GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

The next meeting of the Gloucestershire Hospitals NHS Foundation Trust Main Board will be held on **Thursday 14 November 2019** in the **Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital** commencing at 12:30

(PLEASE NOTE DATE AND VENUE FOR THIS MEETING)

Peter Lachecki
Chair

November 2019

AGENDA

1.	Welcome and Apologies			12:30
2.	Declarations of Interest			
3.	Patient Story			12.32
4.	Minutes of the Public Board meeting held on 10 October 2019	**PAPER** (Peter Lachecki)	**For approval**	13.00
5.	Matters Arising	**PAPER** (Peter Lachecki)	**For approval**	
6.	Chair's Update	**PAPER** (Peter Lachecki)	**For assurance**	13.05
7.	Chief Executive's Report	**PAPER** (Deborah Lee)	**For assurance**	13.10
8.	Trust Risk Register	**PAPER** (Emma Wood)	**For assurance**	13.25
	BREAK			13.35
9.	**Quality & Performance:**			
	▪ Assurance Report of the Chair of the Quality & Performance Committee held on 30 October 2019	**PAPER** (Alison Moon)	**For information**	13.45
	▪ Quality & Performance Report	**PAPER** (Steve Hams Rachael de Caux Mark Pietroni)	**For assurance**	13.50
	▪ Learning from Patient Stories	**PAPER** (Steve Hams)	**For information**	14.00
10.	**Finance & Digital:**			
	▪ Assurance Report of the Chair of the Finance & Digital Committee held on 31 October 2019	**PAPER** (Rob Graves)	**For information**	14.10
	▪ Financial Performance Report including Q4 recovery position	**PAPER** (Jonathan Shuter)	**For assurance**	14.15

11.	**People & Organisational Development:** ▪ Assurance Report of the Chair of the People & Organisational Development Committee held on 21 October 2019	**PAPER** (Balvinder Heran)	**For information**	14.25
	▪ People & Organisational Development Report	**PAPER** (Emma Wood)	**For assurance**	14.30
12.	**Estates & Facilities:** ▪ Assurance Report of the Chair of the Estates & Facilities Committee held on 3 September 2019	**PAPER** (Mike Napier)	**For information**	14.40
13.	EPRR Annual Return to NHSI	**PAPER** (Rachael de Caux)	**For assurance**	14.45
14.	Strategic Objective Amendment	**PAPER** (Simon Lanceley)	**For approval**	14.55

GOVERNOR QUESTIONS

15. A period of 10 minutes will be permitted for Governors to ask questions. 15.00

STAFF QUESTIONS

16. A period of 10 minutes will be permitted for members of staff to ask questions. 15.10

PUBLIC QUESTIONS

17. A period of 10 minutes will be permitted for members of the public to ask questions submitted in accordance with the Board's procedure. 15.20

18.	New Risks Identified	**VERBAL** (All)	15.30
19.	Items for the Next Meeting	**VERBAL** (All)	15.32
20.	Any Other Business		15.35
	CLOSE		15.40

COMPLETED PAPERS FOR THE BOARD ARE TO BE SENT TO THE CORPORATE GOVERNANCE TEAM NO LATER THAN 17:00 ON TUESDAY 5 NOVEMBER 2019

Date of the next meeting: The next meeting of the Main Board will take place on **Thursday 12 December 2019** in the **Lecture Hall, Sandford Education Centre, Cheltenham General Hospital** at **12:30pm**

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

Board Members

Peter Lachecki, Chair

Non-Executive Directors

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

Associate Non-Executive Directors

Bilal Lala
Marie-Annick Gournet

Executive Directors

Deborah Lee, Chief Executive
Emma Wood, Director of People and Deputy Chief Executive
Rachael de Caux, Chief Operating Officer
Steve Hams, Director of Quality and Chief Nurse
Mark Hutchinson, Chief Digital and Information
Simon Lanceley, Director of Strategy & Transformation
Mark Pietroni, Director of Safety and Medical Director
Karen Johnson, Director of Finance

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE TRUST BOARD HELD IN THE CABINET SUITE AT SHIRE HALL, GLOUCESTER ON THURSDAY 10 OCTOBER 2019 AT 12:30

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

PRESENT	Peter Lachecki	PL	Chair
	Deborah Lee	DL	Chief Executive Officer
	Emma Wood	EW	Director of People and Organisational Development and Deputy Chief Executive Officer
	Rachael De Caux	RdC	Chief Operating Officer
	Mark Hutchinson	MH	Chief Digital and Information Officer
	Simon Lanceley	SL	Director of Strategy & Transformation
	Mark Pietroni	MP	Director of Safety and Medical Director
	Sarah Stansfield	SS	Director of Finance
	Claire Feehily	CF	Non-Executive Director and Chair of the Audit and Assurance Committee
	Rob Graves	RG	Non-Executive Director and Chair of the Finance and Digital Committee
	Alison Moon	AM	Non-Executive Director and Chair of the Quality & Performance Committee
	Elaine Warwicker	EWa	Non-Executive Director and Chair of the Charitable Funds Committee
	Balvinder Heran	BH	Non-Executive Director and Chair of the People and Organisational Development Committee
	Mike Napier	MN	Non-Executive Director and Chair of the Estates and Facilities Committee
	Marie-Annick Gournet	MAG	Associate Non-Executive Director
IN ATTENDANCE	Hilary Bowen	HB	Public Governor, Forest of Dean
	Julia Preston	JP	Staff Governor, Nursing and Midwifery
	Suzie Cro	SC	Deputy Director of Quality / Freedom to Speak Up Guardian
	Linda's parents		Linda's parents
	Craig Bradley	CB	Associate Chief Nurse
	Kerry Holden		Lead Nurse - Infection, Prevention and Anti - Microbial Stewardship
	Chantal Sunter	CS	Head of Research and Development
	Craig MacFarlane	CMcF	Head of Communications
	Jill Hall	JH	Interim Head of Corporate Governance
	Carole Webster	CW	Deputy Chief Nurse
	Carolyne Claydon	CC	Corporate Governance
APOLOGIES	Steve Hams	SH	Director of Quality & Chief Nurse
	Bilal Lala	BL	Associate Non-Executive Director
MEMBERS OF THE PUBLIC / PRESS			None present.

202/19 WELCOME AND APOLOGIES **ACTIONS**

Apologies were noted.

203/19 DECLARATIONS OF INTEREST

There were none.

204/19 PATIENT STORY

Linda's story was presented by her parents who explained the struggles they had experienced in obtaining a diagnosis of C Diff for their daughter and obtaining the effective treatment for her in the form of a Faecal Microbiota Transplant (FMT).

The following questions and comments were made in response:

- PL thanked Linda's parents for the story and stated how pleased he was for such a positive outcome.
- MP added that there was a lot of learning from Linda's experience and outcomes and the future potential for FMT is unknown but potentially very exciting. MP thanked Linda's parents for sharing their daughter's story and apologised that their experience was not wholly positive but noted that there were lots of learning points which had clearly been picked up on.
- CW wished to echo everything that MP said and also thanked Linda's parents for bringing their story to the Board.
- CF thanked both parents and stated that their story was very moving and that it was wonderful to see Linda's improvement. Linda's parents responded that if anyone in the community tests positive for C Diff, they should go straight to Infection Control as the communications with CB and KH were appreciated, to which DL commented that they have both been shortlisted for an award in this year's Annual Staff Award.

DL asked why FMT is fourth line treatment and what is the potential for us to change this?

- KH responded that the treatment is restricted by NICE guidelines and that a third episode of C Diff is necessary before the criteria is met to receive FMT. A localised FMT pathway is currently being established to see if it is possible to use the treatment earlier in some defined cases. The Microbiome Treatment Centre in Birmingham is a leading centre and with their support, together with the new pathway, the procedure can hopefully be used earlier than laid down in the recognised guidelines. Conversations are also happening with GPs so that they are aware that this treatment is available.

DL asked CB whether he had considered publishing this particular case in order to start a conversation about the potential use of FMT?

- CB responded that FMT is a new treatment in this country and that this experience does need to be written up and is the perfect case to support this treatment. He will give this some thought.

- AM commented that she felt this was a powerful story for several reasons: the statistics presented, the appreciation of the Infection Control Team, understanding the things that were not listened to through the pathway for diahorrea. AM considered how the system can pick up the triggers better and the possibility of a local case study by

going out in to the GP locality groups.

PL asked how it would be possible to take this in to the system?

- DL responded that we have a system wide Infection Prevention and Control Network and that the discussion around the links and pathways between primary and secondary care can be considered there. Linda's parents said that they felt that GPs should not treat C Diff and that patients should be referred to hospital care. In response, DL said that she believed our focus should be to support GPs and ensure that clear pathways and shared care between GPs and hospital specialists are in place and that GPs know when and how to seek specialist help.

- Linda's parents were thanked for bringing Linda's story to the Board meeting today; in response they reiterated their offer to present to other groups if t would help highlight this important treatment.

205/19 MINUTES OF THE MEETING HELD ON 12 SEPTEMBER 2019

The following changes were requested:

- Page 1 – Elaine Warwicker's initials to be changed to EWa.
- Page 2 – "BME" should read "BAME".
- Page 5 – The last bullet point regarding the Quality & Performance report should state that although there was confidence in the Trust's plan last year, there was a lack of assurance.
- Page 8 – correction to the sentence: "…on *the* grounds of safety".
- Page 13 – section 193/19 – correction to the heading: "Assurance Report *of* the Chair".

RESOLVED: That the minutes of the Board meeting held on 12 September 2019 be agreed as a correct record and signed by the Chair upon completion of the above corrections.

206/19 MATTERS ARISING

It was noted and accepted that all Matters Arising from previous meetings were closed.

207/19 CEO REPORT

DL presented the Chief Executive's report and drew attention to the following:

<u>Operational Performance</u>

A huge amount of effort has gone in to operational performance and it can be seen for the first time how much service transformation is behind this improvement in service standards. Notwithstanding this, more work is needed especially around diagnostics within cancer pathways. Delivering the 2 week standard means that more patients than ever are receiving a timely diagnosis confirming that they do not have cancer. This is a testament to our clinicians and how they are working with the booking office to maximise capacity.

<u>The Big Green Conversation</u>

This was the first session of its kind led by the Trust and national and local leaders and experts had contributed (via digital links) including the lead from Newcastle Hospitals Trust which had been the first NHS Trust to declare a climate emergency. The event had attracted many staff who are passionate about this issue, many of whom don't usually attend corporate events. DL welcomed the agreement of MN to be the Board's Green Champion to help the

Trust progress this agenda and advised that a motion would be coming forward to the Board, from the session.

- PL said that he was delighted to hear that the event went so well and was sorry to have missed it. He said he was pleased about the continuing way this Trust learns and listens to others, and also how this has been achieved through technology.

Mental Health Awareness

Today is Mental Health Awareness Day and DL drew the Board's attention to the focus being placed on the psychological wellbeing of patients and staff. DL expressed her thanks to those willing to step up and share their personal experiences which had received considerable attention nationally and positioned the Trust in a very positive light, in this regard.

Freedom to Speak Up Month

DL summarised the activities underway by Suzie and her team to raise awareness of the Guardian's role. A national index to the measure the "health" of the Freedom to Speak Up culture had been developed using relevant questions from the staff survey and the Trust was rated better than the acute Trust average but she said that she hoped we would do even better in this year's staff survey which was currently underway, given how much had been done in the last year by Suzie and the growing team of guardians.

Fit for the Future

DL gave an update on progress and some of the local events which she had attended. She gave an overview of forthcoming events including the Engagement Hearing due to take place this month.

DL offered to take questions on anything which is topical or which was missed in her update.

The following questions and comments were made in response:

MN asked SL why the strategic outline case for the £39.5m capital scheme had taken so long to approve and whether there were any outstanding issues which might affect the next stage?

- SL responded that the whole process took eleven months and this was largely delayed due to changes in regional structures and personnel which he hoped would not be a feature of the OBC approval.

- PL commented that he had listened to a presentation by Sue Baker, "Time to Change", on the working with organisations involved in mental health and how the NHS is particularly bad at recognising the challenges faced by its own employees. The message needs to be reinforced to support those who do not think that they need help.

CF enquired about mental health and the estate, and whether there was anything the Trust needs to do to make this patient group physically safer in the environment?

- CW described the risk assessment work underway to ensure all estate is compliant with guidance in respect of ligature risks. She also stated that ED environments were compliant following CQC inspection which had flagged some concerns.
- DL described the work done to ensure compliance with regulations around window restrictions which had followed an unfortunate experience when a vulnerable individual had gained access to the roof of the Tower Block. Work has also been undertaken around access to the Tower Block as well as the car park, where specialised lighting has

been installed designed to reduce the likelihood of someone attempting to jump.

- **Action**: The Quality Delivery Group is to consider what a consistent piece of assurance would look like to review the safety of the estate for mental health patients on a regular basis. **SH/(CW)**

RESOLVED: That the Board noted the report.

208/19 TRUST RISK REGISTER

EW presented the update on the Trust Risk Register, the key points of which were:

- There have been seven changes to the risk register following last month's update.
- A fire risk has also been added which has been discussed at various committees.

The following questions and comments were raised in response to the update:

PL commented that it was unusual to have so many changes to risks in one month and asked whether something has changed in terms of the system or process?

- EW responded that nothing has changed in respect of systems or process, to which MP added that the majority of these changes relate to general surgery and reflected the recent reassessment of these risks which had resulted in a single risk being split into distinct domains for quality, safety and workforce.

RG commented that it is good to have a comprehensive report coming regularly to the Board. Stepping back however, there are one or two pages on the risk register where the risks are marked as red or amber with partially incomplete work. Is this unusual and should we be satisfied with this information or at the pace at which it is being tackled?

- EW responded that information being presented this way is not unusual and that there is a process for reviewing these risks. DL added that if a risk is green, it does not make it on to the risk register and so, de-facto, only the highest risks will be presented. The number and nature of the risks is not unusual but maybe it would be possible to evidence the dynamism of the risks, i.e. the way in which they come on and off the risk register and thought would be given to this. DL went on to explain the way in which the Risk Management Group reviews the details of risks which are not captured in the Register presented to Board.

AM commented that the first three new risks concern insufficient cover, inappropriate training and an inability to create rotas. Two risks are sitting with quality and one with workforce and asked about the thought process behind this? Also, how is it ensured that those risks in the sub-committees which might not reach the Trust Risk Register are being captured for bigger themes?

- EW responded that in the People & Operational Development Committee, Datix is searched for all workforce risks at any score and themes are extracted before being placed on to the relevant Divisional Risk Register. As part of this process, the triangulation of risks needs to be refreshed to ensure that the correct risk rating is achieved and whether there are any knock on effects.

- AM responded that it would be helpful to explore this more at the People

& Operational Development Committee. **Action**: EW, as Chair of the Risk Management Group, to give some thought to this. **EW**

- EWa commented on the Trust Risk Register in that it is difficult to get a sense of the urgency and timeliness of the risks e.g. when a risk had been first added, dates on the actions and who the action sits with. DL explained that all this information existed "behind the scenes" and was considered by the Risk Management Group and should be the focus of the Board Committee scrutiny rather than the Board itself. However, she asked EW to consider whether any change to the presentation of the register would capture this additional information without extending the report further e.g. an arrow to show if the risks were increasing or reducing. **Action**. **EW**

- KJ commented that, coming from another Trust, the number of high risks on the Trust Risk Register is not uncommon. Also, although a risk is listed, it might be an accepted risk and it would be helpful to discern between those which were "accepted" i.e. could not be eliminated or further reduced versus those where actions were assigned to reduce or eliminate the risk.

RESOLVED: That the Board noted the Trust Risk Register.

209/19 LEARNING FROM DEATHS

MP presented the Learning from Deaths report, the key points of which were:

- The top line indicators around mortality remain good for the Trust i.e. they are within the expected range.
- Work is being undertaken on the Learning from Deaths report to link up the various information sources which feed into the mortality data, for example, Serious Incidents (SIs) and Structured Judgement Reviews (SJRs), in particular the speed at which these processes are undertaken by the Divisions. In addition, the feedback from family conversations is to be fed in to the report. This is mostly positive but there will also be some learning points which will be fed back at Divisional Board.
- Our Trust is one of the pilot Trusts in the country for the Medical Examiner process which is expanding groups to include not just pathologists but also medical practitioners, as well as expanding in to the community.
- Interesting learning has been received from nurses undertaking SJRs who have talked to family members, having already been reviewed by medical staff.

The following questions and comments were made in response:

CF commented that she was pleased to see the more subjective comments regarding the quality of care contained within the report. Regarding section 2.4 which contains some difficult comments, what do we do with this feedback? If insensitive care has been highlighted, how is the quality improved? Also, how do we arrive at a view of when the time is right to call a family member of a patient who is about to die? Moreover, how do we bring about consistent change?

- MP responded that when the Bereavement Team speaks to a family following a death, the family is always given the opportunity to discuss the care. Should issues be raised, these are noted and addressed through the usual process. The issues would then be picked up by the matron or nurse in charge of the ward, and via reports that go to the

Divisional Board.

- Regarding end of life care, MP continued that there are processes in place to ensure that when a patient is nearing the end of their life, family are aware of this. CW added that ReSPECT is a national programme which is being launched and which covers the importance of this communication from an early stage. The End of Life Team audits this process in terms of what it means for the patient and the carers, and how it impacts on them.

CF further asked whether this programme will catch the uncertainty around family members who want to be present at the end of life but who live five minutes away?

- CW responded that this comes back to good communication and it is expected that the nursing staff would capture this information. This would need to be monitored around the shift patterns. DL added that it relates to the strength of the end of life care planning, and that end of life care is recognised across all specialities. DL added that it would be good to shine a spotlight on ReSPECT through the Governors' Quality Group. **Action**: CF to raise end of life care planning through the Governors' Quality Group. **CF (work plan)**

MAG asked how grief and bereavement is dealt with in the Trust and how is the learning being shared and captured?

- CW responded that this happens in a number of ways, for example, through the Schwartz Rounds, and through the divisional and whole system learning with our partners. MP added that patients' care can suffer when patients are transferred between providers but that moving to the common ReSPECT framework and associated paperwork would help improve communication.

RESOLVED: That the Board noted the report.

210/19 ASSURANCE REPORT OF THE CHAIR OF THE QUALITY AND PERFORMANCE COMMITTEE HELD ON 25 SEPTEMBER 2019

AM presented the report, the key points of which were:

- On the morning of the Q&P Committee, an internal incident was declared and AM was pleased with the commitment of all the Executives in the room.
- AM was pleased to welcome MH to the committee to present on the Electronic Patient Record (EPR). MH provided assurance around the flexibility of the EPR to respond to challenges during its implementation, and that there are healthy challenges taking place within the Executive team. It would be helpful for MH to update the committee in due course, but AM is conscious of not overlapping with the Finance & Digital Committee so this would remain under review.
- Today's patient story highlighted how difficult C Diff is to treat. The Quality & Performance Committee received a report on the June/July outbreak, which showed a lot of reflection and learning. It was suggested to take the report to the Directors' Operational Group (DOG). Amongst other things highlighted in the report, was the need to have ward leaders in place who understand when and how to escalate issues and that as a result, action is taken. AM has asked for a further review of C Diff to come back to committee together with a further review on the risk register.

PL commented that AM's report provided a comprehensive view of the

assurances received and how the committee is working, and thanked AM for the update.

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

QUALITY AND PERFORMANCE REPORT

RdC presented the report, the key points of which were:

- The 4 hour performance target was held despite it being the month of August when the new junior doctors join the Trust.
- The Trust was successful in achieving the release of capital funding from NSHI in support this winter.
- The Trust's early warning system, SHREWD, has gone live from October.
- Regarding elective performance, the Trust is over-delivering against RTT and the 52 week wait trajectory and outpatient clinical utilisation is over 96%.
- Challenges still exist around the 62 day performance, although investment in imaging capacity and reporting in radiology and additional workforce in histology is expected to make a significant impact. A new urology pathway is also now in place.
- MP added that it is known that pressure ulcer, deteriorating patients and falls are the Trust's key risks. The Quality Summit looked at ways of turning this around and it is known which wards have the highest incident of harms and actions are therefore being targeted. Putting more nurses in to the Acute Medical Unit (AMU) over the winter is being considered in order to improve the ratio of substantive to temporary staff with the aim of improving retention rates as well as the quality of care. CW continued that the Quality Summit was successful although it is recognised that there is a need to work much more closely together as a system. There are some further actions to come out of the summit which will continue to be monitored through the Quality Delivery Group.

The following questions and comments were made in response:

BH asked whether the use of SHREWD is just in relation to winter pressure or across all planning and capacity modelling?

- RdC responded that it is initially for winter but essentially will be used across the whole system. It will enable us to see which part of the system is running "hot" and how people's behaviours need to change to de-escalate this.

BH made reference to dementia and stroke showing as "red" in the report and asked whether they are as being reported or are there still data quality issues.

- MP explained that with dementia, the reason remains our inability to collect the data electronically due to issues with TrakCare and manual audits are now being established to provide a snap shot of actual performance, although he believed this would highlight that performance in this area is not as good as it should be. Improvements in stroke are being made evidenced by the recent move from an "E" to a "C" in the national stroke audit (SNAPP), indeed the service had been just one point from being "B" rated.

CF enquired about Discharge Summaries sent to GPs within two hours and why this is reported as red month after month, and whether it is

possible to provide an update on actions being taken to address this?

- MP agreed that we should be concerned as the performance is not good enough and this had been a significant focus with new intake of juniors who are responsible for completing them. It is planned to re-name the Discharge Summaries, "clinical handovers", in the hope that they become of interest and importance rather than a "painful" piece of administration. BH added this is a difficult but important piece to get right as the summary information is critical. MH added that the new EPR will help significantly as it will "auto-populate" much of the information currently entered by the juniors and other staff.

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

211/19 ASSURANCE REPORT OF THE FINANCE AND DIGITAL COMMITTEE HELD ON 26 SEPTEMBER 2019, AND THE FINANCIAL PERFORMANCE REPORT

RG presented the reports, the key points of which were:

- The financial performance position is satisfactory with a small favourable variance on the planned position.
- Delivery of Q3 is forecast although Q4 represents a significant challenge with a shortfall anticipated against the planned position due to under delivery of cost improvement plans (CIP).
- The cash balances are unusually large at present but this represents funds being hosted on behalf of others and a delay to spending capital.
- Going forwards, not only will the historical cash flow be reported on, but also the forward projections.
- SS gave an excellent presentation on the work being undertaken around the long term plan.
- The Gloucestershire Cancer Institute Strategic Outline Case was reviewed and approved.
- A considerable amount of engagement and practical work is being done with staff on EPR to ensure that they are ready and aware of the benefits which can be achieved. A lot of lessons were learnt from the deployment of the last major IT system and have been incorporated into the roll out plans.
- RG listed the individual activities undertaken through the IM&T Programme Update so as not to forget all the significant work that goes on behind the scenes. From an assurance point of view, RG is satisfied that this level of detail is being scrutinised.

PL asked SS to headline the Financial Report. SS responded by highlighting:

- The year to date position is a favourable variance in line with the YTD forecast.
- Page 20 regarding income and expenditure forecast outturn, projects a significant challenge for Q4 of 2020.
- SS would like to flag to the Board a downside scenario which is looking like a £6.9M variance to plan due to the loss of PSF in Q4.

The following comments and responses were made in response:

AM asked for clarification on the non-clinical agency costs?

- SS explained that this is not higher than the budgeted position but relatively high in relation to the overall total reflecting contractors supporting the EPR programme. MH added that these staff are difficult to source on permanent contracts due to the nature of the market place

for these skills.

- **Action**: PL asked that an extra couple of pages are brought back to the Board next month on what the Trust is doing to try to recover the Q4 position. DL added that the contract for the member of staff developing the delivery plan for Q4 has been extended. **SS/JS** **(work plan)**

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

212/19 PEOPLE AND ORGANISATIONAL DEVELOPMENT: RESEARCH STRATEGY

SL introduced CS to the Board who explained the Research Strategy, the key points of which were:

- Between January 2019 and the present day, a new strategic objective regarding University Hospital status has been incorporated.
- There are four pillars which underpin the strategy:
  1. Increasing visibility and awareness;
  2. Celebrating success
  3. Increasing the equity of access; and
  4. Growing our collaborations.
- Within the strategy, there is further detail about these pillars as well as the metrics used to measure the effectiveness of the strategy throughout its lifetime.

The following comments and questions were made in response:

CF said that this was a fabulous report to read. **CF referred to the section of the report concerning "impact" and asked whether there was something that could personalise this and linking in with the patient impact?**

- CS agreed with this and stated that, in terms of operational objectives, patient stories will be collated.

MAG stated that this report was really good to see and enquired about the current engagement with patients?

- CS responded that there is a West of England-wide group which supports patient and public involvement throughout the region. In addition, work takes place locally through projects on which there are patient representatives.

- AM stated that she thought the report was brilliant and is absolutely key to bringing the research up on to a level playing field with clinical care and teaching, which is what is desired. The report has her full support.

