

Adult Inpatients who received a VTE Risk Assessment	Emergency Readmissions Percentage
Friends and Family Test Score - ED % Positive	Friends and Family Test Score - Inpatients % Positive
Friends and Family Test Score - Maternity % Positive	Hospital Standardised Mortality Ratio (HSMR)
Hospital Standardised Mortality Ratio (HSMR) - Weekend	MRSA Bloodstream Cases - Cumulative Totals
Number of Breaches of Mixed Sex Accommodation	Summary Hospital Mortality Indicator (SHMI) - National Data



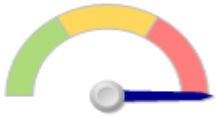
OPERATIONAL PERFORMANCE

- Cancer 62 Day Referral To Treatment (Screenings)
- Cancer 62 Day Referral To Treatment (Upgrades)
- Cancer 62 Day Referral To Treatment (Urgent GP Referral)
- Diagnostics 6 Week Wait (15 Key Tests)
- ED Total Time in Department - Under 4 Hours
- Referral To Treatment Ongoing Pathways Under 18 Weeks (%)

FINANCE

Performance against CIP - % QIA's from PMO completed

YTD Performance against Financial Recovery Plan



LEADERSHIP AND DEVELOPMENT

- Sickness Rate
- Staff Engagement Indicator (as Measured by the Annual Staff Survey)
- Workforce Turnover Rate

STRATEGIC CHANGE

Trust Scorecard

* = unvalidated data

Category	Indicator	Target	Month											Quarter				Annual	
			Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	16/17 Q2	16/17 Q3	16/17 Q4	17/18 Q1	16/17	17/18
Key Indicators - Quality																				
Friends and Family Test Score	Friends and Family Test Score - ED % Positive		87.7%	85.4%	84.7%	88.0%	78.4%	85.7%	80.3%	85.5%	86.9%	84.4%	75.6%	77.5%	87.0%	84.8%	83.9%	81.7%	86.5%	79.9% *
	Friends and Family Test Score - Inpatients % Positive		94.6%	95.3%	95.2%	92.0%	90.1%	88.9%	100.0%	91.6%	89.3%	92.2%	91.2%	90.8%	94.4%	93.0%	93.5%	90.8%	94.0%	90.8% *
	Friends and Family Test Score - Maternity % Positive		85.7%	100.0%	97.8%	98.2%	100.0%	100.0%	100.0%	98.9%	94.5%	96.8%	97.0%	100.0%	92.3%	98.2%	99.1%	96.2%	98.6%	96.8% *
Infections	MRSA Bloodstream Cases - Cumulative Totals	0	1	1	1	1	1	2	2	3	0	0	0 *	1	1	1	3		3	0 *
Mixed Sex Accommodation	Number of Breaches of Mixed Sex Accommodation	0	4	0	0	5	0	3	0	3	4	11	10	16	9	5	6	25	39	41
Mortality	Hospital Standardised Mortality Ratio (HSMR)	Dr Foster confidence level	110.3	111.8	113	112.9	115.2	115.5	113.5	110.7					111.8	115.2	110.7		110.7	
	Hospital Standardised Mortality Ratio (HSMR) - Weekend	Dr Foster confidence level	119.4	119.5	119.9	117.4	119.3	118.7	116.8	115.1					119.5	119.3	115.1		115.1	
	Summary Hospital Mortality Indicator (SHMI) - National Data	Dr Foster confidence level		115.6			114								115.6	114				
Readmissions	Emergency Readmissions Percentage	Q1<6%Q2<5.8%Q3<5.6%Q4<5.4%	6.3%	6.2%	6.4%	5.8% *	7.0% *	6.4% *	6.1% *	5.1% *	7.1% *	7.1% *	5.6% *		6.5%	6.4% *	5.8% *	6.6% *	6.4% *	6.6% *
Venous Thromboembolism (VTE)	Adult Inpatients who received a VTE Risk Assessment	>95%	93.2%	93.9%	93.1%	92.2%									93.7%					
Key Indicators - Operational Performance																				
Cancer (62 Day)	Cancer 62 Day Referral To Treatment (Screenings)	>=90%	89.9%	100.0%	85.7%	97.0%	100.0%	82.8%	92.3%	95.5%	86.3%	91.8%	88.9%	89.1%	96.0%	96.0%	85.7% *	89.3%		
	Cancer 62 Day Referral To Treatment (Upgrades)	>=90%	100.0%	100.0%	50.0%			100.0%		100.0%	100.0%	100.0%	100.0%	57.1%	71.4%	71.4%	100.0% *	100.0%		
	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	>=85%	79.0%	76.8%	72.9%	79.2%	72.0%	62.7%	70.0%	70.7%	78.3%	75.9%	71.2%	74.7%	76.9%	76.9%	66.3% *	75.2%		
Diagnostic Waits	Diagnostics 6 Week Wait (15 Key Tests)	<1%	0.5%	1.5%	1.8%	0.9%	1.5%	1.2%	1.8%	4.6%	7.2%	5.3%	5.3% *	5.3%	0.8%	1.4% *	2.5% *			
ED - Time in Department	ED Total Time in Department - Under 4 Hours	>=95%	90.71%	88.97%	86.05%	86.67%	74.12%	74.75%	76.96%	77.86%	82.85%	79.96%	79.90%	83.50%	88.48%	82.40%	76.56%	80.87%		81.56% *
Referral to Treatment (RTT) Performance	Referral To Treatment Ongoing Pathways Under 18 Weeks (%)	>=92%	90.9%	90.2%	89.9%	87.0%	75.2% *								90.7%	84.4% *	74.3% *			
Key Indicators - Finance																				
Finance	YTD Performance against Financial Recovery Plan			-23.8	-23.9	-18.7	-18	-18	-18 *			-10.15			-23.8	-18				

Trust Scorecard

* = unvalidated data

Category	Indicator	Target	Month											Quarter				Annual	
			Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	16/17 Q2	16/17 Q3	16/17 Q4	17/18 Q1	16/17	17/18
Key Indicators - Leadership and Development																				
Sickness	Sickness Rate	G<3.6% R>4%	3.9%	3.8%	3.9%	3.9%	3.9%	3.9%	3.9%	4.0%	4.0%	4.0%	3.9% *		3.8%	3.9%	3.9%	4.0% *		
Staff Survey	Staff Engagement Indicator (as Measured by the Annual Staff Survey)	>3.8	.04	.04	.04	.04	.04	.04	3.71	3.71	3.71	3.71	3.71		.04	.04	.04	3.71		
Turnover	Workforce Turnover Rate	7.5% - 11%	11.6%	11.1%	12.0%	11.5%	11.7%	11.8%	12.0%	11.5%	12.1%	12.0%	11.8% *		11.5%	11.7%	11.8%	12.0% *		
Detailed Indicators - Quality																				
Dementia	Dementia - Fair question 1 - Case Finding Applied	Q1>86%Q2 >87%Q3>8 8%Q4>90%	88.5%	86.3%	88.6%	90.4%									88.3%					
	Dementia - Fair question 2 - Appropriately Assessed	Q1>86%Q2 >87%Q3>8 8%Q4>90%	100.0%	100.0%	100.0%	100.0%									100.0%					
	Dementia - Fair question 3 - Referred for Follow Up	Q1>86%Q2 >87%Q3>8 8%Q4>90%	100.0%	100.0%	100.0%	100.0%									100.0%					
Fracture Neck of Femur	Fracture Neck of Femur - Time To Treatment 90th Percentile (Hours)		50.6	68	49.2	40.5	49.1	47 *	41.6 *	44.9 *	46.1 *	44.3 *	49 *		63.7	46.9	44.9 *	47.2 *		
	Fracture Neck of Femur Patients Seeing Orthogeriatrician Within 72 Hours		98.6%	96.2%	100.0%	95.8%	100.0%	89.7% *	100.0% *	97.1% *	98.0% *	98.4% *	98.3% *		96.6%	98.0%	94.7% *	98.3% *		
	Fracture Neck of Femur Patients Treated Within 36 Hours		75.4%	67.3%	68.3%	81.7%	63.5%	79.2% *	80.0% *	75.4% *	76.5% *	78.1% *	71.2% *		67.2%	71.6%	77.8% *	75.3% *		
Infections	C.Diff Cases - Cumulative Totals	17/18 = 37	16	20	21	25	27	34	34	42	1	5	8 *	10	20	27	42		42	5 *
	Ecoli - Cumulative Totals												20	37						
	MSSA Cases - Cumulative Totals	No target	50	59	71	79	90	95	105	114	6 *		7	15	59	90 *	114 *		114	6 *
Maternity	Percentage of Spontaneous Vaginal Deliveries		60.3%	63.3%	63.1%	61.1%	61.3%	60.0%	61.1%	61.9% *	61.2% *	64.4% *	65.3% *	62.4% *	63.5%	61.8%	61.7% *	63.6% *	63.6% *	63.1% *
	Percentage of Women Seen by Midwife by 12 Weeks	>90	90.8%	91.5%	91.6%	90.6%	86.2% *	93.4% *	86.9% *	88.8% *	89.3% *	84.9% *	89.2% *	83.2% *	92.3%	89.9% *	81.5% *	85.9% *	87.3% *	81.8% *
Medicines	Rate of Medication Incidents per 1,000 Beddays	Current mean	3.2	3.6	3.6	2.9									3.6					
Never Events	Total Never Events	0	0	0	1	0	0	0	0	0	0	2	1 *	0 *	1	1	0		2	2 *
Patient Falls	Falls per 1,000 Beddays	Current mean	6.1	6.7	5.6	6.2									6					
	Total Number of Patient Falls Resulting in Harm (moderate/severe)		8 *	11 *	6 *	4 *	17 *	12 *	7 *	6 *	3 *	4 *	9 *	5 *						

Trust Scorecard

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Category	Indicator	Target	Month											Quarter				Annual	
			Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	16/17 Q2	16/17 Q3	16/17 Q4	17/18 Q1	16/17	17/18
Patient Safety Incidents	Number of Patient Safety Incidents - Severe Harm (major/death)		3	3	3	8	1	4	0	3 *	3 *	0 *	4 *	2 *	2	4				
	Number of Patient Safety Incidents Reported		932	962	909	986	1,064	1,285	1,162	1,144 *	900 *	1,268	1,148	1,149 *	998	986				
	Patient Safety Incidents per 1,000 Beddays		32.9	33.7	31.1	34.5									34.7					
Performance Initiation & Delivery	Performance in Delivery: Recruiting to Time for Commercially Sponsored Studies														33.3%	27.3%				
	Performance in Initiation: Percentage of Studies that are Eligible to Meet 70 Day Target														50.0%	66.7%	25.0%			
Pressure Ulcers Developed in the Trust	Pressure Ulcers - Grade 2	R:=1% G:<1%	1.17%	0.71%	0.61%	1.14%	1.62%	0.57%	0.97%	0.87%	0.50%	1.23%	0.49% *	1.12% *						
	Pressure Ulcers - Grade 3	R: = 0.3 G: <0.3%	0.23%	0.12%	0.12%	0.11%	0.12%	0.23%		0.37%	0.13%	0.12%	0.12% *	0.50% *						
	Pressure Ulcers - Grade 4	R: =0.2% G: <0.2%									0.13%	0.12%	0.00% *	0.00% *						
Research Accruals	Research Accruals	17/18 = >1100	120	126	104	144	66	90	64	78	123	176	289 *	111 *	135	104	88	717 *	3,045	956 *
RIDDOR	Number of RIDDOR	Current mean	1	1	0	0	4	1	5	2	2	2	3 *	2 *	1	1	3		2	2
Safer Staffing	Safer Staffing Care Hours per Patient Day		7	7	7	7	11	7	7	7	7	7	9	7 *	7	8	7	8 *	8	7 *
Safety Thermometer	Safety Thermometer - Harm Free	R<88% A 89%-91% G>92%	93.5%	92.9%	92.9%	92.8%	91.4%	91.4%	90.6%	91.3%	94.0%	92.4%	92.7%	91.3% *	93.1%	92.4%	0.0% *			
	Safety Thermometer - New Harm Free	R<93% A 94%-95% G>96%	97.6%	97.8%	97.8%	97.7%	95.4%	96.7%	97.1%	97.0%	97.7%	95.8%	96.6%	95.0% *	98.0%	97.0%	0.0% *			
Sepsis Screening	2a Sepsis – Screening	>90%	96.0%	98.0%	98.0%	98.0%	96.0%	100.0%	98.0%	96.0%	88.0% *	88.0% *	98.0% *		97.0%	97.0%	96.0%			
	2b Sepsis - treatment within timescales (diagnosis abx given)	>50%	42.0%	41.0%	60.0%	65.0%	69.0%	44.0%	70.0%	64.0%	78.0% *	69.0% *	67.0% *		45.0%	64.0%	0.0% *	71.0% *		
Serious Incidents	Number of Serious Incidents Reported		1	3	4	4	2	1	2			5	1 *	2 *	2	3				
	Percentage of Serious Incident Investigations Completed Within Contract Timescale		100%	100%	100%	100%	100%	100%	100%			100%	100% *	100% *	100%	100%				
	Serious Incidents - 72 Hour Report Completed Within Contract Timescale		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			100.0%	100.0% *	100.0% *	100.0%	100.0%				

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Category	Indicator	Target	Month											Quarter				Annual	
			Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	16/17 Q2	16/17 Q3	16/17 Q4	17/18 Q1	16/17	17/18
Staff Safety Incidents	Rate of Incidents Arising from Clinical Sharps per 1,000 Staff	Current mean	2.5	1.2	2.2	1.8	2.4	2.2	1.4	2.1	1	1.2	2.2	2.7 *	1.7	2.1	1.9			
	Rate of Physically Violent and Aggressive Incidents Occurring per 1,000 Staff	Current mean	3.1	3	2.7	1.8	1.9	2.7	1.9	2.6	2.3	3.1	4.2	2.4 *	3.3	2.1	2.4			
Stroke Care	High Risk TIA Patients Starting Treatment Within 24 Hours	>=60%	79.5%	63.9%	65.4%	70.4%	85.2%	75.9%	68.2%	68.4%	64.0%	41.9%	70.2%	69.1%	69.8%	73.8%		60.2%		61.2% *
	Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	>=50%									33.3% *	32.5% *	26.1%	38.0%				30.5%		32.5% *
	Stroke Care: Percentage Spending 90%+ Time on Stroke Unit	>=80%	96.2%	88.9%	88.8%	93.3%	84.3%	83.6%	87.3%	66.1%	81.8%	84.6%	92.9%		90.0%	88.6%	0.0% *	86.4%		86.4% *
Time to Initial Assessment	ED Time To Initial Assessment - Under 15 Minutes	>=99%	80.8%	78.2%	77.7%	79.8%	48.8%	57.9%	68.5%	80.2%	81.9%	80.2%	75.9%	87.4%	78.6%	69.0%	69.1%	79.9%		81.4% *
Time to Start of Treatment	ED Time to Start of Treatment - Under 60 Minutes	>=90%	49.4%	44.9%	46.8%	49.1%	27.6%	35.4%	34.0%	31.2%	29.5%	28.8%	25.7%	32.3%	46.0%	41.3%	33.4%	28.0%		29.1% *
Detailed Indicators - Operational Performance																				
Ambulance Handovers	Ambulance Handovers - Over 30 Minutes	< previous year	155	187	186	99	189	201	104	47	34	54	57	47	541	474	352	145	1,884	192 *
	Ambulance Handovers - Over 60 Minutes	< previous year	1	0	1	0	13	7	1	0	1	0	4	0	1	14	8	5	26	5 *
Cancelled Operations	Number of LMCs Not Re-admitted Within 28 Days	0	4	2	3	0									10					6 *
Cancer (104 Days)	Cancer (104 Days) - With TCI Date	0	6	9	9	10	11	11	12	11	10	8	10	8						
	Cancer (104 Days) - Without TCI Date	0	60	65	49	45	49	56	42	42	47	80	32	35						
Cancer (2 Week Wait)	Cancer - Urgent referrals Seen in Under 2 Weeks	>=93%	86.2%	88.6%	89.0%	93.5%	92.6%	85.1%	94.7%	94.6%	91.4%	90.5%	85.9%	79.60%	88.2%	91.7%	90.1% *	89.1%		
	Max 2 Week Wait For Patients Referred With Non Cancer Breast Symptoms	>=93%	93.4%	96.4%	95.7%	92.5%	88.3%	89.4%	95.0%	97.1%	90.4%	94.0%	94.1%	57.30%	93.7%	92.0%	92.2% *	92.8%		
Cancer (31 Day)	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	>=96%	99.7%	98.8%	96.7%	93.8%	94.1%	90.1%	93.6%	96.8%	94.9%	95.9%	95.4%	95.8%	99.2%	94.9%	91.9% *	95.5%		
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	>=98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0% *	100.0%		
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	>=94%	100.0%	98.3%	100.0%	100.0%	95.0%	98.4%	100.0%	98.6%	98.5%	100.0%	100.0%	100.0%	99.5%	98.6%	99.2% *	99.5%		
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	>=94%	100.0%	100.0%	100.0%	89.4%	83.7%	84.2%	97.7%	87.8%	90.0%	97.5%	97.9%	93.60%	99.4%	90.7%	90.0% *	94.5%		

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			Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	16/17 Q2	16/17 Q3	16/17 Q4	17/18 Q1	16/17	17/18
Delayed Discharges	Acute Delayed Transfers of Care - Patients	<14	37	36	45	47	36	31	44	37	28	30	32		36	36	37	30 *	33	30 *
Diagnostic Waits	Planned / Surveillance Endoscopy Patients Waiting at Month End		479	405	350	375	465 *	268 *	694 *	681		963 *	522		405	465 *	681		7 *	
Discharge Summaries	Patient Discharge Summaries Sent to GP Within 1 Working Day	>=85%	89.5%	87.6%	88.9%	86.6%	31.2% *	44.2% *	52.9% *	57.4% *	63.2% *	64.7% *	61.7% *		88.3%	71.3% *	51.7% *	63.2% *	75.4% *	63.2% *
ED - Time in Department	CGH ED - Percentage within 4 Hours	>=95%	97.29%	96.09%	91.32%	94.36%	84.33%	87.47%	88.42%	88.50%	91.80%	92.30%	88.10% *	94.40%	95.46%	92.79%	88.00% *	90.70%	91.60%	91.70% *
	GRH ED - Percentage Within 4 Hours	>=95%	86.97%	84.81%	83.08%	82.38%	68.47%	67.83%	70.56%	71.80%	77.90%	72.90%	75.30%	77.70%	84.49%	82.64%	70.00% *	75.30%	79.20%	76.00% *
Length of Stay	Average Length of Stay (Spell)		5.43	5.55	5.39	5.67	5.84 *	5.76 *	5.56 *	5.34 *	5.11 *	4.87 *	4.99 *	4.97 *	5.38	5.54 *	5.55 *	4.99 *	5.38 *	4.98 *
	Length of Stay for General and Acute Elective Spells	<=3.4	3.84	3.65	3.52	3.5	3.59 *	2.8 *	3.01 *	2.81 *	2.85 *	2.66 *	3.01 *	2.75 *	3.69	3.32 *	2.87 *	2.84 *	3.08 *	2.82 *
	Length of Stay for General and Acute Non Elective Spells	Q1/Q2<5.4 Q3/Q4<5.8	5.81	6.03	5.87	6.32	6.52 *	6.58 *	6.3 *	6.19 *	5.78 *	5.48 *	5.58 *	5.63 *	5.79	6.24 *	6.35 *	5.61 *	6.08 *	5.61 *
Medically Fit	Number of Medically Fit Patients Per Day	<40	77	73	76	83	73	75	84	68	59	55	58	63	73	73	75	56		59 *
Referral to Treatment (RTT) Performance	Referral to Treatment Number of Ongoing Pathways Over 18 Weeks		4,527	4,850	4,978	6,574									13,887					
Referral to Treatment (RTT) Wait Times	Referral To Treatment Ongoing Pathways 35+ Weeks (Number)		419	476	536	579									1,367					
	Referral To Treatment Ongoing Pathways 40+ Weeks (Number)		193	250	215	250									643					
	Referral To Treatment Ongoing Pathways Over 52 Weeks (Number)	0	1	3	4	3									7					
SUS	Percentage of Records Submitted Nationally with Valid GP Code	>=99%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				100.0%	100.0%	100.0%		100.0%	100.0% *
	Percentage of Records Submitted Nationally with Valid NHS Number	>=99%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%				99.8%	99.8%	99.8%		99.8%	99.8% *
Trolley Waits	ED 12 Hour Trolley Waits	0	0	1	0	0	1	0	0	0	0	0	0	0	1	1	0	0	2	0 *

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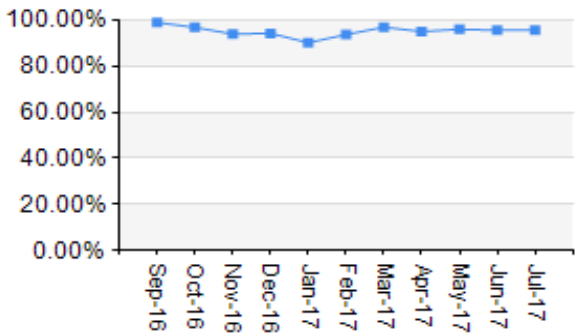
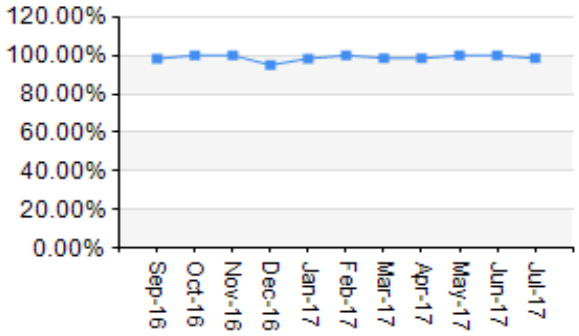
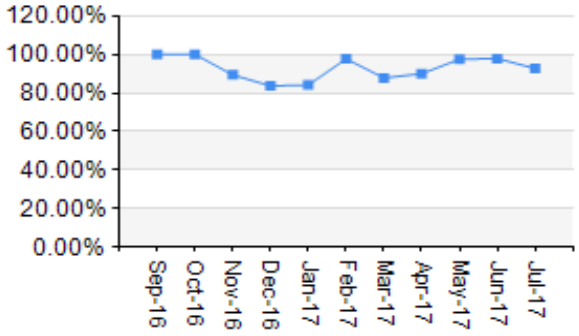
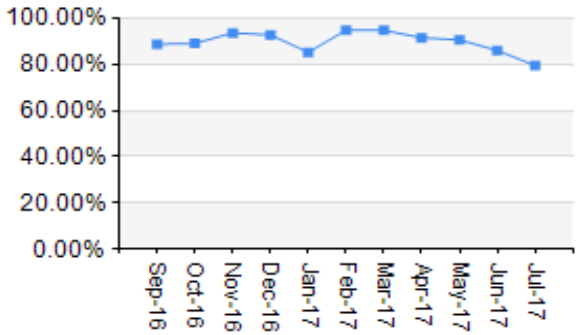
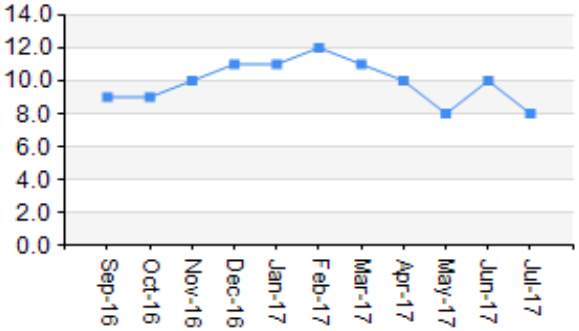
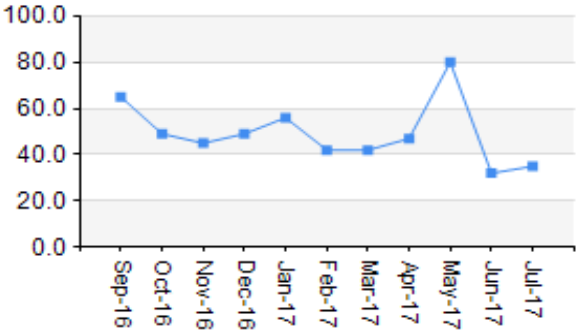
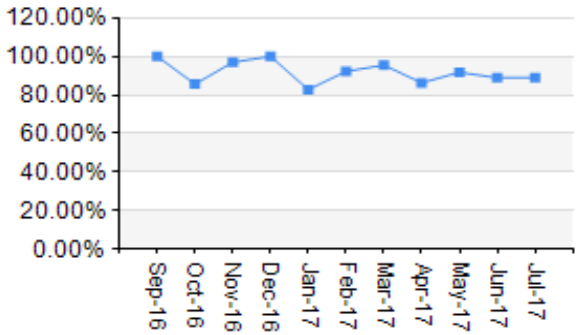
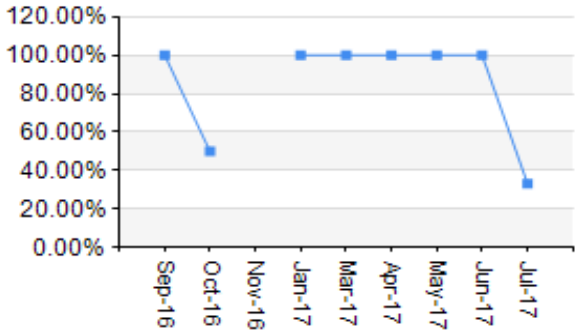
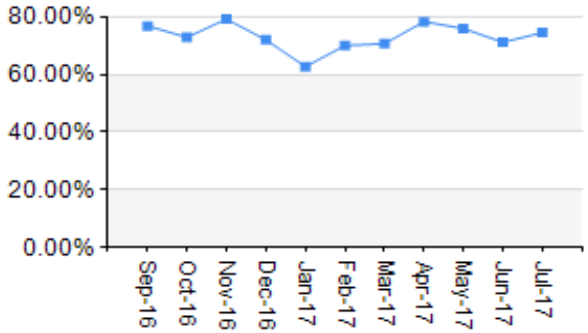
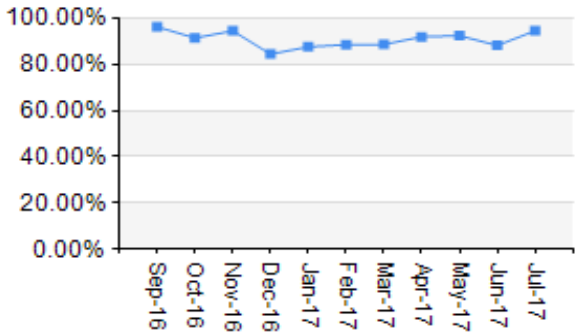
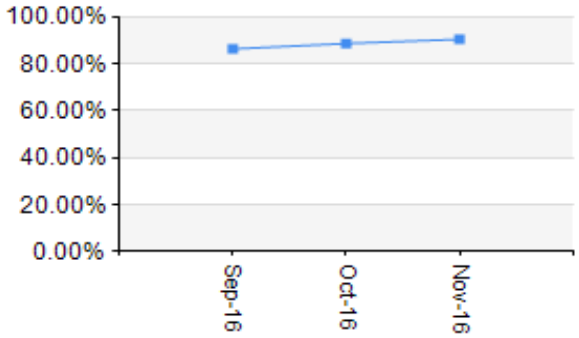
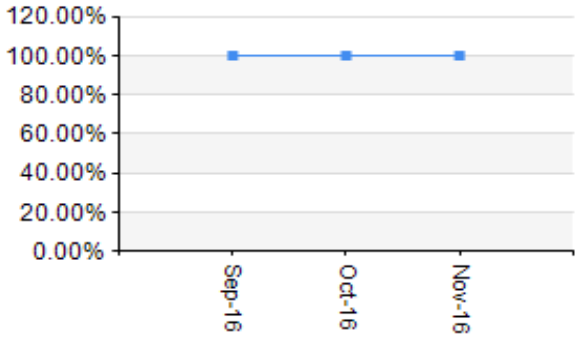
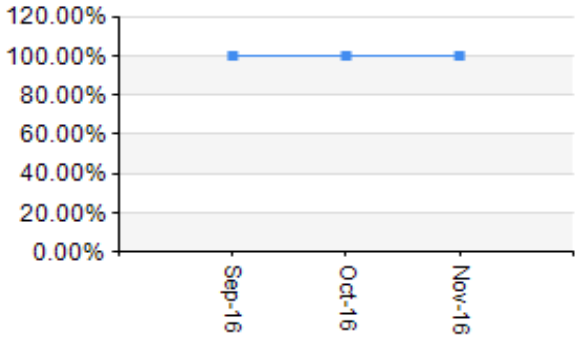
			Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	16/17 Q2	16/17 Q3	16/17 Q4	17/18 Q1	16/17	17/18
Detailed Indicators - Finance																				
Finance	Agency - Performance against NHSI set agency ceiling											3								
	Capital Service											4								
	Liquidity											4								
	NHSI Financial Risk Rating	3	1	1	1	1	1	1	1			4			1	1				
	Total PayBill Spend		28700	27400	28000	27900	27466	26998	27240						83100	83346				
Detailed Indicators - Leadership and Development																				
Appraisals	Percentage of Staff Having Well Structured Appraisals in Last 12 Months	>3.8	3	3	3	3	3	3	3	3	3	3	3		3	3	3	3		
	Staff who have Annual Appraisal	G>89% R<80%	81.0%	80.0%	80.0%	80.0%	80.0%	80.0%	82.0%	82.0%	80.0%	79.0%	78.0%		80.3%	80.0%	81.6%	79.0%		
Staff Survey	Improve Communication Between Senior Managers and Staff (as Measured by the Annual Staff Survey)	>38%	34.0%	34.0%	34.0%	34.0%	34.0%	34.0%	34.0%	34.0%	34.0%	34.0%	34.0%		34.0%	34.0%	34.0%	34.0%		
Staffing Numbers	Total Worked FTE		7,295	7,299	7,290	7,226	7,200	7,238	7,239 *						7,299	7,200				
Training	Essential Training Compliance	>=90%	92%	91%	91%	89%	89%	89%	89%	90%	89%	89%	89%		91%	90%	89%	89%		

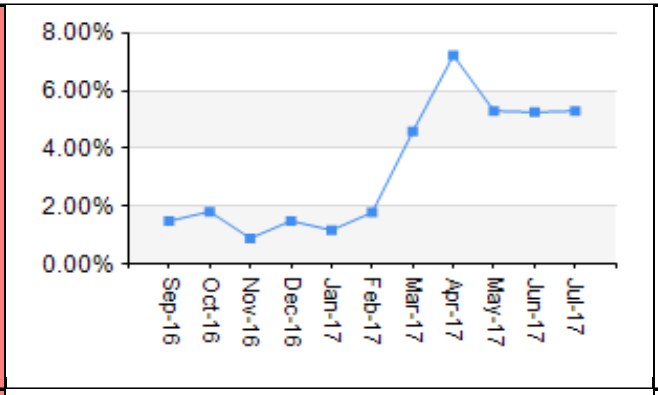
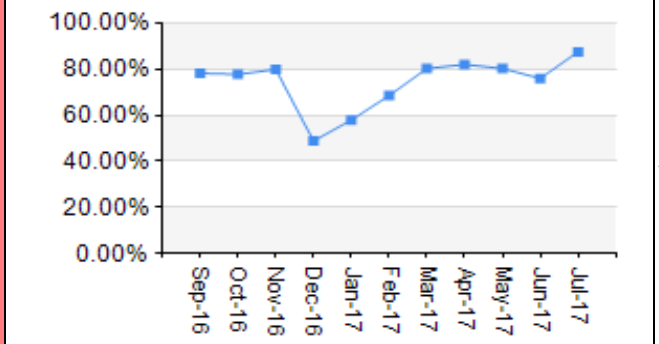
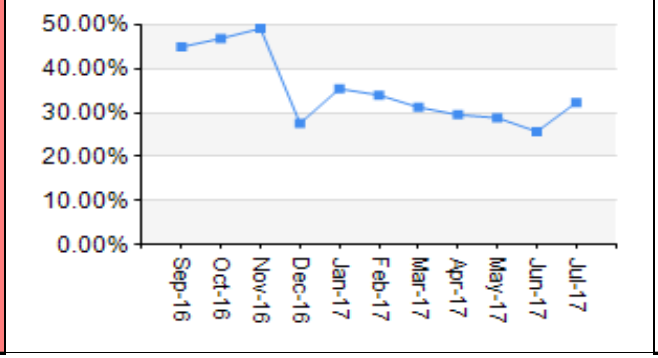
Exception Report

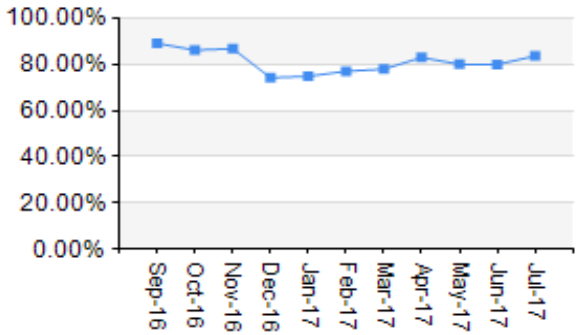
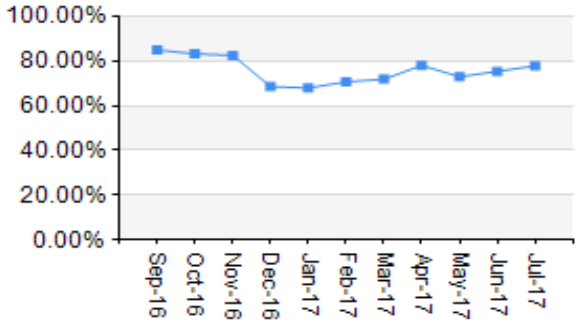
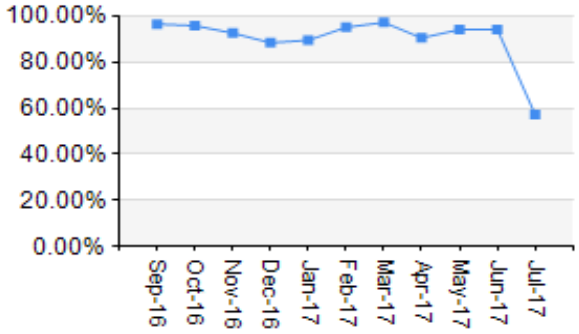
Metric Name & Target	Trend Chart	Exception Notes	Owner
Cancer - 31 Day Diagnosis To Treatment (First Treatments) **Target: >=96%**		Performance: 95.6% (un-validated July). Target: >=96% This represents 266 recorded treatments for July and our rolling average is 322 - so the picture is incomplete. The root cause relates to surgical capacity - refer to 31 Day (Surgery).	Deputy Chief Operating Officer
Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy) **Target: >=94%**		Performance for July is 98.5% (un-validated) which would meet the required standard. The validated performance for June was 100%.	Deputy Chief Operating Officer
Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery) **Target: >=94%**		Performance:93.6% Target: >=96% A worsening position of 5.2% against June's Figures of 97.9%. The root cause of the deterioration in performance is surgical capacity. In order to mitigate this in future months, additional consultant capacity is now in place and will start to have an impact in September.	Deputy Chief Operating Officer