- MN added that he believes this to be a great strategy, and that it is good that it follows the exemplar of the People & Organisational Development strategy. Regarding the University status, he asked for an update on progress. SL responded that a programme team was putting together a business case but it is unlikely to generate the return typically expected and therefore the Board would be devoting some time to the strategy at the December seminar session with a view to determining whether a different approach was warranted.

- PL stated that he can see the value that CS is bringing to this area and thanked her for all her hard work.

RESOLVED: That the report was noted by the Board.

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213/19 AUDIT AND ASSURANCE

ASSURANCE REPORT OF THE CHAIR OF THE AUDIT AND ASSURANCE COMMITTEE HELD ON 17 SEPTEMBER 2019

CF presented this report, the key points of which were:

- It was good to have the Risk Assurance Report brought to committee: it was a first class report and gave assurance around how systems are being made even better.
- External Audit provided confirmation on how well the trust is doing in areas such as the Central Booking Office the CIP infrastructure, for example
- The internal audit service has provided a pragmatic and grounded contribution to the committee.
- A huge thank you to SS for her support to the Audit Committee.

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

214/19 BREXIT BRIEFING

SS presented this report outlining the national, regional and local context and confirming that no additional risks beyond those applicable to the NHS generally, had been identified. The paper set out the actions that will be taken to manage any supply shortages which were essentially those used currently although the hours of operation of procurement and goods receipting would be extended. She added that Trusts were being asked to collate additional costs associated with EU Exit preparations although there was no commitment from the government to refund these.

The following comments and questions were raised in response:

PL enquired about the status of Sit Rep reporting?

- SS responded that there is a national response unit and a number of regional response units. From 16 October 2019, the Trust will be asked to produce a daily report to the regional response team.

EWa asked whether staff time is being logged in terms of costs?

- SS responded that this is not being specifically being logged as this was unlikely to be reimbursable cost even if central funding was provided.

CF enquired whether patients are beginning to raise questions regarding Brexit and, if so, in what form?

- SS responded that the only questions being asked are regarding medicines to which MP added that some patients are asking for a longer than two week supply of medicines to get them through the EU Exit period but this was not being provided with explanations being given as to what patients should do if they run short of medicines. Typically any shortages are national and being managed through national substitution.

RESOLVED: That the Board note the report.

215/19 GOVERNOR QUESTIONS

The Lead Governor submitted the following questions:

1. **Is there a list of Trust Medical Examiners available and how are their approaches to death and bereavement standardised? For example, is there a Lead ME?**

- MP responded that due to our involvement with DHSC since 2009 and shaping and testing the ME system as one of two official pilot sites, we have developed best practice approaches to bereavement service delivery and in the incorporation of the ME function within it. We are nationally recognised as a centre of excellence in this regard and continue to influence how the full system will be implemented across England and Wales. This will include testing the funding model, digital case management system and ME and MEO performance management/quality measures ensuring best practice for our own organisation and to share with others.

- We are looking to increase the number of MEs to 12 in the coming weeks. Until recently the Lead ME was Dr Golda Shelley-Fraser who has now been appointed Regional ME for the South West. This means that she is not able to also be a Lead ME in a Trust as it would be a conflict of interest. Once we have the full complement of MEs we will look to appoint one of them as Lead ME. However, three of the current MEs have over 10 years' experience in the role due to our long flagship pilot status for the DHSC in shaping and testing the ME system.

2. **Regulations were issued on 1 Oct 19 requiring doctors to report deaths to coroners for the first time, in a bid to modernise the death reporting process in England and Wales. To what extent do these regulations apply to the Trust and how will they be implemented?**

- MP responded that as an established ME service we are aware of the Chief Coroner's Guidance 31 'Death Referrals and Medical Examiners' and fully comply with electronic referrals from GHFT ME and Bereavement service to the Coroner. Furthermore the senior Coroner is fully supportive and engaged with our ME service and has a long history of working with us during the pilot phase (2009-2018) and in going forward.

3. **Conscious that, other than private/confidential issues, Board meetings are held in public, how exactly does the Trust publicise Board meetings other than in a fairly specific part of the Trust Website. For example, does the Trust use local news media, Twitter or Facebook to advertise a forthcoming Board meeting, together with its time, location and agenda? If not, are there any plans to do so?**

- CMcF responded that the Trust's Board Meetings and the meetings of the Council of Governors are published on the Trust's main website as suggested. We welcome the suggestion of publicising these meetings via the Trust's social media platforms (Twitter and FaceBook) and will adopt this approach with immediate effect. Therefore the next meeting of the Council of Governors (16 October) will be promoted in this way as will the next meeting of the Board (14 November). Future meetings will be promoted in a similar way.

- As part of work to further develop the Trust's approach to engagement, a new Engagement Strategy is currently in development. Improved Governor and membership engagement is a key pillar within this strategy and at the Governor Strategy & Engagement meeting on 5th December, Governors' views will be sought on how this can be achieved, what outstanding engagement looks like, and how best the work and role of the Council of Governors can be promoted.

216/19 STAFF QUESTIONS

There were none.

217/19 PUBLIC QUESTIONS

There were none.

218/19 NEW RISKS IDENTIFIED

There were none.

219/19 ITEMS FOR THE NEXT MEETING

There were none.

220/19 ANY OTHER BUSINESS

- As this was SS's last Board Meeting, PL expressed his thanks on behalf of the Board for all the work that she has undertaken through some difficult times, and wished her all the best for the future.

- SS stated that a system five year plan will be submitted to the November Board meeting as a recommendation for approval. Given the timing of the committees between now and then, it is recommended that the Trust part of the submissions be presented for recommendation to Finance & Digital Committee. RG and the Board were in approval.

[Meeting closed at 14.55pm]

DATE OF NEXT MEETING

The next **Public** meeting of the **Trust Board** will take place at 12:30 on **Thursday 14 November 2019, Lecture hall , Redwood Education Centre, Gloucestershire Royal Hospital.**

Chair
10 October 2019

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

TRUST BOARD – OCTOBER 2019

MATTERS ARISING

CURRENT TARGETS

Target Date	Month/Minute/Item	Action with	Issue	Action	Update
November 2019	**October 2019 207/19 – CEO Report**	**SH/CW**	CF enquired about mental health and the estate, and whether there was anything the Trust needs to do to make this patient group physically safer in the environment?	**Action**: The Quality Delivery Group is to consider what a consistent piece of assurance would look like to review the safety of the estate for mental health patients on a regular basis.	*Closed:* Individuals audits completed on ligature risk assessments (linked with safety alert) and our wider focus on enhanced care, alongside an annual review with the Patient Led Assessment of the Care Environment (PLACE) audit. New capital scheme will provide opportunities for wider involvement with service users and families.
November 2019	**October 2019 208/19 – Trust Risk Register**	**EW**	AM commented that the first three new risks concern insufficient cover, inappropriate training and an inability to create rotas. Two risks are sitting with quality and one with workforce and asked about the thought process behind this? Also, how is it ensured that those risks in the sub-committees which might not reach the Trust Risk Register are being captured for bigger themes?	AM responded that it would be helpful to explore this more at the People & Operational Development Committee. **Action**: EW, as Chair of the Risk Management Group, to give some thought to this.	***Closed*:** Triangulation of risks now takes place prior Directors Operational Group (DOG) for corporate risks, grouping those risks with similar themes together under an umbrella risk. Risks will occasionally sit under the assurance framework of more than one Committee (for example Temporary Staffing Spend risks now report into both P&OD and Finance and Digital).
November 2019	**October 2019 208/19 – Trust**	**EW**	EWa commented on the Trust Risk Register in that it is difficult to get a	**Action:** DL asked EW to consider whether any change to	***Closed*:** The current DATIX system depends on manual progress

	Risk Register		sense of the urgency and timeliness of the risks e.g. when a risk had been first added, dates on the actions and who the action sits with.	the presentation of the register would capture this additional information without extending the report further e.g. an arrow to show if the risks were increasing or reducing.	tracking. The risk team are currently reviewing whether an updated version of Datix (DATIXCloudIQ) would support the management of this and the benefits of developing a business case for this potential upgrade.
November 2019	**October 2019 209/19 – Learning from Deaths**	**CF**	CF further asked whether this programme will catch the uncertainty around family members who want to be present at the end of life but who live five minutes away?	**Action**: CF to raise end of life care planning through the Governors' Quality Group.	***Closed***: End of Life Care Planning has been added to the items for discussion at a future Governors' Quality Group.
November 2019	**October 2019 211/19 – Finance Performance Report**	**JS**	Recovery of Q4 position.	**Action**: PL asked that an extra couple of pages are brought back to the Board next month on what the Trust is doing to try to recover the Q4 position. DL added that the contract for the member of staff developing the delivery plan for Q4 has been extended.	***Closed***: Incorporated as part of the Financial Performance Report – Item 10 on the agenda.

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – November 2019

CHAIR'S ACTIVITIES UPDATE

In order to present a snapshot of the wider perspective of Chair activities undertaken, a written summary is presented at Public Trust Board meetings. This excludes regular meeting attendances at Board, Council of Governors, Board Committees and 1:1s with Directors and Governors. Period from 4 July to 5 November 2019.

Trust activities

DATE	EVENT
4 7 19	100 Leaders' event
29 7 19	T & O Consultants' recruitment panel
2 8 19	Gastroenterology Consultants' recruitment panel
13 8 19	'Fit for the Future' Engagement Governors' briefing
14 8 19	Medical Director appointment panel
16 8 19	'Fit for the Future' Governors' briefings - GRH/CGH
5 9 19	Opening of Learning Disability Conference
12 9 19	Trust Annual Members' meeting
18 10 19	100 Leaders' event
23 10 19	Shadowing CGH porters

Gloucestershire countywide health

DATE	EVENT
9 7 19	Chairing Research4Gloucestershire Task and Finish meeting
19 7 19	Meeting Mary Morgan - CCG Housing lead
22 7 19	Chairing Research4Gloucestershire Steering Group meeting
23 7 19	Gloucestershire Health and Wellbeing Board meeting
23 7 19	GCS/2gether AGM
24 7 19	Meeting Nick Relph - Interim Chair, Integrated Care System
30 7 19	ICS Board meeting
30 7 19	Integrated Care System (ICS) Chairs' meeting
13 8 19	Chairing Research4Gloucestershire Task and Finish meeting
21 8 19	Meeting with Simon Harper - GCC Head of Democratic Services
27 8 19	ICS Board meeting
3 9 19	Chairing Research4Gloucestershire Task and Finish meeting
9 9 19	Cheltenham Borough Council Scrutiny Committee
10 9 19	Gloucestershire Health Overview and Scrutiny meeting
10 9 19	Chairing Inaugural Research4Gloucestershire Conference
16 10 19	Chairing Research4Gloucestershire Steering Group meeting
24 10 19	'Fit for the Future' Engagement hearing
29 10 19	ICS Board meeting
4 11 19	ICS Independent Chair recruitment panel

National stakeholders + others

DATE	EVENT
1 8 19	NED recruitment panel - Worcestershire Health and Care Trust
3 9 19	Gloucestershire Advisory Roundtable
11 9 19	Leadership Academy Aspiring Chief Exec programme support - Leeds
8 10 19	NHS Providers' Annual Conference - Manchester

Peter Lachecki
Trust Chair - 5 November 2019

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

TRUST BOARD – NOVEMBER 2019

REPORT OF THE CHIEF EXECUTIVE

1 Context

National politics continue to shape the context in which we are operating and no less so this month than previously. For the NHS, and other public services, the announcement of a General Election means that we are required to observe the period prior to an election known as *Purdah;* an Indian term which when translated means the "curtain comes down". During Purdah, public sector organisations are not allowed to conduct any business which could be considered politically controversial and/or appear to be aligned to one party above another; decisions about strategy and resources should also be postponed until after the General Election and so, from Wednesday 6 November, the curtain came down on all such matters.

The practical implications of this include a reduced Board agenda and given the recent political interest in our own *Fit For The Future Programme,* also means that our planned engagement activities have been paused until the 13 December; not ideal, given the positive momentum, but unavoidable without exposing the programme to future risks. The two most immediate impacts are on our intended publication of the headlines from our engagement period activities which have been postponed and the planned *Citizens' Jury* which was scheduled to run from the 9 to 13 December but will now be held in mid-January 2020. We are currently reviewing what this pause means for the programme timeline overall and the programme team will issue a revised plan as soon as possible.

Finally, the obligations associated with *Purdah* also mean that this month's report is more limited in nature to avoid any communication which might be considered to breach best practice.

2 The Trust

Gloucestershire Hospitals, like many neighbouring Trusts, is reflecting the national picture of significant operational pressures, more redolent of peak winter months, affecting both patient and staff experience in many of our services and particularly urgent and emergency care. A&E waiting time performance has been at its poorest for twelve months, despite very significant efforts across the health and care system to limit demand on hospitals services. With this context so early in the winter season, there is a huge focus on staff wellbeing and resilience in all areas across the Trust but especially in those services most impacted by these pressures. This includes a review (and enhancement where needed) of staff rest areas and a renewed focus on ensuring staff are supported to take their breaks and that those breaks are of high quality. Staff morale remains positive and there are some very promising improvements in staffing in some of our most challenged ward areas.

One initiative to support our preparedness for winter is a "re-set" week called *Breaking The Cycle*, which will take place week commencing 11 November. Sometimes known as the *Perfect Week,* the aim of the initiative is to support services and staff to run "optimally" and to identify and address those things that are barriers to this happening routinely. The week is being supported by all partners in the system, including social care colleagues and will conclude with a debrief to the Integrated Care System Chief Executives with further actions to improve our winter response hopefully identified and implemented.

The Trusts outpatient service modernisation programme continues and this month we had another milestone. On the 4 November, we commenced an enhanced text

messaging service to patients, aimed at further reducing our DNA (did not attend) rate. Patients will now not only get their usual 14 day appointment reminder but will also get a three day reminder – this is a change from the prior day text which left very limited time to reallocate an appointment cancelled following a text prompt. Additionally, the appointment location will also be included and more clinics have now been brought on board including telephone appointments meaning that the vast majority of patients accessing outpatient care will get a text reminder. The final step will be to include clinic name which, for those managing multiple appointments, will be a huge benefit and is something patients have asked us to consider.

This month also see the start of our first phase of roll-out of our Electronic Patient Record programme with deployment of electronic nursing documentation on our two pilot wards. Training for all wards is now underway and prospects for a successful go-live across all adult wards in GRH on 4 December are high. Nursing leaders and ward based staff have engaged very positively with the roll-out and the central theme of our EPR programme 'releasing time to care (and/or lead)'. The programme also received a boost this month with the award of additional funding to support the roll out of electronic prescribing following a bid by the Trust almost a year ago.

Since my last report, staff and public support the Trust's charity continues to grow with the most successful *Walk for Wards* so far. Staff have also been active in raising funds for external charities and showing the benefit to team building and staff health and well-being; this month our Diabetes Specialist Nurses and Dieticians joined forces to run 104 miles and, in doing so, raise funds for *Diabetes UK.*

The Trust has also celebrated a whole host of staff by supporting national days aimed at raising awareness of different NHS professions and roles amongst public, patients and other NHS staff. Since my last report the Trust has celebrated Allied Health Professionals in their different guises, hosted some novel activities for *World Radiographer Day* (alongside, of course, cake) and held tea parties for more than 100 Maternity Support Workers employed in our Trust.

We are half way through this year's annual staff survey entitled *Tell us what it's like to work here.* To date 36% of staff have taken the time to complete the online survey, which is 4% points ahead of the national average for acute Trusts. Diagnostics & Specialities Division and Surgery Division continue to vie for pole position with Surgery just eight completed surveys ahead of D&S; Allied health Professionals have completed more surveys than other staff group with Administrative & Clerical staff close behind. This year we have spent time trying to better understand the reasons why staff do not complete surveys and the strongest theme emerging is finding time to prioritise the survey amongst other competing demands and secondly, still some concerns that the survey isn't anonymous; responses to both these themes have been mobilised. The survey closes at the end of November and we continue to aim to exceed last year's completion rate of 46%.

Our approach to staff health and wellbeing includes huge efforts to vaccinate a minimum of 80% of our front line staff against influenza. Despite some challenges with access to the vaccine this year, we are set for our most successful campaign ever. To date, more than 70% of front line staff have been vaccinated against our target which, given just three years we struggled to achieve 60% by the end of the campaign, is phenomenal. Without doubt the success is down to two things – strong leadership and our innovative model of utilising peer vaccinators.

We have come to the end of *Freedom To Speak Up* month and will be reflecting on the period and importantly what it has shown us about the things that are working well and the areas where we have opportunities and can build further. We are fortunate to have recruited two additional Guardians to support Suzie Cro as Lead Freedom To Speak Up Guardian and discussions with a third are underway.

Finally, this month we said goodbye to our Director of Finance, Sarah Stansfield. Few people have left such a positive mark on an organisation, in such a short period. Having joined the Trust as a deputy director, Sarah quickly found herself acting into the Director's role and did this on two separate occasions before securing the substantive role. Sarah's legacies are many but her skill in guiding us through *Financial Special Measures* alongside her very compassionate approach to rebuilding a fragile finance team are two of considerable note.

Sarah's successor Karen Johnson is already getting to know the organisation with some regular "keep in touch days" and will join us substantively from 6 January 2020. In the meantime, I am very grateful to Jonathan Shuter for agreeing to step into the Interim Director of Finance role until Karen joins us.

Deborah Lee
Chief Executive Officer

8 November 2019

Gloucestershire Hospitals
NHS Foundation Trust

TRUST MAIN BOARD – 14 NOVEMBER 2019
LECTURE HALL, REDWOOD EDUCATION CENTRE, COMMENCING AT 12:30PM

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

Purpose

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

Key issues to note

- The Trust Risk Register (Appendix 1) enables the Board to have oversight, and be assured of the active management, of the key risks within the organisation which have the potential to affect patient safety, care quality, workforce, finance, business, reputation or statutory matters.

- Divisions are required on a monthly basis to submit reports indicating any changes to existing high risks and any new 12+ for safety and 15+ other domains to the Trust Leadership Team (TLT) for consideration of inclusion on the Trust Risk Register.

- New risks are required to be reviewed and reassessed by the appropriate Executive Director prior to submission to TLT to ensure that the risk does not change when considered in a corporate context.

Changes in the reporting period

The Trust Leadership Team (TLT) met on 6 November 2019 and considered 4 risks.

Risks reviewed by TLT:

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

C2997RadSafety- The risk of statutory prosecution due to failure to comply with the Ionising Radiation (Medical Exposure) Regulations 2017. Failure to comply the CQC Improvement Notice, specifically the requirement for sufficient written procedures as defined in schedule 2 of IR(ME)R (a)-(n)and a suitable governance structure by 24 October 2019.

Risk lead – Tony Dix. Executive Lead- Mark Pietroni. Score – 4x4 =16 for Statutory
Date Opened: 29 July 2019
Assuring Committee: Radiation Committee, POD,Q&PC

Key Controls (summary	• Radiation Protection Advisors in place to advise specialties • Radiation Safety Committee reports to H&S Committee • Radiation Safety Policy	Mitigation plans	• Employers procedures to be aligned with schedule 2 • ToR for Radiation Safety Committee to be reviewed. • Establish Radiation leads for each

	• Radiation Risk Assessments • Training packages available for practitioner or operator engaged by the employer to carry out exposures • Clinical audit programme • Clinical evaluation of the outcome of each exposure,		speciality and accountable to RSC. • Effective escalation process by RSC • Risk assessments for radiation exposure to be reviewed • Audit programme in place for each area • Assurance needed for third party practitioner or operator on training, competency and compliance i.e. FOCUS who provide services to Urology • Need an inventory of all equipment and establishment of ownership acceptable performance criteria for equipment, testing of equipment procedure, records • Review / develop equipment med physics and Radiographer QA system
Linked risks	None	Highest Scoring Impact	Statutory 4x4=16

C2895COOEFD – Service interruptions arising from failure to make required progress on estate maintenance, repair and refurbishment of core equipment and/or buildings, as a consequence of the Trust's inability to generate and borrow capital.

Risk lead – Akin Makinde. Executive Lead- Rachael De Caux. Score – 4x4 =16 for Environmental
Date Opened: 5 March 2019
Assuring Committee: E&F Committee

Key Controls (summary	• Board approved, risk assessed capital plan including backlog maintenance • MEF and Capital Control Group oversight • Capital funding issue and maintenance backlog escalated to NHSI • All opportunities to apply for capital made • Finance and Digital Committee oversight • GMS Committee and Board oversight	Mitigation plans	• Prioritisation of capital managed through the intolerable risks process for 2019/20 • On-going escalation to NHSI for Capital Investment requirements
Linked risks	None	Highest Scoring Impact	Environmental 4x4 =16

No risks on TRR have been upgraded in this period.

One risk has been downgraded in this period

S2568Anaes- The risk to patient safety of failure of anaesthetic equipment during an operation with currently very few spares to provide a reliable back up.

Risk lead Candice Tyers. Executive lead- Mark Pietroni.
Risk downgraded from a 5x1=5 for safety to a 4x1=4 for safety as machines now replaced in all theatres. Anaesthetic room machines need replacing, but risk level less.

Request removed from TRR and returned to Divisional risk register

One risk was closed on the Trust Risk Register (TRR)

C2775CC- The risk to patient safety of respiratory or/and cardiovascular instability and even death in the event of either an electrical or mechanical failure or as a result of needing to change over to a different mechanical ventilator.

Risk lead Candice Tyers. Executive lead- Mark Pietroni.

Risk closed on 4 October 2019 as all new Servo U ventilators now delivered onto DCC following medical engineering checks. Puritan Bennett ventilators all returned to medical engineering**.**

Proposed Changes to the Risk System (Appendix 2)

Following a review of the current risk system and the risk strategy a number of changes have been recommended, these are summarised in Appendix 2 and if agreed would be included in a revised Risk Management Strategy.

The main changes include : Risk Appetite – To re-consider the table based on the new Trust strategic objectives.

Risk weighting – To consider introducing 4 levels (Low, Medium, High, Very High).

Conclusions

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

Implications and Future Action Required
Ongoing compliance with and continuous improvement to the risk management processes.

Recommendations
To agree changes to the Trust Risk Register proposed in the report. To agree changes to the Risk Management Process
Impact Upon Strategic Objectives
Supports delivery of a wide range of objectives relating to safe, high quality care and good governance
Impact Upon Corporate Risks
The Trust Risk Register is included in the report.
Regulatory and/or Legal Implications
The risk of regulatory intervention (including fines) and poor patient experience resulting from the non-delivery of appointments within 18 weeks within the NHS Constitutional standards (Risk C2628COO)
Equality & Patient Impact
Potential impact on patient care, as described under individual risks on the register.

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

Date the paper was presented to previous Committees and/or TLT							
Audit & Assurance Committee	**Finance and digital Committee**	**GMS Committee**	**People and OD Committee**	**Quality & Performance Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
						6 November 2019	Directors Operational Group 30 October 2019

Outcome of discussion when presented to previous Committees/TLT

TLT recommended to the Board endorsing the above changes to the TRR and consideration of changes to the risk management process.

Trust Risk Register November 2019

Ref	Division	Highest Scoring Domain	Executive Lead title	Title of Assurance / Monitoring Committee	Inherent Risk	Controls in place	Action / Mitigation	Consequence	Likelihood	Current
F2927	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Finance	Director of Finance	Finance and Digital Committee	Risk that the Trust does not achieve the required cost improvement resulting in failure to deliver the Financial Recovery Plan for FY20	1. PMO in place to record and monitor the FY20 programme 2. Finance Business Partners to assist budget holders 3. Fortnightly CIP Deep Dives 4. Monthly monitoring and reporting of performance against target 5. Monthly Financial Sustainability Delivery Group 6. Monthly Finance and Digital Committee scrutiny 7. Monthly and Quarterly executive reviews 8. NHSI monitoring through monthly Finance reporting		Catastrophic (5)	Likely - Weekly (4)	20
C2628COO	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Statutory	Chief Operating Officer	Quality and Performance Committee	The risk of regulatory intervention (including fines) and poor patient experience resulting from the non-delivery of appointments within 18 weeks within the NHS Constitutional standards.	1.The daily review of existing patient tracking list 2. Additional resource to support central and divisional validation of the patient tracking list. 3.Review of all patients at 45 weeks for action e.g. removal from list (DNA / Duplicates) or 1st OPA, investigations or TCI. 4. A delivery plan for the delivery to standard across specialities is in place 5. Additional non-recurrent funding (between cancer/ diagnostics and follow ups) to support the reduction in long waiting	1.RTT and TrakCare plans monitored through the delivery and assurance structures	Major (4)	Likely - Weekly (4)	16
S3038	Surgical	Quality	Medical Director		A risk of sub-optimal care for emergency surgery patients requiring surgical treatment caused by limited day time access to emergency theatres resulting in increased length of stay and poor patient experience.	1. Two slots are allocated in GRH to the gynaecology emergencies first thing 2. Regularly negotiate with other specialities to prioritise cases according to clinical need. 3.The vascular service in CGH reutilises their elective sessions to compensate for the inadequate emergency list provision	1. Task and Finish group in situ to review all possible mitigations, meeting weekly 2. Fit for the Future engagement process re emergency general surgery	Major (4)	Likely - Weekly (4)	16
C2895COO	Corporate, Gloucestershire Managed Services	Environmental	Chief Operating officer	Executive Management Team	Risk that patients and staff are exposed to poor quality care or service interruptions arising from failure to make required progress on estate maintenance, repair and refurbishment of core equipment and/or buildings, as a consequence of the Trust's inability to generate and borrow capital Risk that the Trust's future capital funding is with the resulting impact on business and service continuity.	1. Board approved, risk assessed capital plan including backlog maintenance 2. MEF and Capital Control Group 3. Capital funding issue and maintenance backlog escalated to NHSI 4. All opportunities to apply for capital made 5. Finance and Digital Committee oversight 6. GMS Committee and Board oversight	1. Prioritisation of capital managed through the intolerable risks process for 2019/20 2. Ongoing escalation to NHSI and system	Major (4)	Likely - Weekly (4)	16
F2335	Corporate, Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Finance	Chief Nurse	Finance and Digital Committee, People and OD Committee	The risk of agency spend in clinical and non-clinical areas exceeding planned levels due to ongoing high vacancy levels, with resulting impact of delivery of FY20 CIP programme	1. Challenge to agency requests via VCP 2. Agency Programme Board receiving detailed plans from nursing medical workforce and operations working groups 3. Finance agency report review on a 6 monthly basis 4. Turnaround Implementation Board 5. Quarterly Executive Reviews	Establish Workforce Committee Complete PIDs for each programme Reconfiguring Structures Agency Programme Board recieving detailed plans from nursing medical workforce and operational working groups 1. Convert locum/agency posts to substantive 2. Promote higher utilisation of internal nurse and medical bank 3. Implementation of healthRoster for roster and Bank management 4. implementation of Master Vendor Agreement for Nursing Agency - improving the control of medical agency spend and authorisation 5. Finalise job planning 6. Ongoing recruitment processes including international recruitment 7. Creation of new medical roles such as Associate specialists 8. Creation of a health and wellbeing hub aimed at reducing absence and reliance on costly temporary solutions	Major (4)	Likely - Weekly (4)	16
							Escalation Attempts to recruit 1. Agency/locum cover for on call rotas			

S2275	Surgical	Workforce	Medical Director	People and OD Committee, Trust Leadership Team	A risk of sub-optimal surgical staffing caused by a combination of insufficient trainees, senior staff and increased demand resulting in compromised trainee supervision, excessive work patterns and use of agency staff impacting on the ability to run a safe and high quality surgical rotas. Impact of any changes to non-contractual clinical support to services. Impact of any risk through workload leading to deanery withdrawal of trainees.	1. Guardian of Safe working Hours. 2. Junior doctors support 3. Staff support services available to staff 4. Mental health first aid services available to trainees in ED 5. Guardian of Safe working Hours.	2. Nursing staff clerking patients 3. Prioritisation of workload 4. exisiting junior doctors covering gaps where possible 5. consultants acting down 6. Ongoing recruitment for substantive and locum surgeons for rota including international opportunities 7. Health and well being hub will offer greater emotional well being services Launch of Locum's Nest software for advertising and allocating locum shifts	Major (4)	Likely - Weekly (4)	16
C2667NIC	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Director of Quality and Chief Nurse	Infection Control Committee, Quality and Performance Committee	The risk to patient safety and quality of care and/or outcomes as a result of hospital acquired C .difficile infection.	1. Annual programme of infection control in place 2. Annual programme of antimicrobial stewardship in place 3. Action plan to improve cleaning together with GMS	1. Delivery of the detailed action plan, developed and reviewed by the Infection Control Committee. The plan focusses on reducing potential contamination, improving management of patients with C.Diff, staff education and awareness, buildings and the envi	Major (4)	Likely - Weekly (4)	16
S3035	Surgical	Workforce	Medical Director	Divisional Board	A risk to safe service provision caused by an inability to provide an appropriate training environment leading to poor trainee feedback which could result in a reduction in trainee allocation impacting further on workforce and safety of care	1. Current service configuration does not lend itself to creating an environment for improved training and therefore the risk of poor feedback and the associated implications are not mitigated.	1.Fit for the Future engagement process re emergency general surgery 2.Task and Finish group in situ to review all possible mitigations, meeting weekly	Catastrophic (5)	Possible - Monthly (3)	15
S3036	Surgical	Quality	Medical Director	Divisional Board	A risk of sub-optimal care for patients with specialist care and other sub-specialty conditions caused by a lack of ability to create sub-specialty rotas resulting in inequitable care and different clinical outcomes	An upper GI surgeon is the on call surgeon approximately 50% of the time so patients admitted with gallbladder disease when this is the case do get this optimal treatment. In the event of UGI elective theatre cases being cancelled or DNA emergency gallbladder disease cases may be operated on due to unexpected surgeon availability.	1. Lap Chole Pathway Mapping workshop	Moderate (3)	Almost certain - Daily (5)	15
C1798COO	Medical, Surgical	Quality	Chief Operating Officer	Quality and Performance Committee	The risk of delayed follow up care due outpatient capacity constraints all specialities. (Orthodontics; ENT; Urology; Oral Surgery; Diabetic Medicine; Paediatric Urology; Endocrinology; Cardiology; Paediatric Surgery; Neurology; Colorectal and GI Surgery) Risk to both quality of care through patient experience impact(15)and safety risk associated with delays to treatment(4).	1. Speciality specific review administratively of patients (i.e. clearance of duplicates) (administrative validation) 2. Speciality specific clinical review of patients 3. Utilisation of existing capacity to support long waiting follow up patients 4.Weekly review at Check and Challenge meeting with each service line 5.Do Not Breach DNB (or DNC)functionality within the report for clinical colleagues to use with 'urgent' patients. 6. Use of telephone follow up for patients - where clinically appropriate 7. Additional capacity (non recurrent) for Ophthalmology and ENT specialities to support follow up capacity 8. Review of good practice across Divisions to feed through to corporate approach	1. Revise systems for reviewing patients waiting over time 2. Assurance from specialities through the delivery and assurance structures to complete the follow-up plan 3. Additional provision for capacity in key specialiities to support f/u clearance of backlog	Moderate (3)	Almost certain - Daily (5)	15
M2473Emer	Medical	Quality	Director of Quality / Chief Nurse	Divisional Board, Quality and Performance Committee, Trust Leadership Team	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	1. CQC action plan for ED 2. Development of and compliance with 90% recovery plan	Moderate (3)	Almost certain - Daily (5)	15
						Criteria of patients suitable for transfer to SAU is in place (e.g. NEWS < 2 and specific conditions described in SOP that are suitable for SAU) Limited (one wte) ANP cover for SAU with a plan in place for training of additional ANPs	1.Transformation Delivery Group 2. Risk to be discussed at Surgical Board 3. Fit for the Future engagement process re emergency general surgery			

S2930	Surgical	Quality	Director of Safety and Medical Director	Trust Leadership Team	A risk to patient safety caused by insufficient senior surgical cover resulting in delayed senior assessment and delays to urgent treatment for patients.	plan in place for training of additional ANP's. Current cover (1) Medical: team cover admissions and operating theatre (reducing availability of senior decision makers when they are operating). Consultant 24/7, Specialty trainee (registrar) 24/7, CT (sho) 08:00-00:00, F1 24/7 (2) ANP: 1 wte 37.5 hours/week (3) Nursing: SAU coordinator (band 5/6) 3 trained and 3 HCA (3/2 overnight). Minimum of 1 trained and 1 HCA cover SAU chair area (Bay C) Discretionary informal mitigations by our medical staff include reviewing and operating on emergency patients in the evening, taking emergency patients to elective lists in the event of elective cancellations / DNA's / under-running lists, second Saturday ward round which is unfunded and not job planned, flexibility from juniors in the event of rota gaps	4. Task and Finish group in situ to review all possible mitigations, meeting weekly	Moderate (3)	Almost certain - Daily (5)	15
C2819N	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Director of Quality and Chief Nurse	Quality and Performance Committee	The risk of serious harm to the deteriorating patient as a consequence of inconsistent use of NEWS2 which may result in the risk of failure to recognise, plan and deliver appropriate urgent care needs	Ongoing education on NEWS2 to nursing, medical staff, AHPs etc o E-learning package o Mandatory training o Induction training o Targeted training to specific staff groups, Band 2, Preceptorship and Resuscitation Study Days o Ward Based Simulation o Acute Care Response Team Feedback to Ward teams o Following up DCC discharges on wards • Use of 2222 calls – these calls are now primarily for deteriorating patients rather than for cardiac arrest patients • Any staff member can refer patients to ACRT 24/7 regardless of the NEWS2 score for that patient • ACRT are able to escalate to any department / specialist clinical team directly • ACRT (depending on seniority and experience) are able to respond and carry out many tasks traditionally undertaken by doctors o ACRT can identify when patient management has apparently been suboptimal and feedback directly to senior clinicians	Monthly Audits of NEWS2. Assessing completeness, accuracy and evidence of escalation. Feeding back to ward teams Development of an Improvement Programme	Major (4)	Possible - Monthly (3)	12
C2669N	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Chief Nurse/ Quality Lead	Quality and Performance Committee, Trust Leadership Team	The risk of harm to patients as a result of falls	1. Patient Falls Policy 2. Falls Care Plan 3. Post falls protocol 4. Equipment to support falls prevention and post falls management 5. Acute Specialist Falls Nurse in post 6.Falls link persons on wards 7. Falls monitored and reported at the Health and Safety Committee and the Quality and Performance Committee	4. Discussion with Matrons on 2 ward to trial process 1. Falls training 2. HCA specialist training 3. #Litle things matter campaign 4. Discussion with matrons on 2 wards to trial process	Major (4)	Possible - Monthly (3)	12
M2268Emer	Medical	Safety	Director of Quality and Chief Nurse	Divisional Board, Trust Leadership Team	The risk of patient deterioration (Safety) due to lack of capacity leading to ED overcrowding with patients in the corridor	1.RGN and HCA now identified on every shift to have responsibility for patients in the ambulance assessment corridor. 2. Where possible room 24 to be kept available to rotate patients 9(or identified alternative where 24 occupied) (GRH) 3. 8am - 12mn consultant cover 7/7 (GRH) reviewed by fire officers 4. Safety checklist; 5. Escalation to silver/gold on call for extra help should the department require to overflow into the third (radiology) corridor. 90% recovery plan May 2019.	1. Complete CQC action plan 2. Compliance with 90% recovery plan 3.Silver QI project undertaken to attempt to improve quality of care delivered in corridor inc. fleeced single use blankets and introduction of patient leaflet to allow for patients to access PALS.	Moderate (3)	Likely - Weekly (4)	12
C3034N	Medical, Surgical	Safety	Director of Quality and Chief Nurse	Quality and Performance Committee	The risk of patient deterioration, poor patient experience, poor compliance with standard operating procedures (high reliability)and reduce patient flow as a result of high registered nurse vacancies within adult inpatient areas at Gloucestershire Royal Hospital and Cheltenham General Hospital.	1. Temporary Staffing Service on site 7 days per week. 2. Twice daily staffing calls to identify shortfalls at 9am and 3pm between Divisional Matron and Temporary Staffing team. 3. Out of hours senior nurse covers Director of Nursing on call for support to all wards and departments and approval of agency staffing shifts. 4. Band 7 cover across both sites on Saturday and Sunday to manage staffing and escalate concerns. 5. Safe care live completed across wards 3 times daily shift by shift of ward acuity and dependency, reviewed shift by shift by divisional senior nurses. 6. Master Vendor Agreement for Agency Nurses with agreed KPI's relating to quality	To review and update relevant retention policies Set up career guidance clinics for nursing staff Review and update GHT job opportunities website Support staff wellbing and staff engagment Assist with implementing RePAIR priorities for GHFT and the wider ICS Devise an action plan for NHSi Retention programme - cohort 5 Trustwide support and Implementation of BAME agenda Devise a strategy for international recruitment	Moderate (3)	Likely - Weekly (4)	12

C2997RadSafety	Corporate, Diagnostics and Specialties, Medical, Surgical	Statutory	Medical director	Other, People and OD Committee, Radiation Safety Board, Trust Health and Safety Committee	The risk of statutory prosecution due to failure to comply with the Ionising Radiation (Medical Exposure) Regulations 2017. Failure to comply the CQC Improvement Notice, specifically the requirement for sufficient written procedures as defined in schedule 2 of IR(ME)R (a)-(n)and a suitable governance structure by 24 October 2019.	1.Radiation Protection Advisors in place to advise specialties 2. Some procedures in place i.e. Radiology (although outdated) 3. Practices in place in specialties 4. Radiation Safety Committee reports to H&S Committee 5. Radiation Safety Policy 6. Radiation Risk Assessments 7. Training packages available for practitioner or operator engaged by the employer to carry out exposures 8. Reviews are undertaken at a local level, to evaluate the reasons why diagnostic reference levels (DRLs)have been consistently exceeded 9. Local practices to protect those of child bearing age 10. Clinical audit programme 11. Information about effects of ionising radiation and education about dose and reporting 12. Dose constraints for research exposures where no direct medical benefit for the individual is expected 13. Guidance for carers and comforters 14. Clinical evaluation of the outcome of each exposure, other than exposures to carers and comforters, is recorded. 15. Audit records (for some specialties only) 16. Written instructions and information in cases where radioactive substances are administered	Weekly update calls with Emma Wood Set up task and finish group Review governance for radiation safety Increase the frequency of the Radiation Safety Committee. Chair to pass to Mark Pietroni Run briefing session for Risk Managers and Workshops for Radiation Leads To produce a suitable quality set of IRMER Procedures and SOPs To produce a suitable set of IRMER procedures and SOPs	Major (4)	Possible - Monthly (3)	12
C1945NTVN	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Director of Quality and Chief Nurse	Quality and Performance Committee	The risk of moderate to severe harm due to insufficient pressure ulcer prevention controls	1. Evidence based working practices including, but not limited to; Nursing pathway, documentation and training including assessment of MUST score, Waterlow (risk) score, Anderson score (in ED), SSKIN bundle (assessment of at risk patients and prevention management), care rounding and first hour priorities. 2. Tissue Viability Nurse team cover both sites in Mon-Fri providing advice and training. 3. Nutritional assistants on several wards where patients are at higher risk (COTE and T&O) and dietician review available for all at risk of poor nutrition. 4. Pressure relieving equipment in place Trust wide throughout the patients journey - from ED to DWA once assessment suggests patient's skin may be at risk. 5. Trustwide rapid learning from the most serious pressure ulcers, RCAs completed within 72 hours and reviewed at the weekly Preventing Harm Improvement Hub.	1. To create a rolling action plan to reduce pressure ulcers 2. Amend RCSA for presure ulcers to obtain learning and facilitate sharing across divisions 3. Sharing of learning from incidents via matrons meetings, governance and quality meetings, Trust wide pressure ulcer group, ward dashboards and metric reporting. 4. NHS collabborative work in 2018 to support evidence based care provision and idea sharing Discuss DoC letter with Head of patient investigations Advise purchase of mirrors within Division to aid visibility of pressure ulcers update TVN link nurse list and clarify roles and responsibilities implement rolling programme of lunchtime teaching sessions on core topics TVN team to audit and validate waterlow scores on Prescott ward	Moderate (3)	Likely - Weekly (4)	12
C2817COO	Corporate, Gloucestershire Managed Services	Safety	Chief Operating officer	Divisional Board, Executive Management Team	Risk of fire in Tower Block ward ducts/vents due to build up of dust over many years. Wards needs to be empty for 24 hrs to clean ducts	1.Fire dampers are installed and tested annually by GMS. 2.Ward 9A cleaning complete. 3.Tender for remedial works complete and available to call off. 4.GMS minimise risk of spark or electrical failure within ductwork through control of works and lack of electrical installations in ductwork. Kit being ordered	Duct cleaning only possible when ward is fully decanted. Implement ward closure programe to provide access to undertake the works. Ward 3B being assessed for ability to undertake works this Summer	Catastrophic (5)	Rare - Less than annually (1)	5

Appendix 3

PROPOSED CHANGES TO THE RISK MANAGEMENT PROCESS

1.1 Risk Appetite

The Risk Management Strategy describes the Trust's risk appetite as follows:

	Relative willingness to accept risk				
	Low		Medium		High
	1	2	3	4	5
Safety					
Quality					
Workforce					
Statutory					
Reputation					
Business					
Finance					
Environmental					

1.2 It was recommended and agreed at the last RMG that consideration should be given to realigning escalation scores to match the risk appetite. Using the current scoring of 12 as a starting guide, one proposal would be to escalate to the Trust Risk Register (TRR) if it has a risk rating score of:

- **12 or more for safety and statutory**; or
- **15 or more for quality and finance**; or
- **16 or more for workforce, reputation, business or environment**; or
- a **consequence of 5 and a likelihood of 2**; and
- **it is outside of the control of the divisional leads to reduce the risk to an acceptable level in the immediate future**

1.3 Based on the current risk register this would mean that risk S3035 which scores 15 for workforce and risk C2895COO which scores 15 for environment would not be escalated beyond the divisional risk register. Equally risk C2817COO and risk S2568Anaes have a consequence of 5 with a likelihood of 1 so would remain at divisional level.

1.6 Alternatively the risk appetite table could be reviewed based on the new Trust objectives and then realign the risk register.

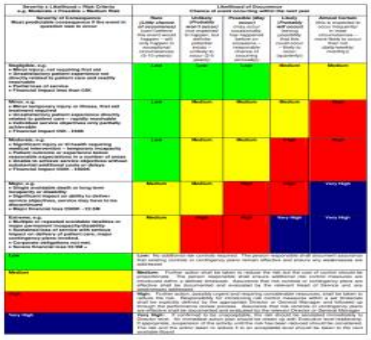
1.7 Risk Domains

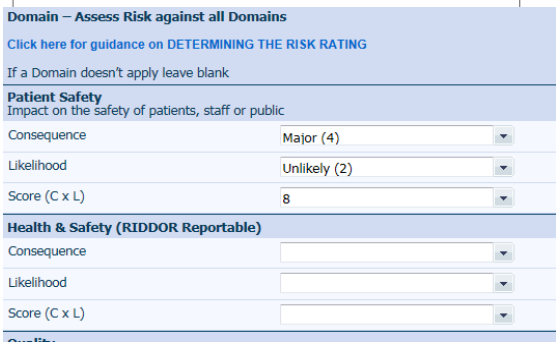
It was reported in July that whilst there are 8 domains identified in the Risk Management Strategy, there are 9 domains on Datix. Safety scores have been split between Patient Safety, which is actually defined as patient, staff or public safety and H&S RIDDOR scoring (see below). However, the score guidance for both is identical and so should result in the same score in either. Further, RIDDOR data is lifted from the incident module on DATIX.

1.8 It was agreed by RMG that the RIDDOR score could be removed. However, the RMG wished to ensure that there was no National Metric which required this domain. The Quality team and confirmed that it is not required. It will now be removed from DATIX.

- 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.





1.9 Risk score weighting

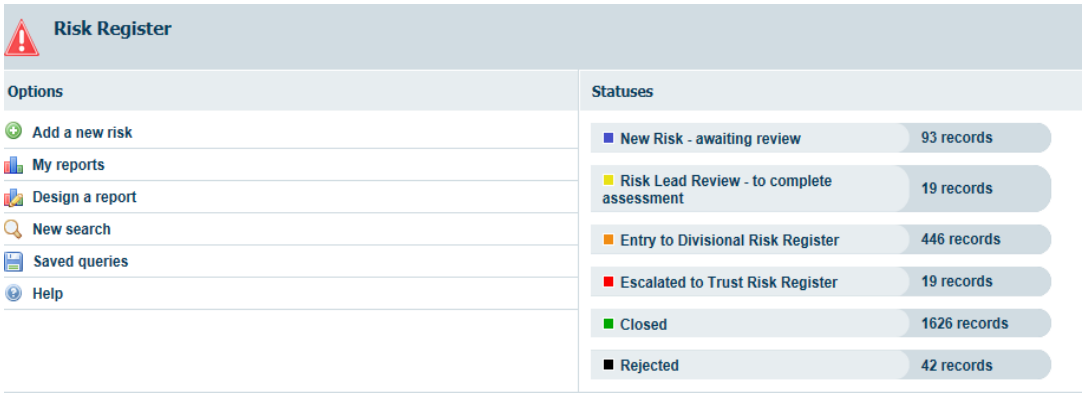
It was recommended at the last RMG that consideration is given using weighted scoring as shown below. This still uses a 5 x 5 matrix and carries the same definition as used by the Trust at present. However, it results in a more accurate, risk sensitive risk rating, with only the 3 highest scores falling into the extreme category rather than the current 6.

1.10 This would result in the following risk ratings:

- **Low risk: 1 - 3**
- **Medium risk: 4 - 9**
- **High risk: 10 - 16**
- **Very high risk : 20 - 25**

1.11 Local Risk Register

At the July RMG it was recommended that a local risk register was identified on DATIX as there is no specific local risk register on Datix for risks of 6 and under – these remain in the sections 'awaiting review' or 'awaiting assessment'; even if they have been reviewed and assessed.



1.12 Further work has since taken place to establish the criteria for entry onto the local risk register and a current risk rating of 5 or more is proposed. Setting this at 5 would capture all risks with a consequence of 5 regardless of likelihood and all risks with a likelihood of 5 regardless of the consequence.

1.13 It is proposed that hazards scoring 4 or less are sufficiently managed and do not necessitate monitoring via the risk register process. Under the legislation, only significant risks must be recorded and the risk register is simply a log of those risks. Low scoring risks will be managed and reviewed annually via the normal risk assessment process.

1.14 Applying this criterion to the current risks on the register, 13 risks scoring 4 or less would be removed from the risk register.

REPORT TO MAIN BOARD – November 2019

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

This report describes the business conducted at the Quality and Performance Committee on 30th October, indicating the NED challenges, the assurances received, and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Quality Strategy	Final draft Strategy document presented. Extensive engagement and feedback through the Trust noted		Strategy welcomed	Consider how future reporting into Q and P adapts to cover strategy objectives
Electronic Patient Record	Positive reporting re plan and timescales. All currently RAG rated green.	Have risks re prescribing been considered? Is e learning effective as training approach? Is there sufficient hands on / doing learning? What resilience is there for 'pushing through' training at immediate proximity to go live?	Risk assessment will form part of detailed planning. E learning not principle training route, classroom/ward based preferred Focus on completeness of training, trajectory likely to be met. Comparative training levels discussed, evidence from Digital Board discussions. Awareness of need for on ward presence, plans for floor walking and other support described	There will be challenging changes to work flow 2 week pilot critical.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
7 day services	Report on recent detailed audit of 2 non complaint standards (St 2 and 8) Helpful clarity on current position St 2 Time to first consultant review St 8 Ongoing patient review	Can we learn anything form elsewhere who are achieving these standards? Is there a link to 'flow' work? Can we focus on impact for patients whose consultant review is delayed? Where are these risks held? What is timescale aimed for compliance with standards	Yes, important to note patients can be reviewed and discharged at Registrar level Divisional level and visible/profile in Divisional reviews	Acknowledged that there is a need to look at 7 day services across ICS and elsewhere. Committee challenges will be addressed and included in future submissions
Performance Framework	Detailed report outlining performance framework to support Divisions in the delivery of trusts key objectives. Based on Trust values.	What is time period between current state and fully embedded framework?	Comprehensive and welcome framework. Framework is iterative. May take 2- 3 months. Executives responses and behaviours important to embed. Expectation of full exec presence at review meetings unless on leave	First exception report to come to Q and P Committee in Q4
Infection control report	Quarterly report on key HCAI metrics, noting MRSA, C diff positions. Focus on hand hygiene at point of care Surgical site infection (SSI) also included, large and small bowel rates similar to national benchmark Spinal rates higher	Spinal surgery SSI, where is the risk held and what mitigation?	Owned by the Division. Change in practice, spinal theatre annex now not used for unscheduled care patients.	SSI update will be included in quarterly HCAI reports to Q and P committee

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	than benchmark			
Quality and Performance report	Detailed data and analysis of key quality and performance indicators. RTT above trajectory 52 week wait within trajectory and improving 4 Hours (Trust) 84% , 6% increase in attendances. Current Quality Summits for Falls with harm Hospital acquired pressure ulcers Clinical Harm review process shared	What is position with pts with mental health issues without a decision to admit, do we know how many and what experience? What is split of pts waiting over 4 hours in time periods? Re ED escalation area waits, does the system 'own' the risks or within the Trust solely? When will review process be fully implemented? Poor quality discharges an issue within medicine, is it limited to medicine? How does QDG review in a lateral way?	ED escalation area waits fully owned across the Trust, more work on system ownership of risks needed. Implementation now through Divisions. Evidence of cross cutting themes being addressed through QDG. The BIg Room, recent case study, poor discharge	Data will be reviewed and updated for future Q and P to include time spent in ED after 4 hours and pts with MH needs. Report back to Q and P in January 2020
Integrated Care System	System winter planning meeting very positive, much reduced gap in bed deficit, signed off at AE Delivery Board.		Assurance received from National Director for Urgent Care on information given by the system	Paper going to Trust Board in December

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Corporate Risk Register and Board Assurance Framework	New risks noted, including emergency general surgery and controls and mitigations discussed. C3034N Risk of pt deterioration, poor experience due to adult nursing vacancies on both sites, S2275, 2930,3036, 3038 C2997 Radiology safety, as a result of recent CQC visit. Revised Board Assurance Framework presented. Key controls less in number and themed	Re radiology, are you confident accurate reporting? How confident no harm in governance structure? Are CQC aware of this new risk?	Redefined and strong governance with MD chairing radiation group, reporting exceptions into DQG and Q and P. All radiation incidents compulsory reporting through datix and to CQC. Divisional performance covered within new performance framework and use of compliance audits. Significant positive work since previous version noted. Clarity on key controls.	cross reference key controls and data seen at Q and P to ensure alignment.