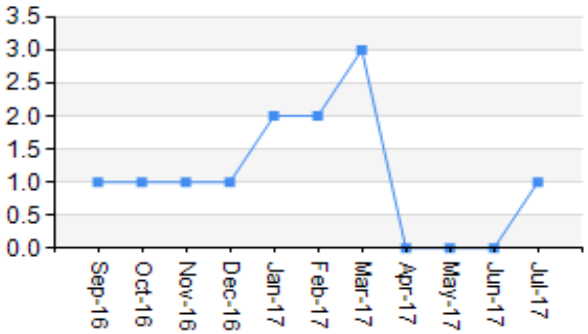
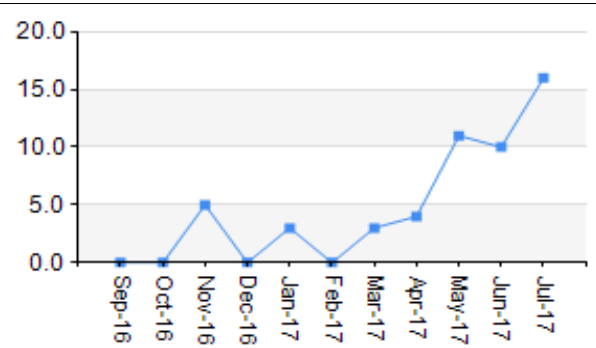
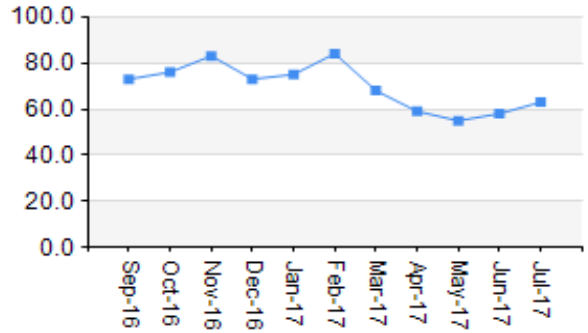
Cancer - Urgent referrals Seen in Under 2 Weeks **Target: >=93%**		Performance: 85.9% June, validated. Performance for July, un-validated is 79.4% Target: >=93% The performance for June 17 was 85.9% against a target of 93% (1903 patients seen, 267 breaches) and a trajectory of 91.2%. The main issue was in Lower GI - 78 of these breaches were in Lower GI and were due to a lack of capacity and increased demand. There were also 33 breaches in Upper GI for the same reason. There has been an issue with Endoscopy capacity which is being addressed with outsourcing; locum capacity and WLIs and capacity is now improving. There were also 54 breaches in Dermatology due to some demand increase and insufficient capacity – this is being addressed with a new consultant post (locum will impact in Autumn and permanent post would impact in early 2018) and the implementation of "super-clinics" (one-stop appointments) from November 2017.	Deputy Chief Operating Officer
Cancer (104 Days) - With TCI Date **Target: 0**		Performance: 8 Target: 0 There are currently 8 patients waiting over 104 days with a TCI, 5 of whom are urology patients. 4 patients have already been treated, but treatments outcomes not yet available (in some cases, due to the clearance of the Histology backlog).	Deputy Chief Operating Officer
Cancer (104 Days) - Without TCI Date **Target: 0**		Performance: 35 Target: 0 There are currently 35 patients waiting over 104 days without a TCI, 12 of whom are urology patients. The trajectory for Urology was recovery in July for this cohort of patients. Progress has been made in this speciality to address the long-waiting patients but the trajectory has not been met. Of the non-urology patients, all of the remainder were waiting due to complex pathways, patient choice or because they were not fit for treatment. All of these patients have plans. The Trust has developed a Clinical Validation Policy which includes a review of all patients waiting 104 days or more on a 62 day pathway. These patients will have a clinical harm review at the point at which they reach 104 days and a Root Cause Analysis of all breaches is undertaken. This policy was implemented from 31st March 2017. To date, 18 reviews have been completed and no patients have come to clinical harm. Overall the number of patients passing the 104 day mark is reducing month on month.	Deputy Chief Operating Officer

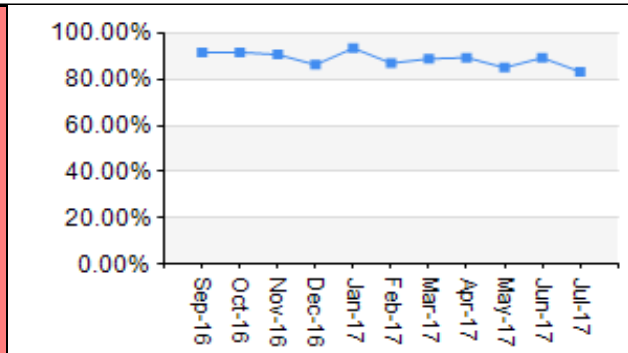
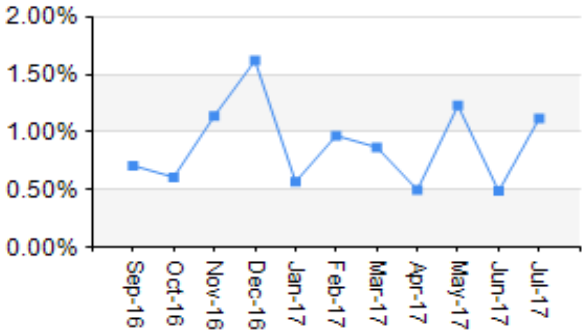
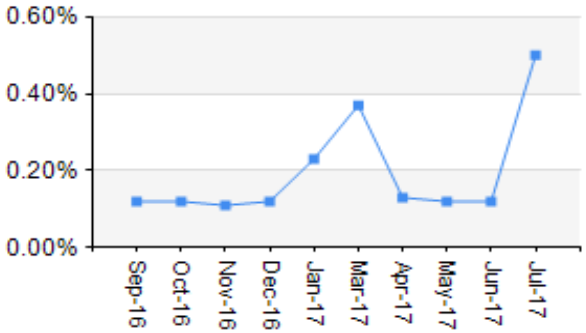
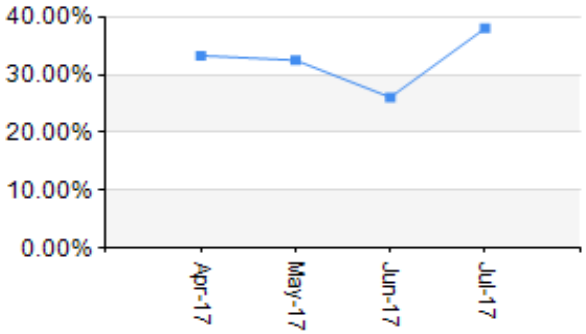
Cancer 62 Day Referral To Treatment (Screenings) **Target: >=90%**		Performance: 89.1% Target: >=90% The issues are similar as for the overall 62 day performance. Diagnostic capacity and surgical capacity are the root cause of under-performance. The Cancer Recovery Plan is included in the Q&P papers for ease of reference.	Deputy Chief Operating Officer
Cancer 62 Day Referral To Treatment (Upgrades) **Target: >=90%**		Performance: 33.3% Target: >=90% 3 patients in total with 2 breaches. One patient was a late referral from Hereford and one patient was a late treatment in Bristol. The third was due to patient choice. This is un-validated July performance and therefore subject to change.	Deputy Chief Operating Officer
Cancer 62 Day Referral To Treatment (Urgent GP Referral) **Target: >=85%**		Performance: 74.5% (un-validated July) Target: >=85% Performance in June was 71% (validated) against a standard of 85% and a trajectory of 81.6%. To date, there have been 29 fewer treatments than projected (153.5 as opposed to 182.5) and 10 more breaches than projected (43.5 as opposed to 33.5). 16 of these breaches were the result of backlog clearance and there were 15 breaches where the histology backlog was a contributory factor. The Histology backlog has since been cleared (as of 12.06.17) and there is a plan to sustain this position using outsourcing and locums until permanent appointments can be made to increase capacity in Histology. Overall the issues are diagnostic capacity (endoscopy, imaging and histology) and surgical capacity. The Trust has an agreed trajectory to recover the 62 day performance by July 2017, however the Trust has not delivered 62 day cancer in June or likely to in July. A recovery plan has been refreshed and a NHS I / IST visit is planned for the 1st September to support Trust delivery. Future recovery of 62 day performance has the following risks - demand increase in the Lower GI & Dermatology; delivery of the Multi Assessment and Diagnostic clinics in Urology; Haematology capacity and Surgical Capacity. All risks are identified by speciality in the Cancer recovery plan.	Deputy Chief Operating Officer

CGH ED - Percentage within 4 Hours **Target: >=95%**		Performance: 94.4% Target: >=95% CGH failed to achieve due a 3 days of increased attendances/acuity and insufficient medical staff to respond to surges in demand. Actions taken to improve performance moving forwards: + Reduction in number/improved managed of diverts + Closer working between ED/Site for early escalation + Work on-going with Surgical specialties re SOP/response times + Training programme for nurses to enhance their skill set	Deputy Chief Operating Officer
Dementia - Fair question 1 - Case Finding Applied **Target: Q1>86%Q2>87%Q3>88%Q4>90%**		Awaiting Trakcare enablement to commence collecting part of the data set required. Data previously collected via the Infoflex Discharge Summary, this functionality is temporarily inaccessible. An internal audit is proposed in conjunction with a review of the functionality improvements	Deputy Nursing Director & Divisional Nursing Director - Surgery
Dementia - Fair question 2 - Appropriately Assessed **Target: Q1>86%Q2>87%Q3>88%Q4>90%**		Awaiting Trakcare enablement to commence collecting part of the data set required. Data previously collected via the Infoflex Discharge Summary, this functionality is temporarily inaccessible. An internal audit is proposed in conjunction with a review of the functionality improvements	Deputy Nursing Director & Divisional Nursing Director - Surgery
Dementia - Fair question 3 - Referred for Follow Up **Target: Q1>86%Q2>87%Q3>88%Q4>90%**		Awaiting Trakcare enablement to commence collecting part of the data set required. Data previously collected via the Infoflex Discharge Summary, this functionality is temporarily inaccessible. An internal audit is proposed in conjunction with a review of the functionality improvements	Deputy Nursing Director & Divisional Nursing Director - Surgery

Diagnostics 6 Week Wait (15 Key Tests) **Target: <1%**		Performance: 5.3 % (July un-validated) Performance: 5.26% (June validated) Target: <1% The Trust did not meet the performance target for diagnostics in June and July. Performance in July deteriorated by 0.04%. Performance is under-delivering in key modalities as follows: - Colonoscopy (274 breaches); Audiology (72 breaches). A recovery plan is in place for these areas and details actions to improve including; for Colonoscopy- WLI clinics; appointment of locums and management of surveillance patients. For Audiology the replacement of capacity during the Autumn will impact performance positively.	Deputy Chief Operating Officer
ED Time To Initial Assessment - Under 15 Minutes **Target: >=99%**		Performance: 87.4% Target: >99% Significant improvements have been made against this. Actions taken to improve: + Streaming at the front door + HCA working with ENPs + re-visiting @see and treat@ model	Deputy Chief Operating Officer
ED Time to Start of Treatment - Under 60 Minutes **Target: >=90%**		Performance: Actions taken: + 2 quality improvement initiatives are being undertaken to improve performance including exploring medical triage + exploring alternative models and SOP with services + Project Manager supporting the service to increase fill rates and explore alternative recruitment models + Co-location of AEC/AMU to increase number of patients being cared for outside of ED	Deputy Chief Operating Officer

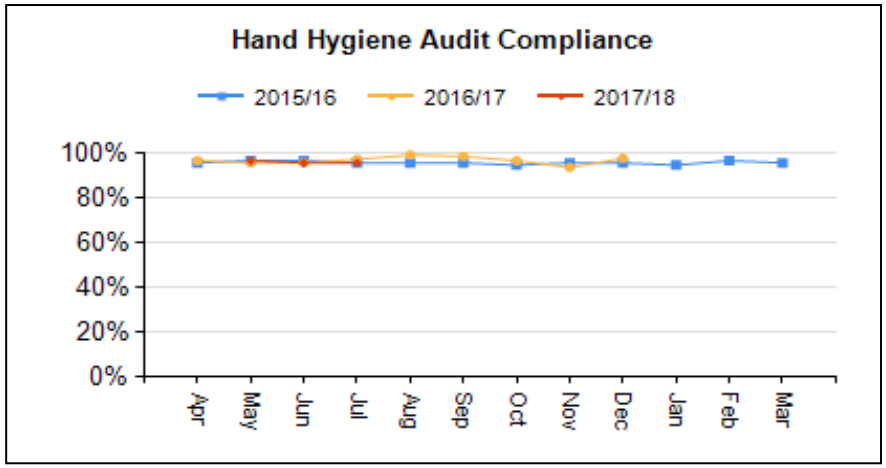
ED Total Time in Department - Under 4 Hours **Target: >=95%**		Performance: 88.3% July Target: >=95% Whilst performance has improved, we are still failing to achieve the key metric. Steps taken to improve performance going forwards: + Project Manager support diverted to assist with ED Medical rotas - focussing on fill rates and new recruitment strategies + The number of acute medical beds increased mid July through the flip of ACU and Cardiology + The co-location of AEC with AMU is increasing the number of patients going through AEC and enabling a significant proportion of GP expected to be seen on AMU rather than ED - numbers associated with both of these will increase going forward + Evening sessions for Frailty team + Increased capacity for inpatient angiogram Please refer to the Emergency Care Pathway report, July 2017 for a full action plan.	Deputy Chief Operating Officer
GRH ED - Percentage Within 4 Hours **Target: >=95%**		Performance: 77.7% Target: >=95% We failed to due to an inability to respond to surges in demand and bed availability Moving forwards: + Project Manager supporting with ED rotas - focussing on fill rate and alternative recruitment strategies + Increased number of Acute Medical beds + Co-located AEC/AMU to increase number of patients going through this pathway, including GP expected + Enhanced evening sessions for frailty service at the front door	Deputy Chief Operating Officer
Max 2 Week Wait For Patients Referred With Non Cancer Breast Symptoms **Target: >=93%**		Performance: 57.3% (un-validated July position) Target: >=93% The deterioration was due to an ongoing lack of Radiologist input into clinics for symptomatic patients. The breast consultants have been covering this shortfall by doing their own imaging, however capacity has been impacted with summer leave. A locum radiologist has now been appointed and the tracking of the August position indicates an improved position (currently 89.4%). It is anticipated that we will meet the standard from September.	Deputy Chief Operating Officer

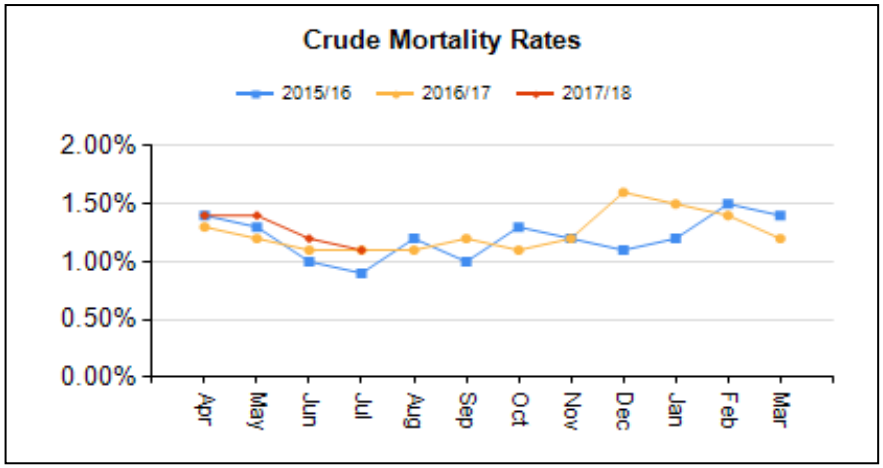
MRSA Bloodstream Cases - Cumulative Totals **Target: 0**		Exception report – ICT have identified 1 x post 48hr MRSA bacteraemia likely source is due to a peripheral cannula. Post infection review has taken place and an action plan is in place. Minutes and action plan available on request.	Director of Nursing and Midwifery
Number of Breaches of Mixed Sex Accommodation **Target: 0**		The routine mixing of sexes in inpatient clinical areas is unacceptable and must only happen in exceptional circumstances. Performance has declined in July. A total of 16 breaches affecting 52 patients was declared by the Trust for the month of July 2017. The analysis shows that all 16 breaches were within the Critical Care departments with the split being 10 at GRH and 6 at CGH. All breaches were due to the inability to move patients out of Critical Care areas once they had been made wardable. This is particularly prevalent at the GRH site where the operational OPEL status is often at level 3 (red) or 4 (black) and bed availability poor.	Head of Capacity and Patient Flow
Number of Medically Fit Patients Per Day **Target: <40**		Performance: 63 Target: <40 Month: 201707 The number of medically fit patients has increased over the past 2 months, social care delays, re-ablement and package of care are amongst the greatest with GRH internal delays contributing. Mitigating actions include the implementation of daily navigations meeting with social care and ward staff to escalate and unpick delays. In August operational standards will be implemented across partnerships to make transparent issues and enable joint holding to account. Internally the delays relate to therapy, diagnostic and SPA referral form completion. Internal professional standards for Therapy and Pharmacy have been agreed therapy and pathology will be signed off in the next week and all will be launched through board rounds. All standards have clearly reportable metrics. With regards Community hospitals the number of steps to get a patient referred and agreed needs to be reduced is too complex and leads to delay.	Deputy Chief Operating Officer

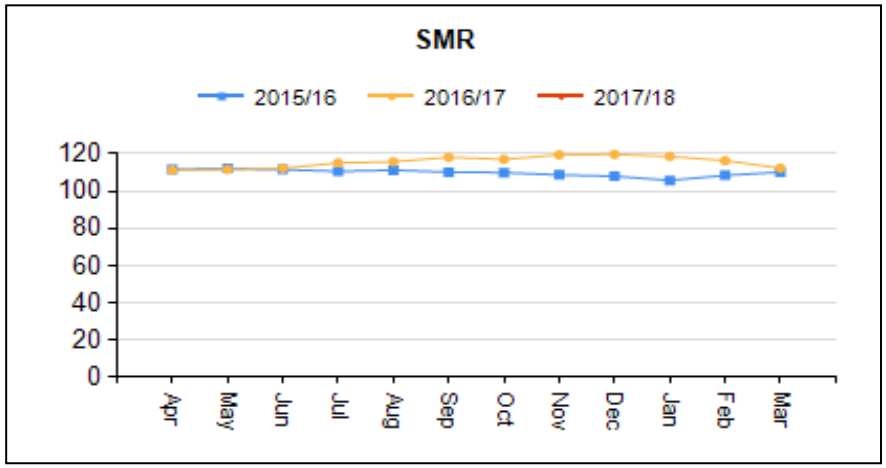
Percentage of Women Seen by Midwife by 12 Weeks **Target: >90**		The Booking data is currently inaccurate. Since implementation of TRACK data concerning date of booking has not been consistently entered onto the system as this is not a Mandatory Filed .The Division are looking to address this by issuing clear standard operating procedures to assist midwives in ensuring all the necessary fields are completed. Plans are in place to enter this data retrospectively from April to support accurate data analysis in future.	Divisional Nursing and Midwifery Director
Pressure Ulcers - Grade 2 **Target: R:=1% G:<1%**		For Grade 2 ulcers they are Datix'd and a modified Incident report is generated, which is then reviewed at Divisional level and at the Tissue Viability Steering group as for grade 3 and 4 ulcers.	Deputy Nursing Director & Divisional Nursing Director - Surgery
Pressure Ulcers - Grade 3 **Target: R: = 0.3 G: <0.3%**		Each grade 3 and 4 Pressure ulcer continues to be investigated against the Datix Proforma, and then presented at each Division via their review forum. There has been an increase in frailty ulcers where there has been a large co-morbidity factor with these patients. The Tissue Viability Steering Group continue to meet every three months to again review overall trends, and ensure the annual action plan to prevent ulcers is been progressed. Nationally the Trust is low in comparison to other Trusts, however, that does not mean we are complacent in our approach.	Deputy Nursing Director & Divisional Nursing Director - Surgery
Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour **Target: >=50%**		A significant amount of work is being undertaken between the Stroke/ED/Imaging teams to improvce performance for this key quality standard. Thorough weekly breach meetings have been established to review each breach - these are then being taken forward in the main Trust ED breach meetings. Common themes/actions have been pulled together for the last month and these have been cascaded to all departments. A wider communications drive is planned for the Organisation at the end of September.	Director of Operations - Medicine

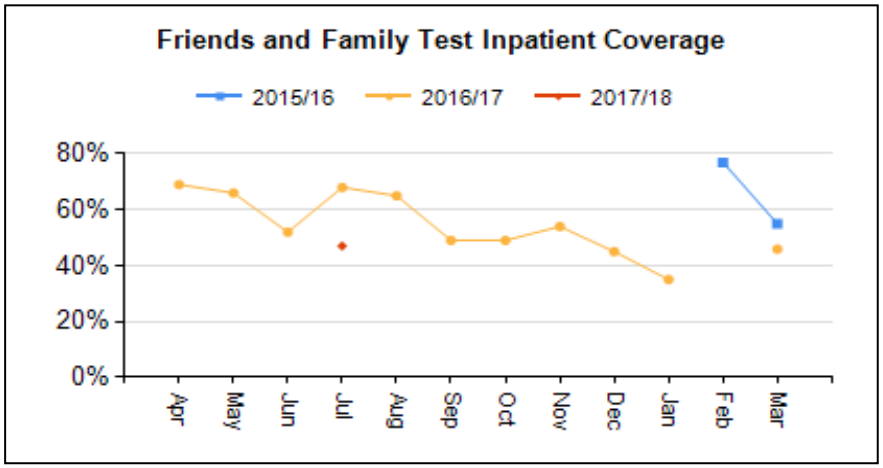
Contextual Indicators

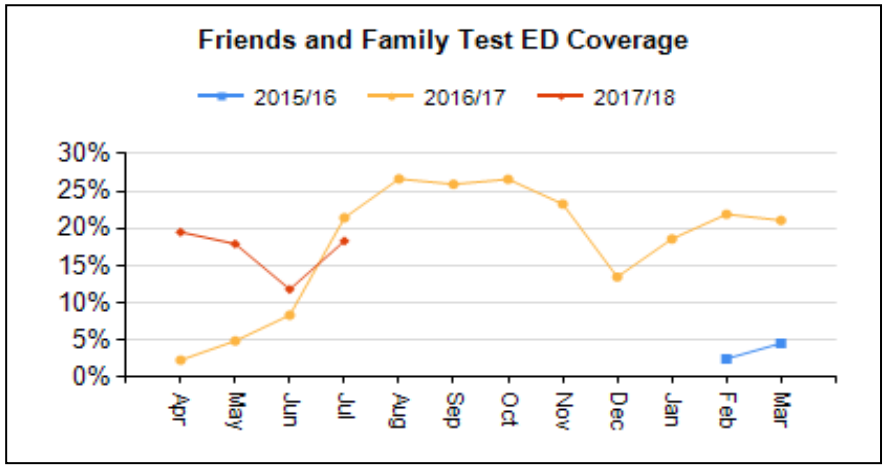
This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, relative to that of previous months and years.

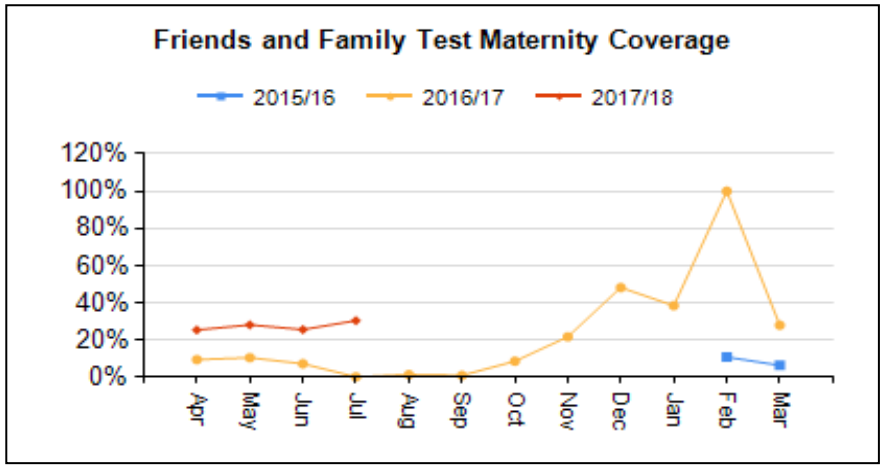


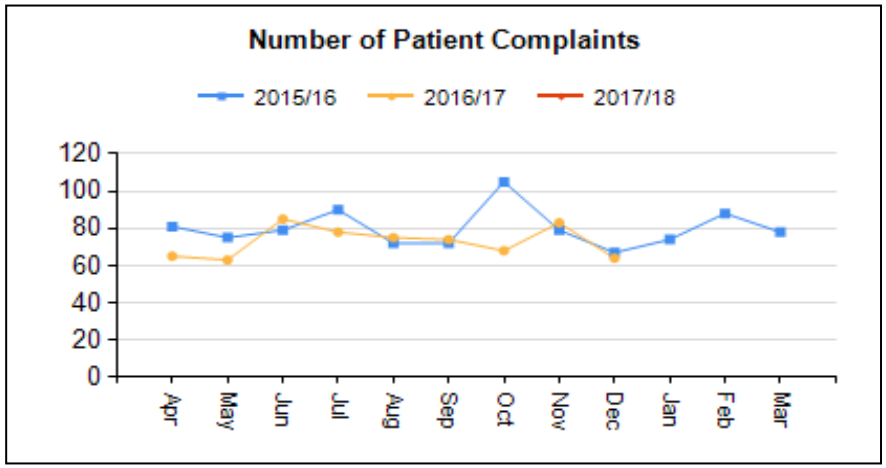


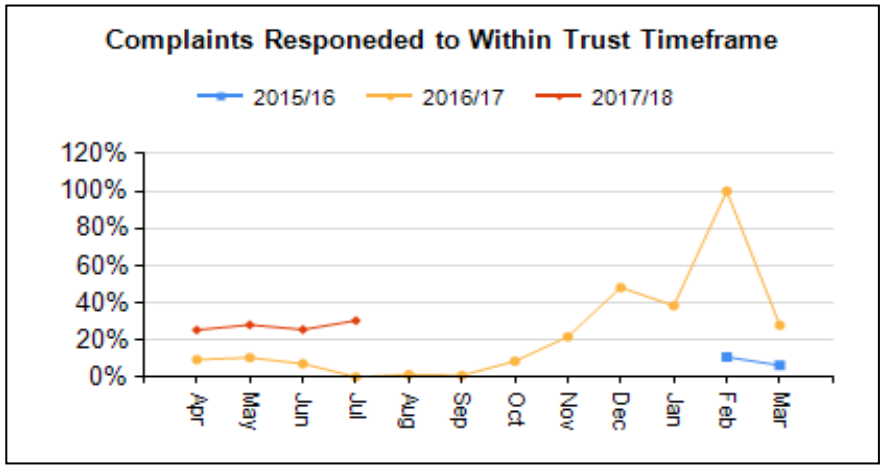


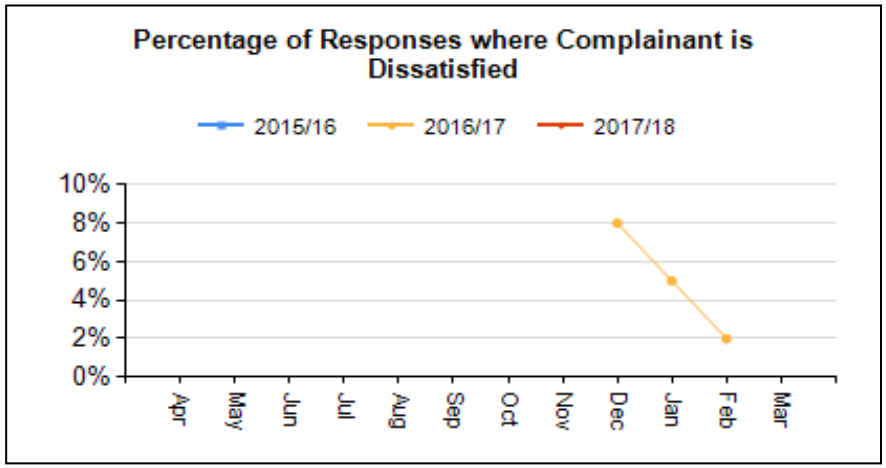


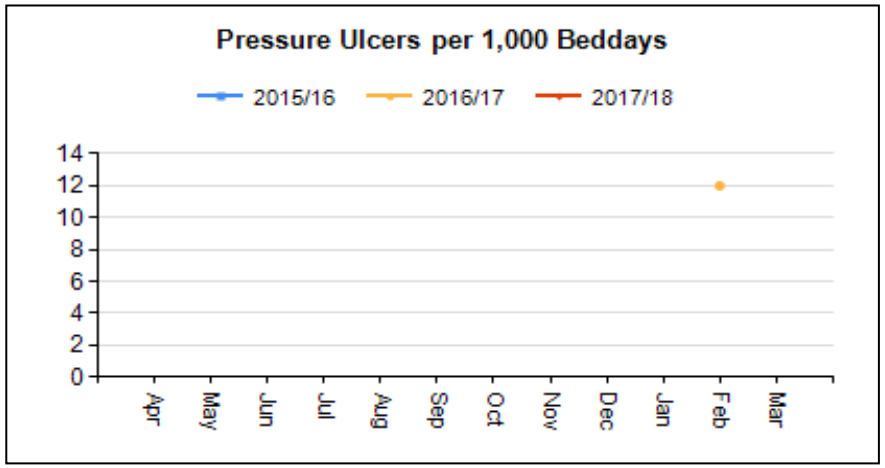

Friends and Family Test ED Coverage
2015/16
2016/17
2017/18
30%
25%
20%
15%
10%
5%
0%
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar

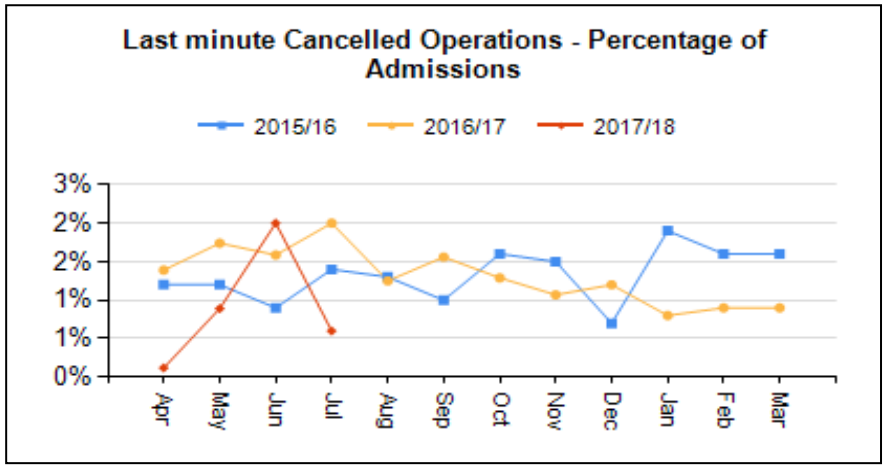

Friends and Family Test Maternity Coverage
2015/16
2016/17
2017/18
120%
100%
80%
60%
40%
20%
0%
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar

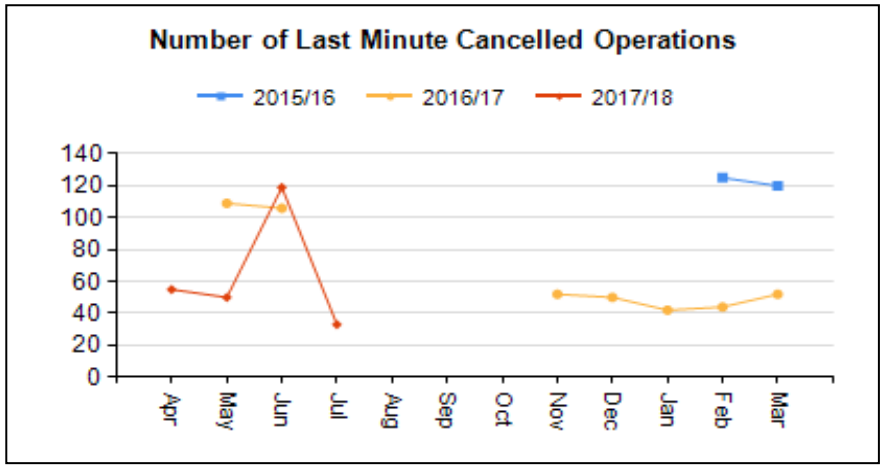

Number of Patient Complaints
2015/16
2016/17
2017/18
120
100
80
60
40
20
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar

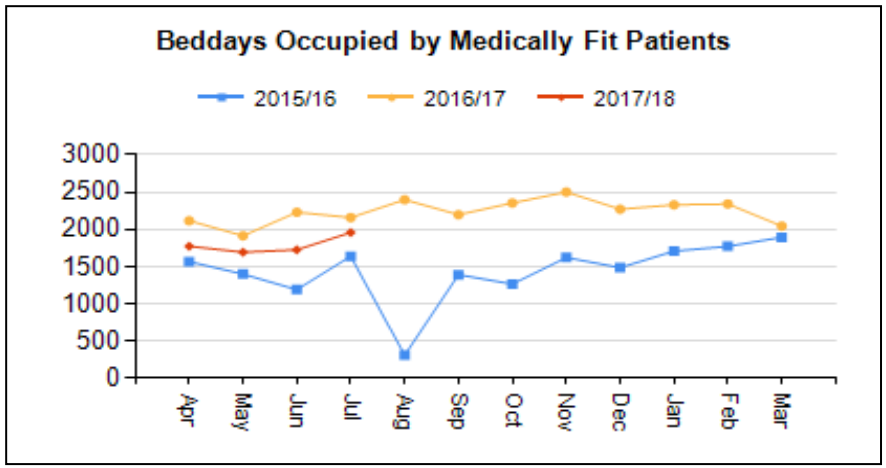

Complaints Responeded to Within Trust Timeframe
2015/16
2016/17
2017/18
120%
100%
80%
60%
40%
20%
0%
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar

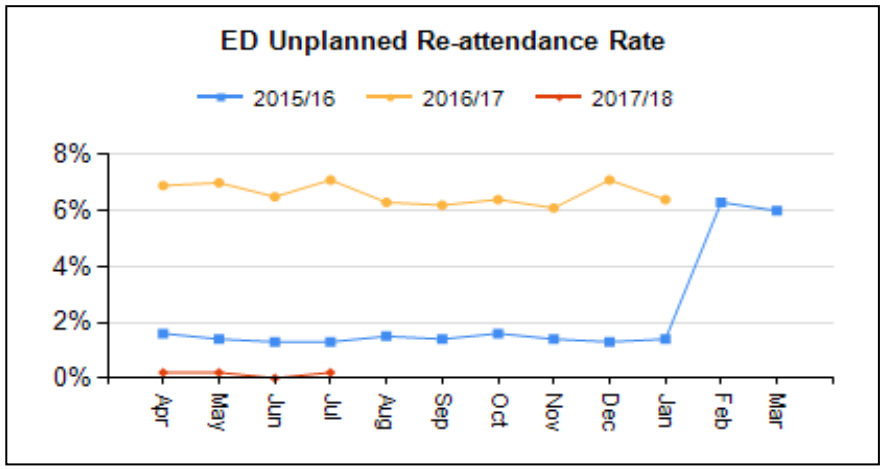

Percentage of Responses where Complainant is Dissatisfied
2015/16
2016/17
2017/18
10%
8%
6%
4%
2%
0%
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar

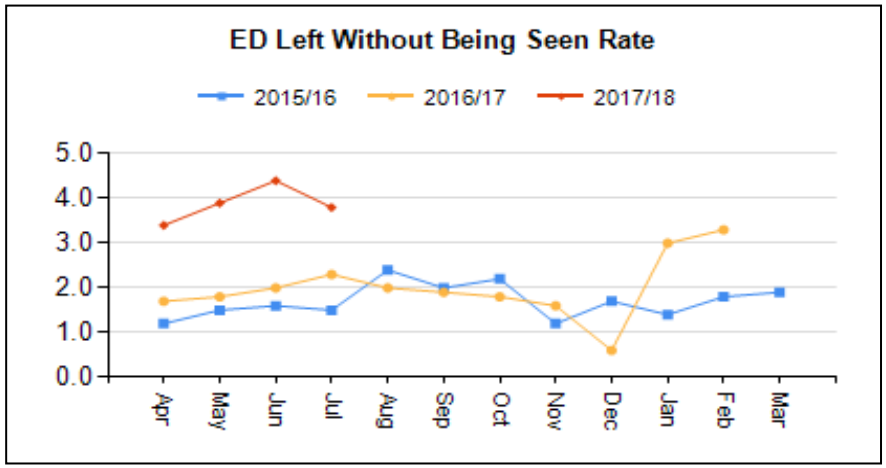

Pressure Ulcers per 1,000 Beddays
2015/16
2016/17
2017/18
14
12
10
8
6
4
2
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar

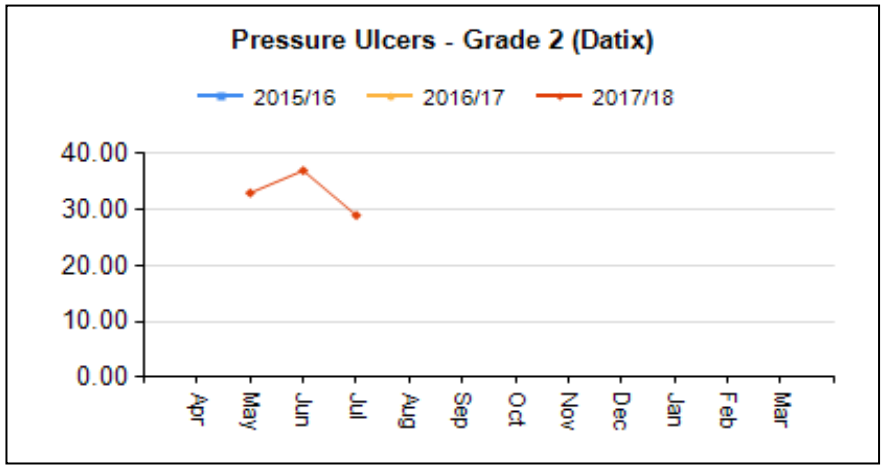

Last minute Cancelled Operations - Percentage of Admissions
2015/16
2016/17
2017/18
3%
2%
2%
1%
1%
0%
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar


Number of Last Minute Cancelled Operations
2015/16
2016/17
2017/18
140
120
100
80
60
40
20
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar


Beddays Occupied by Medically Fit Patients
2015/16
2016/17
2017/18
3000
2500
2000
1500
1000
500
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar


ED Unplanned Re-attendance Rate
2015/16
2016/17
2017/18
8%
6%
4%
2%
0%
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar


ED Left Without Being Seen Rate
2015/16
2016/17
2017/18
5.0
4.0
3.0
2.0
1.0
0.0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar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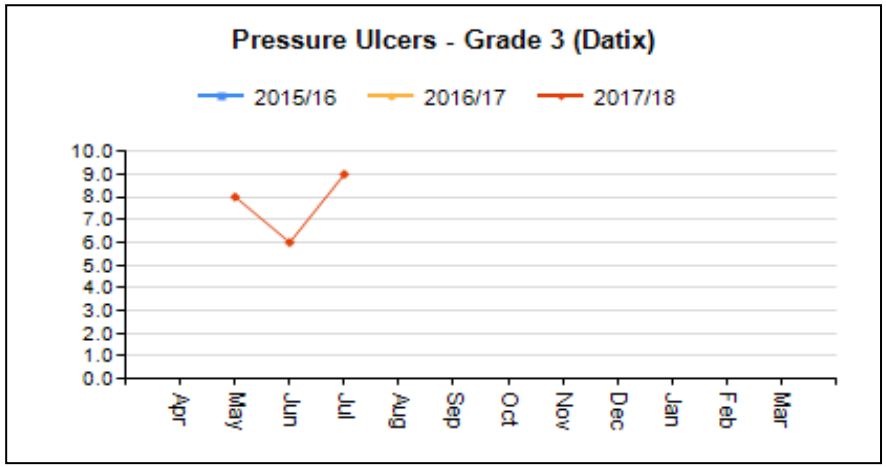
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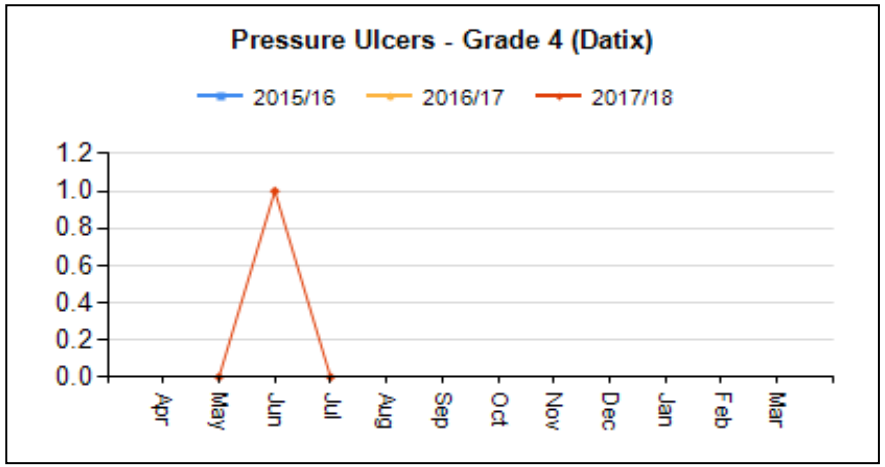
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0.2
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REPORT TO MAIN BOARD – SEPTEMBER 2017

From Quality and Performance Committee Chair – Tracey Barber, Non-Executive Director

This report describes the business conducted at the Quality and Performance Committee on 22nd August 2017 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
Winter Planning Report 2017/2018	Good start to the Winter Plan – with clarity around need for additional staffing, medical staffing and consideration given to alternatives to Doctors in the Emergency Department and Elderly Care.	Need now to develop the plan outlining clearly the blocks, the risks, and what we are doing to mitigate. In addition, come back with how we are working across the local community to deliver effectively. Have we got funding signed and agreed across the local health community?	Plan to come back to Quality and Performance Committee on 28 September and to Board on 11 October.	
Detecting Variations in Clinical Practice	Detailed paper presented to the Committee. Our focus is on improving alignment and understanding external benchmarking and Quality Academy.	Are we collecting the right data? How do we align each episode of care? Are we confident that Paterson could not happen here?	Benchmarking is part of our GIRFT programme. An open culture specifically duty of candour. The 'You Said, We Did' approach.	
Governance Framework for GIRFT *(Getting It Right First Time)*	The Governance Framework was presented for GIRFT oversight. It was agreed we need to celebrate best practice in GIRFT reviews.	How do we read across from GIRFT to SIP? What's our approach to service transformation and service improvement?	Discussions within Executive forums looking at impact of GIRFT not just on clinical best practice but on refocusing SIP.	

Quality & Performance Report	Accident and Emergency performance below target. However it appears that when staffing levels are as they should be, we achieve the target. Cancer performance – we are the worst performer in South West on Two Week Wait. The Critical Friend visit on 1st September is essential. Capacity is again an issue. Ownership of targets is critical.	What additional support do we need on staffing? We are well sighted on Medical staffing but we need to look at different staffing models. How are we training our junior doctors on rapid assessment? How do we work with individual areas and teams to ensure ownership of targets? How do we ensure we receive relative reporting so we understand where we are versus other Trusts? How do we recover the trajectory? How do we get an assurance mechanism that ensures people on the ground sign off to all trajectories and understand the approach to delivery?	Medical Programme Board to assess dips in performance and correlate against staffing. We need to understand what will get us back into the pack on our performance Diagnostic recovery plan to be taken to Executive Team and back to Quality and Performance Committee.	We need visibility of the sign off within the Divisions and assurance brought back to the Committee. The Cancer Services Management Board needs to track the process.
CQC Action Plan (Submitted in response to January 2017 visit)	Action plan received covering all collated actions with timeframes. There are 55 actions. In order to achieve an overall good rating there will be a supplementary plan over and above the action plan.	How do we identify those with the greatest impact and value and how do we track progress against the plan?	A detailed action plan and updates will be brought back to the Committee in November.	

National Cancer Patient Experience Survey Results Publication 2016	The Committee received the survey and it was clear that there were emerging themes year on year, but clear report and good progress.		There was an action plan in place to address the outliers which was taken to the Cancer Service Management Board.	
Operational Recovery (TrakCare)	The Committee received the overview of Trakcare. The focus remains on key priorities with a detailed weekly action plan. Crude mortality is still not being reported. Neither is Dementia. The impact across key elements of the organisation was debated.	Are we aware of the clinical risks within Trakcare? How is this impacting on the Patient Advice and Liaison Service (PALS) and what are we doing to alleviate the strain on PALS as a consequence of the Central Booking Office?	Trakcare and the governance implications would be brought to the September Board Development session.	A solution and action plan to be brought to the next Committee on how we are returning PALS to its correct purpose and mitigating Trakcare impact.
Operational Recovery (Urology)	The Committee received a paper and presentation on Urology performance. There were two key areas of need highlighted: - How do we address the short term need to address outstanding follow ups? - And in parallel how do we deliver a prioritised plan to ensure Urology meets its targets?	How are we creating a clear prioritised plan to deliver against both short term need to ensure there is no clinical risk to patient care and deliver a long term solution which meets the patient, clinical and financial needs of the organisation?	Detailed Recovery Plan to be developed and presented back to the Committee, to include a robust capacity and demand plan and clarity on the preferred model for outpatient assessment and produce revised trajectories for the two week wait, 31 day, 62 and 104 day standards through to the end of March. In addition, it should set out the plan and recovery	

			trajectory for eliminating the follow up backlog and pending recovery, with enhanced oversight of those patients who are overdue follow up care and for whom this is a risk.	
Mortality Report	Comprehensive overview received which showed the ability to now identify patients who die post discharge and supplement our reporting.			

Specific items for Board

- Winter Plan progress and next stage
- Urology action plan moving forward
- Progress on Mortality reporting

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – SEPTEMBER 2017

Report Title
TRUST RISK REGISTER
Sponsor and Author(s)
Author - Andrew Seaton, Director of Safety Sponsor – Deborah Lee, Chief Executive

Audience(s)									
Board members	√	Regulators		Governors		Staff		Public	

Executive Summary

Purpose

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

Key issues to note

- The Trust Risk Register enables the Board to have oversight, and be assured of the active management, of the key risks within the organisation which have the potential to affect patient safety, care quality, workforce, finance, business, reputation or statutory matters.

- Divisions are required on a monthly basis to submit reports indicating any changes to existing high risks and any new 15+ risks 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.

- Work continues to review those Divisional risks at 15+ that have not yet been migrated to the Trust Risk Register.

- Work has now commenced to review all SAFETY risks 12 or more for consideration of inclusion on the Trust Risk Register.

Changes in Period

There are no major changes since the last report to Board.

There are currently 30 risks being reviewed by Divisions for escalation to TLT, these will be further reviewed by the Division and Executive following the normal process to ensure the appropriate significant risks are escalated onto the Trust risk register. Early indications are that many of these will be de-escalated and not migrate to the Trust Risk Register.

The full Trust Risk Register with current risks is attached (appendix 1)

Conclusions

The 15 remaining 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

To ensure that the work to migrate or de-escalate all Divisional risks 15+ is concluded and to progress the review of all safety risks of 12 or over for future incorporation on to the Trust Risk Register.

Recommendations
To receive the report as assurance that the Executive is actively controlling and pro-actively mitigating risks so far as is possible and approve the changes to the Trust Risk Register as set out.
Impact Upon Strategic Objectives
Supports delivery of a wide range of objectives relating to safe, high quality care and good governance
Impact Upon Corporate Risks
The Trust risk register is included in the report
Regulatory and/or Legal Implications
None
Equality & Patient Impact
None

Resource Implications			
Finance		Information Management & Technology	
Human Resources	X	Buildings	

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

Date the paper was presented to previous Committees					
Quality & Performance Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**
				3rd May 2017	

Trust Risk Register - August 2017

Ref	Division	Highest Scoring Domain	Execute Lead title	Title of Assurance / Monitoring Committee	Inherent Risk	Controls in place	Adequacy	Consequence	Likelihood	Score	Current	Action / Mitigation	Review date
S1851	Surgical Services Division	Quality	Chief Operating Officer	Quality and Performance Committee	A risk that patients receive poor quality care as a consequence of demand for beds exceeding the beds available which could include cancelled operations, being cared for on a non-specialty ward or being cared for in an escalation area	1. Extended site management - Silver rota 2. Escalation policy and procedures for use of extra beds 3. Risk assessments evaluating the change in function of the areas.	Inadequate	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Delivery of Winter plan Easter Bank Holiday Plan	19/09/2017
DSP2462OPD	Diagnostics and Specialties Division, Medical Division, Surgical Services Division, Women's and Children's	Quality	Chief Operating Officer	Divisional Board	Risk of compromised quality and patient experience due patients being unable to be offered an appointment within expected waiting times because of increased workload growth in CBO following introduction of Trakcare.	Recruited additional bank and agency staff to help with the workload Additional staff training Identify issues that causes additional workload and report to the Trakcare team to identify a permanent solution by releasing the booking service manager from her current role to work with the Trakcare team. Work with the learning and development team to improve staff morale	Inadequate	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	To complete a Business Case - Recommending additional work force Learning & Development Escalate to executive director to agree further escalation	25/08/2017

Trust Risk Register - August 2017

Ref	Division	Highest Scoring Domain	Execute Lead title	Title of Assurance / Monitoring Committee	Inherent Risk	Controls in place	Adequacy	Consequence	Likelihood	Score	Current	Action / Mitigation	Review date
M2488Card	Medical Division	Safety		Divisional Board, Specialty Meeting, Trust Leadership Team	Risk of Harm to patients as a result of delay in receiving essential, required cardiac interventions.	Efficiency review of cath lab provision suggesting means of increasing throughput which has been actioned. Glanso implemented and ongoing reviewed regularly to ensure within financial allowance for Cardiology Active recruitment strategy to fill consultant posts. Progression of design for nursing/ physiology led roles to support the inability to recruit to consultant posts. Experienced Head of cardiac investigations recruited substantially commencing Nov 2017 previous experience includes advanced practice role development.	Inadequate	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	Business case	25/09/2017
M1746Diab	Diagnostics and Specialties Division, Medical Division, Surgical Services Division	Safety		Divisional Board, Quality Committee, Specialty Meeting	Risk of patients having potentially avoidable procedures (minor or major) due to the lack of a designated Multidisciplinary Footcare Team.	Clinical assessment as required through clinical assessment Referral to specialty in hospital teams on assessment Follow up by surgical specialty team	Inadequate	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	NHSE bid	03/10/2017

Trust Risk Register - August 2017

Ref	Division	Highest Scoring Domain	Execute Lead title	Title of Assurance / Monitoring Committee	Inherent Risk	Controls in place	Adequacy	Consequence	Likelihood	Score	Current	Action / Mitigation	Review date
W1609	Corporate Division, Diagnostics and Specialties Division, Estate and Facilities, Medical Division, Surgical Services Division, Women's and Children's	Workforce	Director of Nursing	Quality and Performance Committee	Risk of poor continuity of care and overall reduced care quality arising from high use of agency staff in some service areas.	1. Pilot of extended Bank office hours 2. Agency Taskforce 3. Bank incentive payments and weekly pay for bank staff 4. General and Old Age Medicine Recruitment and Retention Premium 5. Master vendor for medical locums 6. Temporary staffing tool self assessment 7. Daily conference calls to review staffing levels and skill mix. 8. Ongoing Trust wide recruitment drive 9. Divisions supporting associate nurse and CLIP programme. 10. Initiatives to review workforce model, CPN's, administrative posts to release nursing time	Adequate	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Monitoring at Workforce Committee Establish Quality Impact Assessment for project Overseas recruitment programme	28/09/2017
DSP2460OPD	Diagnostics and Specialties Division, Medical Division, Surgical Services Division, Women's and Children's	Quality	Director of Strategy	Divisional Board	Risk of reduced quality and patient experience as a result of errors in clinic templates leading patient attending the wrong clinic.	Central Booking Office staff, identify and fix any errors identified To restart the clinic validation exercise by working with the specialities, Central Booking Office, Trakcare clinic build team and the Trakcare team. This is led by the Trakcare operational lead	Adequate	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	To rebuild clinic templetes for all specialities Escalation to the Trust Risk register through executive director for Trakcare	24/08/2017

Trust Risk Register - August 2017

Ref	Division	Highest Scoring Domain	Execute Lead title	Title of Assurance / Monitoring Committee	Inherent Risk	Controls in place	Adequacy	Consequence	Likelihood	Score	Current	Action / Mitigation	Review date
DSP2404haem	Diagnostics and Specialties Division	Safety	Medical Director	Divisional Board	Risk of reduced quality care as a result of inability to effectively monitor patients receiving haematology treatment and assessment in outpatients due to a lack of clinical capacity and increased workload.	Telephone assessment clinics Locum and WLI clinics Reviewing each referral based on clinical urgency Pending lists for routine follow ups and waiting lists for routine and non-urgent new patients.	Inadequate	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Develop Business case to meet capacity demand	20/09/2017
F1339	Corporate Division, Diagnostics and Specialties Division, Estate and Facilities, Medical Division, Surgical Services Division, Women's and Children's	Finance	Director of Finance	Finance Committee	Risk that the Trust does not achieve the required cost improvement resulting in failure to deliver the Financial Recovery Plan for FY18	PMO in place to record and monitor the FY18 programme Monthly monitoring and reporting of performance against target Monthly executive reviews	Adequate	Catastrophic (5)	Possible - Monthly (3)	15	15 - 25 Extreme risk		31/08/2017
F2515	Corporate Division, Diagnostics and Specialties Division, Estate and Facilities, Medical Division, Surgical Services Division, Women's and Children's	Finance	Director of Finance	Finance Committee	Risk that the Trust does not agree a FY18 Control Total with NHS Improvement resulting in no access to the Sustainability & Transformation Fund and is also subject to contractual fines and penalties	Regular NHSI FSM meetings	Adequate	Catastrophic (5)	Possible - Monthly (3)	15	15 - 25 Extreme risk		31/08/2017

Trust Risk Register - August 2017

Ref	Division	Highest Scoring Domain	Execute Lead title	Title of Assurance / Monitoring Committee	Inherent Risk	Controls in place	Adequacy	Consequence	Likelihood	Score	Current	Action / Mitigation	Review date
F2511	Corporate Division, Diagnostics and Specialties Division, Estate and Facilities, Medical Division, Surgical Services Division, Women's and Children's	Finance	Director of Finance	Finance Committee	Risk that the Trust's expenditure exceeds the budgets set resulting in failure to deliver the Financial Recovery Plan for FY18	Monthly monitoring, forecasting and reporting of performance against budget by finance business partners Monthly executive reviews Performance management framework		Catastrophic (5)	Possible - Monthly (3)	15	15 - 25 Extreme risk		31/08/2017
DSP2513path	Diagnostics and Specialties Division, GP Services / NHS England, Medical Division, Surgical Services Division, Women's and Children's	Safety	Trust Medical Director	Divisional Board	Risk to patient safety due to delayed diagnosis because of shortage of Histopathology Staff	Locum laboratory staff in place Permanent staff recruitment in progress Locum consultant approved Outsourcing of reporting organised	Inadequate	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	fill vacant histopathologist post complete business case for Histopathology including workforce plan	09/08/2017
WF2335	Corporate Division, Diagnostics and Specialties Division, Estate and Facilities, Medical Division, Surgical Services Division, Women's and Children's	Finance	Director of HR & OD	Workforce Committee	The risk of excessively high agency spend in both clinical and non-clinical professions due to high vacancy levels.	1. Agency Programme Board receiving detailed plans from nursing, medical, workforce and operations working groups. 2.Increase challenge to agency requests via VCP 3. Convert locum\agency posts to substantive 4. Promote higher utilisation of internal nurse and medical bank.	Inadequate	Major (4)	Almost certain - Daily (5)	20	15 - 25 Extreme risk	Establish Workforce Committee Complete PIDs for each programme Reconfiguring Structures	10/10/2017

Trust Risk Register - August 2017

Ref	Division	Highest Scoring Domain	Execute Lead title	Title of Assurance / Monitoring Committee	Inherent Risk	Controls in place	Adequacy	Consequence	Likelihood	Score	Current	Action / Mitigation	Review date
S1748	Surgical Services Division, Women's and Children's	Statutory	Chief Operating Officer	Quality and Performance Committee	The risk of failing national access standards including RTT and Cancer	1. Weekly meetings between AGM and MDT Coordinators to discuss pathway management and expedite patients as appropriate. 3. Performance Management at Cancer Management Board 4. Escalation procedure in place to avoid breaches 5. Performance trajectory report for each pathway	Inadequate	Major (4)	Almost certain - Daily (5)	20	15 - 25 Extreme risk	Re establish Planned care board Interim action plan to recover position	22/09/2017
M2473	Medical Division	Quality	Director of Nursing	Quality and Performance Committee	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	Inadequate	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	CQC action plan for ED	10/08/2017

Trust Risk Register - August 2017

Ref	Division	Highest Scoring Domain	Execute Lead title	Title of Assurance / Monitoring Committee	Inherent Risk	Controls in place	Adequacy	Consequence	Likelihood	Score	Current	Action / Mitigation	Review date
S2045	Surgical Services Division	Safety	Medical Director	Quality and Performance Committee	The risk of poorer than average outcomes for patients presenting with a fractured neck of femur at Gloucestershire Royal	Prioritisation of patients in ED Early pain relief Admission proforma Volumetric pump fluid administration Anaesthetic standardisation Post op care bundle – Haemocus in recovery and consideration for DCC Return to ward care bundle Ward move to improve patient environment and aid therapy Supplemental Patient nutrition with employment of nutrition assistant Increased medical cover at weekends OG consultant review at weekends Increased therapy services at weekends Senior DCC nurses on secondment to hip fracture ward for education and skill mix improvement Review of all deaths	Adequate	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Deliver the agreed action fractured neck of femur action plan	17/10/2017

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

PUBLIC BOARD MAIN BOARD – SEPTEMBER 2017

Lecture Hall, Redwood Education Centre commencing at 09:00am

Report Title
Patient Experience Improvement in Response to Board Stories
Sponsor and Author(s)
Author: Suzie Cro, Head of Patient Experience Improvement Presenting Director: Maggie Arnold, Director of Nursing and Midwifery
Executive Summary
Purpose To provide an update on the patient experience improvement work that has been initiated in response to the stories that have been presented to Board since January 2017. Key issues to note Patient stories are an important component in understanding what has happened to a patient, in conjunction with their perceptions of the health care they have received. Conclusions To give assurance that there has been listening, learning and improvement action. Implications and Future Action Required
Recommendations
The Board are asked to note the contents of this report.
Impact Upon Strategic Objectives
To improve year on year the experience of our patients.
Impact Upon Corporate Risks
Regulatory and/or Legal Implications
None.
Equality & Patient Impact
Improvement work being carried out in response to stories.

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

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

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – SEPTEMBER 2017

PATIENT EXPERIENCE IMPROVEMENT IN RESPONSE TO BOARD STORIES

1. Patient Experience Improvement Work

The aim of this paper is to give the board an update on the patient experience improvement work that has been initiated in response to the stories that have been presented to Board.

2. Patient Experience Stories

2.1 The Patient Experience Improvement Team is very grateful to the patients who so generously share their story with our Trust Board.

2.2 Patient stories are an important component in understanding what has happened to a patient, in conjunction with their perceptions of the health care they have received.

2.3 The Leadership of the Patient Experience Team changed in January 2017 and the process of receiving and reporting of patient stories is to be enhanced with actions taken following the story reported back to the board. This is to give assurance that there has been both listening and learning. The first story within this new system was in January 2017. This report paper is an update of the improvement work that has taken place.

Our patient said…	**In response to his story we did this improvement work**
January's story was a patient who was sent to ED by his GP. He was diagnosed in GRH with Cryptogenic Organizing Pneumonia (COP) a rare lung condition. Oral steroids are the most common treatment for COP. He was admitted onto ward 7A (Gastro) and his experience on this ward was generally good. Upon discharge, he was given instructions on how to reduce his medication. The patient felt the instructions given were unclear and misleading and he has examples of this and suggestions as to how this could have been improved. Since discharge, he has been seen regularly as an outpatient where he has received exemplary treatment with very good communication via SMS (text messaging).	Before coming to Board the patient had already joined a focus group looking at improvements on ward 7A and at this focus group it was identified that there were areas where improvements could be made (The Oxford Project). The ward team have initiated many improvements in response to what they were told at this focus group. For example they were told that the lights woke people up and so the ward now provides eye masks to those patients that require them. The patients found that they couldn't find the information they wanted and so the ward has developed disease/condition specific information boards which have been put up in the ward with racks displaying relevant leaflets placed next to each board. The ward also had "lost" a few hearing aids and so now patients are provided with a specific labelled box to put their aids in. Also at the Focus Group the patients talked about the need to know about their medications and so staff were reminded that it is important to check that **all patients** understand the medication instructions given

Our patient said…	In response to his story we did this improvement work
	to them. One of the Pharmacists took this issue as a quality improvement project through the Gloucestershire Safety and Improvement Academy (GSQIA) for her silver award. Her aim was to improve explanations given to patients on discharge about their medicines. Her work is ongoing and this will include the work that the Board story highlighted which was for clear instructions for patients. The Patient Experience Improvement Team are now working with 4 wards to roll out the 7A project on these wards and their bespoke Silver programme starts in July 2017.
February's story was my story as I had recently received care from this organisation before I was employed here. My care was fantastic in ED and on the ward but I thought there were a few things that could have been done differently that would have improved my experience. Firstly I would have like to have read my records. Secondly I asked if I could go home once my drip "tissued" as I had been told that once I was taking oral antibiotics I could go. I made the request to a nurse and the Doctor arrived with a self-discharge form. We discussed the risks and together we made a shared decision that it was appropriate for me to go home. The third thing was that I was seen in outpatients with no records being present in the room.	Under the Data Protection Act I am entitled to access my clinical records but this comes at a cost to me of approximately £30-£50. For me to get my records I will need to complete a form and then my records will get copied and then be sent to me. http://www.gloshospitals.nhs.uk/en/Wards-and-Departments/Other-Departments/Health-Records/ More work needs to be done to give interested patients access to their records and this will improve when all records are electronic. I discussed the self-discharge form with ward sisters and they have told me that they are actively encouraged to get a form completed and so this is the advice that they give the Doctors for any unplanned discharges. More work needs to be done with doctors and nurses about shared decision making. Lastly I went to outpatients department and did a "secret shopper" observation in the clinic that I went to and every patient was seen with their records and so this must have been a one off situation for me.
March – no board meeting	

3. Recommendation

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

Author: **Suzie Cro, Head of Patient Experience Improvement**
Presenting Director: **Maggie Arnold, Director of Nursing and Midwifery**
September 2017

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

PUBLIC BOARD MAIN BOARD – SEPTEMBER 2017
Lecture Hall, Redwood Education Centre commencing at 09:00am

Report Title
National Guidance On Learning From Deaths
Sponsor and Author(s)
Author & Sponsor: Dr Sean Elyan, Medical Director
Executive Summary
Purpose To update the Board on the Trust's readiness to comply with the new guidance with regards to mortality review. Key issues to note Good progress has been made on the senior leadership of mortality reviews, development of a fit for purpose mortality review group and a policy on our approach to complying with the guidance Training to undertake structured judgement reviews has been started Date capture from reviews and consistent capturing of the learning from these reviews requires further work. Conclusions Good progress against expected timescales in the national guidance has been achieved. Further actions are continuing in line with the guidance. Future Action Required Quarterly reports summarising the number of mortality reviews undertaken and the lessons learned will be brought to the Board.
Recommendations
To accept this update as assurance of progress in line with the national guidance on mortality reviews.
Impact Upon Strategic Objectives
Links to our strategic objective to have a standardised hospital mortality index of below 100 by 2019
Impact Upon Corporate Risks
NA
Regulatory and/or Legal Implications
Important to assure the regulator of progress in this area
Equality & Patient Impact
NA
Resource Implications

Finance		Information Management & Technology	✓
Human Resources		Buildings	

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

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

MAIN BOARD – SEPTEMBER 2017

NATIONAL GUIDANCE ON LEARNING FROM DEATHS

1. Aim

1.1 This paper demonstrates the Trust's readiness to comply with the new guidance with regards to mortality review. The Board should be assured that appropriate progress has being made to be compliant with the relevant components of the Guidance.

2. Executive Summary

2.1 The National Guidance on Learning from Deaths provides a Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care. The background to the Guidance lies in the Francis Report, and the Care Quality Commission (CQC) Report Learning, Candour and Accountability.

2.2 The Trust Board received a paper summarising the requirements of the Guidance in April 2017 and updates on this have been take though the Trust Quality and Performance Committee on a monthly basis since this date.

2.3 This paper includes a plan summarising the actions taken to comply with the Guidance for information.

2.4 Close monitoring of this will continue at the Q+P committee

3. Background

3.1 This paper is an update to the Board on the National Guidance on Learning from Deaths (https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf). This document provides a Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care.

3.2 The background to the Guidance lies in the Francis Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry and by the findings of the CQC Report Learning, Candour and Accountability (December 2016 http://www.cqc.org.uk/content/learning-candour-and-accountability). These documents focus the way NHS Trusts review and investigate the deaths of patients in England. They stress the importance of placing sufficient priority on learning from deaths to improve care and engaging with families to recognise their insights as a vital source of learning.

3.3 The Guidance notes that, "Understanding and tackling this issue will not be easy, but it is the right thing to do. There will be legitimate debates about deciding which deaths to review, how the reviews are conducted, the time and team resource required to do it properly, the degree of avoidability and how executive teams and boards should use the findings."

3.4 The National Guidance provides a framework for Mortality Governance, and engaging with bereaved families and carers, and describes further developments. The plan an appendix 1 summarises the progress against the expected timescales and includes future actions.

4. Progress

4.1 Good progress has been made to developing the Mortality Review Group in line with the National Guidance. A policy is with the Trust Policy Group for final ratification.

4.2 Developments of review processes in line with National Guidance are well advanced.

4.3 Family engagement is in place and a process to test whether this fulfils the spirit of the guidance including the lay challenge to provide assurance to the Board that family involvement is central to the Trust approach.

4.4 There is a well-established process in W+C, for learning disabilities and within patients with mental health problems in line with national recommendations.

5. Remaining Issues

5.1 Training of the required number of individuals is needed to embed the SJR approach across the Trust.

5.2 Capture and reporting of deaths by speciality remains challenging but is a key focus for the Business Intelligence team.

5.3 Data capture of learning form deaths will require further work to bring this in line with the national recommendations.

6 Recommendation

To note the development of the Trust processes towards compliance with the National Guidance on Learning from Deaths

Author: Dr Sean Elyan
Presenting Director: Dr Sean Elyan
Date September 2017

National Guidance on Learning from Deaths-National Quality Board
Executive Sponsor: Dr Sean Elyan, Medical Director
A Framework for NHS Trusts and Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care

Recommendation	Trust Position	Development Required	Lead	Completion Date	RAG Rating
Board Leadership Mortality Governance should be a key priority for Trust Boards. Executives and Non-Executive Directors should have the capability and capacity to understand the issues affecting mortality in their Trust and provide necessary challenge. A lead Executive Director and Non-Executive Director should be identified to lead and provide scrutiny and oversight.	1. Lead Director - Medical Director. 2. Lead Non-Executive Director Chair of the Clinical Governance Committee. 3. Hospital Mortality Group (HMG) chaired by the Medical Director with multidisciplinary and Gloucestershire Clinical Commissioning Group representation. Reporting monthly to the Trust Quality and Performance Committee and to the Board via the NED chair of this group.	1. Briefing paper to the Board outlining the Trust's position and the new recommendation to include on a quarterly basis a paper and supporting data to the public Board meeting.	Dr Sean Elyan	April 2017	G
		2. Trusts should publish by September 2017 on the Trust public website, an updated policy on how it responds to and learns from, deaths of patients who die under its management and care.	Dr Sean Elyan	Sept 2017	G
		3. Changes to Quality Accounts regulations will require that the data providers publish will be summarised in the Quality Accounts from June 2018.	Dr Sally Pearson	June 2018	G
<u>Data Collection and Reporting</u> From April 2017, Trusts will be required to collect and publish on a quarterly basis	1. Head of Business Intelligence to provide deaths on a monthly basis to Chiefs of Service for distribution to specialities via Speciality Directors. 2. Mortality reviews completed by	1. Reporting system to be finalised capturing deaths and reporting to clinical teams from BI team	Leilei Zhu Business intelligence	Nov 2017	A

specified information on deaths (Policy and approach by end of Q2 and publication of the data and learning points from Q3 onwards. The data should include the total number of the Trusts inpatients deaths (including emergency department deaths) and those deaths that the Trust has subjected to a case record review. Of these deaths subjected to review, Trusts will need to provide estimates of how many deaths were judged to have been due to problems in care	adult specialties using standardised mortality proforma (structured judgement review) and reported through divisional governance process. 3. Data and learning to be reported to and reviewed at the Hospital Mortality Group. 4. The Board receives Integrated Performance Dashboard monthly including mortality indicators including Summary Hospital-level Mortality Indicator (SHMI), Hospital Standardised Mortality Ratio (HSMR) and Standardised Mortality Ratio (SMR). Clinical Indicators requiring close scrutiny are reviewed at the HMG. 5. The Trust responds to and reviews any alerts raised by Dr Foster. 6. Initial investigations of unexpected deaths are reviewed by the Speciality Director and reported through the Divisional Governance process. 7. The Trust has in place an established Medical Examiner process through which all deaths have a high level review.	2. Database to collect and report outcomes of investigations still under development. Interim arrangement using DATIX in preparation.	Andrew Seaton	October 2017	A

Responding to Deaths Incident Reporting and Investigation National Guidance on Learning from Deaths should be aligned to existing Serious Incident frameworks.	The Trust has in place a Risk Management Incident Reporting System (DATIX). The Director of Safety and wider Divisional teams reviews incidents daily. Staff report unexpected deaths via DATIX and are investigated using Root Cause Analysis methodology. 2. The Trust has in place a Serious Incident Policy. 3. All incidents clinical related incidents are uploaded to the National Reporting Learning Service on a weekly basis. 4. The Trust has in place a Duty of Candour and Being Open Policy. 5. The Trust has in place a Duty of Candour investigation and family liaison team.		Andrew Seaton	Completed	G
Skills and Training Providers should review skills and training to support the National Guidance with specialist training and protected time under their contract hours to review and investigate deaths to a high standard	1. The Trust has undertaken training in the use of the Structured Judgement Review (SJR) process with clinical teams. 2. The Trust is participating in a national research programme to investigate the comparative value of the Medical Examiner and SJR process. This will include training of a group of clinical staff in the use of the SJR.		Pam Adams Trust Clinical Mortality Lead Co-ordinator Professor Neil Shepherd Lead Medical Examiner.	December 2017	A

Engagement with Bereaved Families and Carers Providers should have a clear policy for engagement with bereaved families and carers, including giving them the opportunity to raise questions or share concerns in relation to the quality of care received by their loved one. Providers should make it a priority to work more closely with bereaved families and carers and ensure that a consistent level of timely, meaningful and compassionate support and engagement is delivered and assured at every stage, from notification of the death to an investigation report and its lessons learned and actions taken.	1. The Trust has a centralised bereavement office through which all families obtain their death certificates and are offered support 2. The Trust has a bereavement service, specialist bereavement Midwife, Learning disability Nurses, Safeguarding Childrens lead, Adult Safeguarding lead, Heads of Nursing and Matrons. 3. The Trust has in place a Duty of Candour and Being Open Policy. 4. The Trust has in place a Bereavement Policy. 5. The Q+P committee has reviewed the current approach to family engagement and in conjunction with the Head of Experience and lay representatives will be undertaking a review of current provision and appropriate changes to the provision.		Dr Sean Elyan	Completed	G
Children and Young People NHS England is currently undertaking a review of child mortality review process both in hospital and Community. A National Mortality Database is	1. The Trust has Executive representation at Safeguarding Childrens' Board. 2. Statutory Policies and Procedures are in place. 3. Lead Paediatricians in place. 4. Multi-Agency Safeguarding Hub (MASH) arrangements in place. 5. Office for Standards in Education		Chief of Service Women's and Children's Division	Completed	G

currently being commissioned. Further guidance is expected in late 2017.	(Ofsted) and CQC reviews completed. 6. All child deaths in hospital are reviewed on monthly basis and reported as per guidance.				
Maternity Services Maternal deaths and stillbirths occurring in acute and community Trusts should be included by Trusts in quarterly reporting from April 2017. This will also include deaths that occur in local midwifery units, or during home births. The definition also covers up to 42 days after the end of pregnancy.	1. Women and Children's Division have in place a process for review of all maternal deaths. 2. Governance leads Policies and Procedures relating to neonatal and maternal deaths are in place. 3. Any unexpected death is investigated using Root Cause Analysis methodology. 4. These deaths are reported through the Divisional Governance process.		Chief of Service Women's and Children's Division	Completed	G
Mental Health Regulations require registered providers to ensure that any death of a patient detained under the Mental Health Act (1983) is reported to the CQC without delay.	1. The Trust is registered with the CQC to provide care to patients detained under the Mental Health Act and is fully compliant with notification and investigation requirements. 2. The Trust has in place a Mental Health Partnership arrangement with the local Mental Health provider. 3. Any unexpected death will be subject to Root Cause Analysis Investigation and reported to the CCG.		Director of Nursing	Completed	G

Learning Disabilities There is unequivocal evidence that demands additional scrutiny be placed on deaths of people with learning disabilities across all settings. This work has already been started by the Learning Disabilities Mortality Review Programme. Once fully rolled out by NHS England, the programme will receive notification of all deaths of people with Learning Disabilities. This will support a standardised approach and trained staff will conduct the reviews.	1. The Director of Nursing sits on both Safeguarding Adult Board and Safeguarding Children's Board. 2. Learning Disabilities Nurses are in place. 3. Safeguarding Children's teams in place. 4. Safeguarding Adult lead in place. 5. All unexpected deaths are subject to a Root Cause Analysis Investigation and reported to the CCG. All deaths of patients on the Learning Disability Register are reported to the Gloucestershire LeDeR panel for external review.		Director Of Nursing	Completed	G
Cross System Reviews and Investigations	1. The Trust has agreed to with the STP clinical forum to undertake cross-service mortality reviews through this group under the Chairmanship of the STP clinical Lead 2. Mortality indicators and investigations are reviewed with commissioners through the Clinical Quality Review Group.	1. Methodology to identify patients dying after discharge from hospital not yet confirmed.	Dr Sean Elyan	March 2018	A

PUBLIC BOARD MAIN BOARD – SEPTEMBER 2017

Lecture Hall, Redwood Education Centre commencing at 09:00am

Report Title
Financial Performance Report - Period to 31st May 2017
Sponsor and Author(s)
Author: Sarah Stansfield, Director of Operational Finance Tony Brown, Senior Finance Advisor Sponsoring Director: Steve Webster, Director of Finance

Audience(s)									
Board members	✓	Regulators		Governors		Staff		Public	✓

Executive Summary

Purpose

This report provides an overview of the financial performance of the Trust as at the end of Month 04 of the 2017/18 financial year. It provides the three primary financial statements along with analysis of the variances and movements against the planned position.