Committee effectiveness survey results noted, Model values consistent with org values and culture. Continued development includes focus on timeliness of papers distribution, agenda timings, prioritisation of agenda items, assurance lens of papers presented, development and induction of members.

Alison Moon
Chair of Quality and Performance Committee

TRUST MAIN BOARD – NOVEMBER 2019
THE LECTURE HALL, REDWOOD EDUCATION CENTRE, GRH
commencing at 12.30pm

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

Purpose

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

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

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

Quality Summits

Hospital Acquired Pressure Ulcers (HAPU)
This quality indicator is in the Quality Summit process and there is an improvement plan being developed. The Tissue Viability Team were involved in the Quality Summit and have attended the NHSI Improvement Collaborative event. Our learning from the quality summit event was that the focus needs to be on prevention and making risk assessments easy for staff. The new EPR digital system will capture HAPU risk assessments and actions in response to risk assessments.

Actions for improvement
- All hospital acquired pressure ulcers are reviewed by ward teams to identify learning.
- Medicine and Surgery have plans to respond and reduce pressure ulcers within their clinical areas.
- The Preventing Harm Hub continues to provide rapid feedback on the high impact actions required, the ward team are tasked to produce evidence of an improvement that is taken through the divisional pressure ulcer groups.
- Through the EPR we will have improved records and be able to undertake electronic audit real time audit.

Falls (with injurious harm)
This quality indicator is in the Quality Summit process and there is an improvement plan being developed. There has been an overall decrease in the incidence of falls in a 12 month rolling period of 14%, however this has not been associated with a decrease in harm from falls which has risen slightly as a proportion of the total. The 12-month rolling average falls per 1000 bed days is 6.5. The 12-month rolling average falls with harm per 1000 bed days is 5.4. We currently have a CQUIN to fully implement the Three High Impact Actions to Prevent Hospital Falls and we are 27% compliant achieving minimum target of 25% (maximum 80%).

Performance

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

In September 2019, the trust performance against the 4 hour A&E standard was 84% including system performance was 89.13% with 6% increase in attendances. Quarter two performance was 91.11%. A 90% recovery plan has been completed and is being monitored at the Unscheduled Care leaders meeting, which is aligned to the preparation for Winter Planning. Internally the review of the winter plan is in place weekly; system support has been sought via A&E Delivery Board.

In respect of RTT, we are reporting 81.38% for September 2019, whilst this is below the national standard, this is above the trajectory set with NHS I. Operational teams continue to monitor and manage the long waiting patients on the Referral to Treatment pathways. As reported previously to the Board we will continue to see 52 week breaches, teams are working hard to address the key specialties in this regard, further information is provided within the exception report. The Trust is currently achieving the trajectory agreed with NHS Improvement to reduce our long waiting patient breaches.

Our performance against the cancer standard saw delivery in delivery for the 2 week standard at 96.5% (un-validated) performance is subject to significant fluctuations in referral rates. Indications are that performance for October will also be met for this standard.

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

Cancer 62 day Referral to Treatment (GP referral) performance for September was 70.7% (un-validated).

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

<u>Key issues to note</u>

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

RTT performance has been sustained above the agreed trajectory and has remained stable since re-reporting in March, likewise the number of 52 week waiting patients, albeit unacceptable has maintained a downward trajectory and is within the locally agreed trajectory.
Diagnostic 6 week wait continues to deliver to the national performance standards.
For Cancer Delivery we have engaged the support of NHS I to facilitate our timed pathways and prepare for the 28 day standards.

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

Improvements to the Quality and Performance Report continue with further changes and reviews in the first & second quarter of 19/20, noting exception reports have been developed to support

additional areas alongside the full QPR.
Recommendations
The Trust Board is requested to receive the Report as assurance that the Executive team and Divisions fully understand the current levels of poor performance and have action plans to improve this position.
Impact Upon Strategic Objectives
Current performance jeopardises delivery of the Trust's strategic objective to improve the quality of care for our patients.
Impact Upon Corporate Risks
Continued poor performance in delivery of the two national waiting time standards ensures the Trust remains under scrutiny by local commissioners and regulators.
Regulatory and/or Legal Implications
Non delivery of 52 week waiting patients subject to National fining regime.

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

Date the paper was presented to previous Committees						
Quality & Performance Committee	**Finance & Digital Committee**	**Audit & Assurance Committee**	**People & OD Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
✓						
Outcome of discussion when presented to previous Committees						
Committee indicated the exception reports provided clear analysis of the reasons for the performance & quality position. The key mitigations and the strength of the actions taken to support performance recovery where appropriate. Specific challenges to review our provision for time to mental health assessment, a review of this will be provided for inclusion in next month. In addition, the plan for operational changes to the outpatient programme was noted.						

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report

Reporting period September 2019

Presented at October 2019 Q&P and November 2019 Trust Board

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Gloucestershire Hospitals NHS Foundation Trust

Delivery of agreed action plans remains critical to restore operational performance to the expected levels. During September the Trust did not meet the national standards for 62 day cancer standard and the 4 hour standard.

The Trust performance (type 1) for the 4 hour standard in September was 84.03% against the STP trajectory at 85.61% against a backdrop of significant attendances. The system did not meet the delivery of 90% for the system in September, at 89.13%.

The Trust has met the diagnostics standard for September at 0.72%.

The Trust has met the standard for 2 week wait cancer at 96.50% in September, this is as yet un-validated performance at the time of the report.

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

For elective care, the RTT performance is above trajectory agreed with NHS I, work continues to ensure that the performance is stabilised. Significant work is underway to reduce our longest waiting patients of over 52 weeks, to date we have met the trajectory agreed with NHS I to reduce our breaches.

The Quality Delivery Group (QDG) continues to monitor the performance of the quality metrics with the Divisions providing exception reports. The delivery of any action plans to deliver improvement are also reviewed within the meeting. There are improvement plans in place for any indicators that have consistently scored in the “red” target area.

Performance Against STP Trajectories

Gloucestershire Hospitals NHS Foundation Trust

The following table shows the monthly performance of the Trust's STP indicators for 2019/20.
RAG Rating: The STP indicators are assessed against the monthly trajectories agreed with NHS Improvement.
Note that data is subject to change.

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

Summary Scorecard

Gloucestershire Hospitals NHS Foundation Trust

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

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

Safe

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

Effective

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

Caring

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

Responsive

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

Well Led

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

Demand and Activity

Gloucestershire Hospitals NHS Foundation Trust

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

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

Measure	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	% change from previous year Monthly (Sep)	YTD
GP referrals	12,842	15,690	14,814	11,965	14,521	13,202	14,044	13,094	13,415	12,709	12,061	10,302	10,429	-18.79%	-11.69%
OP attendances	12,318	14,284	14,707	11,084	14,083	12,474	13,525	12,663	13,025	13,063	13,856	11,850	13,534	9.87%	-1.22%
Day cases	5,793	6,828	6,766	5,833	6,167	5,995	6,318	5,815	6,520	6,198	6,955	6,348	6,276	8.34%	8.76%
All electives	6,831	7,901	7,877	6,837	7,124	6,955	7,465	7,255	7,556	7,213	8,096	7,378	7,238	5.96%	7.6%
ED attendances	12,488	12,610	12,230	12,639	12,962	11,701	13,245	12,949	13,618	13,072	14,066	13,267	13,240	6.02%	6.52%
Non electives	4,668	4,878	5,088	5,081	5,132	3,085	4,900	4,696	4,861	4,586	4,802	4,698	4,833	3.53%	0.97%

Trust Scorecard – Safe (1)

OVERALL SCORE

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

	18/19	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	19/20 Q2	19/20	Standard	Threshold
Infection Control																		
Number of trust apportioned MRSA bacteraemia	1	2	0	0	0	0	0	1	0	1	0	0	0	1	1	2	Zero	
MRSA bacteraemia – infection rate per 100,000 bed days									0	3.5	0	0	0	3.6	1.2	1.2	Zero	
Number of trust apportioned Clostridium difficile cases per month	56	3	4	4	1	6	5	4	7	6	7	10	9	9	29	49	2019/20: 114	
Number of hospital-onset healthcare-associated Clostridioides difficile cases per month												7	6	1	14	23	<=5	
Number of community-onset healthcare-associated Clostridioides difficile cases per month												3	4	8	15	26	<=5	
Clostridium difficile – infection rate per 100,000 bed days									24.7	20.8	25.5	35.7	32.5	32.8	33.7	28.6	<30.2	
Number of MSSA bacteraemia cases	164	14	9	4	2	25	30	31	0	1	1	4	1	2	7	9	<=8	
MSSA – infection rate per 100,000 bed days								31		3.5	3.6	14.3	3.6	7.3	8.4	5.4	<=12.7	
Number of ecoli cases	295	32	25	4	3	39	41	44	5	4	5	1	4	3	8	22	No target	
Number of pseudomona cases	59	3	3	1	0	11	12	12	1	0	0	2	1	0	3	4	No target	
Number of klebsiella cases	135	10	7	3	2	25	28	31	1	3	1	1	3	4	10	25	No target	
Number of bed days lost due to infection control outbreaks									40	66	83	70	136	0	206	395	<10	>30
Patient Safety Incidents																		
Number of patient safety alerts outstanding	5								5	1	0	0	0	0	0	5	Zero	
Number of falls per 1,000 bed days		7.5	7.3	6.8	7.2	6.8	7.1	6	6.6	6	5.3	6.6	5.5	6.2			<=6	
Number of falls resulting in harm (moderate/severe)	8	9	8	6	8	8	2	7	3	4	2	7	1	5			<=3	
Number of patient safety incidents – severe harm (major/death)	1	2	1	0	1	0	3	7	13	7	9	4	12	4			No target	
Medication error resulting in severe harm								0	0	0	0	0	0	0			No target	
Medication error resulting in moderate harm								1	1	3	0	2	3	1			No target	
Medication error resulting in low harm								12	10	15	10	11	11	10			No target	
Number of category 2 pressure ulcers acquired as in-patient									43	36	28	38	36	30			<=30	
Number of category 3 pressure ulcers acquired as in-patient									10	7	7	6	6	4			<=5	

Trust Scorecard – Safe (2)

OVERALL SCORE

	18/19	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	19/20 Q2	19/20	Standard	Threshold
Patient Safety Incidents																		
Number of category 4 pressure ulcers acquired as in-patient									0	0	0	0	0	0			Zero	
Number of unstagable pressure ulcers acquired as in-patient									3		3	14	12	5			<=3	
Number of deep tissue injury pressure ulcers acquired as in-patient								6	10	14	2	8	7	2			<=5	
RIDDOR																		
Number of RIDDOR		5	4	1	4	1	3	3	2	2	1	3	2	1	6		SPC	
Safeguarding																		
Level 2 safeguarding adult training - e-learning package													93.00%				TBC	
Number of DoLs applications authorised													0				TBC	
Safety Thermometer																		
Safety thermometer – % of new harms		98.60%	98.50%	97.90%	97.30%	97.30%	97.70%	97.20%	96.20%	97.20%	98.10%	97.40%	97.90%	96.30%			>96%	<93%
Sepsis Identification and Treatment																		
Proportion of emergency patients with severe sepsis who were given IV antibiotics within 1 hour of diagnosis						88.00%	81.00%	82.00%			64.00%			64.70%			>=90%	<50%
Serious Incidents																		
Number of never events reported	1	0	0	0	0	0	0	1	1	0	0	1	0	0			Zero	
Number of serious incidents reported		4	2	1	1	3	0	3	2	3	4	2	1	5			No target	
Serious incidents – 72 hour report completed within contract timescale		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%			>90%	
Percentage of serious incident investigations completed within contract timescale		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%			>80%	
VTE Prevention																		
% of adult inpatients who have received a VTE risk assessment	93.20%	93.80%	94.80%	95.40%	90.70%	96.60%	94.20%	94.80%	95.40%	88.60%	95.80%	96.70%	92.90%	91.60%	93.80%	93.50%	>95%	

Trust Scorecard – Effective (1)

OVERALL SCORE

	18/19	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	19/20 Q2	19/20	Standard	Threshold
Dementia Screening																		
% of patients who have been screened for dementia (within 72 hours)	1.90%	2.30%	1.80%	2.60%	3.30%	1.90%	0.80%	0.60%	0.40%	0.30%	67.00%	66.00%	85.00%				>=90%	<70%
% of patients who have scored positively on dementia screening tool that then received a dementia diagnostic assessment (within 72 hours)	27.90%	18.20%	33.30%	22.20%	26.30%	40.00%	0.00%	33.30%	100%	50.00%	0.00%	0.00%	N/A				>=90%	<70%
% of patients who have received a dementia diagnostic assessment with positive or inconclusive results that were then referred for further diagnostic advice/FU (within 72 hours)	2.80%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	N/A	N/A	N/A				>=90%	<70%
Maternity																		
% C-section rate (planned and emergency)	26.78%							29.71%	28.93%	30.20%	29.19%	32.49%	25.61%	27.99%	28.83%	29.36%	<=25%	>=27%
% emergency C-section rate	14.13%							16.11%	16.31%	16.73%	15.78%	17.42%	14.02%	16.04%	15.84%	16.11%	No target	
% of women booked by 12 weeks gestation	89.80%	90.20%	89.40%	90.90%	89.60%	89.80%	90.50%	91.50%	89.70%	88.00%	87.90%	89.00%	85.30%	89.40%	87.70%	88.10%	>90%	
% of women that have an induced labour	29.19%							31.17%	29.13%	27.96%	28.99%	28.38%	26.83%	29.66%	28.31%	28.48%	<=20%	>25%
% of women smoking at delivery	11.21%	9.76%	12.43%	12.18%	12.28%	7.79%	13.05%	10.46%	12.06%	11.22%	11.83%	9.78%	10.16%	9.14%	9.68%	10.69%	<=14.5%	
% stillbirths as percentage of all pregnancies > 24 weeks	0.26%							0.21%	0.39%	0.00%	0.00%	0.38%	0.20%	0.19%	0.26%	0.19%	<0.52%	
Mortality																		
Summary hospital mortality indicator (SHMI) – national data	104.7	102.6			104.7												Dr Foster	
Hospital standardised mortality ratio (HSMR)	94.5	99.8	100.8	99.1	97.7	97.2	95.2	94.5	96.5	96.8						96.8	Dr Foster	
Hospital standardised mortality ratio (HSMR) – weekend	96.8	98.4	101.7	101.4	99.3	101.3	97.2	96.8	96.9	96.4						96.4	Dr Foster	
Number of inpatient deaths								168	165	159	166	125	124	143	392	882	No target	
Number of deaths of patients with a learning disability								2	4	1	1	2	2	0	4	10	No target	
Readmissions																		
Emergency re-admissions within 30 days following an elective or emergency spell	6.90%	6.40%	7.00%	6.00%	6.90%	6.50%	6.60%	6.30%	7.30%	7.10%	6.40%	6.30%	7.40%			6.90%	<8.25%	>8.75%
Research																		
Research accruals	1,621	121	199	96	84	71	81	91	115	119	134	123	103	76	301		No target	

Trust Scorecard – Effective (2)

OVERALL SCORE

	18/19	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	19/20 Q2	19/20	Standard	Threshold
Stroke Care																		
Stroke care: percentage of patients receiving brain imaging within 1 hour	36.90%	41.50%	34.30%	26.60%	31.90%	37.10%	32.70%	22.40%	52.10%	55.30%	43.80%	53.50%	50.60%	48.60%	51.10%	50.60%	>=50%	<45%
Stroke care: percentage of patients spending 90%+ time on stroke unit	90.80%	93.40%	80.70%	87.70%	91.90%	88.70%	84.10%	87.70%	85.70%	96.30%	87.10%	80.90%	98.80%			89.40%	>=80%	<70%
% of patients admitted directly to the stroke unit in 4 hours								51.70%	68.10%	62.70%	62.00%	67.90%	68.40%	62.00%	66.20%	65.20%	>=80%	<72%
% patients receiving a swallow screen within 4 hours of arrival								70.70%	52.10%	59.20%	63.80%	66.30%	64.90%	69.40%	66.80%	62.80%	>=90%	<80%
Trauma & Orthopaedics																		
% of fracture neck of femur patients treated within 36 hours	76.00%	85.50%	67.70%	70.10%	75.00%	83.90%	85.60%	77.80%	77.00%	81.80%	82.20%	67.10%	46.60%	66.70%	58.90%	69.50%	>=90%	<80%
% fractured neck of femur patients meeting best practice criteria								77.78%	77.78%	81.82%	80.49%	65.70%	45.21%	66.70%	57.80%	68.40%	>=65%	<55%

Trust Scorecard – Caring (1)

OVERALL SCORE

	18/19	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	19/20 Q2	19/20	Standard	Threshold
Friends & Family Test																		
Inpatients % positive	91.20%	91.90%	92.20%	90.90%	91.50%	91.90%	89.20%	91.50%	89.10%	90.80%	91.60%	90.70%	91.10%	91.50%	91.10%	90.80%	>=96%	<93%
ED % positive	83.10%	85.90%	82.70%	82.70%	81.00%	82.70%	82.80%	82.70%	82.70%	81.90%	85.30%	79.80%	83.30%	82.30%	81.90%	82.50%	>=84%	<81%
Maternity % positive	96.70%	0.00%	100%	98.20%	100%	100%	93.50%	97.50%	96.60%	97.00%	87.10%	96.20%	100%	96.90%	97.90%	95.80%	>=97%	<94%
Outpatients % positive	92.60%	92.30%	93.00%	92.50%	92.90%	93.40%	92.50%	93.10%	92.80%	93.20%	92.50%	92.80%	93.20%	92.70%	92.90%	92.90%	>=94%	<91%
Total % positive	91.20%	91.60%	91.80%	91.20%	90.90%	91.90%	90.70%	91.40%	90.60%	91.10%	91.40%	90.70%	91.30%	91.00%	91.00%	91.00%	>=93%	<90%
Inpatient Questions (Real time)																		
How much information about your condition or treatment or care has been given to you?									71.57%	77.35%	79.55%	79.67%	83.69%	77.40%		76.91%	>=90%	
Are you involved as much as you want to be in decisions about your care and treatment?								89.66%	94.06%	89.44%	89.65%	90.61%	95.03%	89.66%		90.55%	>=90%	
Do you feel that you are treated with respect and dignity?								99.32%	93.07%	97.16%	94.26%	96.09%	98.58%	99.32%		95.12%	>=90%	
Do you feel well looked after by staff treating or caring for you?									96.97%	97.71%	95.37%	98.33%	97.16%	99.31%		96.65%	>=90%	
Do you get enough help from staff to eat your meals?									95.96%	98.86%	95.93%	97.20%	97.17%	100%		97.08%	>=90%	
In your opinion, how clean is your room or the area that you receive treatment in?									96.88%	95.93%	95.81%	96.45%	96.40%	90.97%		96.09%	>=90%	
Do you get enough help from staff to wash or keep yourself clean?									96.97%	98.29%	94.74%	98.87%	97.86%	99.32%		96.63%	>=90%	
MSA																		
Number of breaches of mixed sex accommodation	68	0	7	2	6	2	1	3	4	11	18	16	11	9	36	69	<=10	>=20

Trust Scorecard – Responsive (1)

OVERALL SCORE

	18/19	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	19/20 Q2	19/20	Standard	Threshold
Cancer																		
Cancer – urgent referrals seen in under 2 weeks from GP	90.00%	82.80%	91.70%	90.40%	94.30%	92.00%	93.90%	95.20%	87.90%	86.50%	89.40%	92.70%	86.00%	96.50%	91.70%	90%	>=93%	<90%
2 week wait breast symptomatic referrals	95.80%	98.90%	99.20%	94.60%	97.70%	95.50%	97.00%	95.60%	96.90%	97.30%	99.00%	96.30%	98.40%	99.30%	97.80%	97.90%	>=93%	<90%
Cancer – 31 day diagnosis to treatment (first treatments)	94.60%	93.50%	93.30%	93.20%	94.20%	92.90%	91.60%	92.10%	92.00%	92.90%	93.50%	92.60%	92.30%	91.30%	91.90%	92.70%	>=96%	<94%
Cancer – 31 day diagnosis to treatment (subsequent – drug)	99.90%	98.80%	100%	100%	100%	100%	100%	100%	100%	96.20%	100%	100%	100%	100%	100%	99.40%	>=98%	<96%
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	95.30%	94.30%	98.30%	96.80%	92.90%	93.20%	96.60%	96.60%	94.00%	95.10%	100%	89.60%	89.80%	98%	92.30%	92.70%	>=94%	<92%
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	99.30%	100%	98.60%	98.70%	98.60%	100%	98.90%	98.70%	96.40%	97.50%	96.30%	100%	84.80%	80.80%	88.80%	93.50%	>=94%	<92%
Cancer 62 day referral to treatment (urgent GP referral)	74.80%	69.00%	69.40%	78.70%	74.90%	76.80%	66.20%	77.40%	79.70%	70.70%	66.50%	71.70%	74.10%	70.70%	73.10%	73.30%	>=85%	<80%
Cancer 62 day referral to treatment (screenings)	96.50%	85.50%	93.50%	93.80%	100%	94.10%	96.40%	100%	100%	96.60%	85.20%	84.60%	100%	100%	95.30%	94.90%	>=90%	<85%
Cancer 62 day referral to treatment (upgrades)	68.90%	75.00%	73.30%	58.80%	70.00%	71.40%	60.00%	77.30%	44.40%	57.10%	70.60%	100%	75.00%	71.40%	87.50%	67.60%	>=90%	<85%
Number of patients waiting over 104 days with a TCI date	141	26	7	13	8	8	8	14	20	15	20	18	13	9	40	95	Zero	
Number of patients waiting over 104 days without a TCI date	347	30	39	37	27	42	37	25	19	30	21	37	32	28	97	167	<=24	
Diagnostics																		
% waiting for diagnostics 6 week wait and over (15 key tests)	0.45%	0.63%	0.03%	0.35%	0.20%	0.67%	0.21%	0.45%	0.54%	0.67%	1.08%	0.76%	0.84%	0.72%	0.72%	0.72%	<=1%	>2%
The number of planned / surveillance endoscopy patients waiting at month end	726	576	630	680	686	639	600	726	835	872	966	770	714	756	756	756	<=600	
Discharge																		
Number of patients delayed at the end of each month	37	41	44	40	34	29	24	43	45	39	18	43	41	35	35	35	<=38	
Patient discharge summaries sent to GP within 24 hours	50.50%	51.80%	51.60%	49.10%	47.20%	51.90%	49.60%	51.00%	56.60%	54.60%	53.30%	57.90%	55.80%			55.70%	>=88%	<75%

Trust Scorecard – Responsive (2)