Key issues to note

- The financial position of the Trust at the end of Month 04 of the 2017/18 financial year is an operational deficit of £12.2m. This is a favourable variance to the budgeted position of £4.4m.
- No STF funding has been assumed in the actual position given that the Trust has not agreed a control total for the 2017/18 financial year.
- CIP delivery to Month 04 is £7.6m. This is £1.9m better than the plan for the year to date.
- The current CIP delivery forecast for the year is £25.3m a shortfall to plan of £9.4m.
- The annual plan for the Trust is a **£14.6m** deficit. The current forecast, prior to mitigating actions, shows a deficit of **£23.3m**, an adverse variance of **£8.7m**.

Conclusions

- The financial position for M04 shows a favourable variance to budget of £4.4m. The favourable variance is reflective of both pay underspends and phasing adjustments within the income position, both of which are non-recurring.
- The underlying financial position is adverse to plan
- **Without further action**, the Trust is currently projecting a £23.3m deficit and the focus therefore is identification of further opportunities to reduce costs and improve income.

Implications and Future Action Required

There is a need for increased focus on financial improvement, in the form of both cost improvement programmes, and income recovery linked to the actions around Trak.

Recommendations
The Board is asked to receive this report for assurance in respect of the Trust's Financial Position.
Impact Upon Strategic Objectives
The financial position presented will lead to increased scrutiny over investment decision making.
Impact Upon Corporate Risks
Impact on deliverability of the financial plan for 2017/18.
Regulatory and/or Legal Implications
The variance to plan year-to-date of the financial position presented in this paper will continue to give rise to increased regulatory activity by NHS Improvement around the financial position of the Trust
Equality & Patient Impact
None

Resource Implications			
Finance	✓	Information Management & Technology	
Human Resources		Buildings	

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

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

Gloucestershire Hospitals NHS
NHS Foundation Trust

Report to the Finance Committee

Financial Performance Report
Month Ended 31st July 2017

Gloucestershire Hospitals NHS
NHS Foundation Trust

Introduction and Overview

The Board approved budget for the 2017/18 financial year is for a deficit of £14.631m.

During April, as part of the detailed budget reconciliation and review process and in support of agreeing a reflective control total the profiling of Income, Expenditure and CIP was considered and it was concluded that the monthly outturn profiles should be changed, the outturn deficit of £14.631m was not changed. NHSI have allowed a resubmission of the plan to reflect this change but would not allow change to Q1. As such the plan and budget are consistent in profile from Month 4 and this report now reflects performance against the aligned budget and plan.

Statement of Comprehensive Income

2016/17 Outturn £000s	Month 04 Financial Position	Annual Budget £000s	M04 Cumulative Budget £000s	M04 Cumulative Actual £000s	M04 Cumulative Variance £000s
433,665	SLA & Commissioning Income	439,649	140,510	140,645	135
4,604	PP, Overseas and RTA Income	4,759	1,490	1,437	(53)
66,388	Operating Income	61,222	20,376	20,492	116
504,657	**Total Income**	**505,630**	**162,376**	**162,574**	**198**
329,809	Pay	333,783	114,042	110,157	3,885
174,906	Non-Pay	161,593	56,541	57,227	(686)
504,716	**Total Expenditure**	**495,376**	**170,583**	**167,384**	**3,199**
(59)	**EBITDA**	**10,254**	**(8,207)**	**(4,810)**	**3,398**
(0.0%)	**EBITDA %age**	**2.0%**	**(5.1%)**	**(3.0%)**	**2.1%**
21,135	Non-Operating Costs	24,885	8,312	7,357	955
(21,193)	**Surplus/(Deficit)**	**(14,631)**	**(16,519)**	**(12,166)**	**4,353**
3,225	STF Funding				
(17,968)	**Surplus/(Deficit)**	**(14,631)**	**(16,519)**	**(12,166)**	**4,353**

In July the Trust has delivered a deficit of £1.99m and a cumulative deficit of £12.17m

This represents a favourable variance to budget and plan of £4.35m as at Month 4.

Detailed Income & Expenditure

Gloucestershire Hospitals NHS
NHS Foundation Trust

Annual Budget £000s	Month 04 Financial Position	M04 Cumulative Budget £000s	M04 Cumulative Actual £000s	M04 Cumulative Variance £000s
439,649	SLA & Commissioning Income	140,510	140,645	135
4,759	PP, Overseas and RTA Income	1,490	1,437	(53)
61,222	Operating Income	20,376	20,492	116
505,630	**Total Income**	**162,376**	**162,574**	**198**
	Pay			
307,877	Substantive	105,187	101,494	3,693
7,942	Bank	2,837	3,103	(266)
17,963	Agency	6,018	5,560	458
333,783	**Total Pay**	**114,042**	**110,157**	**3,885**
	Non Pay			
55,539	Drugs	18,758	19,558	(800)
40,041	Clinical Supplies	13,780	13,802	(22)
66,013	Other Non-Pay	24,003	23,867	136
161,593	**Total Pay**	**56,541**	**57,227**	**(686)**
495,375	**Total Expenditure**	**170,583**	**167,384**	**3,199**
10,254	**EBITDA**	**(8,207)**	**(4,810)**	**3,398**
2.0%	**EBITDA %age**	**(5.1%)**	**(3.0%)**	**2.1%**
24,885	Non-Operating Costs	8,312	7,357	955
(14,631)	Surplus/(Deficit)	(16,519)	(12,166)	4,353

The table opposite shows the detailed income and expenditure position.

SLA and Commissioning Income – a £0.1m favourable position. This favourable variance is driven by a combination of budget phasing and the impact of block agreements.

Operating Income – includes education, training and research flows and other income (which includes staff recharges for CITS, Shared services etc.). This shows a small over-recovery as at Month 4.

Pay – expenditure is showing a favourable variance of £3.9m against budgeted levels. This is largely driven by a "time to hire" saving against budget profile.

Non-Pay – Drugs expenditure is showing a £0.8m adverse variance. Other sub-categories of non-pay show small adverse and favourable variances but are largely in line with plan overall.

Cost Improvement Programme

Gloucestershire Hospitals NHS
NHS Foundation Trust

At Month 4 we have delivered £7.6m against the NHS Improvement plan target of £5.7m which is an overachievement of £1.9m against plan. The over performance is largely due to the vacancy factor as well as the operational growth margin. A strategic VCP is being planned for September to review all vacancies and agree an appropriate plan for each one.

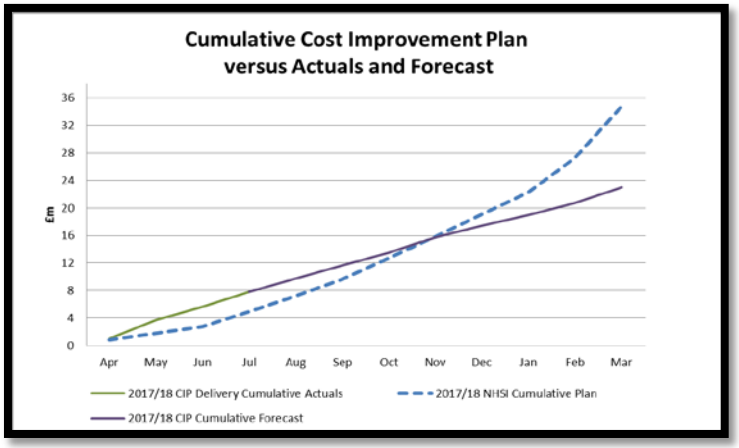
At Month 4, forecast CIP delivery is £25.3m against the Trust's target of £34.7m, a shortfall of £9.4m.

The full year effect of recurrent CIPs is £23.3m, an underlying shortfall to plan of £11.4m

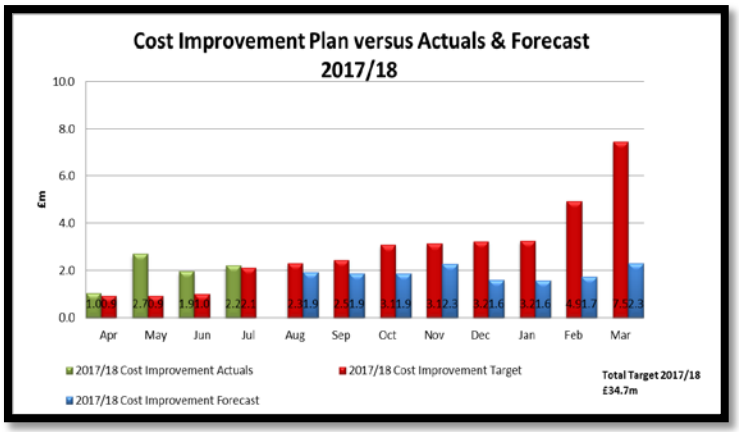
The implications of the block contracts have been identified and removed from the CIP actuals and forecast . A number of income schemes are affected by the block contract and £1.6m of forecast has been removed.

The forecast outturn is currently indicating a negative variance from November. To address this, mitigating actions need to be taken now to enable in-year recovery.

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



The graph below highlight the in-month cost improvement plan versus the in-month actuals and forecast



Forecast Outturn

Gloucestershire Hospitals NHS
NHS Foundation Trust

The Trust is forecasting a CIP shortfall of £9.4m and an overall Income and Expenditure deficit £8.7m adverse to plan (ie £23.3m vs planned £14.6m).

Forecast Outturn Variance To Plan					
Month 4 - based on first draft forecast	CIP £m	Pay Underspend £m	Activity £m	Other £m	Total £m
FOT - Income CIPs not identified separately	(9.4)	4.8	(3.8)	(0.3)	(8.7)
Shortfall in income CIPs	5.1		(5.1)		0.0
Restated Forecast Outturn	**(4.3)**	**4.8**	**(8.9)**	**(0.3)**	**(8.7)**

Month 4 - underlying assessment	CIP £m	Pay Underspend £m	Activity £m	Other £m	Total £m
FOT - Income CIPs not identified separately	(11.4)				(11.4)
Shortfall in income CIPs	5.1		(5.1)		0.0
Restated Forecast Outturn	**(6.3)**	**0.0**	**(5.1)**	**0.0**	**(11.4)**

The table above shows the main drivers for the current forecast movement away from plan at Month 4. The Month 4 position is then shown on an underlying basis:

- CIP deficit increases due to non-recurrent delivery on the current outturn
- Pay underspend is assumed to be non-recurrent (pending 1:1's and strategic VCP) so is removed
- Activity variances assumed to be non-recurrent (pending analysis of income variances as part of deep dive work)

Forecast Key Messages and Actions

Gloucestershire Hospitals NHS
NHS Foundation Trust

Key messages

- We are forecasting a CIPS shortfall of £9.4m, and an overall deficit £8.7m higher than plan (ie £23.3m vs planned £14.6m)
- The in year expenditure CIPS shortfall is broadly balanced by projected pay underspends, but the non-recurring CIPS and pay underspends are not projected to continue at the current level
- The income shortfall (even after blocking) plus the income element of the CIPS shortfall total £8.9m. This relates to a combination of Trak issues and broader capacity issues
- The FYE of recurrent CIPS is £23.3m, £11.4m short of plan. The overall normalised deficit is therefore £11.4m short of plan

Key focus of action required – with pace - to address the in year and normalised shortfalls

- Maximise in year expenditure CIPs in 17/18 and maintain pay underspend
- Maximise impact of all current CIP schemes – Cross Cutting and Divisional
- Generate material new recurrent CIPS – particularly from service improvement/re-design and informed by benchmarking refresh
- Get more clarity of the reasons for the income shortfalls to align corporate & local actions with improvements in income
- Consider what other actions can be taken to improve the financial position
- Consider whether additional capacity around delivery of CIP schemes is needed and how this could be secured

Balance Sheet(1)

Gloucestershire Hospitals NHS
NHS Foundation Trust

Trust Financial Position	Opening Balance 31st March 2017 £000	Balance as at M4 £000	B/S movements from 31st March 2017 £000
Non-Current Assests			
Intangible Assets	7,393	7,663	270
Property, Plant and Equipment	296,272	295,114	(1,158)
Trade and Other Receivables	4,668	4,579	(89)
Total Non-Current Assets	**308,333**	**307,356**	**(977)**
Current Assets			
Inventories	7,400	7,827	427
Trade and Other Receivables	17,697	18,875	1,178
Cash and Cash Equivalents	7,974	4,275	(3,699)
Total Current Assets	**33,071**	**30,977**	**(2,094)**
Current Liabilities			
Trade and Other Payables	(44,355)	(49,442)	(5,087)
Other Liabilities	(2,089)	(4,778)	(2,689)
Borrowings	(5,356)	(5,355)	1
Provisions	(182)	(182)	0
Total Current Liabilities	**(51,982)**	**(59,757)**	**(7,775)**
Net Current Assets	**(18,911)**	**(28,780)**	**(9,869)**
Non-Current Liabilities			
Other Liabilities	(7,612)	(7,486)	126
Borrowings	(83,126)	(84,573)	(1,447)
Provisions	(1,524)	(1,524)	0
Total Non-Current Liabilities	**(92,262)**	**(93,583)**	**(1,321)**
Total Assets Employed	**197,160**	**184,993**	**(12,167)**
Financed by Taxpayers Equity			
Public Dividend Capital	166,519	166,519	0
Reserves	70,501	70,501	0
Retained Earnings	(39,860)	(52,027)	(12,167)
Total Taxpayers' Equity	**197,160**	**184,993**	**(12,167)**

The table shows the M4 balance sheet and movements from the 2016/17 closing balance sheet, supporting narrative is on the following page.

Balance Sheet(2)

Gloucestershire Hospitals NHS
NHS Foundation Trust

Commentary below reflects the Month 4 balance sheet position against the 2016/17 outturn

Non-Current Assets

- There is a reduction in non-current assets which reflects depreciation charges in excess of capital additions for the year-to-date.

Current Assets

- Inventories show an increase of £0.4m (a £0.2m reduction on the prior month). The movement reflects increases in drug stocks. These are charged to the I&E on issue and so this change reflects a movement between inventories and creditors.
- Trade receivables are £1.2m above their closing March 17 level. Invoiced debt balances have dropped by £0.3m in month. This has been offset by accrued income of a similar value to reflect the agreement on block contracts.
- Cash has reduced since the year-end.

Current Liabilities

- Trade payables have increased by £5.1m above their closing March level (a £0.7m reduction on the prior month).

	Cumulative for Financial Year		Current Month July	
	Number	£'000	Number	£'000
Total Bills Paid Within period	39,454	76,860	10,192	17,479
Total Bill paid within Target	35,594	62,373	8,587	14,787
Percentage of Bills paid within target	90%	81%	84%	85%

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 we are not compliant with 30 day terms across all suppliers

Non-Current Liabilities

- Borrowings have increased due to loan financing draw down in July to fund deficit support.

Reserves

- The I&E reserve movement reflects the year to date deficit.

Cashflow : July

Cashflow Analysis	Apr-17 £000s	May-17 £000s	Jun-17 £000s	Jul-17 £000s
Surplus (Deficit) from Operations	**(4,958)**	**(3,284)**	**935**	**(1,031)**
Adjust for non-cash items:				
Depreciation	946	1,719	975	975
Impairments within operating result	0	0	0	0
Gain/loss on asset disposal	0	0	0	0
Provisions	0	0	0	0
Other operating non-cash	(58)	(59)	(58)	(58)
Operating Cash flows before working capital	**(4,070)**	**(1,624)**	**1,852**	**(114)**
Working capital movements:				
(Inc.)/dec. in inventories	(150)	(1,118)	349	192
(Inc.)/dec. in trade and other receivables	(5,066)	1,200	(157)	633
(Inc.)/dec. in current assets	0	0	0	0
Inc./(dec.) in current provisions	0	0	0	0
Inc./(dec.) in trade and other payables	4,930	328	(2,109)	(730)
Inc./(dec.) in other financial liabilities	(520)	3,448	(58)	(181)
Other movements in operating cash flows	835	(995)	32	(31)
Net cash in/(out) from wokring capital	**29**	**2,863**	**(1,943)**	**(117)**
Capital investment:				
Capital expenditure	(148)	(989)	(348)	(214)
Capital receipts	0	0	0	0
Net cash in/(out) from investment	**(148)**	**(989)**	**(348)**	**(214)**
Funding and debt:				
PDC Received	0	0	0	0
Interest Received	4	3	2	3
Interest Paid	0	(162)	(42)	0
DH loans - received	0	0	0	2,355
DH loans - repaid	0	0	0	0
Other loans	0	0	0	0
Finance lease capital	(20)	(20)	(20)	(20)
PFI/LIFT etc capital	(181)	(181)	(181)	(181)
PDC Dividend paid	0	0	0	0
Other	0	0	0	0
Net cash in/(out) from financing	**(197)**	**(360)**	**(241)**	**2,157**
Net cash in/(out)	**(4,386)**	**(110)**	**(680)**	**1,712**
Cash at Bank - Opening	**7,539**	**3,153**	**3,043**	**2,363**
Closing	**3,153**	**3,043**	**2,363**	**4,075**

Gloucestershire Hospitals NHS
NHS Foundation Trust

The cashflow for July 2017 is shown in the table opposite. The major movements are consistent with those already identified within income and expenditure and the balance sheet.

Key movements:

Inventories – Stock movements, other than at year-end, reflect movements in drug stocks. These are charged to the I&E on issue and so this change reflects a movement between inventories and creditors

Current Assets – Invoiced debtor balances have decreased in month due to timely settlement of in-month SLA invoices. This has been offset by accrued income to reflect the block agreements.

Trade Payables – increased in July which reflects an increase in creditors recorded in the less than 30 days category, so is not reflective of an overdue balance, simply timely recording of invoices on the system.

NHSI Single Oversight Framework

Gloucestershire Hospitals NHS
NHS Foundation Trust

	YTD Plan	YTD Actual
Capital Service Cover	(1.68)	(1.06)
Metric		
Rating	4	4
Liquidity	(23.11)	(26.68)
Metric		
Rating	4	4
I&E Margin	(10.30%)	(7.50%)
Metric		
Rating	4	4
I&E Variance from Plan	0.00%	2.80%
Metric		
Rating		1
Agency	48.70%	36.90%
Metric		
Rating	3	3
Use of Resources rating	4	4

The Single Oversight Framework (SOF) has been developed by NHSI and replaces Monitor's Risk Assessment Framework and TDA's Accountability Framework. It applies to both NHS trusts and NHS foundation trusts. The SOF works within the continuing statutory duties and powers of Monitor with respect to NHS foundation trusts and of TDA with respect to NHS trusts. The framework came into force on 1st October 2016.

The performance reported here reflects that for M04 against the new framework.

Recommendations

Gloucestershire Hospitals NHS
NHS Foundation Trust

The Committee is asked to note:

- The financial position of the Trust at the end of Month 4 of the 2017/18 financial year is an operational deficit of £12.7m. This is a favourable variance to budget and NHSI Plan of £4.4m.
- The current forecast before any mitigating actions is for a £23.3m deficit, this is £8.7m adverse to plan. Key areas for focus and action to improve the position have been identified for implementation from September

Author:	**Sarah Stansfield, Director of Operational Finance** **Tony Brown, Interim Senior Finance Advisor**
Presenting Director:	**Steve Webster, Director of Finance**
Date:	**August 2017**

REPORT TO MAIN BOARD – SEPTEMBER 2017

From Finance Committee Chair – Keith Norton, Non-Executive Director

This report describes the business conducted at the Finance Committee held 30th August 2017, 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
Capital Control Group Report & Capital Programme Update	Projected position would mean no effective contingency which is a concern. Ability to fund the capital plan depends on NHSI loan of 8.4m which is not yet secured.	Executives were challenged with actions to maintain the contingency further into the financial year. How is the impact on patient care taken account of in prioritisation decisions? Verbal explanation of the report went further than the report. What are the reasons for the position changing on ability to lease the telephony system?	Report back to next Committee Future key issues should be included in the written report wherever possible. Report back potential rectification regarding telephony leasing and on lessons learnt regarding future procurements	Impact on patient care. All possible actions to secure the loan and contingency planning if full loan not secured.
Financial Performance Report	Income variance effected by the blocking the effect of which will be reversed in future months otherwise the year to	What is the impact on next year?	Looking at choices on what to do regarding both time and finances.	

	date position is as expected.			
Update on Forecast and Associated Actions	Variance to plan at year end of £8.7m before further action. Expenditure Cost Improvement Programmes (CIPs) taken with pay underspend broadly balanced but income £8.9m short of plan.	Has the CIP plan run out of steam? What can we do to pick up momentum?	Acknowledgement that this needs re-energising however there are still many productivity gains to be achieved.	Currently unclear what impact the actions being taken will have on the projected shortfall.
STP Business Case	Capital case being submitted for planned scheme on the basis of benefits which can be delivered without consultation.	What is the basis of determining what changes require consultation	The Chair and Chief Executive would review the consultation aspects.	Who is consulted on this?
Workforce Update	Current pay underspend being maintained for e.g. nursing 37% underspend year to date versus last year. Variances between internal and NHSI reporting.	What is the outturn likely to be given that the latter months of the year include CIP?	There is a strategic VCP during September to look at workforce plans going forward	
Regulatory Review Update	NHSI visit during August and forthcoming NHSI meeting on 12th September.			

Medical Productivity Update	This is a real productivity initiative. Job planning policy agreed and now in place.	How much will this all yield?	This item will remain as a monthly item on the Committees agenda.	
Cost Improvement Programme Update	New format of reporting made clear year to date and forecast position by cross cutting theme and division. Key actions being taken to improve CIPs.	Has CIP run out of steam? What else needs to be done to achieve CIP? Why no lead for Corporate CIP and what falls within 'Other'	Yes – needs re-energising Director of Finance to address and ensure either lead identified or actions distributed elsewhere. Deep dives begin 1st of September. Consideration to be given to external support.	New approach to CIP needs embedding and recruitment to posts
Financial Risk Register	Risk register unchanged.	Should the risk be amended relating to capital and relating to CIPs?		
Work Plan	Medical Productivity to be added to each month.			
Matters to be Escalated to the Board	None.			

Governors Comments	• Concerns regarding presentation of SubCo to Governors. • Interesting to hear the effects of the Capital programme on lift repairs. • Concerns regarding STP and consultation discussions with Governors and the Public. • How learning and evaluation is taken forward.			
Papers for Circulation to Governors	Potentially approach to medical productivity.	To be discussed by Peter and Deborah.		
Committee Reflection	• Open & Honest. • Good Papers. • Honest Contribution from Executives.			
Any Other Business	No other business.			

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – SEPTEMBER 2017

Report Title
Workforce Report
Sponsor and Author(s)
Author: Alison Koeltgen, Acting Assistant Director of Workforce Sponsoring Director: David Smith, Director of Human Resources and Organisational Development
Executive Summary

Purpose

This report presents progress against the Workforce Strategy

Key issues to note

- The development of a detailed KPI Matrix and reporting cycle has provided a framework for the Workforce Committee to measure progress against the Workforce Strategy.
- Whilst agency expenditure increased in July 2017, the current run rate remains significantly lower than in 2016/17; contributing to a £1.7m reduction in Agency spend this year.
- The reductions in agency spend continue to be driven by reduced Nurse Agency usage, via: tighter controls and a more stringent, tiered approach to agency booking.
- The Nurse Vacancy rate has increased, however we expect this to reduce as we realise the benefit of some recruitment pipelines in the autumn.
- Staff Turnover has reduced, notably Nursing Turnover within the Medical Division.
- Staff Sickness Absence levels have reduced and continue to remain below the national average for Large Acute Trusts.
- Appraisal compliance, at 78%, remains lower that the Trust target of 90%. Divisions are subject to continued challenge and scrutiny of this performance through the Divisional Executive Review process.
- Mandatory Training compliance remains stable at 89%, close to the Trust target of 90%.

Conclusions

Reductions in Agency expenditure are encouraging and continue to demonstrate a more favourable position than last year. Given the positive vacancy forecast in Nurse recruitment, we hope to realise further savings. Reductions in Staff Turnover and Sickness Absence are positive, however we must continue with the in depth scrutiny of sickness within Divisions to maintain this improvement and mindful of the impact of winter on staff sickness absence levels.

Implications and Future Action Required

- Divisional engagement with HR Business Partners, to complete Workforce Planning in September and October 2017
- The Reward Strategy Group will evaluate the impact of incentivised shift payments on bank and agency usage over the summer period.
- Implementation of The Medical Bank (TEMPRE)

Recommendations
The Committee is asked to note the positive trends illustrated in the enclosed report
Impact Upon Strategic Objectives
It remains of critical importance that we continue to operate within our financial envelope, reducing agency expenditure and recruiting to establishment as appropriate.
Impact Upon Corporate Risks
Agency expenditure is currently rated as one of the Trusts highest risks to achieving financial balance.
Regulatory and/or Legal Implications
NHSi will continue to scrutinise our performance, particularly in relation to medical agency spend
Equality & Patient Impact
n/a

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

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

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

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – SEPTEMBER 2017

WORKFORCE REPORT AUGUST 2017

1. Aim

This report provides Trust Board with an overview of performance, against the Trust Workforce Strategy.

2. Background – Development of a Reporting Matrix and Annual Plan

The Workforce Committee has spent time scrutinising a matrix of proposed indicators against each element of the Workforce Strategy. Some elements remain under development; however a standard suite of information is presented at each Committee Meeting to indicate overall performance.

In addition to this and in order to measure success against overarching strategic aims and ongoing development work within the Workforce function, the Committee are working to an agreed reporting cycle for in depth progress reports.

3. Workforce

We continue to focus on the reduction of expenditure on agency staff and compliance with NHSI regulations.

3.1 Reducing Agency Expenditure

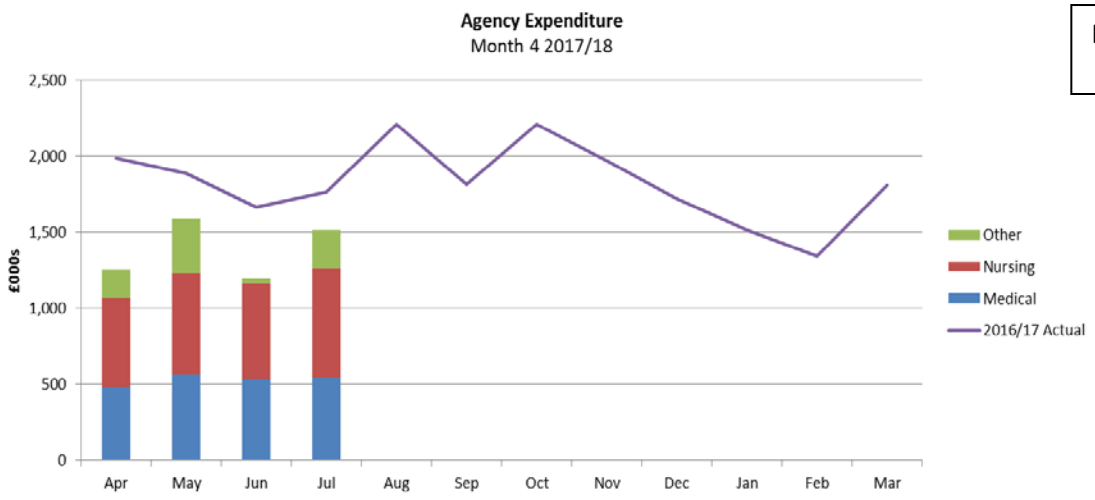


Figure 1

We have observed an overall reduction in of circa £1.7m on agency expenditure, £1.1m of which has been achieved in Nursing; this reflects a 37% reduction on same period last year.

Current measures in place to reduce Nurse Agency use include:

- Shift Incentivisation (ongoing for substantive staff and summer enhancements for bank staff)
- Mid – month supplementary payments for bank staff
- Strict authorisation & control
- Ongoing negotiations to reducing agency contract prices.
- Improved roster visibility and management

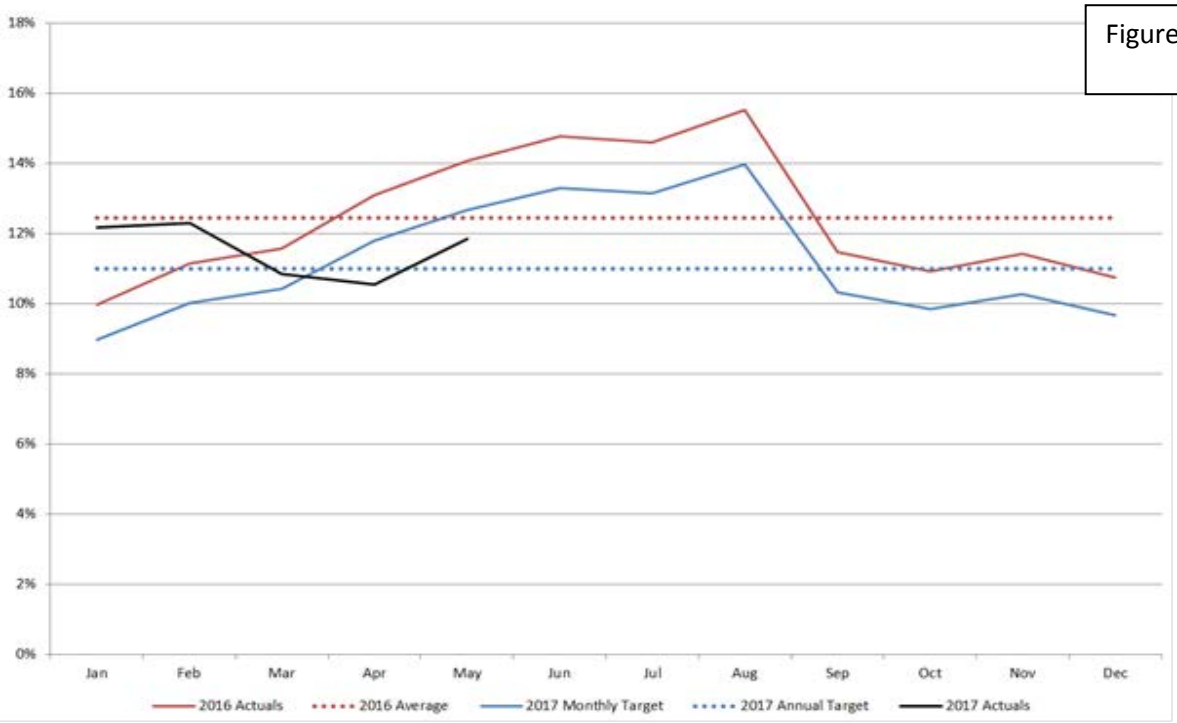
In addition to the above, measures to address Medical Locum Spend include:

- Exception reporting elevated rates to CEO
- Authorisation through Vacancy Control Panel for locum requests.
- Planned introduction of Medical Bank Software (TEMPRE) bank software, including a review of rates and Incentivisation options (planned for Oct 2017).

3.2 Recruiting to Nurse Vacancies

In order to reduce demand on temporary staffing services, it is critical to maximise recruitment to our Nursing establishment.

Figure 2



In May 2017 (fig 2), the vacancy rate increased to 11.84%, this is below the May 2016 rate, but continues to be above the target rate for the month. The year-to-date performance against the 11% target is currently 0.54% adrift the anticipated position.

The current vacancy rate for Band 5 Nursing & Midwifery staff is 8.88% (April 2017: 9.04%), and is forecasted to remain around this level until November 2017, when it is expected to reduce further to the lowest level recorded in recent times: 5.71%.

To ensure recruitment pipelines continue to deliver through 2018/19 the Recruitment Strategy Group are currently investigating the feasibility of further Philippines and Non EU Nurse recruitment.

3.3 Turnover

Whilst we have observed a reduction in staff turnover (fig 3), the current rates remain above the target of 9.50%. Work is currently underway to benchmark this rate against other large acute trusts, to understand whether the target is appropriate.

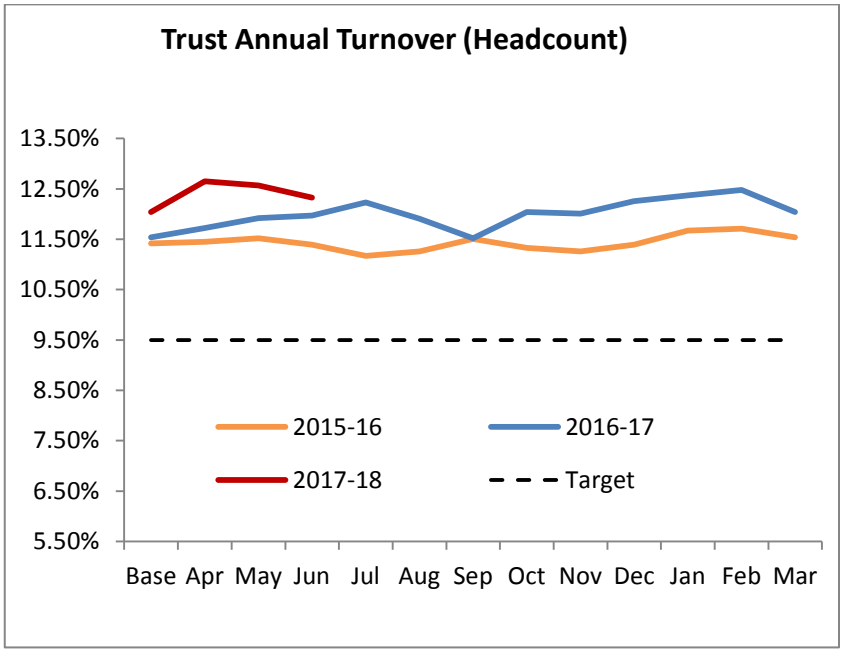


Figure 3

There is a notable decline in Turnover (fig 4) within the Medical Division, compared to 2016-17.

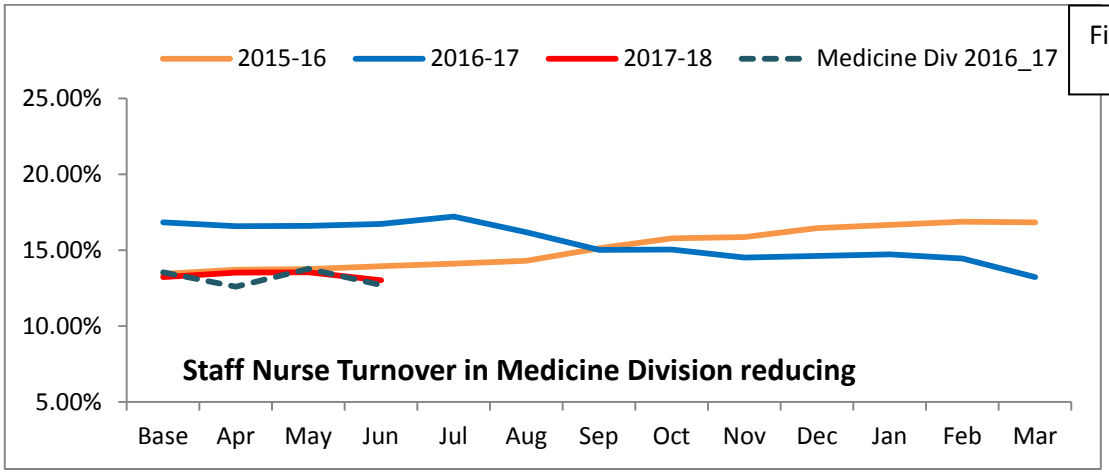


Figure 4

A 'new starter' questionnaire will be launched in September 2017, to enable us to understand more about what attracts employees to the Trust. In addition to this, the exit questionnaire (offered to all leavers) is now available via an online survey, to provide alternative means of gathering intelligence regarding the reasons people leave our Trust.

4. HR Operations & Staff Health and Wellbeing

The Trust annual sickness absence rate of 3.92% remains **lower than the national average** for Large Acute Trusts (4.39% to Jan 17). Long term absence accounts for approximately half of the absence recorded. The estimated cost of sickness absence, excluding backfill is approximately £7.1m.

Figure 5

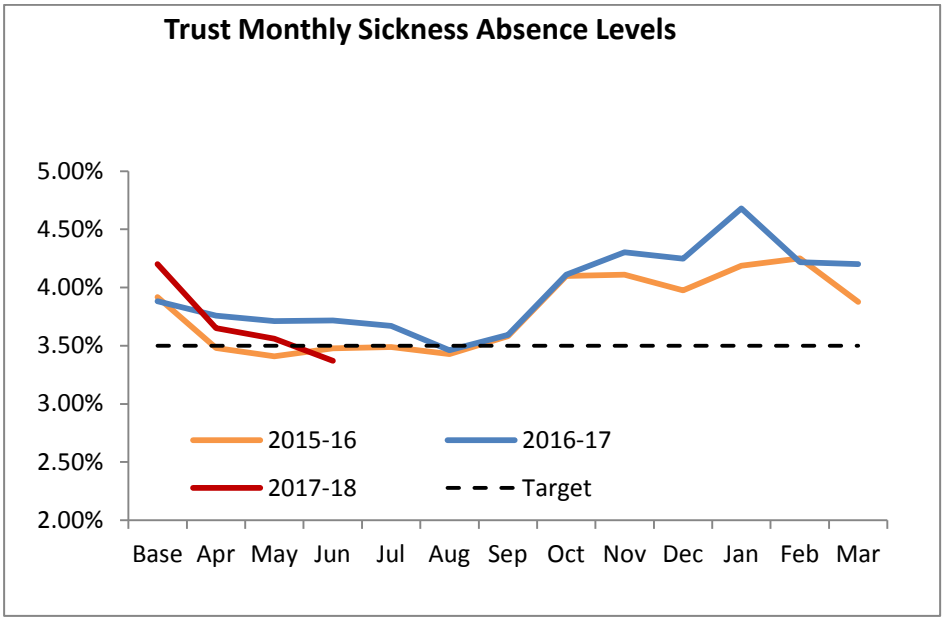


Figure 6

Description	Current Performance			Sickness Absence by month							
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. Target is set annually by HR Director	12 months to June 17 (Annual)	**Actual**	**KPI**	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Movement Apr to May	
		% Abs	**% Abs**								
	Trust Total	3.92%	3.83%	4.67%	4.21%	4.19%	3.65%	3.56%	3.37%	↘	decrease
	Corporate	3.93%	3.50%	4.20%	4.39%	4.51%	3.48%	3.65%	3.20%	↗	increase
	Diagnostics & Specialty	3.61%	3.50%	4.51%	3.51%	3.55%	3.29%	3.31%	3.48%	↗	increase
	Estates & Facilities	4.63%	3.50%	5.21%	5.41%	5.78%	5.21%	4.15%	3.81%	↘	decrease
	Medicine	3.66%	3.50%	4.67%	3.85%	4.20%	3.66%	3.24%	2.96%	↘	decrease
	Surgery	4.01%	3.50%	4.70%	4.53%	4.11%	3.72%	3.87%	3.71%	↗	increase
	Womens & Children	4.30%	3.50%	4.92%	4.56%	4.47%	3.34%	3.39%	2.84%	↗	increase
	Add Prof Scientific and Technic	3.66%	3.50%	4.54%	3.64%	3.54%	4.07%	4.71%	3.37%	↗	increase
	Additional Clinical Services	4.88%	3.50%	5.68%	4.88%	4.73%	3.55%	3.81%	4.31%	↗	increase
	Administrative and Clerical	4.26%	3.50%	5.00%	4.66%	4.97%	4.19%	4.12%	3.61%	↘	decrease
	Allied Health Professionals	2.66%	3.50%	4.18%	2.56%	2.18%	2.50%	2.00%	2.50%	↘	decrease
	Estates and Ancillary	4.43%	3.50%	5.38%	4.78%	5.03%	4.91%	4.03%	4.07%	↘	decrease
	Healthcare Scientists	3.06%	3.50%	2.95%	3.36%	3.06%	2.15%	2.30%	2.24%	↗	increase
	Medical and Dental	1.87%	3.50%	1.93%	2.26%	2.12%	1.53%	1.94%	1.95%	↗	increase
	Nursing and Midw ifery Registered	4.16%	3.50%	5.06%	4.62%	4.56%	4.28%	3.87%	3.32%	↘	decrease

The HR Service Centre are proactively targeting areas with high sickness rates and supporting managers with a range of interventions and training where appropriate. Divisional sickness trends and local actions to improve sickness rates are scrutinised through the Divisional Executive Review process.

5. Education, Learning and Development - Appraisals

Appraisal compliance (fig 7) remains a concern with the current rate of 78% remaining significantly under the 90% target. Divisions continue to be challenged on this performance through the Divisional Executive Review process.

Continued focus on Mandatory Training (fig 8) means compliance remains stable and close to the Trust target of 90%.

Figure 7&8

Appraisals	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Movement since last Month	
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%		
Corporate	79%	82%	81%	84%	82%	83%	80%	82%	86%	82%	82%	75%	↘	decrease
Diagnostics	84%	86%	84%	85%	86%	86%	87%	88%	88%	86%	84%	84%	→	stable
Estates & Facilities	78%	77%	80%	79%	76%	76%	77%	77%	74%	63%	60%	59%	↘	decrease
Medicine	76%	78%	77%	76%	75%	74%	74%	77%	79%	78%	79%	79%	→	stable
Surgery	79%	82%	80%	80%	79%	80%	81%	83%	82%	80%	79%	78%	↘	decrease
Women & Children	79%	79%	78%	78%	78%	77%	78%	80%	78%	77%	81%	83%	↗	increase
Trust	**80%**	**81%**	**80%**	**80%**	**80%**	**80%**	**80%**	**82%**	**82%**	**80%**	**79%**	**78%**	↘	decrease

Mandatory Training	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Movement since last Month	
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%		
Corporate excl Bank	92%	93%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	→	stable
Diagnostics	95%	95%	94%	94%	95%	94%	94%	94%	94%	94%	94%	94%	→	stable
Estates & Facilities	92%	92%	92%	91%	88%	90%	89%	88%	89%	87%	83%	80%	↘	decrease
Medicine	90%	90%	91%	91%	87%	88%	88%	88%	89%	89%	89%	89%	→	stable
Surgery	93%	93%	93%	93%	89%	89%	90%	90%	90%	90%	91%	91%	→	stable
Women & Children	91%	92%	92%	91%	88%	88%	88%	89%	89%	88%	88%	89%	↗	increase
Trust	**91%**	**92%**	**91%**	**91%**	**89%**	**89%**	**89%**	**89%**	**90%**	**89%**	**89%**	**89%**	→	stable

6. Key Progress against the Workforce Strategy

The following additional progress has been made against the workforce strategy during June and July 2017.

Equality and Diversity: Completion of the Trust WRES data submission (see additional WRES report to Board).

Leadership: Draft Talent Strategy submitted to Workforce Committee, additional staff engagement work to be undertaken in order to refine this strategy.

Workforce: Review of the effectiveness of the VCP Process completed, recommendations to be explored.

7. Short Term Priorities

Workforce Planning
This year's Business planning round will feature a requirement to consider workforce planning and all Divisions will be expected to engage with HRBusiness Partners through September and October 2017 to ensure that Workforce Plans align to operational demands.

Recruitment Audit (Immigration)
Price Warterhouse Coopers have been invited to audit our recruitment practice around immigration and visa requirements.

Incentive / Reward Analysis
The Reward Strategy Group will evaluate the impact of incentivised shift payments on bank and agency usage over the summer period.

Implementation of The Medical Bank (TEMPRE)
We are currently working on the Launch of a Web based internal medical bank model, planned for late October 2017 – to ensure that we maximise opportunities for NHS Locum work as an alternative to employing high cost Medical Agency workers.

8. Conclusion

Reductions in Agency expenditure are encouraging and continue to demonstrate a more favourable position than last year. Given the positive vacancy forecast in Nurse Recruitment, we hope to realise further agency savings, however consideration will need to be given the impact of the Winter Plan on temporary staffing usage. Reductions in Staff Turnover and Sickness Absence are positive, however we must continue with the in depth scrutiny of sickness within Divisions to maintain this improvement and mindful of the impact of winter on staff sickness absence levels, similarly ongoing challenge and focus on Appraisals and Mandatory Training must continue.

The Board are asked to note the progress against key elements of the Workforce Strategy

Alison Koeltgen

Acting Assistant Director of Workforce

August 2017

David Smith

Executive Director of HR and OD

August 2017

REPORT TO MAIN BOARD – SEPTEMBER 2017

From Workforce Committee Chair – Tracey Barber, Non-Executive Director

This report describes the business conducted at the Workforce Committee on 24th August 2017 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
Workforce Dashboard	There has been a 37% reduction in agency spend versus the same time last year. Band 5 nurse recruitment is 0.54% adrift. We need to maintain our focus on recruitment. Turnover is currently at 12.5% - is this reasonable or achievable? How does this compare with other organisations? There remains significant concerns around our level of appraisals.	We need to ensure the Dashboard reflects our concerns and the lessons learnt. How robust are our sickness absence numbers? How do we compare with other Trusts in particular in relation to our Agency spend? Do we have a clear enough view of what the drivers are on Nurse and Medical spend?	Introduction of TEMPRE software will improve management information regarding the reasons for medical locum usage. This in turn provides data to support challenge over recorded sickness data for the medical workforce.	Consider deep dive audit into specific areas – sickness absence to understand robustness of figures.
Revised Annual Workplan	Detailed approach mapped to Objectives and subcommittee KPIs was presented.			Consider using in other committees as best practice
Leadership strategy	The Committee received an approach and first thinking on Leadership and talent	Could we approach the Leadership Academy for support? How are we ensuring we are focusing on the right things at the right time? How are we ensuring engagement across the	Proposal to take the strategy forward by a workshop approach, involving key stakeholders and developing an executional plan.	To be brought back to the Committee in December 2017.

		organisation?		
Workforce Race Equality System (WRES)	The Committee received the WRES report and findings from the listening campaign	How are we supporting our EU employees post Brexit? How can we get more people engaged to ensure we deliver change? .	The Trust Diversity Network will be launching in Autumn 2017 and work is underway to launch unconscious bias training, rolling out within HR first, followed by recruiting managers.	WRES statement to be brought to Board to ensure appropriate level of Exec awareness and scrutiny
Impact of IR35	Summary received demonstrating little/no impact in the medium/long term			
Review of Vacancy Control Panel (VCP)	The Committee received an update on the effectiveness of the VCP which indicated the effectiveness of the VCP to stimulate challenge and the value of further consideration of apprenticeships.	How do we ensure that the VCP isn't a paper exercise and directly impacts on procedure?	Streamlining changes to VCP were agreed with a further review end of 2017.	
Risk register and Staff safety	The Committee received the current risks and approach to the Risk Register.	It was agreed that the risks around Agency control were appropriate but the additional risks allocated required review.		Revised approach in line with Workforce strategy to be brought back to the Committee.
Audit of overseas staff	Report received and our compliance recognised against the 9 incorrectly inputted into ESR	Are we assured regarding accuracy of our registration as well as the visa system?		Agreed to extend the scope of the PWC audit to cover the broader area of employment checks, including registration.

Specific items for Board

- That the Leadership strategy is under development and moving forward for completion December 2017
- Continuation of the VCP with some streamlining and amends to facilitate greater questioning
- The WRES submission

PUBLIC BOARD MAIN BOARD – SEPTEMBER 2017
Lecture Hall, Redwood Education Centre commencing at 09:00am

Report Title
Workforce Race Equality Standard (WRES)
Sponsor and Author(s)
Author: Abigail Hopewell, Head of Leadership and OD Sponsor: Dave Smith, Director of HR and OD
Executive Summary

Purpose

To inform the Workforce Committee of the WRES report, submitted to NHS England August 2017, and associated actions and priorities for the remainder of the financial year 2017/18.

Key issues to note

- The WRES report is an annual requirement and looks at the Trust's performance in relation to nine indicators. In 2016/17 we moved in a positive direction on five indicators, our performance deteriorated on three indicators, and remained stagnant for one indicator.
- The findings from the WRES, along with findings from a Listening campaign held with staff in May 2017 during NHS Diversity & Inclusion week, have enabled the Equality Steering Group to identify priorities and formulate an action plan to take us through to the new financial year 2018/19

Conclusions

The findings demonstrate that whilst have made some progression in relation to diversity and inclusion there is still lots more that the Trust needs do to improve the experience of Black, Asian & Minority Ethnic (BAME) staff, and other colleagues with protected characteristics who are more prone to experiencing discrimination in the NHS e.g. staff with a disability

Implications and Future Action Required

- 9 key actions are identified. These to be actioned through the Equality Steering Group

On-going monitoring of progress by the Workforce Committee.

Recommendations

- Trust Board to accept the findings in the WRES report
- Trust Board to accept the Action Plan 2017-18 for the Equality Steering Group
- Trust Board members to provide visible leadership and support, as required, to ensure successful delivery of the action plan

Impact Upon Strategic Objectives

Focusing on diversity and inclusion will support us to achieve the following strategic objectives:

- By April 2019 we will have an Engagement Score in the Staff Survey of at least 3.9
- By April 2019 we will have a minimum of 65% of our staff recommending us as a place to work through the staff survey
- By April 2019 we will be recognised as taking positive action on health and wellbeing, by 95% of

our staff (responding definitely or to some extent in staff survey)

Impact Upon Corporate Risks
Achieving the WRES indicators and delivering the action plan should help to mitigate risk in relation to staff turnover and morale; sickness absence; discrimination and litigation related to legally protected characteristics; patient satisfaction; annual staff survey results.

Regulatory and/or Legal Implications
WRES submissions must be made annually to NHS England. From 2018/19 there will also be an annual Workforce Disability Workforce Standard (WDES). Both standards place expectations on all NHS providers to do more to support staff with these protected characteristics.

Equality & Patient Impact
Work to improve staff diversity and inclusion will have a positive impact on the broader patient experience, and improve relationships between staff and with our service users. Working towards a culture which is consistently open, transparent and supportive will help to improve perceptions and staff experience of being treated fairly.

Resource Implications			
Finance		Information Management & Technology	
Human Resources	X	Buildings	

Action/Decision Required							
For Decision	X	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)**
			24th August 2017		Scheduled 4th October 2017, alongside Listening Campaign findings	

Outcome of discussion when presented to previous Committees

Workforce Committee 24th August 2017:

- Accepted findings and proposed action plan which arose from WRES and Listening Campaign findings.
- Some of the objectives complement and support the actions identified from the 2016 Staff Survey. These have previously been accepted by the Trust Board and include:
    - Priority 2: Developing and promoting a culture of openness and transparency
        - *Embed the principles of openness and transparency into meetings, communications, training*
    - Priority 4: Improving visibility of, and support from, leaders and managers
        - *Generate conversations around the culture we would like in respect of safety and raising concerns*
        - *Relaunching the 'Speaking in Confidence' function including the Freedom to Speak Up Guardian*

- *Launch a new Diversity Network to support staff from different backgrounds and with protected characteristics; promote awareness of diversity issues; generate conversations between staff and leaders across the organisation in relation to diversity and inclusion*

Agreed to share WRES findings and action plans with the Board and secure their visible leadership and commitment for this strand of work

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – SEPTEMBER 2017

WORKFORCE RACE EQUALITY STANDARD

1. Aim

To update the Workforce Committee on progress made in relation to the Workforce Race Equality Standard (WRES) and to share the plans and future priorities for the Equality Steering Group.

2. Background

The WRES was introduced in 2015. It requires all NHS providers to submit an annual return to NHS England and take proactive steps to improve the experience and treatment of BAME staff; research has consistently demonstrated this to be significantly worse, on average, than that of white staff.

The deadline for the WRES data submission is 1st August each year.

WRES coincides with activities already undertaken and scheduled plans by the Equality Steering Group to improve the working lives and experience of staff with legally protected characteristics.

3. Workforce Race Equality Standard (WRES)

The WRES takes a small number of indicators and requires NHS organisations to close the gap between the comparative experience of white and BME staff for those indicators.

The Standard is made up of a small number of indicators that are already collected from most Trusts and in many cases, published. Of the 9 measurements making up the standard, the first 4 relate to workforce data, the next 4 are taken from the annual staff survey and the final metric is linked to the diversity of the Board.

4. Actions Taken in the Last 12 Months

To help address our performance in relation to supporting BAME staff, and indeed all other protected characteristics, in the last 12 months we have undertaken the following actions:

- Published three key strategic objectives around equality and diversity in the Trust's Workforce Strategy:
    1. Embed equality and diversity as part of our Trust 'DNA' extending the opportunity to hear from staff about their real experience of working in our Trust
    2. Introduce and track performance against the Workforce Race Equality Standard (WRES), taking appropriate actions to improve performance
    3. Improve the experience and contribution of staff with a disability or long-term condition
- Appointed a new Chair and Vice-Chair to the Equality Steering Group
- Refocused and redefined the purpose of the Equality Steering Group to make this agenda more central to Trust activity. This includes updating the Terms of Reference, widening the membership of the group, and increasing engagement with staff with particular protected characteristics
- Undertaken a listening campaign in May 2017 to coincide with the NHS Diversity & Inclusion Week. Four listening events were held and an online survey was

available. These were widely publicised via the Trust Intranet and This Week email newsletter. The findings from the listening campaign have informed the Equality Steering Group's action plan, alongside the WRES findings.

- Trust-wide and targeted promotion of the NHS Leadership Academy development programme: **Stepping Up** which is aimed at BAME staff. Two GHNHSFT staff members were approved to join the programme which was extremely competitive (over 1300 applicants nationwide for 200 spaces)

5. WRES Performance at GHNHSFT

Our performance as at April 2017 is presented in detail in Appendix 1 and includes data for comparison from our submission in April 2016.

Below is a summary of how our scores have shifted for each of the indicators:

- **Indicator 1:** There is an overall increase of 2% in BAME staff across our workforce (14%) which is a **positive trend**. This breaks down as 9% of the non-clinical workforce and 15% of the clinical workforce. Both percentages compare favourably to 4.6% of the Gloucestershire population in the 2011 census, although this data is beginning to age.
  However, we have **no BAME** representation in the following bands and staff groups:
  Non-clinical – band 8c, band 8d and VSM
  Clinical – band 1, band 8c, band 8d, band 9 and VSM
  We are also **below** the Gloucestershire BME population of **4.6%** in the following:
  Non-clinical – band 3 (4%), band 7 (2%), band 8a (3%)
  Clinical – band 4 (2%), band 6 (4%)
- **Indicator 2:** The likelihood of white staff being appointed from shortlisting compared to that of BAME staff has dropped for a second year running and this is a **positive trend** (1.47 times more likely - down from 2.07 in 2015/16, and 2.17 in 2014/15).
- **Indicator 3:** unfortunately there has been a slight **negative trend** in the likelihood of BAME staff being involved in formal disciplinary processes compared with white staff (1.47 times **more likely**, up from 1.22).
- **Indicator 4:** We have seen a **negative shift** for this indicator. In 2015/16, BAME staff were 1.27 times more likely to access non-mandatory training/CPD compared with white staff, whereas the most recent data in 2016/17 shows that BAME staff are 0.99 times **less likely** to access these opportunities.
- **Indicator 5:** There has been a **minor positive trend** in the staff survey score of BAME staff experiencing abuse, bullying and harassment from members of the public or patients and relatives (27% down from 28%). There is no significant difference between white and BAME staff (30% vs. 27%), although the score for white staff has increased from 29% in the previous year.
- **Indicator 6:** Again, there has been a **minor positive trend** for BAME staff when we consider the same metric as experienced from managers and staff (26% down from 27%). There is no significant difference compared to white staff that reported 25% for this year, and has not changed since the previous year.
- **Indicator 7:** We have observed a significant increase in the percentage of BAME staff believing that the Trust provides equal opportunities for career progression and promotion (82%, up from 75% the previous year) which is a **positive trend**. This compares to 89% for white staff, which has not changed since the previous year.
- **Indicator 8:** There has been an increase for both white and BAME staff personally experiencing discrimination from their manager or other colleagues, which is a **negative trend** - 15% of BAME staff which is an increase of 2% since the previous year. This compares to 6% of white staff, an increase of 1% since the previous year.
- **Indicator 9:** The percentage of BAME staff on the Board has **not shifted** since the previous year (7%), which is above the BAME Gloucestershire population (4.6%) as per the last census. A different person is in post since the previous year, and they are an interim which will soon be replaced by a substantive job holder who we understand has a white ethnic background.

6. Next Steps for the Coming 12 Months

In light of the findings from the Listening campaign in May 2017, the priorities of the Equality Steering Group, along with the data presented in the WRES report, our actions and focus over the next 12 months are as follows:

- Working with staff members representing a range of protected characteristics, to co-create and launch a Diversity Network in Autumn 2017
- As part of the Diversity Network's activity, in recognition of our growing BAME workforce (13.6%) we will take time to better understand the needs and challenges of BAME staff and explore ways in which we can improve the experience of this group
- Rollout Unconscious Bias training, prioritising in the first instance members of the HR and OD department and recruiting managers
- Embed consideration of equality, diversity and inclusion issues into all leadership development opportunities organised and delivered by the Leadership & OD team
- Better understand the data and incidents identified in the NHS staff survey and HR data in relation to disciplinary investigations, discrimination and bullying/harassment. Work with divisional Risk Managers and HR Business Partners, as appropriate, to formulate local action plans to address findings
- In light of the challenges posed by Brexit, including potential changes around legislation and on-going uncertainty surrounding EU staff members' future residency status/security, it is important that the Trust demonstrates its commitment and support towards this part of our workforce in recognition of their valued contribution to the Trust's activity and our respect for them as individuals. This support will need to be reflected in both verbal and online communications from Executives and senior management as-and-when necessary and throughout the Brexit process
- As-and-whenever any new Board vacancies arise, to proactively consider how BAME staff can be attracted and encouraged to apply

A detailed action plan for the Equality Steering Group in 2017/18 is attached (appendix 2).

7. Recommendations

The Trust Board is asked to:

- **Accept** the findings in the WRES report (appendix 1 – separate attachment)
- **Accept** the Action Plan 2017-18 for the Equality Steering Group (appendix 2)
- **Agree** to provide visible leadership and support, as required, to ensure successful delivery of the action plan

Author: Abigail Hopewell, Head of Leadership and OD (Vice-Chair of the Equality Steering Group)
On behalf of: Dave Smith, Director of HR and OD and Dhushy Mahendran (Chair of the Equality Steering Group)
August 2017

Workforce Race Equality Standard

REPORTING TEMPLATE (Revised 2016)

Template for completion

Name of organisation

Gloucestershire Hospitals NHS Foundation Trust

Date of report: month/year

March 2017

Name and title of Board lead for the Workforce Race Equality Standard

David Smith, Director of Human Resources and Organisational Development

Name and contact details of lead manager compiling this report

Richard Giles, Medical Staffing Manager

Names of commissioners this report has been sent to (complete as applicable)

Gloucestershire Clinical Commissioning Group

Name and contact details of co-ordinating commissioner this report has been sent to (complete as applicable)

Caroline Smith, Senior Manager Engagement & Inclusion, Gloucestershire Clinical Commissioning Group. Email caroline.smith37@nhs.net Tel

Unique URL link on which this Report and associated Action Plan will be found

http://www.gloshospitals.nhs.uk/en/About-Us/About-the-Trust/EqualityandDiversity/

This report has been signed off by on behalf of the Board on (insert name and date)

David Smith, Director of Human Resources and Organisational Development

Publications Gateway Reference Number: 05067

Report on the WRES indicators

1. Background narrative

a. Any issues of completeness of data

None that we are aware of

b. Any matters relating to reliability of comparisons with previous years

None that we are aware of

2. Total numbers of staff

a. Employed within this organisation at the date of the report

7482

b. Proportion of BME staff employed within this organisation at the date of the report

1017

Report on the WRES indicators, continued

3. Self reporting

a. The proportion of total staff who have self–reported their ethnicity

Unknown

b. Have any steps been taken in the last reporting period to improve the level of self-reporting by ethnicity

No due to high level responses reported

c. Are any steps planned during the current reporting period to improve the level of self reporting by ethnicity

We are moving towards Employee Self Service which will give the opportunity for staff to update their personal records through a secure on-line portal. This should help to increase our quality of data above what it is at the current time

4. Workforce data

a. What period does the organisation's workforce data refer to?

1st April 2016 to 31st March 2017

Report on the WRES indicators, continued

5. Workforce Race Equality Indicators

Please note that only high level summary points should be provided in the text boxes below – the detail should be contained in accompanying WRES Action Plans.

	Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
	For each of these four workforce indicators, compare the data for White and BME staff				
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.	Non Clinical BME: B1 - 30% B2 - 5% B3 - 4% B4 - 6% B5 - 5% B6 - 5%	Non Clinical BME: B1 - 27% B2 - 5% B3 - 4% B4 - 5% B5 - 5% B6 - 4%	Overall 14% of staff are BME, an increase of 2% on the previous year. 9% of the non-clinical workforce is BME; compared to 15% of the clinical workforce. We have an increased representation in the following bands: Non-clinical: B1 up 3%; B4 up 1%; B6 up 1%; 8b up 9%; B9 up 50%. Clinical: B3 up 17%; B5 up 2%; B6 up 1%; B8a	We are embedding equality, diversity and inclusion training into all of our leadership and management development programmes and courses. We are planning to launch training sessions in Unconscious Bias. These will be aimed at HR and Recruiting Managers in the first instance. Following a number of listening events in May
2	Relative likelihood of staff being appointed from shortlisting across all posts.	White staff are 1.43 times likely to be appojnted from shortlisting	White staff are 2.07 times more likely to be appointed from shortlisting	Our percentage of BME staff is more than double that of the population of Gloucestershire, although we recognise the census data is starting to become out of date. The data indicates that our appointment of BME staff has increased in the last year.	We are planning to launch training sessions in Unconscious Bias. These will be aimed at HR and Recruiting Managers in the first instance.
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator will be based on data from a two year rolling average of the current year and the previous year.	BME staff 1.47 times more likely to enter formal investigation	BME staff 1.22 times more likely to enter formal investigation	Over the two-year rolling period, this metric has deteriorated since last year.	We will understand the data and where the formal disciplinary investigations are occurring to see if there are any trends/patterns. Continue to monitor this rolling data on a quarterly basis. We are planning to launch training sessions in Unconscious Bias. This will be aimed at HR in the first instance.
4	Relative likelihood of staff accessing non-mandatory training and CPD.	White staff 0.99 times more likely to access non-mandatory training/CPD	BME staff1.27 times more likely to access non-mandatory training/CPD	There appears to have been a negative shift in the likelihood of BME staff accessing non-mandatory training.	We are embedding equality, diversity and inclusion training into all of our leadership and management development programmes and courses. We will use the Diversity Network to engage with staff to understand what affects their ability to access non-mandatory/CPD learning opportunities

Report on the WRES indicators, continued

	Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
	National NHS Staff Survey indicators (or equivalent) For each of the four staff survey indicators, compare the outcomes of the responses for White and BME staff.				
5	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	White 30 BME 27	White 29 BME 28	There appears to be no obvious distinction between BME and non-BME staff with a minor improvement on performance for BME staff over the year.	We will look at this data in more depth to understand which areas across the Trust are reporting a worse experience in this area. We will work with Risk Managers across the high-incident divisions to identify ways to address
6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.	White 25 BME 26	White 25 BME 27	There is no discernible difference between the two groups and we have observed a minor improvement in the last year.	We spent time talking to staff during Diversity & Inclusion week (May 2017) to better understand the reasons behind this. Post the results of the EU referendum, our Chief Executive emailed a Trust-wide message of
7	KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion.	White 89 BME 82	White 89 BME 75	There appears to be a clear distinction between the two groups although we have seen a significant improvement of the experience of BME staff in the last year.	We will use the Diversity Network to engage with staff to understand what prevents and holds people back from accessing career development/progression. We are also planning to launch an Aspiring
8	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	White 6 BME 15	White 5 BME 13	There appears to be a clear distinction between the experience of the two groups and unfortunately this appears to have gotten worse. for both in the last year.	As above, we will engage with our BME staff via the Diversity Network to understand the reasons why they think this might be happening, and build on the data we have already received via the listening events in May 2017.
	Board representation indicator For this indicator, compare the difference for White and BME staff.				
9	Percentage difference between the organisations' Board voting membership and its overall workforce.	4.6% of the Gloucestershire population is BME, compared with 7.7% of the	4.6% of the Gloucestershire population is BME, compared with 7.14% of the	Whilst we have maintained a similar ratio to last year, one of these posts is filled by an interim of BME origin and the substantive holder (commencing October 2017) is white. Therefore we will need to be mindful of how to address this	As-and-when new Board vacancies arise, we will proactively consider how BME staff can be attracted and encouraged to apply.

Note 1. All provider organisations to whom the NHS Standard Contract applies are required to conduct the NHS Staff Survey. Those organisations that do not undertake the NHS Staff Survey are recommended to do so, or to undertake an equivalent.

Note 2. Please refer to the WRES Technical Guidance for clarification on the precise means for implementing each indicator.

Report on the WRES indicators, continued

6. Are there any other factors or data which should be taken into consideration in assessing progress?

The WRES data and associated actions will be discussed and monitored through the Trust's Equality Steering Group on an on-going basis and inform the Group's priorities over the next 12 months.

7. Organisations should produce a detailed WRES Action Plan, agreed by its Board. Such a Plan would normally elaborate on the actions summarised in section 5, setting out the next steps with milestones for expected progress against the WRES indicators. It may also identify the links with other work streams agreed at Board level, such as EDS2. You are asked to attach the WRES Action Plan or provide a link to it.

Currently in draft. To be agreed by the Trust's Workforce Committee, and the Board where appropriate, in due course.

Click to lock all form fields and prevent future editing

Produced by NHS England, April 2016

APPENDIX 2 - Equality Steering Group Action Plan 2017/18

Formulated in response to:

- Findings from Trust-wide Listening Campaign held during NHS Diversity & Inclusion week May 2017
- WRES Report August 2017

No.	Action	Timescale	Lead/s
1	Establish a Diversity Network for staff with protected characteristics to come together, share and learn. Network to be co-created, led and promoted by those who belong to the network.	Autumn 2017	Dhushy Mahendran, Chair ESG Abigail Hopewell, Vice-Chair ESG
2	Introduce and deliver Unconscious Bias training. Priority staff groups in 2017/18 – HR/OD department; lead recruiting managers	Commence Autumn 2017 On-going	Abigail Hopewell, Head of L&OD
3	Leadership & OD team to review all leadership & management programmes/courses and ensure diversity & inclusion topics are incorporated into all content. Liaise with Education team, as appropriate, to conduct similar exercise for professional education activities.	Complete January 2017	Ann Belton, Leadership & OD Specialist
4	Complete detailed analysis of disciplinary investigation incidents to identify any trends/patterns. Make recommendations for divisions/departments which may require additional support/training.	Complete December 2017	David Smith, Director of HR & OD
5	Complete detailed analysis of staff survey data relating to staff experiencing harassment, bullying or abuse from patients/relatives. Work with Risk Managers across high-incident areas to identify ways to address this.	Complete December 2017	Abigail Hopewell, Head of L&OD
6	Complete detailed analysis of workforce demographic to better understand potential support required for EU staff	Complete December 2017	David Smith, Director of HR & OD
7	In response to feedback from staff with disabilities review the Trust's current procedures, timescales and training for staff in relation to: - Reasonable adjustments - Interviews	Complete March 2018	David Smith, Director of HR & OD
8	Devise and implement an 18-month communications and staff engagement plan to help promote and sustain awareness and understanding of diversity and inclusion issues and associated support available for staff. This complements the Staff Survey 17/18 Action Plan to improve the visibility of, and support from, leaders in relation to health and well-being and raising concerns.	Complete December 2017	Kate Jeal, Communications Specialist Abigail Hopewell, Head of L&OD
9	To review the provision of disabled parking spaces and accessibility of public doorways for people with disabilities.	Complete March 2018	Neil Jackson, Director of Estates & Facilities Carol McIndoe, Disability Support Officer

WRES REPORT AUGUST 2017

Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data	Action taken and planned
1. Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.	**Non Clinical BME**: B1 - 30% B2 - 5% B3 - 4% B4 - 6% B5 - 5% B6 - 5% B7 - 2% B8a - 3% B8b - 17% B8c - 0% B8d - 0% B9 - 50% VSM - 0% TOTAL - 9% **Clinical**: B1 - 0% B2 - 11% B3 - 25% B4 - 2% B5 - 24% B6 - 7% B7 - 4% B8a - 5% B8b - 9% B8c - 0% B8d - 0% B9 - 0% VSM - 0% Consultants - 19% Non-Consultant career grade - 41% Trainee grades - 16% Other - 13% TOTAL - 15% **OVERALL TOTAL = 14%**	**Non Clinical BME**: B1 - 27% B2 - 5% B3 - 4% B4 - 5% B5 - 5% B6 - 4% B7 - 5% B8a - 3% B8b - 8% B8c - 0% B8d - 0% B9 - 0% VSM - 0% TOTAL - 8% **Clinical**: B1 - 0% B2 - 12% B3 - 8% B4 - 4% B5 - 22% B6 - 6% B7 - 4% B8a - 4% B8b - 6% B8c - 0% B8d - 0% B9 - 0% VSM - 0% Consultants - 18% Non-Consultant career grade - 41% Trainee grades - 13% Other - 0% TOTAL - 13% **OVERALL TOTAL = 12%**	Overall 14% of staff are BME, an increase of 2% on the previous year. 9% of the non-clinical workforce is BME; compared to 15% of the clinical workforce. We have an increased representation in the following bands: Non-clinical: B1 up 3%; B4 up 1%; B6 up 1%; 8b up 9%; B9 up 50%. Clinical: B3 up 17%; B5 up 2%; B6 up 1%; B8a up 1%; B8b up 3%; Consultants up 1%; Trainee Grades up 3%; Other up 13%. We have seen a drop in representation of BME as follows: Non-clinical: B7 down 3% Clinical: B2 down 1%; B4 down 2% BME staff continue to have representation below the Gloucestershire BME population of 4.6% in the following bands: Non-clinical: B3 (4%); B7 (2%); B8a (3%); B8c (0%); B8d (0%); VSM (0%) Clinical: B1 (0%); B4 (2%); B6 (4%); B8c (0%); B8d (0%); B9 (0%); VSM (0%)	We are embedding equality, diversity and inclusion training into all of our leadership and management development programmes and courses. We are planning to launch training sessions in Unconscious Bias. These will be aimed at HR and Recruiting Managers in the first instance. Following a number of listening events in May 2017 during NHS Diversity & Inclusion Week, we are launching a Diversity Network in the Autumn to strengthen the voice and visibility of staff with protected characteristics.

Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data	Action taken and planned
2. Relative likelihood of staff being appointed from shortlisting across all posts.	White staff are 1.43 times likely to be appojnted from shortlisting	White staff are 2.07 times more likely to be appointed from shortlisting	Our percentage of BME staff is more than double that of the population of Gloucestershire, although we recognise the census data is starting to become out of date. The data indicates that our appointment of BME staff has increased in the last year.	We are planning to launch training sessions in Unconscious Bias. These will be aimed at HR and Recruiting Managers in the first instance.
3. Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator will be based on data from a two year rolling average of the current year and the previous year.	BME staff 1.47 times more likely to enter formal investigation	BME staff 1.22 times more likely to enter formal investigation	Over the two-year rolling period, this metric has deteriorated since last year.	We will understand the data and where the formal disciplinary investigations are occurring to see if there are any trends/patterns. Continue to monitor this rolling data on a quarterly basis. We are planning to launch training sessions in Unconscious Bias. This will be aimed at HR in the first instance. We are also embedding equality, diversity and inclusion training into all of our leadership and management development programmes and courses.
4. Relative likelihood of staff accessing non-mandatory training and CPD	White staff 0.99 times more likely to access non-mandatory training/CPD	BME staff1.27 times more likely to access non-mandatory training/CPD	There appears to have been a negative shift in the likelihood of BME staff accessing non-mandatory training.	We are embedding equality, diversity and inclusion training into all of our leadership and management development programmes and courses. We will use the Diversity Network to engage with staff to understand what affects their ability to access non-mandatory/CPD learning opportunities.
5. KF25.Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	White – 30% BME – 27%	White – 29% BME – 28%	There appears to be no obvious distinction between BME and non-BME staff with a minor improvement on performance for BME staff over the year.	We will look at this data in more depth to understand which areas across the Trust are reporting a worse experience in this area. We will work with Risk Managers across the high-incident divisions to identify ways to address this.
6. KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.	White – 25% BME – 26%	White – 25% BME – 27%	There is no discernible difference between the two groups and we have observed a minor improvement in the last year.	We spent time talking to staff during Diversity & Inclusion week (May 2017) to better understand the reasons behind this. Post the results of the EU referendum, our Chief Executive emailed a Trust-wide message of support for our EU workforce. We will make efforts to better understand our

Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data	Action taken and planned
				existing workforce demographic in order to provide the necessary support. We are introducing Unconscious Bias training to the organisation, and plan to offer more development opportunities to support staff to manage their health/well-being and remain resilient during stressful periods.
7. KF21. Percentage believing that trust provides equal opportunities for career progression or promotion.	White – 89% BME – 82%	White – 89% BME – 75%	There appears to be a clear distinction between the two groups although we have seen a significant improvement of the experience of BME staff in the last year.	We will use the Diversity Network to engage with staff to understand what prevents and holds people back from accessing career development/progression. We are also planning to launch an Aspiring Managers programme and will consult with BME staff to understand what this would need to look like to support them. We were delighted to sponsor two staff members on the national NHS 'stepping up' programme which is aimed at BAME staff.
8. Q12 - In the last 12 months have you personally experienced discrimination at work from any of the following?b) Manager/team leader or other colleagues	White – 6% BME – 15%	White – 5% BME – 13%	There appears to be a clear distinction between the experience of the two groups and unfortunately this appears to have gotten worse. for both in the last year.	As above, we will engage with our BME staff via the Diversity Network to understand the reasons why they think this might be happening, and build on the data we have already received via the listening events in May 2017. One of our Trust-wide priorities following the 2016 staff survey is to encourage managers and leaders to be more visible and give support to staff.
9. Percentage difference between the organisations' Board voting membership and its overall workforce	4.6% of the Gloucestershire population is BME, compared with 7.7% of the Trust's Board	4.6% of the Gloucestershire population is BME, compared with 7.14% of the Trust's Board	Whilst we have maintained a similar ratio to last year, one of these posts is filled by an interim of BME origin and the substantive holder (commencing October 2017) is white. Therefore we will need to be mindful of how to address this moving forward.	As-and-when new Board vacancies arise, we will proactively consider how BME staff can be attracted and encouraged to apply.