OVERALL SCORE

	18/19	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	19/20 Q2	19/20	Standard	Threshold
Emergency Department																		
ED: % total time in department – under 4 hours (types 1 & 3)	92.78%	92.47%	93.60%	93.98%	91.29%	89.02%	90.21%	91.00%	90.39%	91.70%	91.05%	92.20%	92.01%	89.13%	91.11%	91.09%	>=95%	<90%
ED: % total time in department – under 4 hours (type 1)	89.60%	89.01%	90.54%	91.59%	87.55%	84.46%	86.08%	87.13%	86.01%	87.99%	86.80%	88.53%	88.16%	84.03%	86.91%	87.50%	>=95%	<90%
ED: % total time in department – under 4 hours CGH	96.40%	96.40%	96.90%	96.94%	95.47%	93.70%	95.50%	96.10%	94.66%	96.04%	96.40%	95.44%	96.20%	92.68%	94.77%	95.24%	>=95%	<90%
ED: % total time in department – under 4 hours GRH	86.20%	85.20%	87.30%	89.06%	83.82%	80.10%	81.60%	82.80%	81.89%	84.16%	82.77%	85.09%	84.25%	79.90%	83.08%	83.01%	>=95%	<90%
ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Zero	
ED: % of time to initial assessment – under 15 minutes	87.40%	87.30%	88.80%	89.60%	85.40%	85.20%	83.60%	78.40%	75.80%	78.30%	77.30%	71.30%	75.70%	71.40%	72.80%	74.90%	>=95%	<92%
ED: % of time to start of treatment – under 60 minutes	33.50%	29.00%	36.70%	34.50%	32.10%	34.90%	32.40%	32.60%	32.00%	35.90%	37.20%	30.30%	31.20%	29.90%	29.90%	32.40%	>=90%	<87%
% of ambulance handovers that are over 30 minutes								7.90%	1.66%	1.28%	1.01%	1.25%	1.93%	2.48%	1.89%	1.37%	<=2.96%	
% of ambulance handovers that are over 60 minutes								0.10%	0.00%	0.00%	0.00%	0.00%	0.00%	0.02%	0.02%	0.02%	<=1%	>2%
Operational Efficiency																		
Number of patients stable for discharge	73	80	75	76	69	74	72	77	86	77	63	79	88	88	85	80	<=70	
% of bed days lost due to delays									4.74%	3.78%	2.24%	3.42%	4.26%	4.51%	4.51%	4.51%	<=3.5%	>4%
Number of stranded patients with a length of stay of greater than 7 days	384	376	374	382	374	399	412	397	389	391	370	371	360	371	367	375	<=380	
Average length of stay (spell)	5.05	5	5.05	5.14	4.83	5.14	5.35	5	5.03	5.35	4.85	4.87	4.79	4.9	4.85	4.97	<=5.06	
Length of stay for general and acute non-elective (occupied bed days) spells	5.66	5.58	5.72	5.77	5.29	5.7	6.07	5.67	5.53	5.99	5.42	5.5	5.3	5.43	5.41	5.53	<=5.65	
Length of stay for general and acute elective spells (occupied bed days)	2.71	2.75	2.47	2.84	2.89	2.59	2.67	2.65	2.78	2.68	2.55	2.56	2.69	2.64	2.62	2.65	<=3.4	>4.5
% day cases of all electives								84.60%	80.00%	86.28%	85.92%	85.91%	86.04%	86.71%	86.22%	85.18%	>80%	<70%
Intra-session theatre utilisation rate								84.70%	87.80%	88.49%	85.50%	87.40%	87.60%	87.70%	87.60%	87.50%	>85%	<70%
Outpatient																		
Outpatient new to follow up ratio's								1.93	1.92	1.91	1.9	1.87	1.9	1.73	1.83	1.87	<=1.9	
Did not attend (DNA) rates								6.40%	6.80%	6.80%	6.80%	7.00%	6.90%	7.40%	7.10%	7.00%	<=7.6%	>10%

Trust Scorecard – Responsive (3)

OVERALL SCORE

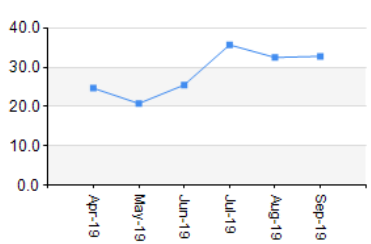
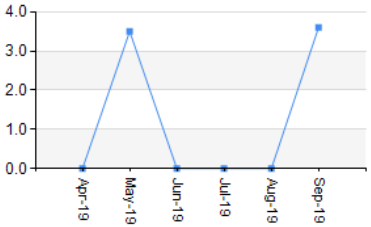
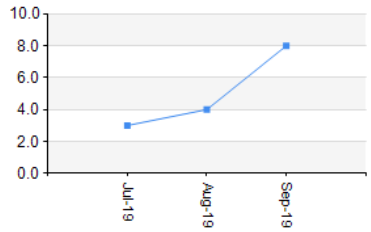
	18/19	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	19/20 Q2	19/20	Standard Threshold
RTT																	
Referral to treatment ongoing pathways under 18 weeks (%)								79.75%	79.46%	80.63%	81.11%	81.80%	81.41%	81.38%	81.38%	81.38%	>=92%
Referral to treatment ongoing pathways 35+ Weeks (number)								2,352	2,163	2,149	1,953	1,772	1,703	1,699	1,699	1,699	No target
Referral to treatment ongoing pathways 40+ Weeks (number)								1,860	1,699	1,748	1,626	1,437	1,378	1,390	1,390	1,390	No target
Referral to treatment ongoing pathways over 52 weeks (number)	95	105	103	105	97	89	97	95	93	91	90	78	77	78	78	78	Zero
SUS																	
Percentage of records submitted nationally with valid GP code	100%	100%	100%	100%	100%	100%	100%	100%	100%	99.90%	100%	100%				100%	>=99%
Percentage of records submitted nationally with valid NHS number	99.80%	99.80%	99.80%	99.80%	99.80%	99.80%	99.80%	99.80%	99.90%	99.40%	99.80%	99.80%				99.70%	>=99%

Trust Scorecard – Well Led (1)

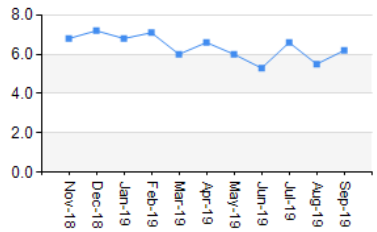
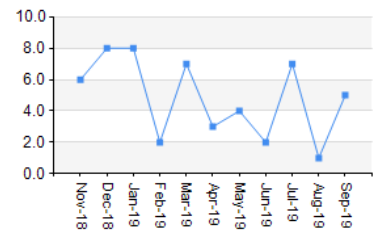
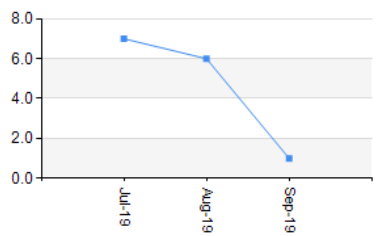
OVERALL SCORE

	18/19	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	19/20 Q2	19/20	Standard	Threshold
Appraisal and Mandatory Training																		
Trust total % overall appraisal completion	79.00%	79.00%	80.00%	79.00%	79.00%	79.00%	79.00%	81.00%	80.00%	81.00%	82.00%	83.00%	81.00%	79.00%		81.00%	>=90%	<70%
Trust total % mandatory training compliance	89%	90%	91%	91%	91%	89%	89%	91%	91%	91%	92%	92%	92%	91%		91%	>=90%	<70%
Finance																		
Total PayBill Spend		27.5	29.5	29.03	29.7	29.4	29.9	33.3	31.8	30.8	30.9	30.7	31.7	30.9				
YTD Performance against Financial Recovery Plan		0.2	0.2	0.4	0.04	-3	-6.6	-14.1	0.2	0.3	0.6	0.5	0.5	0.6				
Cost Improvement Year to Date Variance		2,975	2,994	2,013	1,593	0	-1,784	-3,378	0	1	1	2	2	2				
NHSI Financial Risk Rating		4	4	4	4	3	4	4	4	3	3	3	3	3				
Capital service		4	4	4	4	4	4	4	4	4	4	4	4	4				
Liquidity		4	4	4	4	4	4	4	4	4	4	4	4	4				
Agency – Performance Against NHSI Set Agency Ceiling		3	3	3	3	3	3	3	3	3	4	3	3	3				
Safe Nurse Staffing																		
Overall % of nursing shifts filled with substantive staff									96.55%	96.40%	95.10%	97.40%	95.40%	96.40%	96.38%	96.20%	>=75%	<70%
% registered nurse day									97.90%	97.90%	96.60%	98.70%	96.50%	97.40%	97.54%	97.50%	>=90%	<80%
% unregistered care staff day									97.00%	99.20%	99.40%	101.0%	99.40%	98.60%	99.67%	99.10%	>=90%	<80%
% registered nurse night									94.10%	93.50%	92.40%	94.80%	93.30%	94.50%	94.23%	93.80%	>=90%	<80%
% unregistered care staff night									100.3%	99.40%	104.8%	105.7%	105.3%	106.7%	105.9%	103.7%	>=90%	<80%
Care hours per patient day RN								6.2	4.61	4.6	4.7	4.8	4.7	4.7	4.7	4.7	>=5	
Care hours per patient day HCA								3.2	2.8	2.9	3	3	3	2.9	3	2.9	>=3	
Care hours per patient day total	7.1	6.8	7.2	7.1	7.3	7.3	7.2	8.1	7.4	7.5	7.7	7.8	7.6	7.6	7.7	7.6	>=8	
Vacancy and WTE																		
% total vacancy rate									9.03%	10.02%	9.54%	8.65%	8.60%	8.75%			<=11.5%	>13%
% vacancy rate for doctors									8.07%	8.86%	8.53%	8.20%	0.53%	0.53%			<=5%	>5.5%
% vacancy rate for registered nurses									12.09%	9.52%	9.42%	8.65%	8.65%	10.02%			<=5%	>5.5%
Staff in post FTE									6181.16	6150.11	6148.56	6171.97	6226.64	6305.28			No target	
Vacancy FTE									610	683	650	652.42	500	500			No target	
Starters FTE									65.5	52.8	45.2	66.66	60.55	163.94			No target	
Leavers FTE									55.14	37.5	57.4	44.69	46.75	83.14			No target	
Workforce Expenditure and Efficiency																		
% turnover	11.80%	12.10%	11.90%	11.60%	11.70%	11.70%	11.90%	12.20%	11.80%	11.60%	11.60%	11.80%	11.10%	11.70%			<=11%	>15%
% turnover rate for nursing	10.99%								1.09%	10.93%	10.87%	10.99%	10.77%	11.24%			<=11%	>15%
% sickness rate	3.90%	3.90%	3.90%	3.90%	3.90%	3.90%	3.90%	3.90%	3.90%	3.40%	3.80%	3.80%	3.90%	3.90%			<=3.5%	>4%

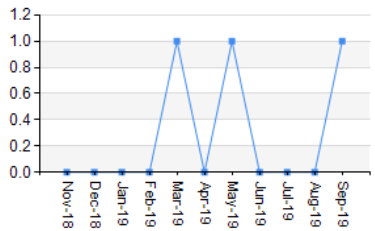
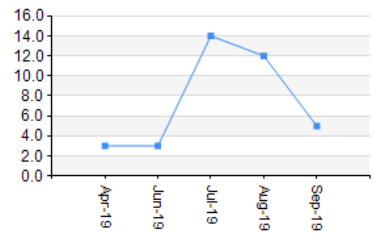
Exception Reports – Safe (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Clostridium difficile – infection rate per 100,000 bed days **Standard: <30.2**		We continue to be under trajectory for C. difficile infection	**Associate Chief Nurse and Deputy Director of Infection Prevention and Control**
MRSA bacteraemia – infection rate per 100,000 bed days **Standard: Zero**		There was one case of MRSA bacteraemia. this was a community-onset case however the blood culture was not collected from the patient when admitted and therefore this is assigned to the Trust.	**Associate Chief Nurse and Deputy Director of Infection Prevention and Control**
Number of community-onset healthcare-associated Clostridioides difficile cases per month **Standard: <=5**		There were 8 cases of community-onset, healthcare-associated cases during September. This is within expected and tolerable levels.	**Associate Chief Nurse and Deputy Director of Infection Prevention and Control**

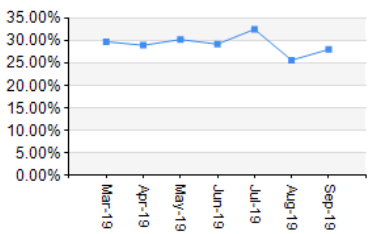
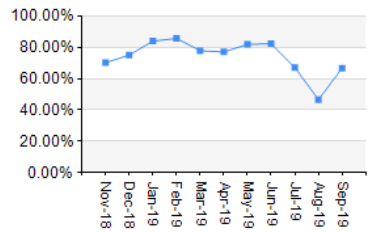
Exception Reports – Safe (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of falls per 1,000 bed days **Standard: <=6**		There has been an overall decrease in the incidence of falls in a 12 month rolling period of 14%, however this has not been associated with a decrease in harm from falls which has risen slightly as a proportion of the total. The 12-month rolling average falls per 1000 beddays is 6.5.	**Director of Safety**
Number of falls resulting in harm (moderate/severe) **Standard: <=3**		There has been an overall decrease in the incidence of falls in a 12 month rolling period of 14%, however this has not been associated with a decrease in harm from falls which has risen slightly as a proportion of the total. The 12-month rolling average falls with harm per 1000 beddays is 5.4.	**Director of Safety**
Number of hospital-onset healthcare-associated Clostridioides difficile cases per month **Standard: <=5**		There was 1 case of hospital-onset, healthcare-associated C. difficile during September. Significantly improved performance.	**Associate Chief Nurse and Deputy Director of Infection Prevention and Control**

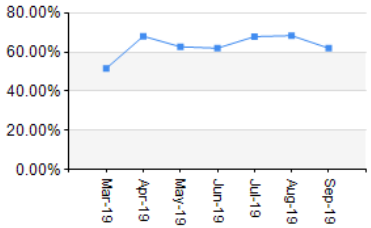
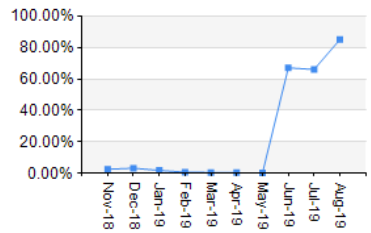
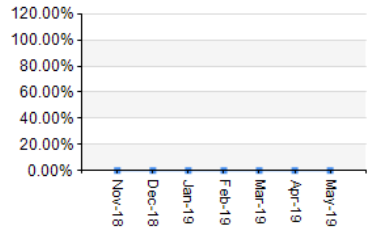
Exception Reports – Safe (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of trust apportioned MRSA bacteraemia **Standard: Zero**		There was one case of MRSA bacteraemia. this was a community-onset case however the blood culture was not collected from the patient when admitted and therefore this is assigned to the Trust.	**Associate Chief Nurse and Deputy Director of Infection Prevention and Control**
Number of unstagable pressure ulcers acquired as in-patient **Standard: <=3**		During September 2019 there were 5 hospital acquired unstageable pressure ulcers sustained in patients across 5 wards. Hospital acquired unstageable pressure ulcers are reviewed at the weekly preventing harm hub. Issues raised at the Hub include missed opportunities to complete risk assessment documentation, timely provision of equipment and robustness of pressure relieving measures. The Hub provides rapid feedback on the high impact actions required, the ward team are tasked to produce evidence of an improvement that is taken through the divisional pressure ulcer groups. Medicine and Surgery have plans to respond and reduce pressure ulcers.	**Deputy Nursing Director & Divisional Nursing Director - Surgery**

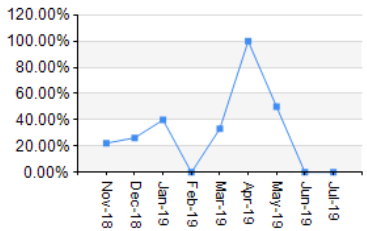
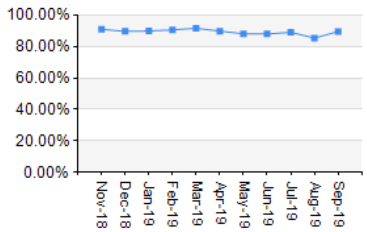
Exception Reports – Effective (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% C-section rate (planned and emergency) **Standard: <=25%**		Due to workload commitments, the registrar has been struggling to complete the c-section audit. The service have now allocated an additional junior to support with the audit, with the hope the results will be available by the end of the year. An action plan has also been completed in order to improve the rates of vaginal births and reduce c-section births. Having looked at 2018 and early 2019 Regional and National data, we note that the emergency caesarean rate both Nationally and Regionally is 16% and for all caesareans 30%. Throughout the South West the rate for all LSCS is 29%. The department has therefore agreed a suitable target for both would be 30% and this will be changed in time for the October report. % Emergency Caesarean Rate (<=16%) % C Section Rate (Planned & Emergency) Standard <=28%, Threshold >= 30%	**Divisional Chief Nurse and Director of Midwifery**
% of fracture neck of femur patients treated within 36 hours **Standard: >=90%**		Action plan in place but increase in trauma have resulted in cancellations of elective list provision. Escalation policy from T&O service line being presented at October's Surgical Divisional Board.	**Director of Operations - Surgery**

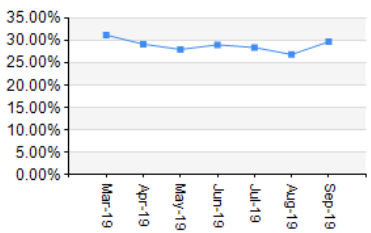
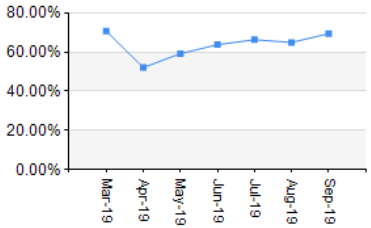
Exception Reports – Effective (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of patients admitted directly to the stroke unit in 4 hours **Standard: >=80%**		44 patients met the target of being admitted directly to the stroke unit within 4 hours; 27 patients did not meet this target. The majority of patients breached due to non-strokes on the stroke unit. This was due to challenging operational pressures and increased ED attendances.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
% of patients who have been screened for dementia (within 72 hours) **Standard: >=90%**		EPR as the long term solution remains unresolved. Data collection methodology change from June 2019 onwards: 20 sets of notes will be audited every month and reported retrospectively in the QPR. There continues to be unresolved issues regarding Trak. The Trust is committed to dementia tier 1 and 2 training which is currently being reviewed through the Dementia steering group. There is now Dementia Friends training provided across the organisation to both clinical and non clinical staff. September statutory return results: 1.5%	**Deputy Chief Nurse**
% of patients who have received a dementia diagnostic assessment with positive or inconclusive results that were then referred for further diagnostic advice/FU (within 72 hours) **Standard: >=90%**		EPR as the long term solution remains unresolved. Data collection methodology change from June 2019 onwards: 20 sets of notes will be audited every month and reported retrospectively in the QPR. There continues to be unresolved issues with Trak. The Medical director is supporting through junior doctor engagement. August audit results: N/A (unable to assess); no positive or inconclusive cases found. September statutory return results: 0%	**Deputy Chief Nurse**

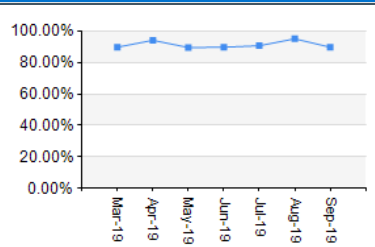
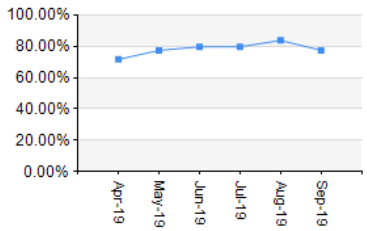
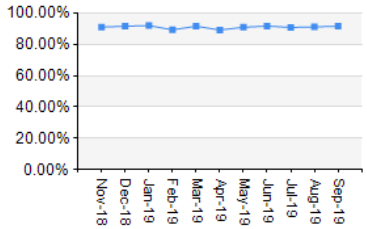
Exception Reports – Effective (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of patients who have scored positively on dementia screening tool that then received a dementia diagnostic assessment (within 72 hours) **Standard: >=90%**		EPR as the long term solution remains unresolved. Data collection methodology change from June 2019 onwards: 20 sets of notes will be audited every month and reported retrospectively in the QPR. The Trust continues to focus on dementia screening. There is a delirium screening tool being developed, which will also support dementia screening. August audit results: N/A (unable to assess); no positive or inconclusive cases found. September statutory return results: 16.7%	**Deputy Chief Nurse**
% of women booked by 12 weeks gestation **Standard: >90%**		Improvements have been made in comparison to last month. The service are continuing to review each patient that has a late booking and working with individual midwives . However, an issue has come to light whereby if an ultraosund scan date had been entered onto the system (Trak) for the patient, the midwives could not enter their original booking date, which would have altered the figures. A work around has now been developed in order to address this issue and we hope to see further improvement in the coming months.	**Divisional Chief Nurse and Director of Midwifery**

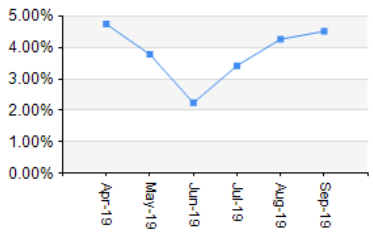
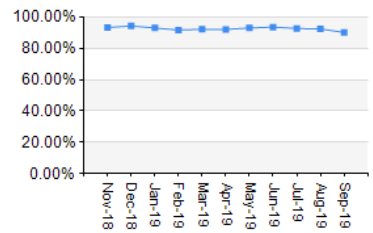
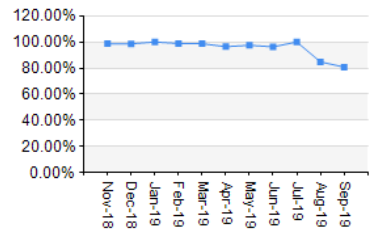
Exception Reports – Effective (4)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of women that have an induced labour **Standard: <=20%**		Understanding that the South West induction of labour average is 31.2%, we have reviewed the National as well as the Regional performance metrics and the Division has met to agree suitable targets. Moving forwards the metrics will be: Standard <=30, Threshold >33%. We have requested that the metrics are changed in time for the October report.	**Divisional Chief Nurse and Director of Midwifery**
% patients receiving a swallow screen within 4 hours of arrival **Standard: >=90%**		50 patients received a swallow screen within 4 hours; 22 patients did not meet this target. 20/22 breaches were due to organisational reasons (non-strokes on the stroke unit leading to the patient being held on AMU) and in 2 cases the patient was not medically well enough for the swallow screen to take place. 95.5% of patients did receive a swallow screen within 72 hours.	**Director of Unscheduled Care and Deputy Chief Operating Officer**

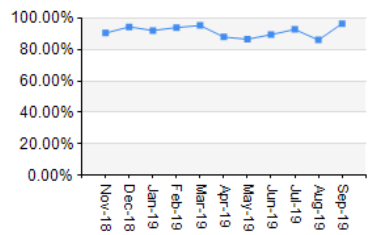
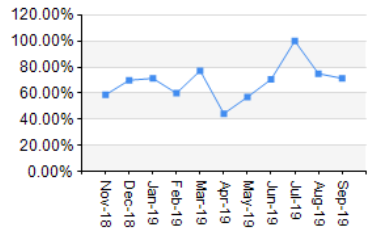
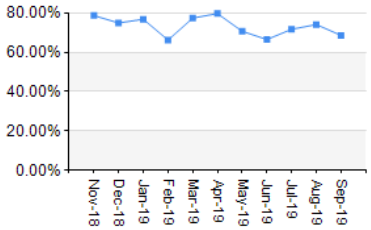
Exception Reports – Caring (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Are you involved as much as you want to be in decisions about your care and treatment? **Standard: >=90%**		We have struggled to recruit volunteers for real time surveys recently, meaning we have had lower responses this month which may have affected the results. We are currently proactively looking at how we manage the survey programme moving forwards.	**Head of Patient Experience Improvement**
How much information about your condition or treatment or care has been given to you? **Standard: >=90%**		We have struggled to recruit volunteers for real time surveys recently, meaning we have had lower responses this month which may have affected the results. We are currently proactively looking at how we manage the survey programme moving forwards.	**Head of Patient Experience Improvement**
Inpatients % positive **Standard: >=96%**		The Trust FFT rate is fairly static - we are hoping that with the implementation of the new FFT guidance we may be able to introduce different methodologies and approaches that might increase our response rate and the quality of feedback received. There is a task and finish group being set up with divisional representation to support implementation and roll out.	**Deputy Director of Quality**

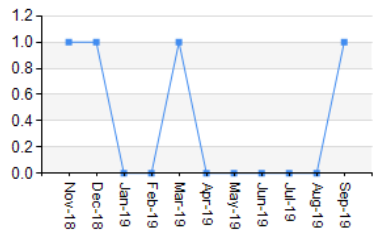
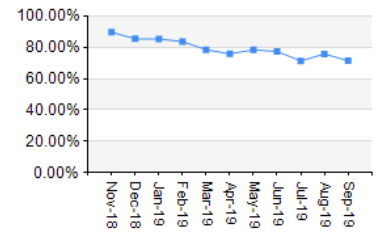
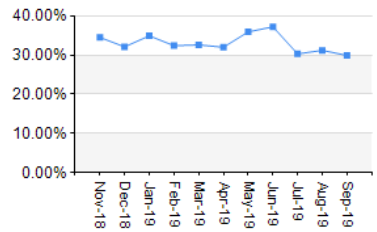
Exception Reports – Responsive (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of bed days lost due to delays **Standard: <=3.5%**		The organisation has been in increased escalation, and have not recovered from August 2019. Main waits were for Adult Social Care assessment, and patients awaiting support in their own home. An internal mAjor incident was raised in September by COO. A work programme is in place to implement the national November 2018 DToC guidance. There are winter plans being agreed where there will be additional capacity in the community.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
Cancer – 31 day diagnosis to treatment (first treatments) **Standard: >=96%**		31 day new performance - 91.2% target - 96% 222 tx - 24 breaches Uro - 17 Gynae 2 Skin 2	**Director of Planned Care and Deputy Chief Operating Officer**
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy) **Standard: >=94%**		Performance 80.5% Target 94% National performance - 96.3% Breaches mainly in breast due to capacity. Raised with oncology with a plan to increase capacity by running machines until 7/8pm.	**Director of Planned Care and Deputy Chief Operating Officer**