REPORT TO MAIN BOARD – SEPTEMBER 2017

Report to the Board of Directors meeting – Robert Graves, Non-Executive Director

This report describes the business conducted at the Audit and Assurance Committee held on Tuesday 11th July 2017, 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
Internal Audit Report – Controls over the Use of Agency Doctors	The Report highlighted the insufficiency of processes and controls in this critical area of operation and expenditure. It is acknowledged that scrutiny and procedures are improving.	Is the level of detail shared with Divisions and reviewed at Finance Committee adequate? Is there effective integration of control initiatives e.g. VCP - Management reporting – Finance Committee? How robust is the approach to non-compliance?	Executives described the improved financial reporting that is being deployed which is being accompanied by a cascade of training to division staff. The HR and Medial Directors are undertaking a cross-cutting review of initiatives.	Further review at A & A committee required in November to assess the level of traction from the actions described.
Internal Audit Report – Risk Management	The report confirms the significant steps in amending the approach to risk management that have been undertaken by the Trust in the last year.	What is the approach to the recommendations?	All have an agreed action plan.	Follow-up review in January 2018.
Internal Audit review of Information Security and Trust Presentation on Cyber Security	Internal Audit had conducted a phishing exercise to assess the robustness of Trust systems and staff's degree of awareness of risks. Trust IT staff presented the current approach to cyber security preparations and	Does the result of the phishing exercise within the trust, which was higher than peer organisations, indicate the need for an improved communication strategy?	The Trust's recent positive experience during the nationwide hacking episode is evidence of the fundamental robustness of the Trust's procedures but must not lead to complacency.	The communication team will be asked to participate in the Cyber Security Panel. The subject will be a standing item on the A & A Committee's agenda.

	awareness within the organisation.			
Internal Audit Recommendation Tracker	Progress of implementation of recommendations was reviewed against target.	What actions are necessary to further improve the timeliness of implementing recommendations?	Director of Finance to conduct an internal review of the follow-up process incorporating a trial analysis of outstanding actions as discussed at the committee meeting.	Effectiveness/pace of follow-up requires improvement.
Developing Work on Systems of Internal Control	A trial assessment of the Risk Management System has been undertaken using a 5 point questionnaire. This approach will be the basis of an organisation–wide assessment.			An ongoing initiative lead by the CEO & Audit Committee Chair
Briefing on Shared Services	Comprehensive presentation by the head of Shared Services to inform the Committee of the role, scope, and resources of the operation.	What systemisation & technology opportunities are there? Why are so many travel expense claims manual? What income opportunities?	The team is alert to opportunities but investment constraints have limited progress. The Director of Finance plans to progress a number of strategy idea	Policies need to minimise exceptions to automated procedures. Progress to be monitored.

PUBLIC BOARD MAIN BOARD – SEPTEMBER 2017

Lecture Hall, Redwood Education Centre commencing at 09:00am

Report Title
SmartCare Progress Report
Sponsor and Author(s)
Sponsor: Dr Sally Pearson Author: Gareth Evans: Smartcare Programme Manager
Executive Summary

Purpose

To provide assurance to the Board, from the Trust Leadership Team and the Smartcare Programme Board, on progress towards the stable operation of TrakCare post Phase 1 go-live and planned implementation of Phase 1.5

Key issues to note

- The programme is set at amber status based upon achieving acceptable level of resolution of issues identified that are impacting on operational activity.
- Performance against contracted services is being monitored and reported in line with SLA based reporting and delivery of contracted functionality.
- Key high priority system related issues (TRC) are identified and reported with current status.
- Contractual and functional review of the system meeting OBS requirements under way.
- Service Reviews continuing within Programme Team until such time that BAU consultation process has completed. Next meeting to be set up for September.
- Update to Maintenance Release MR7 and associated ad-hoc patches implemented.
- Changes to proposed Programme Delivery plan for Phase 1.5 components is to be presented to the Programme Board on 4th September. Phase 2 planning to be completed.
- 2017.2 MR3 upgrade scheduled for January 2018 will include the ECDS requirement.
- Risk to Phase 2 proposed go-live for Oncology including Chemotherapy prescribing is the timeline for proposed planned go-live of Pharmacy in February 2018.
- Phase 2 Operational Assessment to commence in October 2017.
- Revised project financial forecast is to be reviewed – 4th September.
- Training progressing with priority based upon preparation for Phase 1.5 Radiology Order Comms.
- Trust ownership and responsibility for Training as a whole is to be reviewed at a second meeting to be scheduled for September.
- Programme Team attendance at Operational Impact Group maintained and resources assigned as available. Over-reliance on specific team members to be reviewed.

Conclusions

TrakCare is in full Phase 1 operation across the Trust but with operational issues as identified. Recovery action plans are in place or being progressed to achieve resolution with Cymbio involvement having commenced. The project team are supporting the BI related activity in this respect.

Implications and Future Action Required

The programme will continue to provide assurance to the Smartcare Programme Board
A further update for the Board will be provided in October.

Recommendations

The Board is asked to note this report as a source of assurance that the programme to identify issues within the respective operational and support areas to achieve a satisfactory recovery for Phase 1 and planning for subsequent phases is robust.

Impact Upon Risk – Known or New

Implementation of phase 2 of Smartcare will reduce the risk on the corporate risk register associated with the instability of the Oncology Prescribing system. Additionally, the Clinical Risk Review process will identify any additional corporate risks and their mitigation.

Equality & Patient Impact

The patient benefits from the implementation of Smartcare will be realised across all patient groups.

Resource Implications

Finance	X	Information Management & Technology	X
Human Resources	X	Buildings	

Action/Decision Required

For Decision		For Assurance	X	For Approval		For Information	

Date the paper was presented to previous Committees		
Divisional Board	**Trust Leadership Team Sub-group**	**Other (Specify)**
	6 September 2017	Smartcare Programme Board
Outcome of discussion when presented to previous Committees		
Endorsed		

GLOUCESTERSHIRE HOSPITAL NHS FOUNDATION TRUST

PROGRESS REPORT SmartCare			
Date completed:	30/08/17	**Version**	1.0
Project Sponsor:	**Dr Sally Pearson**	**TRUST RAG Status**	**AMBER**
Project Manager:	Gareth Evans		

SmartCare Progress Report – September 2017

Executive Summary & Programme Status

An overall Trust RAG status of **AMBER** until such time that phased deployment timescales for all deliverables are agreed.

Phase 1

Contract performance

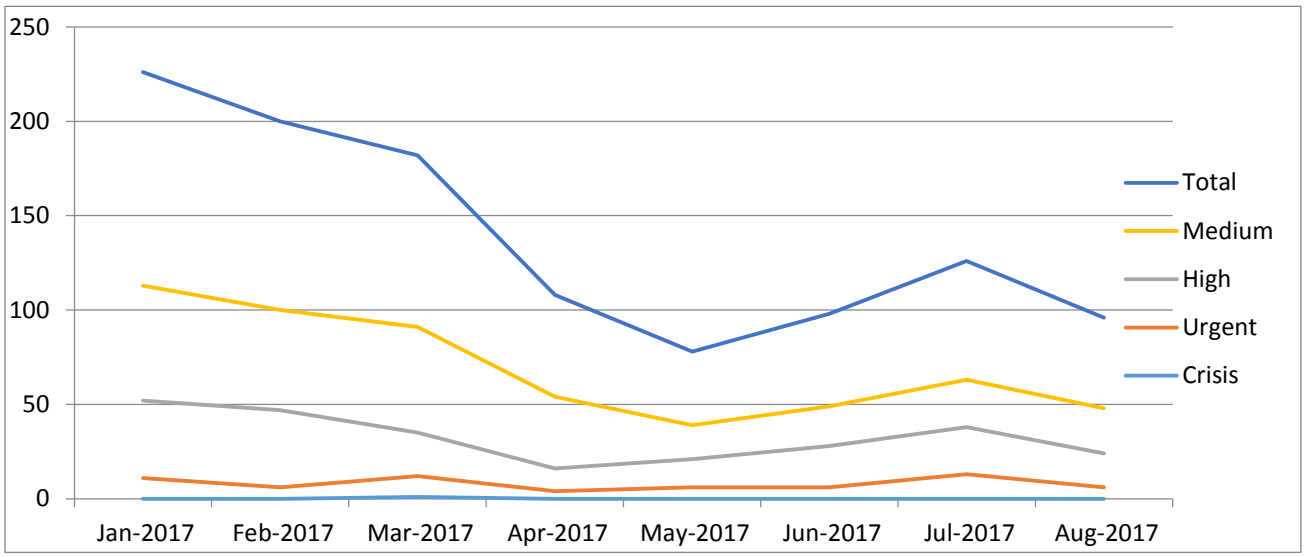
Contract Performance is measured against Incident call statistics against the InterSystems Call Centre (TRC) and availability of TrakCare to end users. Current trends and ongoing totals provided below.

Contract review still requires the revised CCN to be presented and any revised financial milestones reconciled.

TRC Incident reporting Summary: Jan – Aug 2017

Incidents Opened YTD:	556
Incidents Closed YTD:	485
Incident Closure (%):	87
Open Incidents:	173

Trend for Open Incidents



A report on Open URGENT and HIGH Priority TRC issues is included with this report. The following items are highlighted in terms of their impact related to urgency of resolution/progress:

- TRC i100468/ i99185 / 214298 – Appointments not showing as available to book – Clinic schedule built correctly randomly provides clinic slots for booking. This is essential to correct to enable correct use of the system and is highest priority.
- TRC i100063/i100065/ i100067/ i100069/ i100070/ i100075. This is a related set of issues that result in incorrect FCE creation resulting in an inability to report correctly and subsequently unable to provide billing information. This is currently impacting in excess of 2,500 patient episodes.
- TRC i83944 - Resolution of postcode issues QAS TRUD files. – No effective or acceptable work-round in place. We have incidents logged on our local helpdesk every day where the patient cannot be registered and therefore the activity and clinical information for the patient cannot be recorded. We need an urgent workaround to be able to register these patients.
- TRC i99337 – TCI issue where TCI time is after session time. Urgent ad-hoc patch required.
- TRC i93082 – ERS appointments not showing on Trak,
- TRC i82609 – Nil records on Maternity Booking Summary. 2017 fix queried if available for 2016.

Overall TRC logging trend has decreased in the last month. However, the impact of the previous month's increased number of calls did affect SLA performance with a total of 1,317 service credits recorded.

A full, formal response to last month's concerns expressed is pending including the Root Cause Analysis for the outage that occurred on 19th July.

Status reporting of all identified 'system' issues relating to Operational Impact is provided in the Operational Impact Log. In addition, a weekly review of TRC status is being undertaken for reporting back to the Operational Impact Group. The Group has raised its concern on the length of time to resolve identified issues.

System Deliverables

Maintenance Release MR7 together with ad-hoc patches relating to identified fixed issues was deployed into Live on Tuesday 22nd August as opposed to the original date of 15th August. The overall downtime was approximately 3.5 hours, one hour longer than was planned. This was due to a slightly longer time to complete a CCR process compared with the 'test run' the day before and this caused a mistiming in the regeneration of questionnaires, which needed to be resolved and re-run. InterSystems are undertaking an internal review, the results of which will be reviewed by the Programme team.

Note that the support for the implementation consisted of Project based contractors and InterSystems on-site deployment staff.

The deployment of MR7 was an essential dependency for the re-baselining of the GHT environments, which in turn is the major pre-requisite for progressing with phased go-lives. The re-baselining exercise commenced on 23rd August but internal resource requirements within InterSystems may risk the planned completion of the process – currently planned as 12th September.

2017.2 software version has been delivered into the Trust Scratch environment as of 25th August, originally planned for 9th August. The deployment requires significant post patch configuration which is to be carried out jointly by the Trust team and InterSystems. The delivery of 2017.2 includes MR2 as originally defined for Pathology and Pharmacy. However, a further MR release – MR3, which includes delivery of the ECDS requirement is the minimum software release for deployment of 2017.2 into the Live environment. The planned go-live for 2017.2 MR3 is 15th January 2018 – previously scheduled in MR2 for 18th October 2017.

Deliverables for Advanced Clinical use are in planning and subject to carrying out Operational Assessment which has been requested to commence in October. Clinical areas within Operational Assessments in October 2017 will include at least Oncology, Clinical Theatres, Anaesthesia, Mortuary and ePMA.

Confirmation of the availability of the two System Deliverables – **Customer developed and built questionnaires** and use of **Layout Editor** is required to be provided prior to Operational Assessment commencing and the associated questionnaire training.

Contract Payment schedule and any variance from plan

There are no reported variances to the contracted milestone payments.

A revised milestone payment schedule is required urgently to be incorporated into the Contract Change Note (CCN) to be raised by InterSystems in respect to planned implementation schedule for Phases 1.5 and 2.

Central Funding

The submission to SLCS for the next six-month funding period has been submitted. It has identified those elements within the phased deployment that have defined payment milestones associated to enable release of funding. The Phase 1.5 elements of Radiology Order Comms and Pharmacy will effectively release a total of 40% of the Phase 1.5 funding with the remainder released against the delivery of Pathology. Subsequent matching payment milestones for InterSystems will be incorporated into the pending CCN.

The SLCS funding submission also takes into account the movement of benefit realisation in line with delayed deployment. This has not had a negative impact on funding provision.

SLCS has also put forward the release of additional funding related to Benefit Realisation support in terms of backfill funding for benefit dashboards, assisted benefit realisation consultancy and a longer term clinical impact analysis on a set of defined areas to be agreed across the three Trusts in the SmartCare collaborative group. This equates to a total of £199,625 over the contracted period.

Service Review and Phase 1 Recovery

The Programme Team is continuing to engage with ISC Support in terms of Service Management until such time that the BI consultation process has completed and this element can be moved into BAU activity.

A quarterly Service Review that will also involve discussion around service quality including software releases and patching processes is to be arranged for September.

The Trust Programme / Project Team and ISC implementation resources continue to support Operational Services in resolving issues associated with the use of TrakCare. To support this process and to supplement the pending BAU activity, a weekly review of TRC issues is being undertaken to ensure that appropriate escalation is maintained as well as improving local call logging quality.

All Trust staff with the ability to raise TRC issues with InterSystems have been requested to include a clear statement of Trust Impact in all calls logged at High or Urgent priority. This is to ensure that the receiving support analyst can immediately identify with the urgency placed and escalate accordingly. This information also improves the local reporting of TRC with ease of identification of priority items.

The action plan for the re-training and improvement in the Central Booking Office and associated devolved areas is pending the provision of an ad-hoc patch to fix the issue where appointment slots are not being offered as per the TRC identified above. This has been escalated as the No 1 priority for resolution with InterSystems.

Phase 1.5

Preparation and planning

Phase 1.5 deliverables are dependent upon the resolution of the deployment issue with TrakCare Labs Enterprise (TCLE) and subsequent re-baselining of the environments. This is currently planned as 12th September.

A request for a full programme plan to incorporate all of the deliverable clinical functionality has yet to be responded to by ISC.

The proposed go-live of August for Lab's has been considered within ISC and a revised deployment has been requested to be considered that brings Lab's functionality live at an earlier date. Planning for this is to be presented by ISC to the Pathology team for consideration together with any resource requirements. It should be stressed that a revised timetable and associated resource implications has not been agreed. As stated at the August Programme Board by PB, this advance is supported but subject to an agreed process and capability.

The inclusion of internal Consult Orders, originally deemed to be part of Phase 2, has been requested to be incorporated into the current planned activity around Order Comms with availability by mid-November. This is due to the Trust deployment of a revised Intranet environment that will no longer support the current internal referral process. This presents challenges around resource and build activity and review of the requirement has been impacted by key staff on leave in August. Specification of the requirement together with required configuration detail is to be prepared.

Phase 2 - Component delivery.

The Operational Assessment required to establish both scope and Trust resource alignment from a clinical perspective has been requested to commence in October 2018. This takes into account key staff availability due to pre-planned summer holiday absence.

The operational Assessment requires specific InterSystems resource allocation and demonstration capability for all clinical functionality. In addition, the use of Trust defined questionnaires and layout editor is required to be confirmed prior to the Operational Assessment taking place.

InterSystems are to present a delivery plan that establishes a timeline for clinical deployment prior to the Operational Assessment.

Risks to Planned Phase 1.5 & 2 Timelines

The currently planned timeline is heavily dependent upon resource availability and software deliverables in order to meet the requirements for each stage.

Key Trust engagement across divisional areas impacted is essential, not only in respect of further training but in terms of setting operational requirements against as-is and to-be processes. Training attendance or completion of e-Learning is a major requirement to enable access to the 'play' environment and the clarification of operational use prior to go-live.

A specific risk of a lack operational involvement in the testing of functionality prior to full deployment is required to be mitigated. It is proposed to initiate a defined set of operational staff on a per specialty basis for use in test/UAT and pre-deployment phases rather than the more ad-hoc requesting that has taken place to accommodate operational activity to date. This request will be managed via the Operational Group.

A specific risk to Oncology as initial Phase 2 implementation is the timely go-live of Pharmacy stock control in Phase 1.5. Any delay will impact the provision of ePMA as a pre-requisite to Chemotherapy prescribing.

The Resource Schedule in the form of a revised cost forecast has been submitted for review prior to the September Programme Board. This also takes into account a revised programme structure with key Business Change involvement supported by BAU operational support across all areas.

Phase 1 Deployment Lessons Learned

The Action Plan against the lessons learned report is in preparation.

Order Communications Update

Order Communications maintains progress within Radiology. The build against MR7 in BASE was completed on schedule on 9th August. However, the subsequent deployment of MR7 into the Live environment did not take place on 15th August as originally planned but was completed on 22nd August. The delay has impacted the planned re-baselining of the environments – now scheduled to be completed by 12th September based upon all required ISC resource provision as planned.

The revised Programme Plan has taken into account the availability of the environment for User Acceptance Testing and use of the 'sandpit' environment by trainees together with the impact of MR7 slippage. The resultant change is a go-live with ED of 18th October. In addition there are several Level 1 JIRAs (faults) logged that are required to be resolved prior to go-live. PD is to issue a clinical risk status against the time required for resolution as

not all of the issues relate to ED.

Pharmacy Update

Pharmacy Stock Control had originally moved to 26th January for its planned go-live but this is under review as the latest iteration of the plan has indicated a further move to 19th February. That review is starting on 30/8/17 and the results will be communicated to the September Programme Board.

A request for additional ISC Pharmacy resource to be available was defined within the revised planning. The resource plan provide by InterSystems indicates a significant improved amount of time required for the ISC personnel however, early indications are that guaranteed availability of specific resource are not in place. A requirement for the pharmacy SME to be available was originally declined due to a conflicting new site deployment which was eventually cancelled. It needs to be recognised that key personnel availability is considered as part of the planning process and need to be adhered to on both ISC and Trust.

Oncology

Planning review for Oncology is due to take place on 31st August. Results of this review will be communicated to the September Programme Board.

Go-live of Pharmacy stock control against the proposed plan is a dependency for the implementation of ePMA and Oncology. This includes the replacement of OPMAS and the provision of SACT & COSD reporting. The move of Pharmacy to January 2018 is likely to impact the originally required April Oncology requirement. However, consideration of modifying the Pharmacy build process to include ePMA configuration is to be reviewed in order to shorten the overall timescale for ePMA deployment. This does have the potential for delaying further the initial Pharmacy deployment.

For potential Oncology delivery in April 2018, the option to take an incremental approach without ePMA for go-live is being considered ahead of a full implementation e.g. Active Clinical Note.

Pathology Update

Pathology build continues to be subject to a 'freeze' due to the continuing ongoing issue with the complete resolution of the issue where 17 specific system components were identified as not being progressed in line with the MR5.1 update.

The delay in completing the Element XML recovery has moved the Pathology build activity to recommence from 20th September 2017 in the 2016 environment. Build in the 2017.2 environment has moved to commence from 12th October.

Re-planning of all pathology related activities including resource allocation is to ensure adherence to the re-planned dates.

Training

The Training team is actively working on preparation for Radiology Order Comms as well as maintaining existing training requirements. A review with ED is planned for Friday 1st September to ensure that all ED process based requirements are included and an acceptable training plan is agreed.

The second part of the overall Training/Learning & Development review is to be arranged for September.

InterSystems are to deliver a second set of Analytics Training to clinicians, operational staff and BI in September 2017.

Programme Resourcing

Resource requirements will be reviewed against the revised forecast and structural definition.

The initial request for four contract based Test Analysts is in final stages of engagement with the individuals.

The role of Interface Developer is still to be determined in terms of Trust engagement but is a necessary requirement for progressing the project in a timely manner due to the workload application on SPi.

Finance

A revised cost forecast has been provided. A review of the indicated requirement is to be undertaken, An initial meeting between GE, EC, ZP and Steve Webster is scheduled for immediately prior to the September Programme Board meeting.

Programme Risks

The Programme continues to monitor Issues and Risks through the reporting structure used by the Support Team as well as the Operational Impact Board. Any Clinical Risks are monitored by the Clinical Risk Review Group.

Operational Activity

The team is supporting the activity undertaken and managed through the Operational Leads Group. Attendance is maintained at the weekly Operational Impact Board meeting and any relevant escalations managed. In addition, the project team is supporting the initial BI related work that Cymbio are undertaking in terms of reporting and production of their Dashboard. Initial meetings have been held and actions agreed for taking forward the data collection activity.

A scoping meeting within the Operational Impact Board to establish planned recovery capability is scheduled for Thursday 31st August.

The involvement of some Programme Team members is maintained but it should be noted that a significant oversubscription on the time required from Jackie Vincent is prevalent. Detail of the workload currently being presented to Jackie is to be reviewed in the Thursday meeting. A request for specific operational staff to own and engage in this level of support is to be made.

Next Planned activities

Completion of revised planning for current and future functional deployment.

Phase 2 scope development in line with requested Operational Assessment.

Definition of internal referral functionality requirement within TrakCare for November deployment.

Preparation of Radiology Order Comms Training material and ‘sandpit’ environment.

Commencement of re-structured BI/Project Reporting meetings.

Confirmation of Business based support management.

Statement of Work to be completed for Medical device Integration as part of Phase 2 delivery

Continuation of Phase 1 recovery action plan activity via the Operational Impact Board incorporating Cymbio activity supported by Project team as appropriate.

Status against communications plan

Communication via Emergency Planning process of planned downtime.

TrakCare comms via Operational Lead.

Progress
(against project plan / project brief)

Tasks/Milestones completed			
Task	**Start**	**Finish/ % comp.**	**Comments**
Detailed implementation Plan		31/03/15	Version 1.0 Completed for payment milestone confirmation.
Project Initiation Document		29/04/15	Version 1.0 Completed for payment milestone confirmation.
Phase 1 Operational Assessment Stage Complete		31/05/15	Milestone Achievement Certificate Issued.
Phase 1.5 Operational Assessment Complete		30/09/15	Milestone Achievement Certificate Issued.
Phase 1 Build Milestone		17/07/16	Milestone Achievement Certificate to be Issued from Programme Board 07/11/16.
Phase 1 ATP Complete (Technical Live)		25/10/16	Milestone Achievement Certificate to be Issued from Programme Board 07/11/16 on basis of Technically LIVE system being available and supported.
Revised Milestone Plan pending InterSystems CCN		Dec 16	CCN has been completed and signed off.
Phase 1 ATP Complete (Operationally Live)		5 Dec 16	System Live
Phase 1 Deployment Verification Complete		6 Mar 17	Completed

Milestones approaching		
Milestone	**Due**	**Activity to progress**

Risks

(where score on risk log requires escalation to Programme Board)

NOTE: All risks under review in line with Issue Management

Title & Description	Impact	Resolution
Level of clinical engagement is key to the successful implementation of agreed strategy and solution.	10	Monitored and actioned by clear prioritization by collaborative and Trust Boards. Datix Risk 2006
Scale of operational change may require additional and possible external resource to be identified to progress in parallel with implementation.	8	To be revised in line with identified Issues and remedial action plans. Datix Risk 2069
Lack of power/network in areas not covered by generators leading to lack of access to TrakCare.	12	Risk to be assessed with input from Estates. Datix Risk 2320
Lack of Trust resource assigned to project configuration/validation for Pathology. Original level of resource agreed is not being provided.	12	In progress with Phase 1.5 planning in Pathology. Datix Risk 2362

PUBLIC BOARD MAIN BOARD – SEPTEMBER 2017

Lecture Hall, Redwood Education Centre commencing at 09:00am

Report Title
Risk Management Strategy
Sponsor and Author(s)
Author – Andrew Seaton, Director of Safety Sponsor – Deborah Lee, Chief Executive
Executive Summary

Purpose

To gain approval of the new risk strategy and associated policies from Trust Board.

Key issues to note

The new strategy and policies have been developed due to inconsistencies in the previous approach to risk management identified at committee and through the risk management internal audit report.

The strategy has been developed over the past year bringing together key learning points and system improvement. The strategy and polices have been reviewed and signed off by the Trust Leadership Team and Risk Management Group.

The Risk Management Internal audit showed that the new risk system met or partially met 20/25 key elements of effective risk management, as defined by the Institute of Risk Management (12 standards were met, 8 partially met with 3 not met, 2 not applicable). The report also recommended that the new approach should be standardised through agreeing a new set of risk documentation\policies to ensure clarity across the Trust and to draw out more trend analysis from risk data. A full action plan is in place to work towards compliance with the risk management standards and other recommendations, which will be monitored by the Risk Management Group.

Key addition to the process is the consideration of risk appetite when prioritising risks. The Trust Risk Register will now consist of risks scoring 15 and above plus patient safety risk of 12 and above reflecting prioritisation within the risk appetite.

An additional group has been established to monitor and challenge the risk management system known as the Risk Management Group, chaired by the Chief Executive the group will oversee the delivery and development of the risk management strategy

For approval:

1. Risk Management Strategy (Appendix 1)
2. Health & Safety Policy (Appendix 2)
3. Risk Register Procedure (Appendix 3)

Conclusions

The approval of the strategy and policies will bring together the main structural improvements in the risk management system. Work will continue to improve the quality of the risk management system through the internal audit findings and associated actions. This will ensure greater understanding of the risk management process and improved assurance that key risk are being identified and managed appropriately.

Implications and Future Action Required

Continued development of the risk process.

Recommendations

To approve the Risk Management Strategy and associated polices.

Impact Upon Strategic Objectives

Supports delivery of a wide range of objectives relating to safe, high quality care and good governance.

Impact Upon Corporate Risks

Standardises the approach to risk management after a period of development.

Regulatory and/or Legal Implications

The Risk Strategy and Health & Safety Policy require regular Trust Board approval.

Equality & Patient Impact

None

Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required

For Decision		For Assurance		For Approval	√	For Information	

Date the paper was presented to previous Committees

Quality & Performance Committee	Finance Committee	Audit & Assurance Committee	Workforce Committee	Remuneration Committee	Trust Leadership Team	Other (specify)
					5th July 2017	Risk Management Group 17th May 2017

Outcome of discussion when presented to previous Committees

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

Risk Management Strategy

April 2017-2020

1. Introduction

Gloucestershire Hospitals is committed to a comprehensive, integrated approach to the management of risk to ensure that associated risks in the delivery of services and care to patients are minimised, the health and well-being of patients, staff and visitors is optimised and that the assets of the Trust, business systems and income is protected.

In fulfilling this aim, Gloucestershire Hospitals will establish a robust and effective framework for the management of risk. One that is proactive in understanding risk, builds upon existing good practice and is integral to all decision making, planning, performance reporting and delivery processes. The Board however, acknowledges that some risks will always exist and never be eliminated and accepts responsibility for risk where this occurs.

This strategy is predicated on the belief that risk management is an important activity and should be an inclusive and integrative process covering all risks, set against a common set of principles, and a major corporate responsibility which requires strong leadership and regular review.

To fulfil this requirement, the Board of Directors will ensure that the organisation:

- Minimises the potential for harm to patients, all staff and visitors to a level as low as reasonably practicable;
- Protects everything of value such as high standards of patient care, staff safety, reputation and assets or income streams through effective risk systems, practices and processes
- Operates an effective system of risk management through the deployment of sound policies, procedures and practices including the operation of a Risk and Incident Reporting System;
- Anticipates and respond to changing circumstances, i.e., social, environmental, legal and financial;
- Maximises opportunity by adapting and remaining resilient to changing risk factors;
- Secures the commitment of management at all levels to promote risk management and provide the necessary leadership and direction to ensure risk management is integrated and managed holistically;
- Adopts common standards throughout the Trust to provide and maintain robust systems to ensure compliance with relevant statutory requirements;
- Monitors and reviews risk management performance at all levels against agreed standards to ensure that standards are met and corrective action is taken where necessary;
- Informs policy and operational decisions by identifying risks and their mitigations alongside likely impact;

- Recognises the contribution of all key stakeholders, including patients, staff and the public, to ensure their involvement and participation in the overall risk management process;

- Has in place effective systems of Trust wide communication to ensure the dissemination of information on risk management;

- Secures the provision of resources, facilities, information, training, instruction and supervision to meet these objectives

This strategy is the high level document within the Trust and does not set out to cover in detail the management of specific risks. This more detailed information is set out in relevant strategies and policies, in particular the Risk Assessment / Risk Register and managing reporting and Investigating Incidents procedure.

Accountability arrangements in relation to the category of risks, are covered in this strategy and it is recognised that robust governance is supported by an effective risk management system designed to deliver continual improvements in safety and quality.

2. Purpose

The purpose of the Risk Management Strategy is to detail the Trust's framework within which the Trust leads, directs and controls the risks to its key functions. This is undertaken in order to comply with all legislative requirements including Health and Safety legislation, NHS Improvement Terms of Authorisation, key requirements by regulatory bodies such as Care Quality Commission, and the Trust own strategic objectives. The risk management strategy underpins the Trust's performance and reputation, and is fully endorsed by the Trust Board.

The Trust's strategy is aimed at creating a coordinated and focused framework for the management of risk within the Trust. Implementation of the strategy will be monitored by the Risk Management Group, on behalf of the Board of Directors and Chief Executive who has delegated responsibility from the Board for effective risk management, with significant commitment, support and effort from all members of Trust staff including management teams and senior clinicians.

The Trust's overall strategic aim in respect of risk is to make the effective management of risk an integral part of everyday management practice. This is achieved by having a comprehensive and cohesive risk management system underpinned by clear responsibility and accountability arrangements throughout the organisational structure of the Trust. These arrangements are set out in more detail in the Trust's Standing Financial Instructions, Scheme of Delegation and Trust wide policies and procedures.

This strategy formalises the Risk Management responsibilities of the Board of Directors and sets out how the public can be assured that our risks are managed effectively. The overall goal of risk management is to have an environment of 'no surprises' where Board members understand the risks facing the Trust and eliminate or control them to an acceptable level, by creating a culture founded upon assessment, mitigation and prevention of risk. To realise this goal, this strategy seeks to achieve the effective management of risk within a common set of principles which will:

- Be integral to all decision making, planning (including resource allocation), performance, reporting and delivery processes;

- Manage risk closest to where the risk can be most effectively managed and mitigated;
- Improve the quality of patient care by preventing or reducing harm or potential harm to patients and staff;
- Minimise liabilities in the event of harm to a patient, visitor or member of staff;
- Improve the safety and quality of the working environment for the benefit of all staff; and
- Ensure stakeholders are kept informed of the developing risk management process

3. Process for Risk Management

   Risk Management can be defined as the identification, assessment, and prioritisation of risks followed by a coordinated and economical application of resources to minimise, monitor and control the probability and/or impact of unfortunate events. Risks should also be reviewed at appropriate intervals to ensure they continue to be appropriately mitigated.

4. The Board Assurance Framework (BAF) acts as the Trust's primary mechanism for ensuring that the Trust Board receives adequate assurance, that the Trust is actively pursuing its corporate objectives and that the risks to these objectives are being appropriately treated. Gloucestershire Hospitals is faced with a number of factors that may impact upon its ability to meet its objectives. This strategy describes the direction that the Trust will take to manage risk.

5. The Board Assurance Framework (BAF) and Trust Risk Register reflect the organisation's risk profile. The BAF contains the strategic risks to the objectives identified by the Executive team, describe the controls in place and give the strength and quality of assurance available to the Trust Board, the Trust risk register identifies the significant operational risks, controls and mitigation showing how well the risks are being managed. These documents support the Board in making a declaration on the effectiveness of the Trust's system of internal control in the Annual Governance Statement.

6. The Trust is exposed to a wide range of potential risks, including:

   - Clinical risks e.g. unavoidable and avoidable risks in treatment or provision of care
   - Operational risks e.g., unavoidable and avoidable risks in the delivery of services to staff and patients;
   - Health and safety risks e.g. accidents involving patients, staff or visitors and related financial consequences
   - Workforce and recruitment risks e.g. insufficient staff, or skill shortages
   - Financial and business risks e.g. not achieving the corporate objectives
   - Estate and environmental risks e.g. poor maintenance or faulty equipment

- Information Governance risks e.g. breaches of confidentiality

Risk assessment is implicit in every activity in the Trust, and the Trust Board must manage its risks in such a way that people are not harmed and losses are minimised to the lowest acceptable levels and clinical and organisational quality are maintained at all times.

7. Strategic Risk Management Objectives

The strategic objectives in relation to risk management will be achieved by:

- Clearly defining the roles, responsibilities and reporting lines within the Trust for risk management;
- Ensuring that all staff are adequately trained and competent to execute their duties in respect of risk management;
- Including risk management issues when writing reports and considering decisions;
- Continuing to demonstrate the application of risk management principles in line with the Risk Management Policy;
- Reinforcing the importance of effective risk management as part of the everyday work of all staff employed or engaged by the Trust;
- Maintaining a comprehensive register of risks and reviewing these on a periodic basis;
- Ensuring controls are in place to effectively mitigate the risk and are understood by those expected to apply them;
- Ensuring gaps in control are rectified and assurances are reviewed and acted on in a timely manner;
- Maintaining documented procedures of the control of risk and provision of suitable information, training and supervision; and
- Monitoring arrangements and continually seeking improvement

The Trust is using the principles of the National Patient Safety Agency model risk matrix used to inform grading of severity. The overriding principle is that the Trust will have in place an effective risk management system. This can be defined as the effective and systematic application of management policies, procedures, and practices to provide the context of identifying, evaluating, treating, monitoring and communicating risk.

8. Risk Framework

This section describes the broad framework for the management of risk. Operational instructions for risk registers, management of safety alerts, investigation of incidents, and learning from incidents are detailed in separate policies and procedures.

8.1 The Approach

The Trust has a structured approach to risk management. This involves:

- A pro-active approach to the identification and mitigation of principal risks that may threaten the achievement of strategic, operational and divisional objectives;
- A reactive approach to the identification and management of risks that may threaten the achievement of the Trust's risk management systems and processes; and
- Progress reports to the Board via the submission of the Trust Risk Register on a monthly basis; and
- Delegated authority of the oversight of risk management to the Risk Management Group

Detail of these processes set out in associated Risk Management procedures are listed at the end of the document.

8.2 The Board Assurance Framework

The Board Assurance Framework (BAF) is the key document enabling the Board to understand the strategic risks facing the organisation. The BAF provides the Trust with a single but comprehensive method for the effective and focused management of the principle risks to meeting the Trust's overall strategic objectives. The risks identified from the BAF cover the full range of strategic objectives and includes consideration of present risks, future risks, risks arising from within the organization and risks occurring as a result of external pressures and changes.

The BAF is a live document updated by the Executive leads for each of the strategic objectives on a quarterly basis and provides the basis for both the assurances and gaps in control reported in the Annual Governance Statement.

8.3 Trust Risk Register

The Trust Risk Register is comprised of risks that:

- Are assessed as having a current rating of 15 or above
- For Safety ratings of 12 or above to reflect the Boards low tolerance of safety risks
- Risk that score 12 or above that have been referred by the sub-board committees

The risks identified on the Trust Risk Register are fed directly to the BAF where appropriate.

8.4 Divisional Risk Register

Each division has its own risk register which captures in one place how divisional risks are being managed. The Divisional Management Team is accountable for the assessment, communication and management of risks within their area of responsibility.

Each Divisional Management Team will identify the operational lead for its risk register, it

is anticipated that this will be the Divisional Director of Operations. The Divisional Risk Register comprises risks scoring 8 or above or have an impact of 5.

All risks assessed as 15 and above and 12 and above for safety must be reviewed by a relevant Executive Director and then presented to the Trust Leadership Team as a part of the Trust risk report.

8.5 Specialty Risk Register

Each specialty has its own sub set of the Divisional risk register to ensure local ownership and management of the risks. The specialty teams are accountable for the assessment, communication and management of risks within their area of responsibility.

The Specialty / Department Manager will be responsible for the risk register, these are risks scoring 8 or above or have an impact of 5. Other risks will be managed by local risk assessment and management controls.

All risks assessed as 15 and above or assessed as 12 and affecting multiple Divisions must be reviewed by Divisional management team.

8.6 Sub- Board Committees Risk Register

The following formal sub-committees of the Board will review on a quarterly basis a sub-set of relevant risks taken from the Divisional and Trust Risk registers. Their specific role will be to review the current controls and mitigation plan from the perspective of the experts in the committee. They may also refer risks or re-evaluate risks for further consideration by the Trust Leadership Team.

The following committees will review risks scoring 12 or above or an impact of 5 from the following domains, reputational risks will be considered by the relevant committee:

Committee	Domains
Quality & Performance Committee	Patient Safety, Quality, Statutory, Environment
Workforce	Workforce, Health & Safety
Finance	Finance, Business
Trust Board	Reputation

8.7 Risk Assessment

Risk assessment is fundamental to risk management as without it effective controls cannot be introduced. In managing risks, decisions will need to be taken on where resources should be targeted. Risks are reported and monitored through risk management software for incidents reporting (Datix). The system supports the Trust to demonstrate regulatory compliance and drive continual improvements in quality care.

8.8 Risk Evaluation

The evaluation aspect of the risk assessment will involve the analysis of the individual risk to identify the impact, consequences, severity and likelihood of the risk being realised. The consequence and likelihood of the risk is given a numeric score based on the matrix as recommended by the National Patient Safety Agency (NPSA now NHS Improvement).

The higher the risk, the greater the urgency for action and the more frequent its review. Urgent action is required for very high risks in order to mitigate their likelihood and consequence, and such risks and actions should be reviewed regularly to ensure mitigation is effective. Low rated risks are likely to require less urgent action and less frequent review.

Descriptors of the consequence of risk are outlined in Risk Management procedures, on the safety website and on the Trust risk management software system (Datix) so that there is consistency to guide staff as to what would amount to each level of severity/consequence/impact and likelihood respectively.

Risk thresholds are intended as a guide to decision-making and the reporting of risk. They do not describe the risk in absolute terms and instead provide a means by which risks may be prioritised, as relative to each other.

Further direction on the handling of risks dependent on risk thresholds are described in the Risk Assessment/ Risk Register procedures and supporting documents.

8.9 Process for Board level review of Risk Management Framework

As noted above, the Board Assurance Framework is the primary mechanism for ensuring that the Trust Board received assurance that the risks to the Trust's strategic objectives are being appropriately treated, this in combination with the performance management framework should provide assurance towards the achievement of the objectives.

9. Board Statement of Risk Appetite

The Trust acknowledges that a certain degree of risk is unavoidable and therefore it needs to take action in a way that it can justify, to manage risk to a tolerable level. Risk appetite is the degree of risk exposure, or potential adverse impact from an event, that the Trust is willing to accept in pursuit of its objectives.

If no such statement exists, there is insufficient guidance for managers on the levels of risk that they are permitted to take, or opportunities are not seized upon due to the perception that taking on additional risk is discouraged – risk appetite involves taking considered risks where the long term benefits outweigh any short term losses.

The Trust has adopted the following principles/definitions, to be applied to the key business drivers in Table 1 below, in determining risk appetite:

Assessment	Description of potential effect
Lowest threshold	
Zero Risk Appetite 1	The Trust Board **aspires to avoid risks under any circumstances that may** result in reputation damage, financial loss or exposure, major breakdown in services, information
Low Risk Appetite 2	The Trust Board **aspires to avoid (except in very exceptional circumstances) risks that may** result in reputation damage, financial loss or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and / or legislative compliance, potential risk of injury to staff / service users.
Moderate Risk Appetite 3	The Trust Board **is willing to accept some risks in certain circumstances that may** result in reputation damage, financial loss or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and / or legislative compliance, potential risk of injury to staff / service users.
High Risk Appetite 4	The Trust Board **is willing to accept risks that may result** in reputation damage, financial loss or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and / or legislative compliance, potential risk of injury to staff / service users.
Upper threshold	
Very High Risk Appetite 5	The Trust Board accepts risks that are likely to result in reputation damage, financial loss or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and / or legislative compliance, potential serious risk of injury to staff / service users.

10.Overarching statement

The Trust operates within a high overall range of risks. The Trust's lowest risk appetite is for safety risks, specifically patient, staff and visitor safety and for breaching our legal obligations. This means that reducing these risks so far as is reasonably practicable will take priority over meeting our other business and strategic objectives.

Where business and strategic risks can be effectively controlled, and within clearly defined limits of authority, positive risk taking will be encouraged where it may deliver innovation, service improvement or greater efficiency in our operations.

11. Relative willingness to accept risk

To support decision-making, the Trust sets out its relative willingness to accept risk across domains as follows:

	Relative willingness to accept risk[1]				
	Low		Medium		High
	1	2	3	4	5
Safety					
Quality					
Workforce					
Statutory					
Reputation					

Business					
Finance					
Environmental					

Definitions of the domains listed above:

Domain	Definition
Safety	Impact on the safety of patients, staff or public
Quality	Impact on the quality of our services. Includes complaints and audits.
Workforce	Impact upon our human resources (not safety), organisational development, staffing levels and competence and training.
Statutory	Impact upon on our statutory obligations, regulatory compliance, assessments and inspections.
Reputation	Impact upon our reputation through adverse publicity.
Business	Impact upon our business and project objectives. Service and business interruption.
Finance	Impact upon our finances.
Environmental	Impact upon our environment, including chemical spills, building on green field sites, our carbon footprint.

The relative willingness to take risks is intended as an aid to decision making where two or more areas of risk come into conflict, and balances our willingness to accept risks relative to each other. It does not attempt to describe the Trusts absolute willingness to accept risk in any area.

[1] Adapted from *Understanding and articulating risk appetite*, KPMG 2008

12. Duties, Roles and Responsibilities

These are summarised below however, additional roles and responsibilities for are described in individual risk management procedures listed at the end of the document

13. Trust Board of Directors

The Executive and Non-Executive Directors have a collective responsibility as a Trust Board to ensure that the Risk Management processes are providing them with adequate and appropriate information and assurances relating to risks against the Trust's objectives. The Executive and Non-Executive Directors are responsible for ensuring that they are adequately equipped with the knowledge and skills to fulfil this role.

The Board is also responsible for reviewing the effectiveness of its internal control systems and is required to ensure that the Trust's risk management arrangements are sound and protects patients, staff, the public, and other stakeholders against risks of all kinds.

The Annual Governance Statement made by the Trust's Chief Executive in the annual report and accounts must demonstrate that the Trust Board has been informed on all risks and has arrived at its conclusions on the totality of risk based on all the evidence presented to it through the responsibilities delegated to the committees within the organisation.

13.1 Executive Directors

The Executive Directors are responsible for managing risk as delegated by the Chief Executive

and set out in the Risk Management Policy and the Terms of Reference of the Risk Management Group. Executive Directors are also responsible for risks allocated to them on the Trust Risk Register. The diagram below provides the Risk Management Framework: this shows the principal bodies responsible for the governance and oversight of risk within the Trust and the reporting hierarchy. It details all committees and groups which have some responsibility for risk and report directly to the Trust Board of Directors. This provides assurance to the Board that risk management processes are in place and remain effective.

13.2 Chief Executive

The Chief Executive is accountable to the Chair and the Board and, as the Accountable Officer, has overall responsibility for ensuring that the Trust operates effective risk management processes in order to protect all persons who may be affected by the Trust's business. The Chief Executive is required to sign annually, on behalf of the Board, an Annual Governance Statement, in which the Board acknowledges and accepts its responsibility for maintaining and reviewing the effectiveness of a sound system of internal control, including risk management.

13.3. Medical Director

Accountable to the Chief Executive and the Board, the Medical Director has joint lead responsibility for healthcare governance with the Director of Nursing. The post holder is accountable to the Chief Executive and the Board for the delivery of the Trust's Safety initiatives. The Medical Director is also responsible and accountable for clinical performance of the medical workforce. Other responsibilities also include implementation of Quality Improvement and Clinical Audit programmes: medical innovation and medical education

The medical director is the Trust named The Caldicott Guardian will play a key role in helping to ensure that the Trust satisfies the highest practical standards for managing information governance risks. The Caldicott Guardian will act as the conscience of the organisation in this respect, and will actively support work to manage such risks.

13.4. Director of Nursing

The Director of Nursing has joint lead responsibility for healthcare governance with the Medical Director and is accountable to the Chief Executive and the Board for the delivery of the Trust's Quality initiatives. The Director of Nursing is also responsible and accountable for the operational management of the nursing teams and Allied Healthcare Professionals and leads on the development of clinical nursing practice to achieve excellence in all aspects of nursing. The post-holder will ensure the highest standards of care at ward level and lead on the improvements to patient experience. The Director of Nursing also coordinates the Care Quality Commission Registration and the maintenance of compliance with the regulations and outcomes that apply to the Trust.

13.5 Chief Operating Officer

The Chief Operating Officer is accountable to the Chief Executive and the Board for overall management of Trust corporate services excluding the Trust Secretariat and the delivery of organisational / business associated initiatives. The COO ensures that risks in relation to this portfolio are managed in line with the Trust's risk management systems and processes. The post is also responsible for the operational management of divisional teams, supporting the Trust's risk management systems and processes.

The Chief Operating Officer will report key operational risks to the Board on a routine basis.

13.6 Director of Clinical Strategy

The Director of Clinical Strategy is accountable to the Chief Executive and the Board leading the development of local health and social care services, strategic development, business planning research governance and service transformation in the Trust. The Director of Clinical Strategy ensures that all risks in relation to this portfolio will be managed in line with the Trust's risk management systems and processes.

The Director of Clinical Strategy shall also fulfil the Senior Information Responsible Officer, SIRO) and is accountable to the Chief Executive for the management of information risks

13.7 Director of Finance

The Director of Finance is accountable to Chief Executive and the Board for the management of Financial Governance including advising on financial and business risk, audit and their assurance processes.

13.8. Director of Workforce and Organisational Development

The Director of Workforce and Organisational Development is accountable to the Chief Executive and the Board for the management of all human resources and associated risks, including those relating to training and organisational development.

The Director of Workforce and Organsiational Development is also responsible for monitoring risks escalated from the Trust Health and Safety Forum

13.9 Director of Safety

The Director of Safety has responsibility for leading the Gloucestershire Safety Improvement Academy, safety and quality systems and risk management for both staff and patients. He liaises closely with the Divisional teams to support effective quality activities, co-ordination and monitoring the quality and safety programmes.

- Contributing to the development and monitoring of the annual safety objectives through consultation and review.
- Responsible for developing and maintaining a continuous quality improvement culture and supporting governance system
- Responsible for the establishing of an open and fair system for the investigation of incidents and accidents, including a confidential reporting process and Duty of Candour.
- Coordination of the Executive visits to all areas in the organisation ensuring wide understanding of safety issues and concerns from all staff
- Delivery of agreed Safety objectives

13.10 Trust Secretary

The Trust Secretary is responsible for ensuring that the Trust Board of Directors is cognisant of its duties towards risk governance and management and for coordinating the annual cycle of Board business to ensure these duties are incorporated on the Board's agenda. The Trust Secretary is also responsible for the coordination of the Trust's Board Assurance Framework to ensure proactive management to ensure that the Board remains sighted on the key risks facing the Trust.

13.11 Trust Leadership Team

The Trust Leadership (TLT) is responsible for maintaining the Trust Risk Register. The TLT receives risk exception reports from divisions at each business meeting, informing them of any risks with the division that TLT should have sight of. These may be either risks scoring 15 or above, or safety risks scoring 12 and above.

13.12 Audit Committee

The Audit Committee shall review the establishment and maintenance of an effective system of governance, risk management and internal control across the whole of the organisation's activities.

13.13 Divisional and Specialty Management Teams

Divisional Management Teams comprising Chief of Services, Director of Operations and Divisional Director of Nursing (and Heads of Departments if applicable) are responsible for ensuring they have effective local risk management processes in place supporting compliance with the Trust Risk Management Strategy and associated Trust risk related procedures. The Divisional Management Team will include the responsible lead for risk for the division, it is recognized that this may be different to the delegated lead for quality as the former may be seen more as an operational role.

Specialty teams comprising specialty directors, matrons and operational leads will inform Divisional management teams of progress with risk related issues and updates of risk registers for escalation to the Trust Leadership team based on confirmed risk assessment and entry onto the Trust Risk Management software. Divisional Management teams are required to present 6 monthly governance based reports to the Quality and Performance Committee and Trust Leadership Team describing progress with agreed aspects of quality, risk.

13.14 Ward Managers, Head of Departments

Each manager is responsible for ensuring Risk Assessments are completed with implementation of suitable and sufficient control measures and for communicating the risk assessment to those affected. Line managers must allocate sufficient time for the risk assessor to complete their assessor responsibilities within normal working hours.

13.15 Staff Side Health and Safety Representatives; Workplace Improvement Teams

Designated representatives will engage with staff groups or union members (dependant on role) and consult, communicate and provide feedback to and from health and safety meetings. They will advise (within their competence) on effective health and safety management and engage in safety improvement work, safety inspections, including investigation and risk assessment activity in partnership with the Trust Safety team.

13.16 All staff (including Honorary Contract holders, locum and agency staff and contractors)

All staff have a responsibility to follow health and safety instructions and report any patient and staff safety incident/ accident immediately, co-operating with any subsequent investigation (Procedure for Managing, Reporting and Investigating Incident and Accidents to include Serious Incidents). Their safety training needs will be identified during annual appraisals as part of the training matrix for professional groups as well as specific needs. For those staff identified by their professional body as having additional Health and Safety responsibilities a recognised qualification will be gained. Staff

are encouraged to participate in improvement programmes promoting patient and staff safety and opportunities to participate in setting the safety agenda for the organisation are encouraged.

14. Associated procedures and documentation

This Strategy should be read in conjunction with all other Trust key documents, policies and procedures, having relevance to the management of risk, that have been set in place to support the Trust in the management and control of risk.

15. References

National

Building the Assurance Framework: A Practical Guide for NHS Boards (DOH March 2003)

Assurance – The Board Agenda (DOH July 2002)

A Practical Guide for NHS Boards (DOH March 2003)

NPSA Guide: Healthcare Risk Assessment Made Easy

Understanding and Articulating Risk Appetite, KPMG 2008

Associated Trust Procedures

- Risk Assessment / Risk Register Process & Action cards
- Procedure for the Management of Incidents & Action cards
- Health and Safety Policy and associated policy/ procedural documents

16. Definitions

The following terms are used in this document:

Objective	The objectives set by the Trust Board of Directors in the annual planning process specify the standards, outcomes, achievements and targets for various areas of the Trust's operations.
Consequence	The outcome or potential outcome of an event. Sometimes referred to as 'impact' or 'severity'.
Control	A measure in place to mitigate a risk.
Current score	What the risk score is when assessed.
Inherent risk	An assessment of the risk prior to any mitigation and controls being applied. This is the "raw" risk.
Likelihood	The probability that the consequence will actually happen.
Risk	The effect of uncertainty on objectives. An 'effect' may be positive, negative or a deviation from the expected position.
Risk appetite	The amount of risk exposure an organisation is willing to accept in connection with delivering a set of objectives.
Risk assessment	The process of identifying and analyzing risk. Risk is measured as a combination of the likelihood and the consequence of an event occurring
Risk framework	The stages of the life-cycle of an individual risk, from identification to closure.
Risk owner	The person responsible for ensuring the risk is adequately managed.
Target risk	An assessment of the current or anticipated risk after the planned actions have been applied.

Gloucestershire Hospitals NHS
NHS Foundation Trust

TRUST POLICY

TRUST HEALTH AND SAFETY POLICY

FAST FIND:

- **Read this policy in conjunction with the Statement of Intent (add hyperlink)**
- **For details of roles and responsibilities relating to health and safety requirements, see section 4.**
- **Information on Health and Safety Controls Manuals (add hyperlink) is also available.**
- **Details of other related health and safety policies and procedures are set out in the Policy Map (add hyperlink)**

1. INTRODUCTION / RATIONALE

This Policy sets out the principles and arrangements upon which the Trust bases its Health and Safety commitment. It forms part of the Trust's overall approach to Risk Management and should be read in conjunction with the Risk Management Framework (and related documents) (hyperlink to Risk Management Framework).

2. DEFINITIONS

Word/Term	Descriptor
Health and Safety	• The promotion and maintenance of the highest degree of physical, mental and social well-being of workers in all occupations • The prevention amongst workers of departures from health caused by their working conditions • The protection of workers in their employment from risks resulting from factors adverse to health.
Controls Manual	• Department/ building/ward based resource for all staff containing risk assessments for key Health and Safety issues describing safe systems of work.
Controls Manual officers	• Delegated person with responsibility for maintaining Health and Safety Controls Manual • Responsible for health and safety practices in a designated area, building or specific team, e.g. ward.
Trade Union Health and Safety Staff Side Representatives	• Health and Safety trained Trade Union representatives of employees who belong to a trade union.
Workplace Improvement Team	• Workplace Improvement Team are a cohort of staff that either volunteer for Health and Safety Duties (such as old health and Safety Link Person, representative of Employee, Workplace Safety Reps etc.) or additionally they are managers/supervisors with Health and Safety responsibility.

3. POLICY STATEMENT

3.1 The Trust recognises its duties to ensure, as far as reasonably practicable, the health and safety of staff, patients, members of the public and other persons whilst they are on Trust property. The Trust recognises and accepts its responsibility as an employer to consult with Trade Union Health and Safety representatives and Workplace Improvement Team to provide a safe and healthy workplace for all its employees (to include contractors) .

3.2 The Trust undertakes all measures required to meet its general duties under the Health and Safety at Work Act 1974 in the provision of:

- Plant, equipment and systems of work that are safe and without risk of harm.

- Arrangements to ensure the safe use, handling, storage and transport of articles and substances.
- Suitable and sufficient information, training and supervision to enable all employees to avoid hazards and contribute positively to their own health and safety at work.
- A safe place of work with safe access and egress (see Access and Egress Policy – add hyperlink)
- Adequate and suitable welfare facilities

3.4 The Trust recognises that it has a duty of care to contractors. Contractors are required to recognise their duty of care to the Trust and are required by their terms of contract to comply with the Health and Safety at Work Act 1974 and related regulations. This responsibility to be assured and monitored by the employing department

3.5 The Trust recognises its duty as a landlord to its tenants and employees, under the Health and Safety at Work Act 1974. The Trust will require its tenants and their employees to recognise their duties to the Trust under the Health and Safety at Work Act 1974 and relate regulations. The Trust will liaise and cooperate on all matters regarding Health and Safety with its tenants

3.6 Where the Trust occupies property belonging to another organisation, it recognises its duty as tenants under the Health and Safety at Work Act 1974. The Trust will liaise and cooperate on all matters regarding Health and Safety with its landlords.

4. ROLES AND RESPONSIBILITIES

Post/Group	Details
Chief Executive	• Accountable Officer for the Trust. • Trust executive lead for safety management; accountable for ensuring that the Trust can discharge its legal duty for all aspects of safety each year, and specifically for the health and safety of staff, visitors and contractors on Trust premises.
Non-Executive Director	• Appointed by the Chair; scrutineer for health and safety at board level and receives assurance from the Chief Executive that health and safety is appropriately managed. • Assure the Board that health and safety risks are managed robustly.
Executive Team	• Ensure safety measures are effective for staff (including contractors), patients and visitors to the site. • Ensure that safety risks are identified and assessed and integrated into their planning and delivery of services with appropriate levels of monitoring to ensure compliance. • Make adequate arrangements to provide or access competent advice on health and safety issues for themselves and their teams. • Carry out programmed executive visits to wards and departments to ensure safety processes are in place and provide a direct forum for staff to discuss safety matters.
Human Resources Director	• Managing the Service Level Agreement for Occupational Health, ensuring that suitable levels of service are given to trust in accordance with SLA. • Chair of the Trust Health and Safety Committee.
Director of Safety	• Lead for safety programmes and risk management for staff, patients and visitors. • Provide support to divisional activities, co-ordinate and monitor safety programmes and ensure provision of reports on appropriate metrics. • Contribute to the development and monitoring of the annual safety objectives through consultation and review. • Establish an open and fair system for the investigation of incidents and accidents, including a confidential reporting process. • Coordinate Executive visits to all areas in the organisation ensuring wide understanding of safety issues and concerns from all staff. • Delivery of agreed safety objectives.
Trust Risk Manager (Health and Safety)	• Provide advice to the Director of Safety on health and safety process and policy. • Trust wide Competent Person responsible for strategic advice to the organisation on occupational health and safety matters.
Divisional Chief of Service	• Accountable for the safety activities of in their areas of responsibility. • Ensure their organisational structure is able to discharge the requirements of staff and patient safety. • Identify forums for the planning, delivery, action and checking of patient and staff health and safety, facilitated by NEBOSH certificate trained Risk Manager, with competent advice from specialist staff as required. • Ensuring that all staff in division are competent to perform health and safety tasks in their area of work and that all proactive and reactive monitoring of systems is undertaken.
Divisional Risk Manager	• Attend divisional risk meetings. • Manage Divisional and health and safety policies, procedures and guidelines. • Undertake such training as required to ensure competence of themselves and other divisional staff in health and safety. • Advise managers on divisional risk assessments required by safety legislation are carried out and reviewed regularly.

Post/Group	Details
	• Ensure residual unacceptable health and safety risks are placed on the divisional risk register. • Advise on the correct investigation and reporting of health and safety incidents. • Be divisional lead on health and safety training.
Local managers	• Identify, assess and manage safety risks. • Ensure that safety management is integrated into the planning and delivery of services. • Ensure appropriate monitoring of compliance within their area. • Participate in wider governance, quality and risk management issues within their division. • Identifying health and safety training needs within team
Employees/contractors	• Take reasonable care for own health and safety and that of others • Work in accordance with training provided and use safe systems of work where they apply • Do not undertake tasks where authorisation and/or training has not been given, that might endanger the health and safety of others • Wear PPE where this is provided • Do not intentionally misuse or recklessly interfere with any item that has been provided in the interest of health and safety • Report accidents and incidents (including near misses) and shortcomings in Trust health and safety systems, and defects in plant and equipment
Trade union safety representative/ Workplace Improvement Team	• No **direct** responsibility for managing health and safety (unless a designated manager) • Perform functions to assist the Trust to manage health and safety, including consulting with staff groups and union members (dependent on role) and participating in health and safety meetings • Advise (within their competence) on effective health and safety management • Engage in safety improvement work, safety inspections, investigations and risk assessment activity in partnership with local managers, Divisional Risk Managers and the Trust Safety team

5. ARRANGEMENTS

5.1 The Trust has developed and maintains a framework of health and safety procedures including:

- Trust-wide policies/procedures regarding health and safety issues common to most parts of the organisation which are accessible to all staff on the Trust Policy Intranet site (see Health and Safety Policy map – add hyperlink).
- Divisional/Departmental procedures specific to the area, identifying the safe systems of working for that area.
- The Trustwide **Health and Safety Control Manual,** providing the mechanism for assessing and review of issues relating to Health and Safety on a programmed basis (See section 6)

5.2 The Trust Health and Safety Committee comprises divisional health and safety leads, specialist health and safety representatives, and staff health and safety representatives, including trade unions and Representatives of Employee Safety (see Terms of Reference – add hyperlink). This committee reviews the strategic issues associated with health and safety and reports to the Trust Quality Committee, a subcommittee of the Trust Board.

5.3 Divisional Health and Safety Committees have membership from relevant professional groups and as well as health and safety representatives from individual trade unions and Representatives of Employee Safety. The divisional committees review the operational assessment, implementation and monitoring of health and safety issues for that area (see Terms of Reference – add hyperlink).

6. HEALTH AND SAFETY CONTROLS MANUAL

6.1 The Trust Health and Safety Controls Manual (add hyperlink) describes key health and safety topics requiring risk assessment and scheduling review and escalation.

6.2 Controls Manual Officers are departmental managers/matrons with delegated responsibility for health and safety (see Risk Management Framework – add hyperlink). They are required to ensure completion of the controls manual in all areas of their responsibility and monitor its content through a process of inspection and audit.

6.3 Risk assessment and review of health and safety issues must be undertaken by staff trained and competent in risk assessment through a recognised training course (see training needs analysis – add hyperlink).

6.4 Contents of controls manuals must be made available to all staff members with changes in risk assessments communicated to staff members to ensure continuation of safe systems of working.

7. ACCIDENT AND INCIDENT REPORTING

7.1 The Procedure for Managing Reporting and Reviewing Incidents (add hyperlink) provides a framework for identifying issues to prevent injury and promote safe systems of working. This is the procedure for ensuring compliance with reporting incidents under the RIDDOR regulations

7.2 All staff are encouraged to report accidents/incidents (actual and near miss) using Datix Web or via the Trust Hotline (extension 5757). The Trust will investigate all incidents/accidents as described in the Trust Procedure for Managing, Reporting and Reviewing Incidents (add hyperlink).

7.3 Trade Union Health and Safety staff side representatives and Representatives of Employee Safety (RoES) are encouraged to support the investigation of accidents associated with health and safety on completion of recognised training programmes.

8. INSPECTIONS/AUDITS

- **Trustwide** - compliance with assessment of health and safety practices will be reviewed by audits/ inspections:
- **Divisional level** – review of content of Health and Safety Controls Manual/risk assessments and escalation to risk registers.

9. WELFARE SUPPORT FOR STAFF

9.1 Occupational safety and health - The Trust has engaged the Working Well Occupational Health Department (2gether Trust) to support staff in ensuring optimum wellbeing through supporting

- Pre- employment checks
- Surveillance reviews
- Management referrals
- Self-referrals

Working Well Occupational Health also support the Trust in proactive identification of circumstances harmful to staff through individual workplace assessments.

9.2 Staff support - The Trust uses a resource provided by Health Psychology for staff support with referrals from Working Well (Occupational Health), managers and self-referral.

10. TRAINING

The Trust provides awareness and competency based training for health and safety and ensures that attendance is recorded and monitored on the Trust wide training database. See Training Needs Analysis (add hyperlink).

Specialist training in health and safety topics is required as described in health and safety related policies/procedures, e.g. Manual Handling, Control of Substances Hazardous to Health (CoSHH).

11. MONITORING OF COMPLIANCE

Do the systems or processes in this document have to be monitored in line with national, regional or Trust requirements?	YES/NO

Monitoring requirements and methodology	Frequency	Further actions
• Trust annual report includes achievements and challenges associated with Health and Safety management	Annual	• Escalation of Trust Health and Safety Forum minutes to Trust subcommittee of the Board
• Completion and review of contents of controls manual	Annual	• Inspection/audit annual report
• Escalation of health and safety issues through the Trust Risk Register process	Quarterly	• Divisional reports to Trust Management Team
• Reporting of health and safety issues through the Trust incident/accident reporting process	Quarterly (minimum)	• Reports to divisional health and safety committees

10. REFERENCES

National Guidance

Statutory Instruments (1974). Health and Safety at Work Act 1974. London: HMSO.

Statutory Instruments (1999). Management of Health and Safety at Work Regulations 1999. London: HMSO.

Statutory Instruments (1977). Safety Representatives Safety Committee Regulations 1977. London: HMSO.

Statutory Instruments (1996). Health and Safety (Consultation with Employees) Regulations 1996. London: HMSO.

Statutory Instruments (2016). Ministry of Justice Sentencing Guidelines for Health and Safety, Food Safety and Corporate Manslaughter . London: HMSO

HEALTH AND SAFETY POLICY – DOCUMENT PROFILE

DOCUMENT PROFILE	
REFERENCE NUMBER	B0403
CATEGORY	Non-Clinical
VERSION	3
SPONSOR	Andrew Seaton, Director of Safety
AUTHOR	Gary Monaghan, Trust Risk Manager (Health and Safety) (technical authoring support,)
ISSUE DATE	MM/YYYY
REVIEW DETAILS	MM/YYYY – review by Director of Safety
ASSURING GROUP	Trust Policy Approval Group
APPROVING GROUP	Trust Health and Safety Forum: Trust Board
APPROVAL DETAILS	Policy approval: add minutes details of local approval, including date and any reference number where appropriate TPAG approval: details will be added by Policy Site Administrator
EQUALITY IMPACT ASSESSMENT	Add completion date of Equality Impact Assessment
CONSULTEES	Divisional Health and Safety Committees. Joint Staff Side Committee
DISSEMINATION DETAILS	Upload to Policy Site; global email; cascaded via divisions
KEYWORDS	Health and Safety, Controls Manual, Risk Assessment
RELATED TRUST DOCUMENTS	Risk Management Framework, Risk Assessment Procedure, Procedure for reporting accidents and incidents to include RIDDOR,
OTHER RELEVANT DOCUMENTS	
EXTERNAL COMPLIANCE STANDARDS AND/OR LEGISLATION	• Health and safety at work act 1974 • HSG 65 Successful Health and Safety management •

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

TRUST HEALTH AND SAFETY FORUM

TERMS OF REFERENCE

Policy	✓
Review of Policy	✓
Review of Trust Area of Activity	✓
Operations	X
Resource Management	X

The Forum is responsible to the Trust for the following main functions:

1. **Policy** - To agree Health and Safety Policies and Procedures in the Trust ensuring compliance with H&S legislation

2. **Plan -** To support the implementation of the Risk Management Strategy and the Staff, Contractors and Visitors Safety Strategy

3. **Plan/ Review** - To agree an annual health and safety plan to include local/ trustwide inspection/ audit and review action pans arising from inspections

4. **Plan/ Deliver** - To agree and monitor training progammes for Health and Safety related topics for trust members arising from training needs analysis demonstrating competency of staff

5. **Deliver** - To engage with staff representatives (Workplace Improvement Team) in the promotion of Health and Safety on Trust property

6. **Deliver** - To monitor and promote the implementation of national guidance and alerts, specifically Health and Safety Executive, Environment Agency and other enforcing agencies, Central Alert Systems and other High Level Enquiries from external sources

7. **Deliver** – To critically review themed accident/ incident reports and, and where applicable and appropriate, identify recommendations for corrective action

8. **Deliver** - Receive divisional reports on Health and Safety inspections/ concerns informing the Trust annual / business plan for Health and Safety at Work

Membership & Responsibilities

Chair
Director of Human Resources / Organisational Development

Vice Chair
Chief Operating Officer

Members
Trust Risk Manager Health and Safety
Trust Risk Manager
Divisional Health and Safety leads (5)
Manual Handling Team Representative
Infection Control Team Representative
Occupational Health Department Representative
Trust Security Advisor
Staff Side Health and Safety Representatives (6)
Workplace Improvement Team

Co-opted members
Specialty advisors as indicated by agenda

Quorum
The Committee shall be quorate when either the Chair or Vice-Chair and representation from both staff side and management.

Frequency of Meetings
Alternate months. Members are expected to attend two thirds of meetings

Reporting Line
Quality Committee

9. **Review and Monitor** -To review and monitor the annual Risk Management Improvement Programme.

10. **Review** – To review key trust risks register entries as part of the annual plan

11. **Review and deliver** – to recommend consideration of key risks to divisional risk registers as part of trust procedure based on risk assessments

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

Appendix 2

DIVISIONAL HEALTH AND SAFETY FORUM

TERMS OF REFERENCE

Policy	X
Review of Policy	✓
Review of Trust Area of Activity	✓
Operations	X
Resource Management	X

The Committee is responsible to the Trust for the following main functions:

7. **Policy** - To ensure Health and Safety Procedures in the division comply with trust policy and H&S legislation

8. **Plan -** To support the implementation of the Risk Management Strategy and the Staff, Contractors and Visitors Safety Strategy within the division

9. **Plan/ Review** - To agree an annual health and safety plan in the division to include annual inspections/ audit and review action plans arising from inspections

10. **Deliver** - To ensure implementation national guidance and alerts, specifically Health and Safety Executive, Environment Agency and other enforcing agencies, Central Alert Systems and other High Level Enquiries from external sources

7. Deliver - To critically review themed accident/ incident reports and, and where applicable and appropriate, identify recommendations for corrective action

8. **Deliver** – Provide divisional reports on Health and Safety inspections/ concerns to the Trust Health and Safety Committee informing annual / business plans for Health and Safety at Work

12. **Review and Monitor** -To identify, implement, review and monitor the annual Risk Management Improvement Programme for the division.

13. To review key risks in the division and monitor progress and recommend entry to the Divisional risk register

Membership & Responsibilities

Chair
Divisional lead for Health and Safety (senior manager from the Tri)

Vice Chair
Senior Manager

Core Members
Divisional Risk Manager
Professional reps
Staff Side Health and Safety Representatives
Workplace improvement Team (WIT Key Worker)

Attendees as required
Manual Handling
Divisional Infection Control Nurse
Human Resources business partners
Estates Officer

Co-opted members
Specialty advisors as indicated by agenda

Quorum
The Committee shall be quorate when either the Chair or Vice-Chair and representation from both staff side, WIT and management.

Frequency of Meetings
Monthly. Members are expected to attend two thirds of meetings

Reporting Line
Divisional Quality Group
Trust Health and Safety Committee

Standing Agenda Items

1. Annual Plan
2. Inspections
3. Incident
4. Risk assessments
5. Training
6. Feedback from other committees
7. Lessons learnt (including areas of good practice)

Gloucestershire Hospitals
NHS Foundation Trust

TRUST PROCEDURE

RISK ASSESSMENT / RISK REGISTER PROCESS

FAST FIND:

- **How to complete a risk assessment (RR/AC1)**
- **Escalation to Risk Register process (RR/AC2)**

1. INTRODUCTION / RATIONALE

This document is produced under the Risk Management Strategy (insert hyperlink) and outlines the process for risk assessment and actions to be taken on completion. Read this in association with

- Trust Risk Management Strategy (add hyperlink)
- Health and Safety Policy (add hyperlink)

2. DEFINITIONS

Word/Term	Descriptor
Risk assessment	An examination of what could cause harm to staff, patients, public and the organisation so that the competent staff can identify appropriate precautions (controls) to put in place to prevent occurrence or if further actions can be implemented to prevent harm.
Hazard	A situation that could cause harm to people or to organisations e.g. equipment, lifting and handling, violent and aggressive behaviour,
Risk	Describing the effect of the hazard occurring based on impact and likelihood of the hazard occurring
Harm	'Injury (physical or psychological), disease, suffering, disability or death'. In terms of patient incidents, harm can be considered to be *unexpected* if it is not related to the natural cause of the patient's illness or underlying condition
Inherent Risk	An assessment of the risk prior to any mitigation and controls being applied. This is the "raw" risk.
Controls/ mitigating factors	Precautions implemented to mitigate the risk
Gaps in controls	Additional action required to minimise the potential for the risk to occur
Assurance	Methods used to ensure that the controls are effective
Model Matrix	Nationally provided guidance for staff including criteria supporting assessment of the risk against 8 different domains
Consequence	The outcome or potential outcome of an event. Sometimes referred to as 'impact' or 'severity'
Likelihood	The probability that the consequence will actually happen
Risk Register	Centralised register of the key risks
Trust Risk Register	Risks confirmed as scoring ≥15 using the Model Matrix definitions (Related Document)
Divisional/ Specialty Risk Register	Risks confirmed as ≤12 using the Model Matrix definitions (Related Document)

3. ROLES AND RESPONSIBILITIES

Post/Group	Details

Post/Group	Details
Chief Executive	• Responsible for ensuring systems in place to maintain a centralised Risk Register • Responsible for presentation of the Trust Risk Register (risks scoring ≥15) to the Trust Board
Director of Safety	• Delegated responsibility for co-ordinating the updating of the Trust Risk Register • Co-ordinates escalation of risk entries from senior committees e.g. Audit Committee, Trust Board
Executive Risk Management Group	• Provides assurance role for monitoring the review and progress of risk registers owned by Divisions and Executive Team
Trust Leadership Team	• Acts as the interface between Divisional and Trust Risk Registers • Monitors progress of Trust Risk Register reviewing action plans and their implementation minimising risks
Divisional Chief of Service / Divisional designated lead	• Maintains and monitors progress of risks entered on Divisional register • Co-ordinates interface between Trust and Divisional risk registers • Responsible for escalating risks (≥15) to Trust Leadership Team •
Specialty Boards / Specialty Director	• Maintains specialty register • Co-ordinates interface between Specialty and Divisional risk registers
Risk leads e.g. Matron, Specialty Leads, Heads of Department, General Managers	• Complete risk assessments for identified risk for escalation in specialty/ division • Update risk assessments
Trust / Divisional Risk Managers	• Provide guidance and support to staff for the risk assessment process • Facilitates risk register process for Trust/ Divisional / Specialty Risk Registers • Provides training to risk leads of risk register process
Specialist Advisors (Subject Matter Experts)	• Provide guidance and support to staff for the risk assessment process for specialist topics
Staff Health and Safety representatives / Work Improvement Team	• Assist risk assessment process relevant to their area – clinical / non clinical

SECTION A - CARRYING OUT A RISK ASSESSMENT

4. RISK ASSESSMENT DOCUMENTATION

Risk assessment proformas may differ based on the topic involved reflecting national and local guidance.