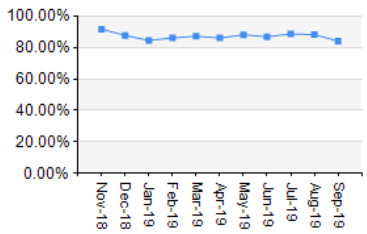
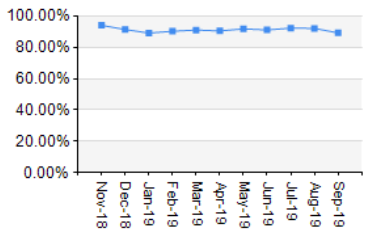
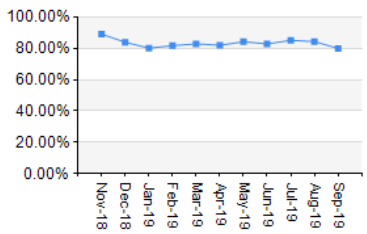
Exception Reports – Responsive (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Cancer – urgent referrals seen in under 2 weeks from GP **Standard: >=93%**		2ww performance (Sept) - 96.5% Target - 93% National performance - 89.4% Best performance since Insight data began in 2013.	**Director of Planned Care and Deputy Chief Operating Officer**
Cancer 62 day referral to treatment (upgrades) **Standard: >=90%**		Performance - 80.7% Target - NA National performance - 83.5% 13 tx 2.5 breaches 1 Haem 1 LGI 0.5 lung	**Director of Planned Care and Deputy Chief Operating Officer**
Cancer 62 day referral to treatment (urgent GP referral) **Standard: >=85%**		Performance - 70.3% (unvalidated) Target - 85% National performance - 78.5% Uro 23.5 LGI 6 UGI 5 Gynae 4.5 33 breaches related to patients waiting over 90 days therefore 62 day performance has suffered but 104 position has dropped as has the overall backlog	**Director of Planned Care and Deputy Chief Operating Officer**

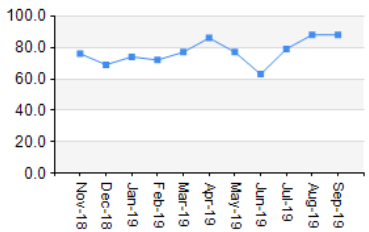
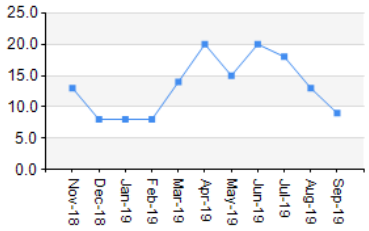
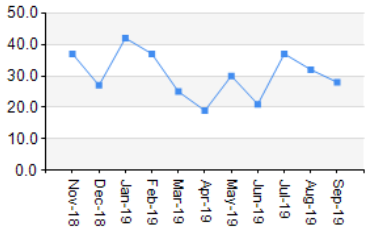
Exception Reports – Responsive (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Count of handover delays 60+ minutes **Standard: Zero**		There was 1 complex case when a clinical decision was made to provide ongoing care in the ambulance, prior to transfer to the crowded ED.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % of time to initial assessment – under 15 minutes **Standard: >=95%**		The 95% standard for triage is for patients arriving by ambulance. Data, including ambulance handover delays, demonstrates this patient group are still well served. The pressure of increased attendances is seen in these figures with a deterioration in this performance metric.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % of time to start of treatment – under 60 minutes **Standard: >=90%**		The National Quality Indicator for this metric is a "mean consistently within 60 minutes". Though there has been a deterioration in performance in September, this reflects good performance in the face of attendances.	**Director of Unscheduled Care and Deputy Chief Operating Officer**

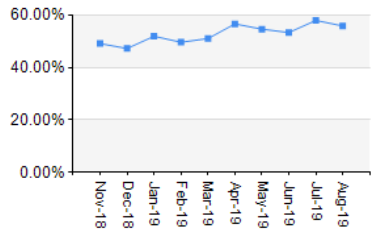
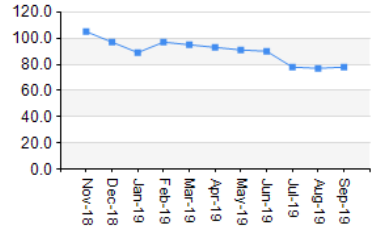
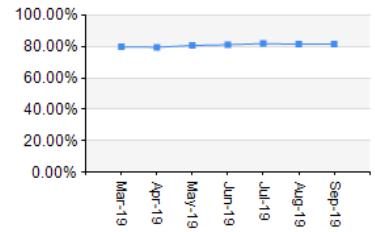
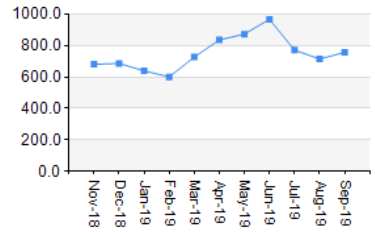
Exception Reports – Responsive (4)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % total time in department – under 4 hours (type 1) **Standard: >=95%**		Monthly performance for September was 84.03% compared with 88.16% in August. Contributory factors include an increase in attendances by an average of 13.4 a day. There were over 450 attendances over 10 days in September and 2 days with over 500 attendances. Also contributing is the high number of Medically Fit patients in the hospital as well as delayed transfers of care.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % total time in department – under 4 hours (types 1 & 3) **Standard: >=95%**		In September, 14% of admissions to hospital had to wait on a trolley before being admitted. There are increased risks, though the safety checklist and increased corridor staffing partially mitigates this.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % total time in department – under 4 hours GRH **Standard: >=95%**		In September, 14% of admissions to hospital had to wait on a trolley before being admitted. There are increased risks, though the safety checklist and increased corridor staffing partially mitigates this.	**Director of Unscheduled Care and Deputy Chief Operating Officer**

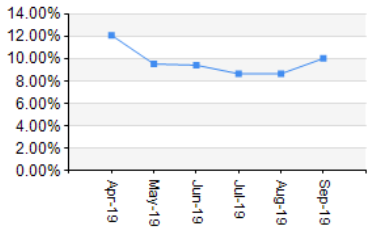
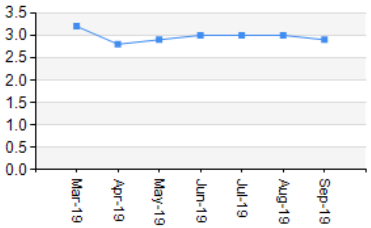
Exception Reports – Responsive (5)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of patients stable for discharge **Standard: <=70**		The organisation has been in increased escalation, and have not recovered from August 2019. Main waits were for Adult Social Care assessment, and patients awaiting support in their own home. An internal mAjor incident was raised in September by COO. A work programme is in place to implement the national November 2018 DToC guidance. There are winter plans being agreed where there will be additional capacity in the community.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
Number of patients waiting over 104 days with a TCI date **Standard: Zero**		104 days with TCI Cancer Category Total Breast 1 Urological 14 Grand Total 15 1 104 day referral 150+ days from Worcester	**Director of Planned Care and Deputy Chief Operating Officer**
Number of patients waiting over 104 days without a TCI date **Standard: <=24**		104 days with no TCI Cancer Category Total Urological 11 Lower GI 8 Head & neck 1 Upper GI 1 Haematological 1 Skin 1 Grand Total 23	**Director of Planned Care and Deputy Chief Operating Officer**

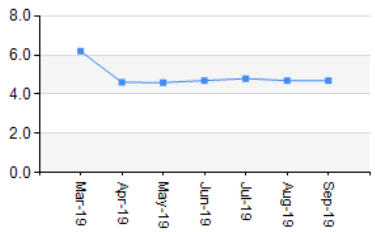
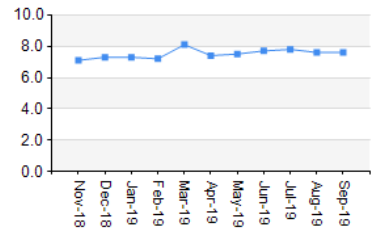
Exception Reports – Responsive (6)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Patient discharge summaries sent to GP within 24 hours **Standard: >=88%**		Performance remains poor, although more engagement since highlighting quality alerts to SDs to emphasize the issue. Some areas of improvement one speciality to 90%, and one to 75% from low 60%.	**Medical Director**
Referral to treatment ongoing pathways over 52 weeks (number) **Standard: Zero**		The September performance is in line with the agreed trajectory. Operational teams continue to work to address our longest waiting patients. The full speciality breakdown is provided within the exception report.	**Deputy Chief Operating Officer**
Referral to treatment ongoing pathways under 18 weeks (%) **Standard: >=92%**		Performance is above the trajectory set with NHS I and commissioners. Work to address performance through operational actions and validation continues. Further details are provided within the planned care exception report.	**Deputy Chief Operating Officer**
The number of planned / surveillance endoscopy patients waiting at month end **Standard: <=600**		There has been a slight increase in the number of patients waiting past recall due to increased pressures in month on the 2ww colorectal straight to test pathway and 6ww diagnostic pathway. Patients are being prioritised in order of clinical urgency and then longest waiting. The specialty are still in the process of clinically validating the waiting list and it is anticipated this will further reduce the backlog through discharging back to GP.	**Medical Director**

Exception Reports – Well Led (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% vacancy rate for registered nurses **Standard: <=5%**		Registered Nurse vacancies continue to be of concern at 10.02%, reflecting the national picture relating to nurse recruitment. Efforts continue to find innovative ways to attract and recruit Nursing staff from both domestic and international pipelines with significant focus on internal talent development and staff health and wellbeing. The Trust has joined the NHSI/E retention collaborative, a clinically led programme of support. Work continues to review exit feedback methodology, with a task and finish group established to focus on driving up compliance with exit interviews and capturing leaver feedback.	**Director of Human Resources and Operational Development**
Care hours per patient day HCA **Standard: >=3**		The Lead Nurse for Retention, Recruitment and Retention is now in post and is supporting all divisions, recruitment events taking place. Strategy for retention being developed and immediate actions being taken.	**Director of Nursing and Midwifery**

Exception Reports – Well Led (2)

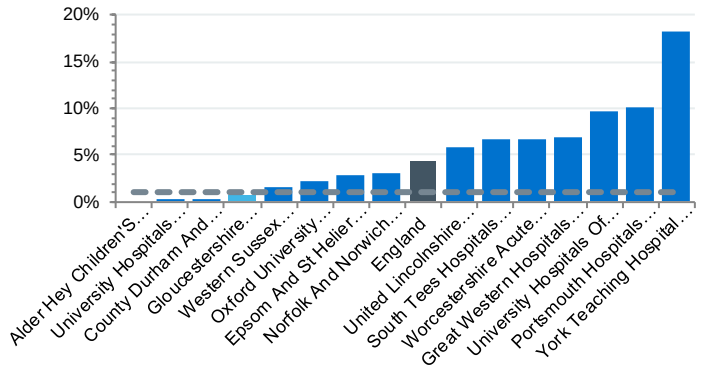
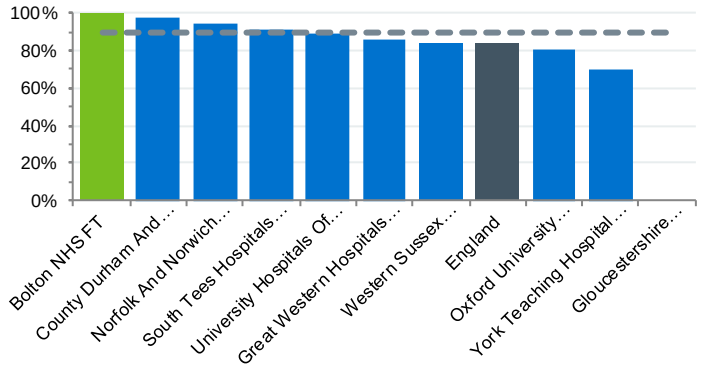
Metric Name & Standard	Trend Chart	Exception Notes	Owner
Care hours per patient day RN **Standard: >=5**		The Lead Nurse for Retention, Recruitment and Attraction is developing retention strategy, has reviewed student nurse recruitment and supporting all recruitment events.	**Director of Nursing and Midwifery**
Care hours per patient day total **Standard: >=8**		The Lead Nurse for Retention, Recruitment and Retention is now in post and is supporting all divisions, recruitment events taking place. Strategy for retention being developed and immediate actions being taken.	**Director of Nursing and Midwifery**

Benchmarking (1)

Gloucestershire Hospitals NHS Foundation Trust

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

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

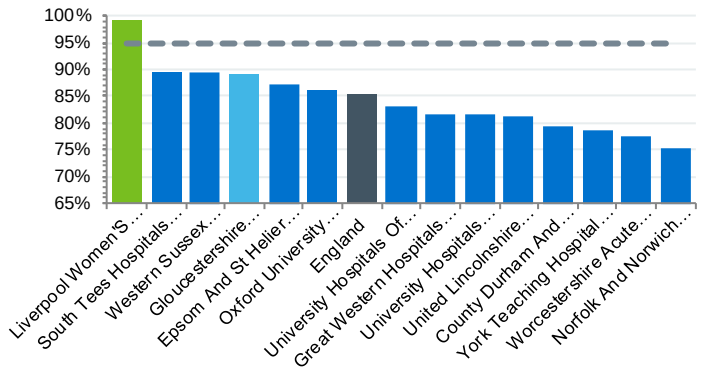
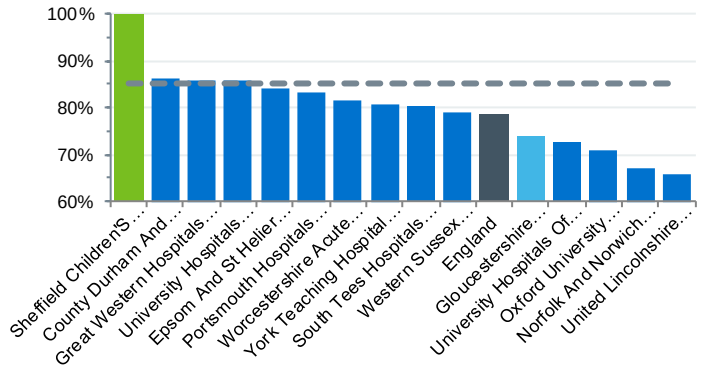
Metric	Period	Peer Group	Rank	Quartile
Diagnostics	August-19		52 / 169	2nd
Dementia	July-19		84 / 84	4th

Benchmarking (2)

Gloucestershire Hospitals NHS Foundation Trust

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

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

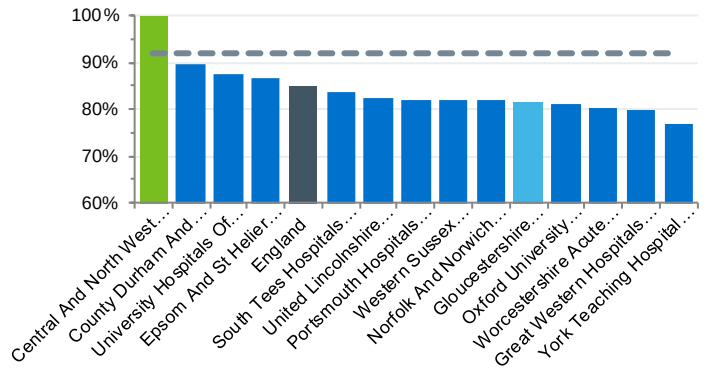
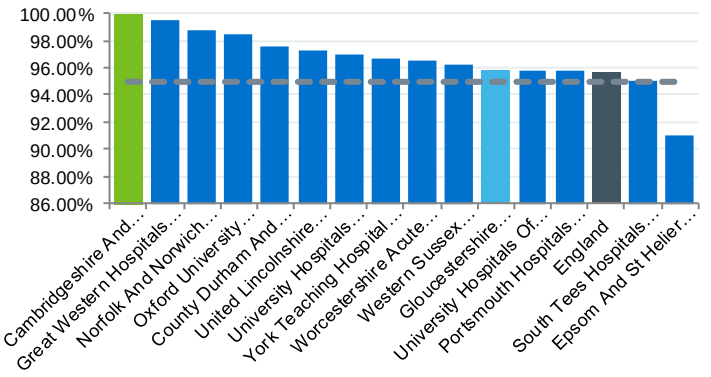
Metric	Period	Peer Group	Rank	Quartile
ED 4 Hour (Type 1 & Type 3)	September-19		29 / 120	1st
Cancer 62 Days GP Referrals	August-19		111 / 143	4th

Benchmarking (3)

Gloucestershire Hospitals NHS Foundation Trust

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

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

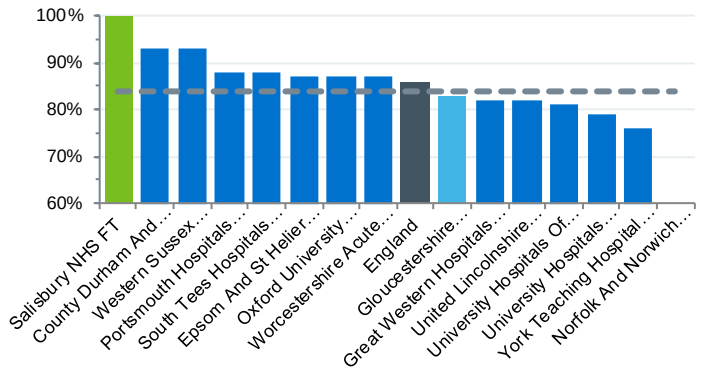
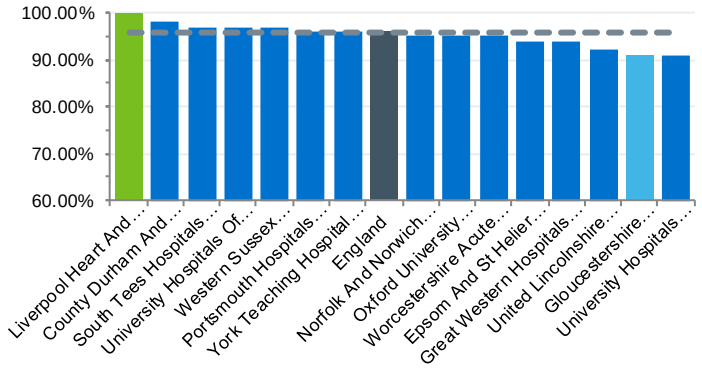
Metric	Period	Peer Group	Rank	Quartile
RTT	August-19		133 / 166	4th
VTE (published quarterly)	June-19		80 / 146	3rd

Benchmarking (4)

Gloucestershire Hospitals NHS Foundation Trust

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

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

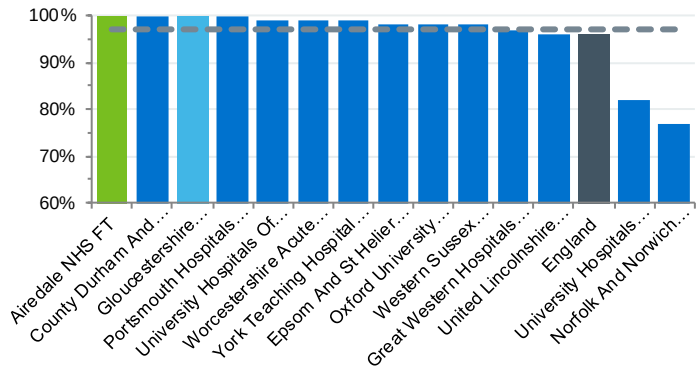
Metric	Period	Peer Group	Rank	Quartile
FFT - ED (percentage recommended)	August-19		94 / 131	3rd
FFT - Inpatient (percentage recommended)	August-19		133 / 145	4th

Benchmarking (5)

Gloucestershire Hospitals NHS Foundation Trust

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

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

Metric	Period	Peer Group	Rank	Quartile
FFT - Maternity (Q2 birth touchpoint - percentage recommended)	August-19		11 / 121	1st

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – NOVEMBER 2019
LECTURE HALL REDWOOD EDUCATION CENTRE, GRH

Report Title
Patient Experience Improvement in Response to Board Stories
Sponsor and Author(s)
Author: Suzie Cro, Deputy Director of Quality & Freedom to Speak up Guardian Sponsor: Steve Hams, Director of Quality and Chief Nurse
Executive Summary

Purpose

To provide an update on the patient experience improvement work that has been initiated in response to the stories presented to Board from June - October 2019.

Key issues to note

Our stories are told by individuals, who choose to come to Board, to tell us their story from their own perspective. The stories provide us with an opportunity to understand their experience of the care they have received – what was good, what did not meet their needs and what could be done to improve their experience.

We use patient stories: -

- To get a better understanding of individuals' experiences and perspectives on a specific issue or service.
- Alongside other data sources to gain powerful insight into what is happening with our services and/or systems.
- To improve our services.
- To enable Board members to step into the shoes of the patient and see our care through the eyes of our patients.

Patient experience improvement must be the golden thread throughout any improvement work that is undertaken in our Trust and patient experience insights should be an improvement measure in most if not all of our quality improvement projects. As a Trust we are committed to using the patient voice and their insights to drive our improvement priorities. Fundamental to the principle of quality improvement is an understanding that those closest to the patients (front line staff) are often best placed to find the solutions for improvement.

Conclusions

The developing emphasis on service user involvement in our Trust health is a powerful asset in our quality improvement work.

Implications and Future Action Required

The Deputy Director of Quality will continue to provide the Board with stories and will include all the improvement work that has happened as a result.

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

Impact Upon Strategic Objectives
Outstanding rating by CQC
Impact Upon Corporate Risks
Listening to stories helps identify our risks and where improvements can be made.
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	
		None	√

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)**

TRUST BOARD – NOVEMBER 2019

PATIENT EXPERIENCE LEARNING AND 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 were presented to Board from June 2019 – October 2019.

People who come to our Trust Board to tell their story provide us with evidence that gives us confidence that services are being delivered effectively, or conversely, they can highlight some areas that need improvement by telling us that certain aspects are ineffective or there are gaps that need to be addressed. Whatever we hear we will always strive to make sure that quality improvement is at the heart of everything we do.

2. Our New Quality Strategy and Quality Framework

All our services need to understand the people they serve – (**Insight)**. Without this understanding we have less chance of delivering care that is safe, effective and that is experienced positively. By listening to people come and tell of their experiences we can check in and challenge ourselves about what we really know, or what we think we know. Listening to people's stories provides us with insight and people's insight helps us understand how are local services are being delivered.

We want our colleagues and our patients to be involved in our improvement work from the set up to the completion of a project – (**Involvement)**.

Our new Quality Strategy will support our colleagues in the delivery of patient experience quality improvement to our patients. Within the strategy, we have provided our colleagues with a quick an easy model to enable this to happen – (**Improvement**).

Picture: Our Quality Strategy quality improvement framework

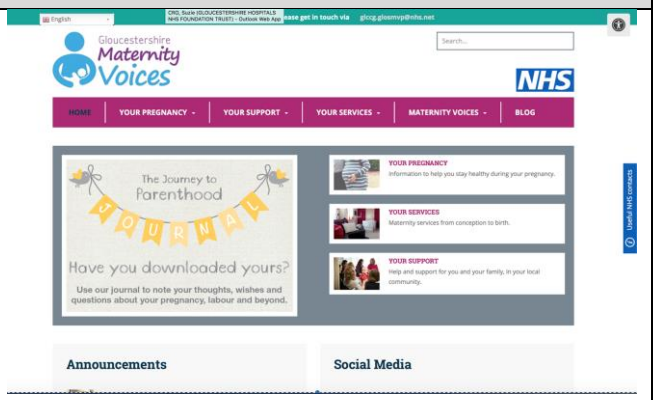
3. Patient Experience Stories

June 2019

Maternity Story Recap

Emma Rawlinson, Chair of the Gloucestershire Maternity Voices Partnership, (GMVP) came to Board to talk about her personal experience of our maternity services and to tell us about her work aiming to promote personalisation of care within our maternity services through her Maternity Voices Partnership work. A Maternity Voices Partnership is a NHS working group (a team of women and their families, commissioners and providers (care assistants, midwives and doctors) working together to review and contribute to the development of local maternity care).

Also, Emma spoke about our Trust's maternity improvement plan called Gloucestershire's Better Births Programme for which women's choice is a key focus. The programme has many work streams and one is aimed at mothers to see one carer or midwife consistently from start to finish. As part of Emma's story, we discussed the research evidence and the importance of continuity of carer. Below in the table are some highlights of our improvement work.

Care issues discussed at Board (positive and areas for improvement)	**Improvements being made**
Gloucestershire Maternity Voices Partnership have launched their website and this can be visited by the below link - https://www.glosmaternityvoices.nhs.uk	
The Deputy Director of Quality has been in touch with Emma and she was proud to tell me about her new blog and I have put an extract for the Board to see how delighted Emma was to come and talk about her experience. **An update from Emma Rawlinson on the Maternity Voices Partnership website** It's hard to believe how quickly the months in my post as Chair have flown by, but I'm really proud of what we've done up to this point and I know there is so much more to look forward to. Building our MVP from scratch means it has been a busy but exciting year so far. From the launch of our website (www.glosmaternityvoices.nhs.uk), building a community of more than 400 people on Facebook (www.Facebook.com/GlosMVP) in just a few months and signing up more than 44 mums, dads, partners and professionals who are interested	

Care issues discussed at Board (positive and areas for improvement)	Improvements being made
in getting involved with the group. It has been great to chat to new parents across the county and hear their stories, working together to share our experiences and help shape maternity services in Gloucestershire. It's exactly why I took on this role; nobody is better placed to help make changes than us as parents and users of the service. **My personal highlight so far was presenting to the Gloucestershire Hospitals Trust Board as part of their service user stories programme. It was a real privilege to be able to promote the MVP and to see how much our feedback is valued.** Another moment that will stay with me was when we hosted a coffee morning, not knowing how many people to expect, and we had to expand into a neighbouring hall to accommodate all the mums, babies and buggies! It was at that point I realised how important the MVP could be as so many of you really wanted to give your feedback and help other parents. So, what comes next? In the immediate future, I'm really looking forward to very first Partnership meeting at Roots Community Cafe on 10th October. It's an opportunity for you to just drop in for a chat, meet other parents, share experiences and grab a coffee on us. These events are a favourite of mine; partners and kids are welcome, so it is entirely possible that there will be a dozen or more toddlers/crawlers on the loose at any one time (including my hyperactive 21-month-old)! If you don't already 'like' us on Facebook, head on over to our page and let us know if you can attend. In the longer term, we have plans for Facebook 'Ask the Expert' sessions, covering topics such as infant feeding, healthy eating and medicines during pregnancy. We will also be developing this blog, which will have regular contributions from me and other members of the MVP team, as well as guest posts from health professionals about specific topics. If there's anything in particular you'd like us to cover, just drop us a message on Facebook or on email, glccg.glosmvp@nhs.net. This group is for you, so please do tell us what would be useful and we'll try to make it happen!	
Better Births Programmes – continuity of carer programme	Please see appendix 1a, b & c for quality improvement work presented through Silver Quality Improvement Projects.

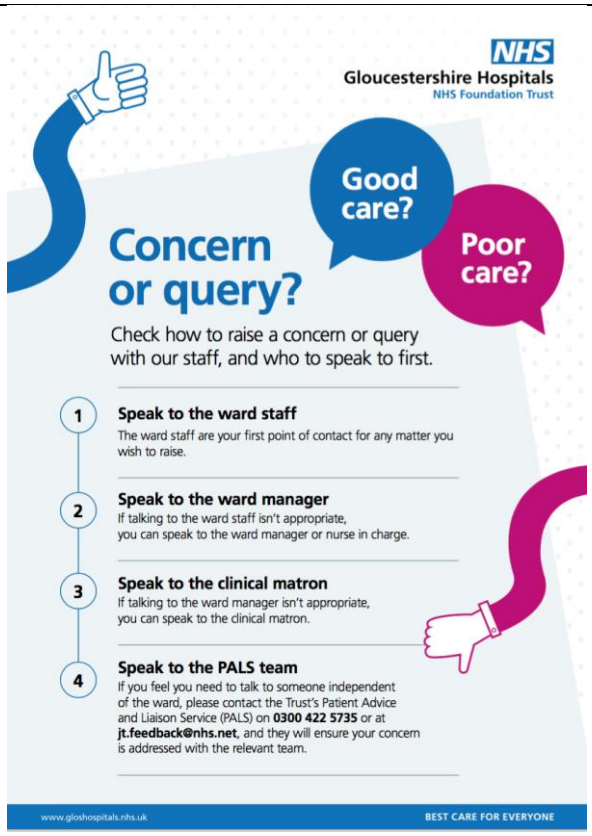
July 2019

<u>Staff Experience Story Recap</u>

The Director of Quality and Chief Nurse, Steve Hams, proudly introduced 3 of our Matrons, Fran Wilson, Jo Harvey and Claire Powell, who had come to the Board to represent all of their matron colleagues and to present their staff experience story. The Foundation of

Nursing Studies had been commissioned to facilitate several sessions with the Matrons in order for them to realise their ambition and potential and agree upon their shared vision for their role.

Staff experience issues discussed at Board	**Improvements being made**
Operational Matrons Group (OMG)	The OMG group has been growing from strength to strength with the aim to improve the care and experience of our patients. One of their focused work streams has been reviewing how they can work to better to improve the "flow" of our patients through our hospital and another is reviewing how they can support and advise nurses by providing an on-call service.
The Matrons have produced "pop up" banners which are displayed all over the Trust.	
The Matrons are in the process of developing a Matron's Charter	A copy of which will go onto the public intranet when it has been finalised.
Several of the Matrons are closely working with their Ward Teams through our own **Best Care for Everyone** Patient Experience Improvement Programme	November update - The Best Care for Everyone programme is nearly complete, with six teams, led by their Matrons, presenting their patient experience improvement projects in December 2019. Ward Teams have focused on topics such as reducing noise at night for inpatients, improving communication between ward teams and patients, and focusing on

Staff experience issues discussed at Board	Improvements being made
	increasing patient and families understanding of our enhanced recovery programme. The teams have had training and support from Patient Experience Improvement Team in using patient experience improvement methodologies, and will all be submitting their projects for the Patient Experience National Network Awards (PENNA) in January 2020.
The Patient Experience Improvement Team are working with the Matrons to develop some posters encouraging people to feedback about the quality of their care. This is a draft copy of a poster that they are developing together with the PALs team. This poster will be tested with our patients to get their views before we go live with the design.	

September 2019

Organ Donation Story and Annual Report - Recap

In September, the Annual Organ Donation Report was received by the Board and the report was accompanied by Jill Hall who shared her inspiring story of how she turned the tragic death of her son into hope and joy through the gift of organ donation. Jill said she has always been a strong believer in organ donation but had no idea that her personal experience would change her life forever. Jill presented her film that told her family's story and the story of organ donation from a "mother's side". Jill asked everyone to see that

through the gift of giving you get so much more back. Please find attached a link to the video here: Link: Jill's story

Ian Mean, Chairman of the Organ Donation Committee, Dr Mark Haslam and Specialist Nurse Kate Hurley explained their roles and their involvement in organ donation. Everybody who is considered to be a potential donor is referred to the service. The number of patients who become donors is very low but all potential donations are identified and Specialist Nurses are available during the whole process to support families in their decision making. One third of families who say no to organ donation later regret their decision. The national consent rate is 70% and Gloucestershire are leading the way with 80% consent rate.

The campaign 'Pass it On' was launched with the aim of targeting older people to become organ donors and the other challenge is the BAME community. We have listed some of improvements in the table below.

Care issues discussed at Board (positive and areas for improvement)	**Improvements being made**
Organ Donation "Pass It On" Campaign	The year-long campaign started in April 2019 and the campaign aims to highlight on several different levels: • Organ donation as a precious gift • Making sure you share your decision • Spreading the word.
BAME community representation	Coral Boston has volunteered and is now our local BAME representative for organ donation. She has been invited to a BAME community group which is reviewing how the NHS connects with community and their meeting is in early December.

October 2019

A Story from our BAME Community - Recap

Mr Haroon Kadodia presented some slides on his and the experiences of his parents during a recent stay at Gloucestershire Royal Hospital. The key points of Haroon's presentation were:

- Haroon had a good experience, because he asked about prayer rooms and was then supported by staff, including the Muslim chaplain; but this was because he prompted the conversation.
- It was positive to see BAME staff in Gloucester in a variety of roles, important as makes it a welcoming and comfortable environment.

- Ward staff could be more confident when talking to patients from BME background – how can we make your stay comfortable here? What matters to you?
- Assumption was made that his parents can understand information from. professionals because of passable English – but they did not always understand. what was happening, leading to confusion and Haroon having to be called to clarify what was going on.

Care issues discussed at Board (positive and areas for improvement)	**Improvements being made**
Cultural awareness sessions for staff	The Patient Experience Improvement Team are working with chaplaincy team to develop a cultural awareness session awareness session for colleagues across the Trust, focused on promoting a culture where we do not make assumptions and feel comfortable to ask questions. This will cover religion, spirituality, and culture more broadly, with involvement of people from various faiths and BAME backgrounds. The presentation has been developed and plans are for this to be rolled out in February 2020
Improvements to translation and interpreting services	We are currently re-commissioning our translation and interpretation contract, and the relaunch of the provider will include a campaign focussed on raising awareness of the importance of booking interpreters, and encouraging people to use telephone interpreting more often in the ward environment to ensure we are giving people the information they need
Electronic Patient Record (EPR) capturing protected characteristics data	Making sure that we are capturing people's ethnicity, religion and communication needs is a key part of the new EPR documentation going live later this year, to support conversations about how we can understand and meet people's needs
A more accessible PALs service	PALS are planning more proactive engagement with BAME communities to understand the concerns people have about coming into hospital, and to build relationships that enable us to share information and proactively resolve any issues people may fear or have

Care issues discussed at Board (positive and areas for improvement)	Improvements being made
	experienced
Person-centred care	We are developing a person-centred care charter, in partnership with communities and colleagues, focussed on how we will deliver care that meets the needs of the individual, which will include spiritual, religious and cultural needs
Cultural awareness	The cultural awareness app resource will be promoted and shared with colleagues across the organisation as an easy to use digital resource to help promote confidence and better conversation with other colleagues and patients. There are currently some technical issues with the app, but this is being looked into and will be circulated to colleagues as soon as it is available.
Conversations with our BAME community	A meeting is planned in December with NHS bodies and local BAME communities to get a better understanding of how organisations currently engage with BAME communities, and how we can work differently to more truly understand the experiences of BAME communities in accessing NHS services, so we can do more meaningful and focussed improvement on removing the barriers and concerns
Our BAME community (our colleagues)	10% of the workforce comes from the BAME community, and this rises to 30% in the medical staff group. Historically the BAME voice has not been heard well enough but significant steps have been taken to address this: - - Including the recent recruitment of three BAME Board members to ensure the Board is more representative of the communities we serve and the staff we employ. - Common with other Trusts,

Care issues discussed at Board (positive and areas for improvement)	Improvements being made
	representation BAME staff in senior management roles is poor and we are taking steps to address this including the inclusion of a BAME panel member on all senior manager interviews and sponsorship of. - BAME staff on the national Stepping Up Programme which is aimed at the development of BAME staff and support into senior roles. - Staff Diversity Network has developed a BAME subgroup and the group are supporting a BAME Black History Celebration day on 9th December 2019

Our learning and the improvement continues

A quick update on a previous story…

The Chaplaincy Team wanted access to Trakcare to improve access to Spiritual Care. Please read the improvement journey below and visit the GSQIA pages.

https://www.gloshospitals.nhs.uk/work-us/training-staff/gsqia/quality-improvements/

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Using TrakCare to improve access to Spiritual Care

Mark Adams and Allysun Gore - EPR Team

1.Background

Spiritual and pastoral care is an important aspect of the overall care of our patients and their families. Attending to a patients spiritual needs can influence their health, recovery and overall wellbeing.

"At its best, our National Health Service is there when we need it, at the most profound moments in our lives. At the birth of our children. At the deaths of our loved ones. And at every stage in between - as we grapple with hope, fear, loneliness, compassion -some of the most fundamental elements of the human spirit."

Simon Stevens, Chief Executive, NHS England 2015

The GHNHSFT Department of Spiritual Care needs information regarding patients within our care in order to visit them in a timely manner. They used a report to identify regarding patients requiring a spiritual care visit. However, the report was based on data created more than 24 hours earlier. Due to the nature of admissions, transfers and discharges, inevitably they would attempt to visit patients who moved wards, in theatre, undergoing tests or were discharged. The lack of contemporaneous data resulted in patients being missed by the chaplaincy team.

2. Analysing Team Needs

An TrakCare/EPR Configuration and Business Analyst met with the chaplain's team to understand the teams needs and potentially how these could be met using the TrakCare system. They considered all appropriate options, exploring available functionality within TrakCare to meet these requirements. It was important for the Chaplaincy team to identify which patients they were required to visit and the patients ward location, making best use of time and resources.

3. Method

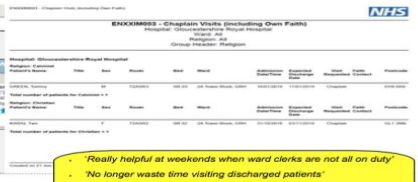
Suitable ENXX roles within the TrakCare system were found for the chaplaincy team and in liaison with the Smartcard Team, associated Smartcard roles were defined. Using the reporting functionality, a report was configured in TrakCare to enable the chaplaincy team to utilise on a daily basis. The reporting functionality was configured according to the teams needs.

4. Training

A bespoke training package was created for the chaplaincy team, including an introduction to TrakCare, use of the spiritual care visit icon, ward floorplan and use of the reporting tools to run their reports.

5. TrakCare Reports

- Chaplains Visits: This shows all current patients that have the **'Chaplain Visit Required'** option selected against their inpatient episode.
- Chaplains Visits - Own Faith: This report can also be filtered by specific religion.
- Current Admissions by Speciality: This shows current admissions for either a specific ward or a compiled report for all wards for a specific hospital location.



- *'Really helpful at weekends when ward clerks are not all on duty'*
- *'No longer waste time visiting discharged patients'*
- *'Helped us to give patients the care they deserve'*
- *easy to 'flow' patients around the hospital'*

6. Project Outcomes:

The chaplaincy team have fully utilised the TrakCare reporting tools, enabling them to fulfil their job role. Outcomes include:

- Reduction of time required to locate patients.
- Eliminated chaplaincy teams reliance on clerical staff to locate patients
- Enables allocation of the most appropriate team member to visit a patient using the 'Own Faith' report.

The chaplaincy teams' comments are extremely positive:

- *It has saved us so much time when we need to find a patient'*
- *''Saved us hours every week'*
- *So easy to find patients now'*

7.Conclusion:

This was a worthwhile project, resulting in exceptionally positive impact to a team caring for our patients spiritual needs. Engagement with the specialty team to analyse problems, needs and workflow enabled the EPR/TrakCare team to use existing TrakCare functionality to provide a bespoke solution, transforming the teams working pattern. The skills of the TrakCare / EPR Configuration and Business Analyst realised the successful outcome, along with providing bespoke training package to the Chaplaincy Team.

Appendix 1a

Gloucestershire Safety & Quality Improvement Academy

Gloucestershire Hospitals NHS
NHS Foundation Trust

CHELTENHAM CONTINUTY OF CARE TEAM

Delivering Women Centred Care

Better Births Gloucestershire

Safety Concern

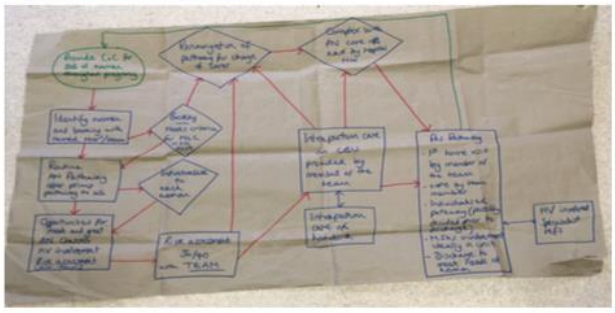
NHS Commissioned a National Maternity Review in 2016, Better Births: A Five Year Forward View for Maternity Services. 'Every woman should be able to access support that is centred to individual needs and circumstances'.

Continuity of care significantly improves outcomes for mothers and babies, improve patient and family experience and is linked to the need to reduce nationally the stillbirth and prematurity rate.

AIM

By March 2019 20% of women to be booked onto the Continuity model pathway to receive Continuity of Carer to include Antenatal, Intrapartum and Postnatal period. The majority of women to be booked for this model of care by 2021

Process Mapping



Baseline Audit

AUDIT RESULTS

Our initial audit has provided baseline figures to compare changes in care to demonstrate improvements through the Continuity Model.

Until those booked under the Team reach delivery we are unable to audit Continuity in labour and postnatally.

Engagement with Stakeholders

- **Midwives working at Aveta Birth Unit**
- **Liaise with Patient Experience for a Friends and Family Test**
- **Engage with GP Practices locally**
- **Liaise with Commissioners**

PDSA Cycles

PLAN — Plan process for Continuity Model, bookings, clinics, Teams, training and staffing

DO — Engage with staff and commence delivery of care model

STUDY — Plan and evaluate Patient and staff experience

ACT — Deliver Continuity of Care and evaluate outcomes

CYCLE 1 — Measure existing process for Antenatal, Intrapartum and Postnatal care within Cheltenham.

CYCLE 2 — Consultation with staff and their engagement

CYCLE 3 — Create the process of assessment and referral to the Continuity Team to include revamping of the initial Patient contact referral form

CYCLE 4 — How and where care will be delivered

CYCLE 5 —Staff training

CYCLE 6 — Role out of the Continuity Model of Care

NEXT STEPS

Continue to offer Continuity of Carer to all low risk women in our hub

Friends and Family testing to evaluate patient and family experience

Multiparous women - Consider if their care experience has been enhanced from previous experience

Evaluate outcome of care model on birth numbers at Aveta Birth Unit

Presentation of findings to colleagues and Division

Social media—spread the word

Involvement of outreach areas—further process mapping needed

CHELTENHAM CONTINUITY TEAM - HAZEL WILLIAMS, LISA LAND, EMMA ROSS AND DEBBIE MUMFORD

www.gloshospitals.nhs.uk

BEST CARE FOR EVERYONE

Appendix 1b

Gloucestershire Safety & Quality Improvement Academy

Gloucestershire Hospitals NHS
NHS Foundation Trust

Multiple Birth Team—Continuity of Carer

Kate Harrison and Mel Woolman

Better Births Gloucestershire

1. Background

NHS England has a vision for maternity services, which is that care will be safer, more personalised, kinder, professional and family friendly. Every woman should be able to access support that is centred around her individual needs and circumstances. (National Maternity Review (2016), Better Births: A Five Year Forward View for Maternity Services).

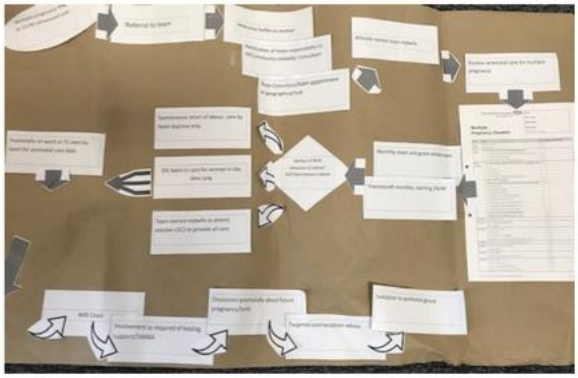
2. Aim

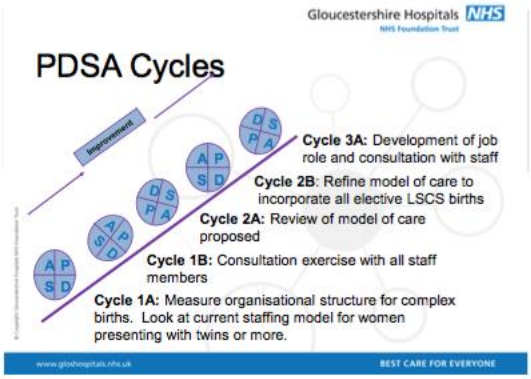
To introduce continuity of care for women who are having twins or more.

- To increase the numbers of women with a multiple pregnancy who experience continuity of care.
- To improve satisfaction amongst these women and the midwives caring for them.

3. Engagement with stakeholders

- Contact local TAMBA group
- Poster presentation to midwives in all clinical areas
- Consultants meeting attended
- Face to face meetings with midwives to discuss options of care





4. Outcome

This project assessed factors which may contribute to effective implementation of the continuity model. We realised that midwives did not want to work in a compartmentalised model and also wanted to work in a team which would have balance of both normal and complex care.

This project contributed to understanding our organisational readiness for change, especially areas of the department which have so far lacked engagement with the continuity models.

Facilitated training with King's College London highlighted the need for a sustainable model which is chosen by the teams who will work within it.

5. Next Steps

- Be clear about purpose of the change
- Ask staff for input ideas and opinions regarding caseloading model
- Identify team of both hospital and community midwives who wish to work in continuity model
- Work within Better Births framework to provide true continuity model of care that encompasses both normal and complex care
- Work with Better Births operational group and consult staff members on new proposals
- Implement acceptable continuity model and evaluate extent to which the particular models realise the benefits set out in Better Births evidence.

Appendix 1c

Gloucestershire Safety & Quality Improvement Academy

Gloucestershire Hospitals NHS
NHS Foundation Trust

Integrated Birth Unit Team Continuity Of Carer

Tracy Browning & Lisa Hernaman

Better Births Gloucestershire

1. Background

Better Births, the report of the National Maternity Review, set out a clear recommendation that the NHS should roll out continuity of carer, to ensure safer care based on a relationship of mutual trust and respect between women and their midwives. This relationship between care giver and receiver has been proven to lead to better outcomes and safety for the woman and baby, as well as offering a more positive and personal experience; and was the single biggest request of women of their services that was heard during the Review.

2. The Aim

For 20% of pregnant women in the Stroud area to be booked on to a Continuity of Carer Pathway by March 2019

3. The Safety Concern

Currently women only receive intrapartum continuity in an "ad hoc" manner. NHS Maternity Review Better Births strongly supports Continuity of Carter models to improve safety outcomes and women's experience.

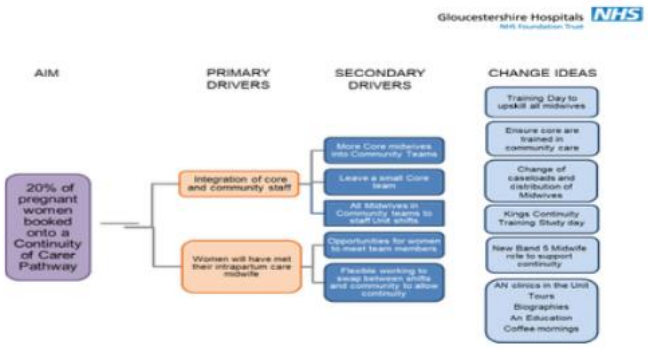
4. Measures

OUTCOME—Number of women booked onto the Continuity of Carer Pathway

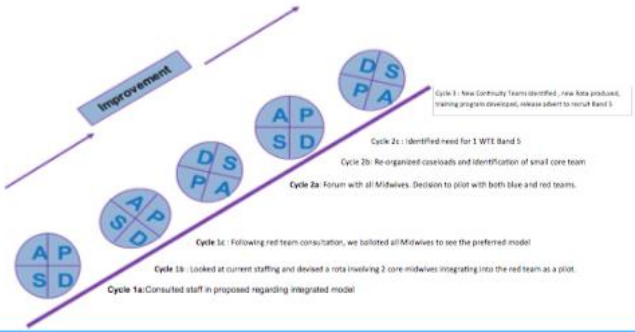
BALANCING—If we increase births at home or in the Birth Unit we may not be able to support this model or place of birth without increase in staffing.