4.1 Clinical risk assessments

All **patient clinical** risk assessment documentation is ratified by the Trust Documentation Group if to be filed as part of the patient's health record e.g. Emergency Mental Health Risk Assessment; Gloucestershire Patient Profile (GPP); Venous Thrombo-embolism (VTE) assessment etc. These risk assessments have been considered for inclusion into the development of the electronic patient record systems implemented in the Trust (TrakCare)

4.2 Health and Safety based risk assessments

- **Topic of the Month** – ward/ department based staff complete the Trust risk assessment template based on the Health and Safety Executive '5 Steps to Risk Assessment' guidance. These risk assessments are stored in the Health and Safety Control Manual supporting wider access and review (either electronically or paper based). Further details of this process is described in the Health and Safety Policy (include hyperlink)

- **Other risk assessment documentation** - It is recognised that some risk assessment documentation follows national guidelines e.g. Manual handling (TILEO). For details of this documentation please review individual topic policy and procedural guidance.

It is not expected that staff document risk assessments for low consequence (impact) risks and hazards.

5. SCORING AND ESCALATION OF RISK ASSESSMENTS

Completion of a risk assessment (Action Cards RR/RA 1 and RR/RA 2) includes the calculation for each component of the risk for likelihood of occurrence (1-5) multiplied by its consequence (1-5) using the definitions included in the 5x5 National Model Matrix (hyperlink, related document). The risk must be assessed against all applicable domains on the Model Matrix listed below unless not applicable.

Domain	Definition
Safety	Impact on the safety of patients, staff or public
Quality	Impact on the quality of our services. Includes complaints and audits.
Workforce	Impact upon our human resources (not safety), organizational development, staffing levels and competence and training.
Statutory	Impact upon on our statutory obligations, regulatory compliance, assessments and inspections.
Reputation	Impact upon our reputation through adverse publicity.
Business	Impact upon our business and project objectives. Service and business interruption.
Finance	Impact upon our finances.
Environmental	Impact upon our environment, including chemical spills, building on green field sites, our carbon footprint.

The overall grade of the completed risk assessment (1 – 25) is the highest scoring entry on the proforma (using the '5 steps' based proforma or the Trust risk management software, see section 11). This grading determines which risk register is appropriate for its management and monitoring of progress See Action card RR/RA3 (add hyperlink)

If the overall grade of the risk is calculated at the same level for two domains, consideration must be given to separate the entries, one for each domain demonstrating the significance of the risk to the Division/ Trust (it is appreciated slight adaptions to the description will be required to demonstrate the focus of the inherent risk). Also consideration must be given to the risk appetite and toleration of risk for the different domains as described in the Risk Management Strategy (para 6, hyperlink) and Action Card RR/RA 2 (add hyperlink)

6. REVIEW AND UPDATING OF RISK ASSESMENTS

Risk assessments must be reviewed at a frequency defined by the grading of the risk.

6.1 Clinical risk assessments

Review and requirement for updating clinical risk assessments is stipulated in the owning procedural document i.e. VTE policy, Prevention of Pressure Ulcers/Waterlow, GPP etc.

6.2 Health and Safety

- **Topic of the month** – The Health and Safety Policy requires an annual review against a programme of topics. However, if the risk assessment indicates a higher level of risk ($\geq$8) for staff, patients, organisation then consideration must be given to escalating the risk within the division necessitating a more frequent review.
- **Other Health and Safety based risk assessments –** these must be reviewed at a frequency based on the calculation of risk.

For risks not managed by these processes, the specialty / division must define the frequency for review based on it grading e.g. risks scoring 8-12/ high risk – quarterly, 15 or more/ or extreme risk – monthly / each divisional board

The Executive Risk Management Group will review progress of risk entries in its regular 'stocktake report'.

SECTION B - ENTRY TO RISK REGISTER

7. SOURCE OF RISKS FOR ENTRY ONTO RISK REGISTERS

Risks for consideration for entry to risk registers can also be **organisational** or **operational** and therefore may be derived from a variety of sources, to include (not an exhaustive list)

- Review of Strategic Objectives based on the Trust's Annual Plan,
- Review of the Trust Assurance Framework
- Monitoring and review of the Performance Management Framework with information generated internally and externally
- Review of financial risks (including financial plans, financial performance, results of Audit Committee consideration of reports from internal audit process, local Counter Fraud Service)
- Review of risks identified by external bodies (e.g. Care Quality Commission, National Audit Office, Confidential Enquiry reports, Medical and Healthcare products Regulatory Agency, (MHRA) NHS England/ Improvement, NHS Litigation Authority, Health and Safety Executive);
- Trust quality processes (e.g. claims, inquests, incidents, complaints, surveys);
- Compliance with contractual arrangements with commissioners
- Health and Safety associated inspection audits and assessments
- Major project risks e.g. Cost Improvement Programme process (CIP/QIA)

The Risk Register will have two classifications of risk – 'open' and 'closed'.

8. TRUST RISK REGISTER

All **risks scoring 15 – 25 (extreme risk or red)** according to the Trust adopted Model Matrix (hyperlink related document) need to be considered for entry to the Trust Risk Register. The owning Divisional Designated lead for their risk register will discuss with the appropriate executive lead for the highest scoring domain see below (Action Card RR/RA 3 hyperlink).

• Safety – Medical Director	• Statutory – Chief Executive	• Finance – Dir of Finance
• Quality – Nursing Director	• Business – Chief Operating Officer	• Environment – Dir of HR and OD
• Workforce – Dir of HR and OD	• Reputation – Chief Executive	

Based on the Executives confirmation of the level of risk for the Trust, the risk will be presented to the Trust Leadership Team for consideration for entry to the Trust risk register and allocation of appropriate Assurance Committee for monitoring progress.

Safety risks scoring 12 - Risks with the highest scoring domain confirmed as safety scoring 12 must be discussed with the Executive lead for Safety and included in the exception reports to the Trust Leadership Team for their awareness and consideration for entry to the Trust risk register demonstrating the low tolerance for Safety focused risks (see Risk Management Strategy).

Documentation of the risk to be presented to the Trust Leadership Team is by completion of the exception reporting proforma and submitted to the Director of Safety prior to the scheduled meeting (Action Card RR/RA hyperlink).

9. DIVISIONAL RISK REGISTERS

All **risks scoring rating 8 – 12 (orange or high risk)** will be managed and monitored by the divisional boards (Action Card RR/RA 3 hyperlink). The Division will review the proposed risk treatment plan provided by the specialty/ committee and will have an opportunity to comment on the risk and re-grade if necessary and monitor progress with its implementation.

The Divisional Board will consider where risks where the impact/ consequence is confirmed as **catastrophic (5)** and escalate to the Trust Leadership Team for review and awareness

The Corporate Safety Department will co-ordinate an annual review the content of the Divisional Risk Register with the Chief of Services/ designated Divisional lead for Risk on behalf of the Trust Leadership Team and scheduled into their programme of meetings. The review will also include any risk where the impact score is 5 e.g. catastrophic.

10. SPECIALTY RISK REGISTERS

All **risks rating 1 – 6** (green /yellow, low risk) remain under the remit of the appropriate Specialty/ Department. The Specialty/ Department lead will propose a risk treatment plan which will be reviewed by the specialty who will note the existence and management of that risk. If the risk is re-graded upwards then the process for that grading of risk will be followed.

The Specialty Board will escalate any risk where the impact/ consequence is confirmed as **catastrophic (5)** to the Divisional Board who in turn will inform the Trust Leadership Team for review and awareness

11. RISK MANAGEMENT SOFTWARE PROCESS (DATIX)

All entries to the risk register must be entered onto the Trust Risk Management Software.

12. TRAINING

12.1 RISK ASSESSMENT TRAINING

Clinical – Training is provided in the procedural documents for specific clinical topics e.g. Emergency Mental Health Assessment, VTE training, GPP as defined in their procedural documents

Health and Safety

- **Topic of the month –** Staff undertaking Health and Safety risk assessments must attend the Trust Risk Assessment training workshop (see training needs analysis in Health and Safety policy add hyperlink)
- **Other Health and Safety based risk assessments-** Training is provided in the procedural documents for specific clinical topics e.g. manual handling

Risk Register process – Generic training of the process is described in the Risk Management Strategy and Risk Register procedural document (B0636). It is also included in the risk assessment training provided by the Trust/ Divisional Risk Managers. This is reinforced by the trainer introducing staff to the risk management software, see para 11 with supporting training documents (hyperlink related documents)

12.2 RISK REGISTER PROCESS

Risk Leads are provided with training on the risk register process during sessions supporting access to the Trust Risk Management Software.

13. MONITORING OF COMPLIANCE

Do the systems or processes in this document have to be monitored in line with national, regional or Trust requirements?	YES

Monitoring requirements and methodology	Frequency	Further actions
• Review of risk register process as part of internal audit requested by the Audit committee	Annually	Terms of reference for review agreed on an annual basis

14. REFERENCES

- **Trust policies**
  Risk Management Strategy
  Health and Safety Policy / Control Manual

- **National**
  Grading matrix – adapted from NPSA (add hyperlink)
  5 steps to Risk assessment (insert hyperlink)

RISK ASSESSMENT / RISK REGISTER PROCESS – DOCUMENT PROFILE

DOCUMENT PROFILE	
REFERENCE NUMBER	B0636
CATEGORY	Non-Clinical
VERSION	This will be added by Policy Site Administrator
SPONSOR	Andrew Seaton (Director of Safety)
AUTHOR	Beverley Williams, Trust Risk Manager
ISSUE DATE	This will be added by Policy Site Administrator
REVIEW DETAILS	Review by Director of Safety 2020
ASSURING GROUP	Trust Policy Approval Group
APPROVING GROUP	Risk Management Group/ Trust Leadership Team for senior management approval
APPROVAL DETAILS	Procedure/Protocol/Guideline approval: Risk Management Group ? April 2017 TPAG approval: details will be added by Policy Site Administrator
CONSULTEES	Executive Risk Management Group Director of Safety/ Trust Risk Managers Divisional Risk Managers/ teams
DISSEMINATION DETAILS	Patient Safety Forum / Health and Safety Committee for wider dissemination in Divisions
KEYWORDS	Risk Assessment, Risk Register
RELATED TRUST DOCUMENTS	Model Matrix Trust Risk Register Exception reporting proforma
OTHER RELEVANT DOCUMENTS	Risk Management Strategy Health and Safety Policy / H&S Controls Manual Procedure for managing, reporting and investigation incidents/ accidents to include serious incidents Safety Alert Guidance and External Visits Management Trust Annual Plan Performance Management Framework Board Assurance Framework
EXTERNAL COMPLIANCE STANDARDS AND/OR LEGISLATION	•

RISK ASSESSMENT / RISK REGISTER PROCESS ACTION CARD	
HOW TO CARRY OUT A RISK ASSESSMENT (H&S Topic of the Month)	**RR/RA 1**
FOR USE BY: **Ward Managers, Heads of Departments, Managers, designated staff**	LIAISES WITH: **Divisional Risk Manager, Trust Risk Manager (H&S)**

Rationale – To provide a standardised approach to risk assessment **–** *Adapted from Health and Safety Executive '5 Steps To Risk Assessment'*

Complete **Topic of the Month** risk assessment template following training provided as per procedural document

1. **Identify the Hazards** (anything with the potential to cause harm) by:

- Observing tasks being performed and identifying potential for harm
- Undertaking workplace inspections/ audits
- Reviewing accident incident forms for trend/ themes
- Reviewing legislation/ guidance e.g. COSHH Regulations 2002, LOLER regulations, Health and Safety Guidance (HSG), Safety Alerts and Guidance (NICE, MHRA etc).

2. **Identify who may be harmed and how -** anyone involved in carrying out the task, or coming into contact with the person carrying out the task e.g. patients, visitors, other members of staff/ contractors.

3. **a) Evaluate the Risks***.* The risk score is calculated by multiplying the likelihood of recurrence and the consequence of harm. This will demonstrate the significance of the risk.

b) Confirm precautions **(Controls)** in place to prevent harm **referring to the hierarchy of controls:**

- **Eliminate** - control measures implemented to **eliminate the hazard** (gold standard)
- If not possible, then **Reduce** the risk so that harm is unlikely by:
  - **Isolating** the hazard from people
  - **Control exposure to the hazard** by implementation of safe systems of working, operational procedures, training etc
  - Issuing **Personal Protective Equipment** (PPE)
  - Implementing safe systems of work **(Discipline)**

4. **Record monitoring and assurance that control measure have been implemented**

Monitor staff training re hazard/ risk, maintenance records
Review of audit findings/ action plans for hazardous events
Review accident investigation reports for hazard
Document when risk assessment was shared and discussed with wider team
Escalate risk assessment based on scoring

5. **Review the Risk Assessment: -** The risk assessment must be reviewed

- When there are changes in legislation/ regulations/ national recommendations
- After an accident or near-miss, audit or as a result of an inspection
- When new equipment is introduced
- Following introduction of new control measures
- After a specific period of time has elapsed – dependant on the level of risk identified

ALWAYS ENSURE ALL RELEVANT ACTIONS ARE DOCUMENTED!

RISK REGISTER PROCESS ACTION CARD

RISK REGISTER PROCESS	RR/RA2
FOR USE BY: Divisional Management Teams Specialty Management teams (Matrons/ Specialty Directors/ General Managers/ Head of Department.	**LIAISES WITH:** Divisional Risk Managers, Director of Safety, Executive Leads for individual domains (>15) Trust Risk Manager

Rationale – To provide a standardized approach for completion of risk assessment for entry to the risk register process This is supported by training provided on the risk management software system and associated training materials – see related documents (hyperlink)

- **Entering new risk**

Field	
Cause	Describe the cause of the risk
Effect	Identify the effect the risk has
Impact	Record the impact of the risk
Inherent risk	Assessment of the current risk prior to any extra mitigation and controls being applied
Risk Lead	Enter the Operational Lead for risk (email sent to named staff member to inform them of ownership of risk to complete next stage)
Trust, Site, Division, Specialty	Select from drop down box all stakeholders affected by the risk
Date first discussed	Enter date first discussed in specialty/ division
Date opened	Defaults to date entered on system

- **Risk Lead review**

Field	
Cause, Effect, Impact, Inherent Risk	Check details pulled through from initial entry if completed by another person
Risk lead	Change if you are not the Operational Lead for the risk
Executive Lead for Risk (name and title)	Complete only if scoring at ≥15
Trust, Site, Division, Specialty	Check details pulled through from initial entry if completed by another person
Groups involved in risk	Consider only this directly affected by risk, not by association
Date first discussed/ opened	Confirm dates
Name of group retaining operational responsibility	Select from dropdown – if it does not appear select '**other**' and enter title
Date of review	Enter date of next meeting, consider a week earlier to support updating of entry prior to meeting, this date needs to be entered proactively as updates Risk Leads 'To Do' list
Frequency of review	Enter frequency of review to inform planning for meetings -. This should be based on risk grading – extreme risk – monthly high risk – quarterly moderate risk – 6 monthly
Name of Assuring Committee	Select from dropdown – if it does not appear select '**other**' and enter title
Frequency of review	Enter frequency of review to inform planning for meetings
Domains • **Consequence/ impact** - the outcome or potential outcome of an event • **Likelihood** - probability that the consequence will actually happen	Assess the inherent risk against each domain using the guidance included in the hyperlink for the model matrix - enter final calculation. If a domain is not relevant leave blank
Highest scoring domain	Select the highest scoring domain as reflected by the entries in the section above. This should directly relate to the description included in the inherent risk and groups affected. • If more than one domain scores highly – consideration to entering an additional risk (may need subtle change in focus for inherent risk field) • The risk appetite for the Trust must also be considered with any risk

RISK REGISTER PROCESS ACTION CARD

RISK REGISTER PROCESS	RR/RA2
FOR USE BY: Divisional Management Teams Specialty Management teams (Matrons/ Specialty Directors/ General Managers/ Head of Department.	**LIAISES WITH:** Divisional Risk Managers, Director of Safety, Executive Leads for individual domains (>15) Trust Risk Manager

	scoring highly in the domains for safety and statutory taking precedence over other domains - see below
Current risk – assessed risk score	This must reflect the score of the highest scoring domain calculated in the earlier section
Target risk - assessment of the anticipated risk after the planned actions have been applied.	The aim is to reduce the frequent of recurrence or the impact of the hazard should it occur.
Approval status after save	Selection confirms addition to divisional or Trust Risk Register following presentation to Divisional Board/ TLT
Detailed objectives	List any key targets/ guidance to be met either national or local
Controls in place – measures in place to mitigate a risk	Describe controls implemented to minimize the likelihood of occurrence or its impact referring to the hierarchy of controls Eliminate, reduce, isolate, safe systems of working (or control), protective working and discipline (ERICPD)
Adequacy of controls	Assess the adequacy of the controls for recurrence
Gaps in controls	List any further actions planned to further mitigate against the risk occurring. This then forms the action plan
Action plan	Allocate actions to individuals with target dates

- **Definitions of domains**

Domain	Definition
Safety	Impact on the safety of patients, staff or public
Quality	Impact on the quality of our services. Includes complaints and audits.
Workforce	Impact upon our human resources (not safety), organizational development, staffing levels and competence and training.
Statutory	Impact upon on our statutory obligations, regulatory compliance, assessments and inspections.
Reputation	Impact upon our reputation through adverse publicity.
Business	Impact upon our business and project objectives. Service and business interruption.
Finance	Impact upon our finances.
Environmental	Impact upon our environment, including chemical spills, building on green field sites, our carbon footprint.

- **Relative willingness to accept risk**

	Low		Medium		High
	1	2	3	4	5
Safety					
Quality					
Workforce					
Statutory					
Reputation					
Business					
Finance					
Environmental					

RISK REGISTER PROCESS ACTION CARD

RISK REGISTER PROCESS	RR/RA 3
FOR USE BY: Divisional Management Teams Specialty Management teams (Matrons/ Specialty Directors/ General Managers/ Head of Department.	**LIAISES WITH:** Divisional Risk Managers, Director of Safety, Executive Leads for individual domains (>15) Trust Risk Manager

Rationale - All members of staff at any level within the organisation are responsible for identifying risks and for taking action within their authority and control to reduce or eliminate risk. Risks that are outside their ability to action should be reported to their Line Manager. A record must be kept of any actions and preventative measures taken.

Member of staff identifies risk and notifies Line Manager who completes risk assessment or other appropriate documentation to describe risk/ concern, controls and outstanding actions taken. Escalate to Service Line leads – General Manager, Matron, Specialty Director

⇩

Specialty leads enter risk on Datix Risk Register Module, allocating risk lead at operational management level. Risk assessment completed identifying **domain** for focus of risk and also **adequacy** of existing controls

⇩

Risk presented at Specialty Group (either divisional or topic specific) for review of **controls/ assurances** and listing further **actions** required. Specialty group confirms entry to Risk Register

Risks confirmed as scoring ≤6 (**low/ moderate risk**)

- Reviewed and acted upon by Specialty / Specialist Group
- Scheduling of review of risk agreed by Specialty / Specialist Group
- Monitoring of progress of risk by Divisional Boards/ reporting line for Specialist Groups

If risk **consequence is 5** (likelihood 1) - division to include in reviews presented to **Risk Management Group**

Risks confirmed as scoring 8-12 (**High risk**)

- Reviewed and acted on by Specialty / Specialist Group
- Scheduling of review of risk agreed by Specialty / Specialist group
- Monitoring of progress of risk by Divisional Boards/ reporting line for Specialist Groups

If **risk consequence is 5** (likelihood 2) - division to include in reviews presented to **Risk Management Group.**

Risks graded ≥15 **(Extreme risk)**

- Reviewed and maintained by Specialty / Specialist group
- Scheduling of review of risk agreed by Specialty / Specialist group
- Monitoring of progress of risk by Divisional Boards/ reporting line for Specialist Groups

All risks reviewed monthly by Divisional Board and included in Divisional reports to sub committees of the Board/ Risk Management Group

Divisional Board Meetings – receive updates from Specialty Group of **new risks assessed at ≥12**, **progress of risks assessed as ≥ 15+** or **risks whose score has decreased to ≤15** and where **risks score 5 for consequence**

Risks scoring 15

- Divisional leads must discuss with appropriate Executive lead for the **domain** to review risk assessment/ controls/ assurances and outstanding actions
- Completed template presented to Trust leadership team confirming risk for division and risk for trust informing status of risk register entry
- **NB – risks may be >15 for division but < 15 for Trust**

RISK REGISTER PROCESS ACTION CARD	
RISK REGISTER PROCESS	**RR/RA2**
FOR USE BY: Divisional Management Teams Specialty Management teams (Matrons/ Specialty Directors/ General Managers/ Head of Department.	**LIAISES WITH:** Divisional Risk Managers, Director of Safety, Executive Leads for individual domains (>15) Trust Risk Manager
Insert link to exception reporting proforma	

PUBLIC BOARD MAIN BOARD – SEPTEMBER 2017
Lecture Hall, Redwood Education Centre commencing at 09:00am

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

Sponsor and Author(s)
Dr Sean Elyan, Medical Director Dr Russell Peek, Guardian of Safe Working Hours

Audience(s)									
Board members	✓	Regulators	✓	Governors	✓	Staff		Public	

Executive Summary

Purpose

New terms and conditions of service (TCS) for junior doctors were introduced in August 2016. Under these TCS, the trust must provide an exception reporting process to allow junior doctors to report working hours or educational opportunities that vary from those set out in their work schedule. The guardian of safe working hours has oversight of exception reporting and assures the board of compliance with safe working hours limits. The guardian reports at least quarterly to the trust board.

Key issues to note

This paper summarises 170 new exception reports made between 25th March and 31st July 2017. The greatest number of exceptions arise from neurology, as observed previously. The Guardian and Director of Medical Education (DME) met with a representative from the Neurology team to develop strategies to address the issues.

What is immediately clear from exception reports is the dedication of junior doctors in the trust to providing uninterrupted, consistent patient care. Most exceptions highlight occasions where doctors have worked beyond scheduled hours to manage a significant clinical workload.

The current exception reporting system was developed internally. It has functional limitations, needing administrative support to track and resolve exception reports. This introduces a variable delay in managing the process and data analysis. The majority of the limitations will be addressed through the implementation of a nationally recognised software solution (Allocate). This was originally due to be implemented in August however was delayed. Conference calls with Medical Staffing Department and the Director of HR&OD have focused on temporary solutions to improve the speed and flow of information to the Guardian pending the proposed implementation on October 1st.

Allowing for the functional limitations of the current system, there is no evidence that junior doctors are routinely working unsafe hours (current high reporting areas are being investigated and action plans determined). Improvements to the reporting system will allow the Guardian to have greater confidence that issues are being identified and resolved in a timely fashion and that we are fully meeting the requirements of the 2016 terms and conditions of service.

Implications and Future Action Required

Action is required to ensure that the implementation (including the training of all relevant stakeholders) scheduled for October will not be delayed again. Assurance has been provided by Medical Staffing that this will not happen.

Recommendations

Prioritise the implementation of the new reporting software.

Impact Upon Strategic Objectives

Our Services:
To improve the health and wellbeing of our staff, patients and the wider community – need to ensure work schedules promote safe working hours.

Our Staff:
To redesign our workforce – need to ensure that work schedules are used to promote efficient workforce planning.

Our Business:
Harnessing the benefits of information technology – potential to reduce administration costs through using an exception reporting tool that is fit for purpose.

Impact Upon Corporate Risks

Regulatory and/or Legal Implications

The 2016 Junior Doctor Terms and Conditions of Service set out requirements for work scheduling and exception reporting.

Equality & Patient Impact

Significant staff fatigue is a hazard to patients and to staff

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 Committee	Remuneration & Nomination Committee	Senior Leadership Team	Other (specify)

Outcome of discussion when presented to previous Committees

MAIN BOARD SEPTEMBER 2017

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

Executive summary

This paper summarises 170 new exception reports made between 25th March and 31st July 2017, and 25 outstanding exceptions from the last quarterly report to the board.

Neurology remains the department with the greatest number of new exceptions. The Guardian and Director of Medical Education (DME) met with a representative from the Neurology team to help the team develop strategies to address the underlying issues.

What is immediately clear from exception reports is the dedication of junior doctors in the trust to providing uninterrupted consistent patient care. Most exceptions highlight occasions where doctors have worked beyond scheduled hours to manage a significant clinical workload.

The current exception reporting system was developed internally. It has significant functional limitations, needing administrative support to track and resolve exception reports. The challenges and planned improvements are presented below.

Allowing for the functional limitations of the current system, there is no evidence that junior doctors are routinely working unsafe hours. Improvements to the reporting process will provide greater confidence that issues are being identified and resolved in a timely fashion and that we are fully meeting the requirements of the 2016 terms and conditions of service.

Introduction

Under the 2016 terms and conditions of service (TCS) for junior doctors, the trust must provide an exception reporting process for working hours or educational opportunities that vary from those set out in work schedules. The guardian of safe working hours oversees exception reports and assures the board of compliance with safe working hours limits.

Foundation year 1 (F1) doctors and some year 2 (F2) doctors moved to the new TCS in December 2016. There was a rolling schedule for transfer of trainees in other programmes, with most junior doctors working under 2016 TCS from August 2017.

Doctors in training may raise an exception report whenever working hours breach those set out in their personalised 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 structure of this report follows guidance provided by NHS Employers.

High level data

Number of doctors / dentists in training (total):	390
Number of doctors / dentists in training on 2016 TCS:	370
Amount of time available in job plan for guardian:	2PA
Administrative support:	agreed in principle, not yet in place
Amount of job-planned time for educational supervisors:	0.25/0.125 PAs. (first/additional trainees to maximum 0.5 SPA)

Exception reports (working hours)

Exception reports by department				
Specialty	Exceptions carried over from last report	Exceptions raised	Exceptions Closed	Exceptions outstanding
General/GI Surgery	5	20	*	*
Urology	0	1	*	*
Trauma/ Ortho	0	5	*	*
General/old age Medicine	0	5	*	*
Orthogeriatrics	0	4	*	*
Stroke	0	1	*	*
Neurology	14	41	*	*
Cardiology	0	0	*	*
Respiratory	0	17	*	*
Endocrinology	0	0	*	*
Oncology	0	4	*	*
Haematology	0	2	*	*
Gastroenterology	0	28	*	*
Renal medicine	0	3	*	*
Paediatrics	6	18	*	*
Sexual Health	0	0	*	*
Emergency Department	0	0	*	*
Acute medicine/ ACUA	0	21	*	*
Total	25	170	*	*

*Data unavailable at time of writing

Exception reports by division				
Specialty	Exceptions carried over from last report	Exceptions raised	Exceptions Closed	Exceptions outstanding
Surgery	5	26	*	*
Medicine	14	126	*	*
Women and Children	6	18	*	*
Diagnostic / specialties	0	0	*	*
Total	25	170	*	*

*Data unavailable at time of writing

Exception reports (response time)				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
Surgery	ǂ	ǂ	ǂ	ǂ
Medicine	ǂ	ǂ	ǂ	ǂ
Women and Children	ǂ	ǂ	ǂ	ǂ
Diagnostic / specialties	ǂ	ǂ	ǂ	ǂ
Total	ǂ	ǂ	ǂ	ǂ

ǂ Current reporting tool is not sensitive enough to identify response time

Locum bookings
Data from finance team:

Total spend April-July 2017 on Junior Medical agency locums was £1,309,090
Total spend April-July 2017 on Junior Medical Trust employed locums was £691,751

Vacancies

Junior Doctor Vacancies by department (January 2017)					
Department	F1	F2	ST 1-2	ST 3-8	Additional training and trust grade vacancies
Emergency Dept	0	0	3	0.2	2
Anaesthetics	0	0	0	0	2
ENT	0	0	0	0	1
General Medicine	0	0	4	2	24 (Clinical Fellows, Chief Registrars and Doctors for Ambulatory Emergency Care) Includes Speciality Doctor in Respiratory and Orthogeriatrics
General Surgery	0	0	1	1	3
Histopathology	0	0	2	0	0
Obs & Gynae	0	0	1	1	2
Ophthalmology	0	0	0	0	2
Oral & Max Fax	0	0	2	0	0
Trauma & Ortho	0	0	0	0	5
Paediatrics	0	0	1	3	1
Total	0	0	14	7.2	42

Fines

Fines by department		
Department	Number of fines levied	Value of fines levied
Neurology	1	Information available for next Board paper
Total		

Fines (cumulative)			
Balance at end of last quarter	Fines this quarter	Disbursements this quarter	Balance at end of this quarter

Issues arising from the exception reports
Five trainees raised safety concerns in their exception report(s). The concerns related to the number of medical staff relative to the number of patients or ward areas covered. In most cases the concerns were escalated to supervising consultants at the time.

A second junior doctor in neurology breached safe working hours limits over the latest rota cycle. This will result in another fine, subject to confirmation of hours worked and planned resolution (time off in lieu or payment for additional hours).

Actions taken to resolve issues regarding excessive hours worked.
The Guardian and DME met with Dr Golestani as Neurology lead to discuss exception reporting and highlight the need for review of work schedules and support for junior doctors. The department has identified some strategies to address the problems identified. These include adjusting the work schedule to reflect expected hours of work and developing a

business case to appoint a physicians' associate or other staff member to help manage the workload.

Qualitative information

Most exceptions highlight occasions where doctors have worked beyond scheduled hours to manage a significant clinical workload.

These instances generally fall into 4 categories:

- acute staff shortage due to sickness
- unusually high levels of clinical activity
- long term problems with unfilled posts or insufficient staffing to manage a departmental workload
- work schedules not accurately reflecting expected hours of work

The last two categories result in frequent reporting from neurology and, more recently, gastroenterology.

Issues with the current exception reporting process

To facilitate the exception reporting required under the terms of the 2016 terms and conditions of service (TCS), the Medical Staffing Manager worked with the IT department to produce a bespoke reporting system, recognising that at a future point it would be necessary to migrate to one of the software systems being developed nationally.

The reporting system is hosted on the intranet, meaning that any reporting must be carried out from within the Trust. When a junior doctor submits a report, an email is generated to the appropriate educational or clinical supervisor, as well as the Director of Medical Education (DME). It provides the name of the doctor, the specialty, the date the exception occurred, the reason for it and any steps taken by the doctor to address the situation. The supervisor then meets the junior doctor to discuss the exception and agree the next steps. A confirmed exception involving additional hours worked can be resolved by payment for extra hours or time off in lieu.

To identify potential problems with working patterns or support and provide assurance on safe working hours, I need to understand exception report outcomes, actions and resolution in a timely way. Under the current reporting system, collecting and analysing the data is a labour-intensive manual process; dependent upon the Medical Staffing Manager following up the educational supervisor for their resolution and then populating a spreadsheet with the information.

A Junior Doctors Forum meets regularly to scrutinise the work of the guardian and advise on the distribution of any monies accrued through fines. At the most recent meeting, forum members expressed a lack confidence in the exception reporting process, based on difficulties accessing the system (intranet only), delays in resolution of exception reports and delay in receiving payment for additional hours after agreement with the supervisor.

It has been agreed that the Trust would procure Allocate software to automate some of the reporting and monitoring tasks. The software is designed to follow the contractual process. It provides supervisors, administrators, DME and Guardian with a 'dashboard' function to display and prioritise exception reports in real time, highlighting those needing action and facilitating timely resolution. It records outcomes and decisions at all review stages.

This software should remove some of the delays in managing the exception report process and allow greater transparency. The aim is to enable all Junior Doctors to use the new tool by the 1st October 2017. The original timetable for implementation was set for August. This did not happen, largely due to the logistical challenge of setting up a large number of junior doctors and educational supervisors on the system.

Delay in resolving exception reports may also occur if the junior doctor is unable to discuss with the educational supervisor within the expected timescale set out in the TCS. Allocate will not solve this issue, but will enable us to identify when this sort of delay occurs. There is further work needed to better train and support supervisors in meeting the expectations of them in the exception reporting pathway

Actions
I have discussed action plans with the Medical Staffing Manager and the Director of HR&OD. Planned actions include;

- Ensuring that the Guardian receives email notification of all exceptions at the same time as the educational supervisor and the DME.
- Pending implementation of Allocate, all updates/resolutions to be posted daily by the Medical Staffing Manager.
- Weekly calls with the Guardian to identify any reporting issues/shortfalls
- Publication of step by step guides to using Allocate and a timetable for introduction to all junior doctors, the Guardian, DME and educational supervisors. This will also be published on the intranet.
- Attendance at the next Junior Doctor Forum by the Medical Staffing Manager to outline the implementation programme and to publicise dates for drop-in workshops.
- Inclusion of exception reporting training in the educational and clinical supervisor annual CPD programme
- Review and publicise the resources for educational and clinical supervisors available on the intranet.

Summary
A total of 303 working hours exception reports have been made since trainees started to move onto the new TCS in December 2016. The reports identify occasions where doctors in training are working beyond scheduled hours to maintain service delivery. The process has identified departments where the workload, team expectations or available support for junior doctors results in a high level of exception reporting.

The current exception reporting process has significant limitations and we look forward to implementation of Allocate. This software should improve timely management of exception reporting and allow real-time oversight of the process, providing greater assurance on safe working hours for junior doctors.

Author: **Dr Russell Peek, Guardian of Safe Working Hours**

Presenting Director: **Dr Sean Elyan**

Date 27/08/2017

Recommendation.
- To endorse
- To approve

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

ITEM 13

ITEMS FOR THE NEXT MEETING AND ANY OTHER BUSINESS

DISCUSSION

ITEM 14

GOVERNOR QUESTIONS

Peter Lachecki
Chair

ITEM 15

STAFF QUESTIONS

Peter Lachecki
Chair

ITEM 16

PUBLIC QUESTIONS

(Procedure attached)

Peter Lachecki
Chair

PROCEDURE FOR PUBLIC QUESTIONS AT BOARD MEETINGS

The Trust welcomes feedback from members of the public. We are committed to delivering the best care and constantly looking at ways to improve the services we provide at out hospitals. There are a variety of ways in which you can give your feedback. These are:-

- As a patient or visitor to the hospital by completing a comment card which is available on wards and departments
- By contacting the Patient and Liaison Service (PALS) who offer confidential, impartial help, advice or support to any aspect of a patient's care. The team aim to help resolve issues and concerns speedily by liaising with appropriate staff on your behalf. PALS can be contacted by phone on 0800 019 3282; by text on 07827 281 266; by e-mail pals@gloucestershirehospitals@glos.nhs.uk or by writing to the PALS Office, Gloucestershire Royal Hospital, Great Western Road, Gloucester GL1 3NN. Complaints can be made to the Complaints Team by phoning 0300 422 5777, by e-mail complaints.team@glos.nhs.uk of by writing to the Complaints Team at Gloucestershire Royal Hospital/at the above address
- By asking a question at our Board meeting by following the procedure below. Board meetings are open to the public and are normally held on the last Friday of the month and alternate between the Sandford Education Centre in Cheltenham and the Redwood Education Centre at Gloucestershire Royal Hospital. Meetings normally start at 9.00am

All feedback is taken seriously and is used to either praise staff for the excellent care or service they have provided or used to make improvements where needed.

Written questions for the Board Meeting

People who live or work in the county or are affected by the work of the Trust (including members of the Trust who live outside of the County) may ask the Chair of the Trust Board a question on any matter which is within the powers and duties of the Trust.

Ten minutes will be allocated at the end of the public section of each Board meeting for written questions from the public to be answered. Where it is not possible for all written questions to be dealt with within this timeframe a written response will be provided to the questioner and copied to all Board members within 7 working days of the meeting. In exceptional circumstances, the Chair may extend the time period for public questions.

Notice of questions

A question may only be asked if it has been submitted in writing to the Board Administrator by 12.00 noon 3 clear working days before the date of the Board meeting. Each question must give the name and address of the questioner. If a question is being asked on behalf of an organization then the name of the organization must be stated. Written questions are to be submitted to the Board Administrator, Alexandra House, Cheltenham General Hospital, Sandford Road, Cheltenham, GL53 7AN or by e-mail to natashia.judge@glos.nhs.uk No more than 3 written questions may be submitted by each questioner.

Procedure

At the Board meeting the questioner, if present, will be invited to read out the question. If absent, the Chair may read out the question. A written answer will be provided to a written question and will be given to the questioner and to members of the Trust Board before being read out at the meeting by the Chair. Copies of the questions and

the responses will be recorded in the minutes.

Additional Questions

A questioner who has submitted a written question may, with the consent of the Chair, ask an additional oral question arising directly out of the original question or the reply.

An answer to an oral question will take the form of either:

- A direct oral answer; or
- If the information required is not easily available a written answer will be sent to the questioner and circulated to all members of the Trust Board

Unless the Chair decides otherwise there will not be discussion on any public question.

Written questions may be rejected and oral questions need not be answered when the Chair considers that they:

- are not on any matter that is within the powers and duties of the Trust
- are defamatory, frivolous or offensive
- are substantially the same as a question that has been put to a meeting of the Trust Board and been answered in the past six months; or
- would require the disclosure of confidential or exempt information

For further information, please contact Natashia Judge, Board Administrator on 0300 422 2932 by e-mail natashia.judge@glos.nhs