Antenatal continuity may reduce impacting on outcomes e.g. Preterm birth

5. Driver Diagram



6. PDSA Cycles



7.Next Steps

- Launch of model in June 2019
- Monthly data collection (RCM audit forms)
- Review Outcomes May 2020
- Share ongoing data with Better Births Team Lead
- Share experiences at Better Births Carer Forum and service users

REPORT TO MAIN BOARD – November 2019

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

This report describes the business conducted at the Finance and Digital Committee held on 31 October 2019, indicating the NED challenges, the assurances received, and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Digital Care Board Programme Update	Project updates utilising an RAG rating approach provided for: - Trakcare Optimisation - TCLE Pathology Implementation - Chemocare (OPMAS) - Document Viewer - ICNet PAS & Lab Success of Chemocare (live from 30/9/19) implementation an important step Pragmatic approach to TCLE Pathology project with some practical issues identified	Re Pathology what are the links to the wider network? Re Chemocare - which individuals/team have contributed to the success? Re Document Viewer – how future proof is the system? Re ICNet PAS & Lab – what issues/risk with planned delay?	Extensive discussion in the wider system but important to keep in mind that not everything benefits from "joining up", Success essentially a team effort but with some major individual contributions – these have been acknowledged Platform allows integration with neighbouring organisations Old system remains operational	Deep dive scheduled for early 2020

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Sunrise EPR Highlight Report	Programme overview and detailed workstream updates covering: - Communication & engagement - Training - Clinical site readiness - Clinical documentation - Enterprise configuration - Infrastructure and Integration - Interfacing and Data Priming - Reporting & Business Continuity - Benefits - Go Live Planning - Testing Currently all workstreams are **Green**	How is the related cultural change for people who do not like change being addressed? How can nurses get a feel for the impact form the ea;ry go live wads? What are the contingency plans in the event of initial system failure? What are the key concerns? How is the training programme progressing? Have staff been advised that this is not optional? Have the measures of success been established?	Extensive discussion around all these challenges with many detailed actions in place or planned. Key to acceptance/success are the significant contingent of super users that are being trained and the robust communication plan that has been developed and is being implemented.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Next Generation Telephony Project Deep Dive	An overview of the issues experienced with the programme and plans for proposed recovery	What is the timetable for the detailed review? What are the financial/contractual implications? Is this appropriately captured on the relevant risk register	Effective overview and action planning now taking place.	Follow up review to be scheduled (provisionally April 2020) Risk register entries to be checked
Digital Risk Register	No additions or deletions Highlighted issue of Freedom of Information Requests	What is the volume of FOI requests? What opportunities for streamlining the process and lessening the number of requests?	Process and actions are compliant	Opportunity to look at some potential improvement opportunities
Digital Care Board Project Report	Detailed project progress report (Excl the seperate item for EPR) - No project closures this month - Chemocare continues to be closely monitored	Has the Chemocare assessment changed following the previous critical deadline?	Yes – now proceeding to go live with use in shadow form now commenced. Continues to be closely monitored. All training in place.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Sunrise EPR Highlight Report	Detailed update on project elements with particular emphasis on communication and engagement.	How are Agency staff trained in system use?	Overall plan and progress considered to be very sound with significant learning from earlier implementation embedded Covered by standard procedures for new staff	
IM & T Programme Board Update	Programme by programme status review covering - Desktop Imaging - Imprivata implementation - Next Generation telephony - Windows 2003 Upgrade - Fax replacement - MDT video conferencing - PC Refresh - Firewall replacement - Back up solution - Email archiving - Network remediation - WiFi Review - DOCMAN10 Transfers of Care	Additional cost information requested e.g. revenue/capital split	Comprehensive report received detailing project status and issues. Windows 2003 replacement programme remains “Red”	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Digital Strategy	Detailed 5 year Digital Strategy draft	Is this integrated with an ICS Digital Stategy? Is there adequate reference to/emphasis of back office systems?	Yes – meetiogns scheduled and working towards sign off at the ICS level	 Should be included
Finance Performance Report	6 months' cumulative deficit at £11.7 million (on a Control total basis) is a £0.6 million favourable variance against plan. Key favourable variances: - Commissioner income £2.3m - Other income £1.0m - Pay £1.8m Partially offset by non-pay adverse variance Detailed variance analysis presented Cash balance (£17.3 million) continues to be relatively high representing cash held following loan receipts for committed capital expenditure Balance sheet commentary	When can we see the detailed future cash flow forecast? Will the Q3 plan be delivered? Is it too early to confirm the expected outcome for Q4	 Yes Yes – detailed analysis and planning under way	November meeting

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	Challenges and opportunities for balance of year described in detail. Currently a downside risk identified in Quarter 4			
Cost Inprovement Programme Update	Ytd delivery is £7.7m v £5.6 m plan Detailed actual and planned performance described. Total year continues to have a shortfall c. £7m Recovery opportunities and initial planning for 2020/21 described		Reporting is clear and comprehensive	
Clinical Productivity Update	Next stage of this important analysis – using data to identify clinic utilisation in a number of clinical areas. Work has identified data capture limitations.	When should the next review take place to allow for data validation etc?		February 2020

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
ICS 5 Year Planning Submission	**Draft** Long Term Plan document presented and reviewed	Is it too early to approve this document?	Yes	Work continues with ICS partners – timetable dynamic!
Finance Risk Register	Summary of risks added/changed			

Rob Graves
Finance & Digital Committee

TRUST BOARD – November 2019
Redwood Education Centre, Gloucestershire Royal Hospital commencing at 12:30

Report Title
Financial Performance Report – Month 6 2019/20
Sponsor and Author(s)
Author: Tony Brown, Senior Finance Advisor Sponsor: Jonathan Shuter, Acting Director of Finance

Executive Summary

Purpose

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

Key issues to note

- At Month 06 the Trust is reporting a cumulative deficit of £11.7m, which is £0.6m favourable to plan.
- Commissioner income is £2.3m favourable against plan.
- Other NHS patient related income is £0.5m favourable against plan.
- Private and paying patients' income is £0.5m favourable to plan.
- Other operating income (including Hosted Services) is £0.8m favourable to plan.
- Pay expenditure is showing a favourable variance of £1.8m.
- Non-pay expenditure is showing an adverse variance of £5.3m.
- Non-operating costs are £4.9m adverse to plan (reflecting the impairment of TrakCare) – this is reversed out from a control total point of view leaving a small favourable variance to the planned position.
- The closing cash position contains a high level of committed cash – relating to planned expenditure for both revenue and capital.
- The Trust is working on a number of initiatives to mitigate the outstanding financial gap to deliver its planned control total, noting the risks to delivery.

Conclusions

The Trust position is favourable to plan as at Month 6 of the 2019/20 financial year. The second half of the year requires a material decrease in run-rate to deliver the planned deficit position.

Implications and Future Action Required

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

Recommendations

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

Impact Upon Strategic Objectives

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

Impact Upon Corporate Risks

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

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

Regulatory and/or Legal Implications

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

Equality & Patient Impact

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

Resource Implications

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

Action/Decision Required

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

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

Audit & Assurance Committee	Finance & Digital Committee	Estates & Facilities Committee	People & OD Committee	Quality & Performance Committee	Remuneration Committee	Trust Leadership Team	Other (specify)
	31st October 2019						

Outcome of discussion when presented to previous Committees/TLT

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

Gloucestershire Hospitals NHS
NHS Foundation Trust

Report to the Trust Board

Financial Performance Report
Month Ended 30th September 2019

Introduction and Overview

Gloucestershire Hospitals NHS
NHS Foundation Trust

The Trust submitted a revised budget for the 2019/20 financial year to NHSI on 15th May 2019 reflecting a deficit of £1.5m on a control total basis (after removing the impact of donated asset income and depreciation). This plan forms the basis for reporting in month 6.

The financial position as at the end of September 2019 reflects the Group position including Gloucestershire Hospitals NHS Foundation Trust and Gloucestershire Managed Services Limited, the Trust's wholly-owned subsidiary company. The Group position in this report excludes the Hospital Charity.

In September the Group's consolidated position shows a year to date deficit of £11.7m. This is £0.6m favourable against plan. The position includes an impairment of £4.9m for the writing down of TrakCare expenditure incurred in previous financial years, which has no impact on the control total position.

Statement of Comprehensive Income (Trust and GMS)

	TRUST POSITION			GMS POSITION			GROUP POSITION *		
Month 06 Cumulative Financial Position	Budget £000s	Actuals £000s	Variance £000s	Budget £000s	Actuals £000s	Variance £000s	Budget £000s	Actuals £000s	Variance £000s
SLA & Commissioning Income	237,697	239,952	2,255	0	0	0	237,697	239,952	2,255
PP, Overseas and RTA Income	2,401	2,934	533	0	0	0	2,401	2,934	533
Other Income from Patient Activities	449	916	468	0	0	0	449	916	468
Operating Income	38,321	38,896	576	23,000	23,184	184	40,267	41,024	757
Total Income	**278,868**	**282,699**	**3,831**	**23,000**	**23,184**	**184**	**280,815**	**284,827**	**4,012**
Pay	179,325	176,918	2,407	9,246	9,762	(516)	188,403	186,598	1,805
Non-Pay	100,438	106,255	(5,817)	12,545	12,083	462	92,097	97,364	(5,267)
Total Expenditure	**279,762**	**283,172**	**(3,410)**	**21,790**	**21,845**	**(55)**	**280,500**	**283,962**	**(3,462)**
EBITDA	**(895)**	**(473)**	**421**	**1,209**	**1,339**	**129**	**315**	**865**	**551**
EBITDA %age	**(0.3%)**	**(0.2%)**	**0.2%**	**5.3%**	**5.8%**	**0.5%**	**0.1%**	**0.3%**	**0.2%**
Non-Operating Costs	11,552	16,321	(4,769)	1,209	1,339	(129)	12,762	17,660	(4,898)
Surplus/(Deficit) with Impairments	**(12,447)**	**(16,795)**	**(4,348)**	**0**	**0**	**0**	**(12,447)**	**(16,795)**	**(4,348)**
Less Fixed Asset Impairments	0	4,918	4,918	0	0	0	0	4,918	4,918
Surplus/(Deficit) excluding Impairments	**(12,447)**	**(11,877)**	**570**	**0**	**0**	**0**	**(12,447)**	**(11,877)**	**570**
Excluding Donated Assets	221	219	(2)	0	0	0	221	219	(2)
Control Total Surplus/(Deficit)	**(12,226)**	**(11,658)**	**568**	**0**	**0**	**0**	**(12,226)**	**(11,658)**	**568**

* Group Position excludes £22.1m of intergroup transactions including dividends

Group Statement of Comprehensive Income

Gloucestershire Hospitals NHS
NHS Foundation Trust

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

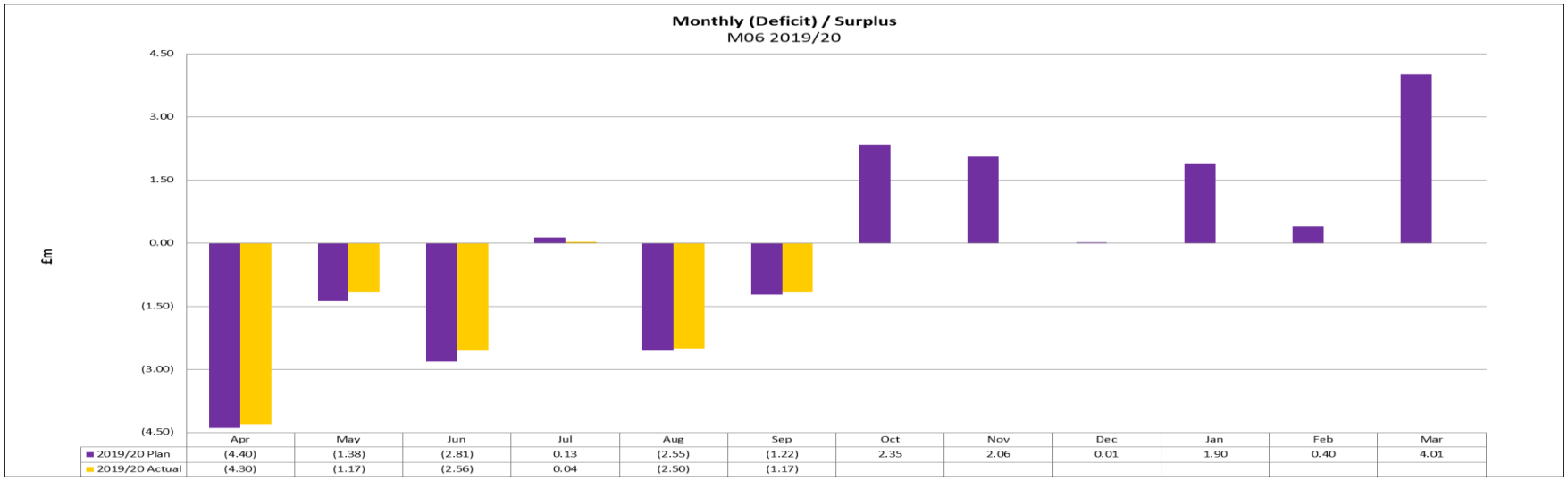
In September the Group's consolidated position shows an in month deficit of £1.2m on a control total basis, a favourable variance to plan of £53k.

Month 06 Financial Position	Annual Budget £000s	M06 Budget £000s	M06 Actuals £000s	M06 Variance £000s	M06 Cumulative Budget £000s	M06 Cumulative Actuals £000s	M06 Cumulative Variance £000s
SLA & Commissioning Income	482,404	39,856	40,503	646	237,697	239,952	2,255
PP, Overseas and RTA Income	4,802	400	336	(65)	2,401	2,934	533
Other Income from Patient Activities	898	259	279	20	449	916	468
Operating Income	86,911	7,662	7,282	(380)	40,267	41,024	757
Total Income	**575,015**	**48,178**	**48,399**	**221**	**280,815**	**284,827**	**4,012**
Pay	368,128	32,187	30,964	1,224	188,403	186,598	1,805
Non-Pay	182,303	15,122	16,459	(1,337)	92,097	97,364	(5,267)
Total Expenditure	**550,431**	**47,310**	**47,423**	**(113)**	**280,500**	**283,962**	**(3,462)**
EBITDA	**24,584**	**868**	**976**	**108**	**315**	**865**	**551**
EBITDA %age	**4.3%**	**1.8%**	**2.0%**	**0.2%**	**0.1%**	**0.3%**	**0.2%**
Non-Operating Costs	25,526	2,127	2,182	(55)	12,762	17,660	(4,898)
Surplus/(Deficit) with Impairments	**(942)**	**(1,259)**	**(1,206)**	**53**	**(12,447)**	**(16,795)**	**(4,348)**
Less Fixed Asset Impairments	0	0	0	0	0	4,918	4,918
Surplus/(Deficit) excluding Impairments	**(942)**	**(1,259)**	**(1,206)**	**53**	**(12,447)**	**(11,877)**	**570**
Excluding Donated Assets	(558)	37	37	(0)	221	219	(2)
Control Total Surplus/(Deficit)	**(1,500)**	**(1,222)**	**(1,169)**	**53**	**(12,226)**	**(11,658)**	**568**

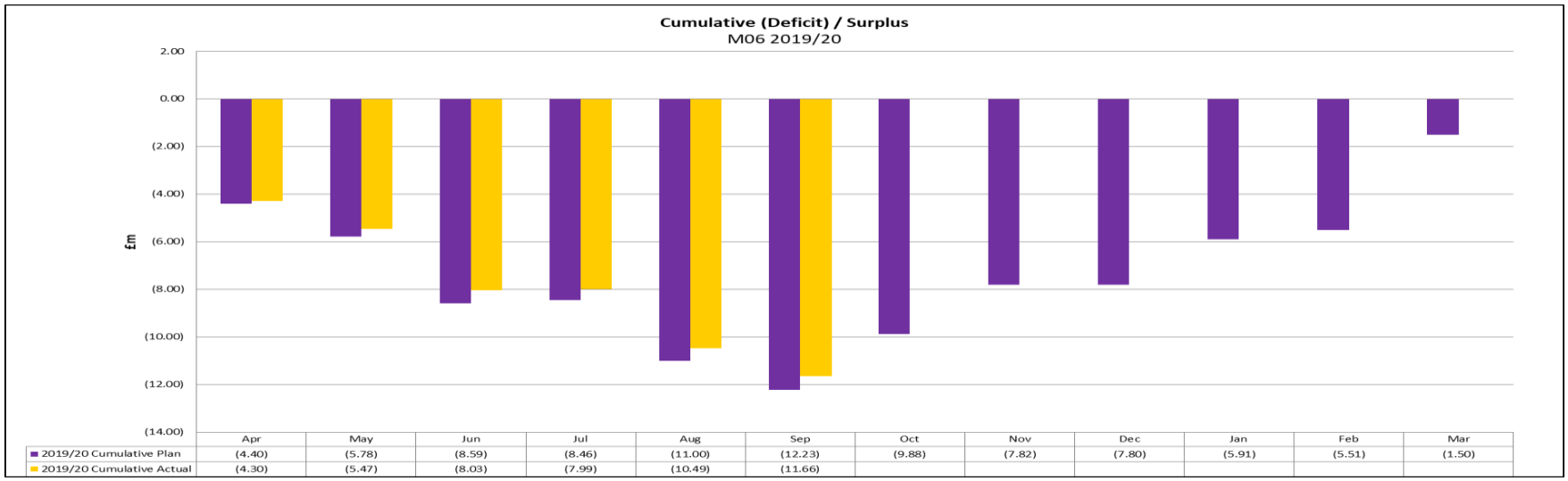
2019/20 Position Trend

Gloucestershire Hospitals NHS
NHS Foundation Trust

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



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



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

Detailed Income & Expenditure

Gloucestershire Hospitals NHS
NHS Foundation Trust

Month 06 Financial Position	M06 Budget £000s	M06 Actuals £000s	M06 Variance £000s	M06 Cumulative Budget £000s	M06 Cumulative Actuals £000s	M06 Cumulative Variance £000s
SLA & Commissioning Income	39,856	40,503	646	237,697	239,952	2,255
PP, Overseas and RTA Income	400	336	(65)	2,401	2,934	533
Other Income from Patient Activities	259	279	20	449	916	468
Operating Income	7,662	7,282	(380)	40,267	41,024	757
Total Income	**48,178**	**48,399**	**221**	**280,815**	**284,827**	**4,012**
Pay						
Substantive	30,099	28,441	1,658	176,217	170,916	5,301
Bank	976	1,267	(291)	5,861	7,490	(1,630)
Agency	1,112	1,255	(143)	6,326	8,191	(1,866)
Total Pay	**32,187**	**30,964**	**1,224**	**188,403**	**186,598**	**1,805**
Non Pay						
Drugs	5,585	6,393	(807)	33,273	36,123	(2,849)
Clinical Supplies	3,249	3,218	31	19,555	19,880	(325)
Other Non-Pay	6,288	6,848	(560)	39,268	41,361	(2,093)
Total Non Pay	**15,122**	**16,459**	**(1,337)**	**92,097**	**97,364**	**(5,267)**
Total Expenditure	**47,310**	**47,423**	**(113)**	**280,500**	**283,962**	**(3,462)**
EBITDA	**868**	**976**	**108**	**315**	**865**	**551**
EBITDA %age	**1.8%**	**2.0%**	**0.2%**	**0.1%**	**0.3%**	**0.2%**
Non-Operating Costs	2,127	2,182	(55)	12,762	17,660	(4,898)
Surplus/(Deficit)	**(1,259)**	**(1,206)**	**53**	**(12,447)**	**(16,795)**	**(4,348)**
Fixed Asset Impairments	0	0	0	0	4,918	4,918
Surplus/(Deficit) after Impairments	**(1,259)**	**(1,206)**	**53**	**(12,447)**	**(11,877)**	**570**
Excluding Donated Assets	37	37	(0)	221	219	(2)
Surplus/(Deficit)	**(1,222)**	**(1,169)**	**53**	**(12,226)**	**(11,658)**	**568**

Non-Pay – expenditure is showing a year to date £5.3m overspend, reflecting overspends on pass through drugs and clinical supplies which are offset within income (£2.9m). The clinical supplies overspend of £0.3m reflects the hire from Cobalt of MRI and CT Scanners (£0.3m), and tube repairs (£0.1m). The overspend on other non pay of £2.1m reflects expenditure mainly for outsourced clinical services e.g. D&S outsourced reporting (£0.2m), Glanso and the timing of receipt of the CNST rebate (£0.3m) for the Women & Children Division, which has now been confirmed.

SLA & Commissioning Income – is reporting an over performance of £2.3m year to date, reflecting over performance on Gloucestershire CCG and Specialised Commissioning, offset by under performance on other commissioners.

PP / Overseas / RTA Income – is reporting a year to date over performance of £0.5m, this has reduced slightly in Month 6 as private Oncology patients activity in D&S has reduced.

Other Operating income – Includes over-recovery of Deanery income in Medicine and Surgery £0.3m, additional non-commissioned income in Cytology, Microbiology and Histology £0.3m.

Pay – Cumulatively there is an underspend of £1.8m, reflecting an underspend on substantive budgets (£5.3m), offset by overspends on bank (£1.6m) and agency budgets (£1.9m).

Cost Improvement Programme

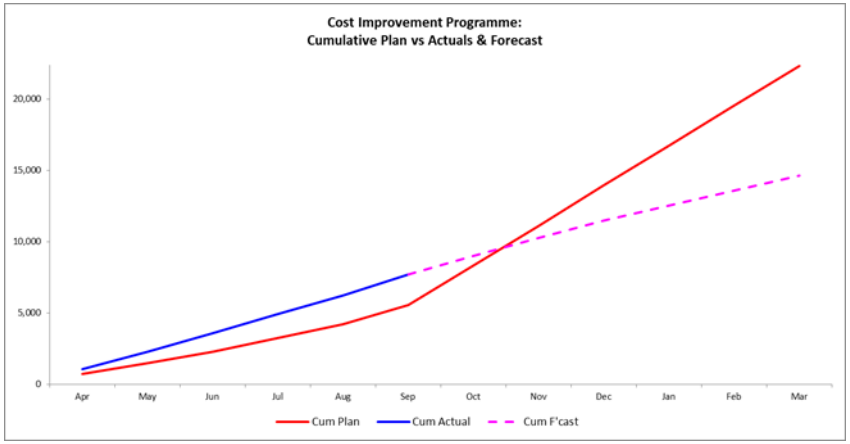
Gloucestershire Hospitals NHS
NHS Foundation Trust

1. At Month 6 the Trust has delivered £7.7m of CIP against the Year to date NHS Improvement target of £5.6m, a favourable variance of £2.1m. Within the month, the Trust has delivered £1.5m of CIP against an in-month NHSI target of £1.4m. a favourable variance of £0.1m largely due to vacancy factor (i.e. underspend against pay budgets).

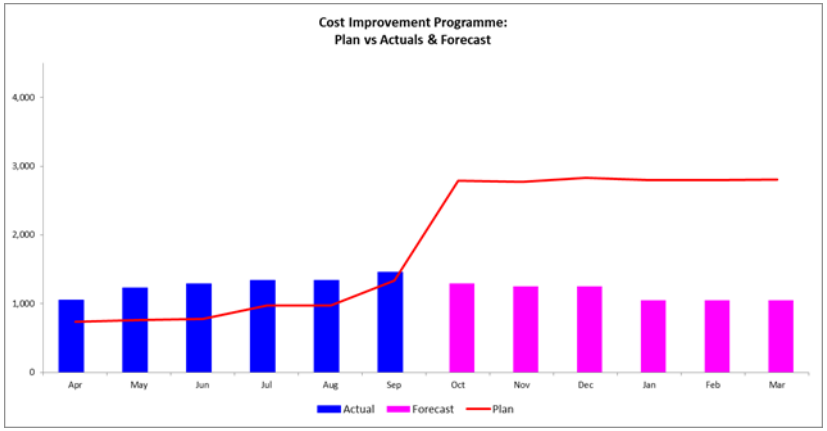
2. At Month 6, the Divisional year end forecast figures indicate delivery of £14.7m against the Trust's target of £22.4m. This has stayed relatively steady with a decrease of £0.1m since month 5 which leaves an under performance against target of £7.7m.

3. The recovery measures, started in month 4, continue to be actively pursued. The list of unpalatable as well as Divisional and cross cutting 'opportunities' continue to be progressed.

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



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



Balance Sheet (1)

Gloucestershire Hospitals NHS
NHS Foundation Trust

Trust Financial Position	Opening Balance 31st March 2019 £000	GROUP Balance as at M6 £000	B/S movements from 31st March 2019 £000
Non-Current Assets			
Intangible Assets	10,412	5,497	(4,915)
Property, Plant and Equipment	231,216	230,212	(1,004)
Trade and Other Receivables	5,185	4,662	(523)
Total Non-Current Assets	**246,813**	**240,371**	**(6,442)**
Current Assets			
Inventories	7,571	7,745	174
Trade and Other Receivables	25,419	30,101	4,682
Cash and Cash Equivalents	7,317	17,330	10,013
Total Current Assets	**40,307**	**55,176**	**14,869**
Current Liabilities			
Trade and Other Payables	(54,315)	(63,842)	(9,527)
Other Liabilities	(5,837)	(2,271)	3,566
Borrowings	(12,527)	(11,954)	573
Provisions	(160)	(160)	0
Total Current Liabilities	**(72,839)**	**(78,227)**	**(5,388)**
Net Current Assets	**(32,532)**	**(23,051)**	**9,481**
Non-Current Liabilities			
Other Liabilities	(6,860)	(6,672)	188
Borrowings	(135,294)	(155,316)	(20,022)
Provisions	(1,434)	(1,434)	0
Total Non-Current Liabilities	**(143,588)**	**(163,422)**	**(19,834)**
Total Assets Employed	**70,693**	**53,898**	**(16,795)**
Financed by Taxpayers Equity			
Public Dividend Capital	172,676	172,676	0
Equity			
Reserves	23,915	23,915	0
Retained Earnings	(125,898)	(142,693)	(16,795)
Total Taxpayers' Equity	**70,693**	**53,898**	**(16,795)**

The table shows the M06 balance sheet and movements from the 2018/19 closing balance sheet, supporting narrative is on the following page.

Balance Sheet (2)

Gloucestershire Hospitals NHS
NHS Foundation Trust

The commentary below reflects the Month 6 balance sheet position against the 2018/19 outturn.

Current Assets

- Inventories have increased in year by £0.2m reflecting an increase in pharmacy stock.
- Cash has increased by £10m since the year-end, reflecting the deficit income and expenditure position, offset by borrowing, the movement in working balances and the timing of capital expenditure.

Non-Current Liabilities

- Borrowings have increased by £19.4m, reflecting working capital loan support of £12.5m and a capital loan of £10m, offset by the repayment of loans approved in prior years.

Retained Earnings

- The retained earnings reduction of £16.8m reflects the impact of the in year deficit.

Better Payment Practice Code (BPPC)

Gloucestershire Hospitals NHS
NHS Foundation Trust

	Cumulative for Financial Year		Current Month September	
	Number	£'000	Number	£'000
Total Bills Paid Within period	51,963	117,951	7,247	20,806
Total Bill paid within Target	44,790	101,635	6,645	19,881
Percentage of Bills paid within target	86%	86%	92%	96%

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

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

Liabilities – Borrowings

Analysis of Borrowing	As at 30th September 2019 £000
<12 months	
Loans from ITFF	2,988
Distress Funding	6,800
Obligations under finance leases	1,598
Obligations under PFI contracts	568
Balance Outstanding	**11,954**
>12 months	
Loans from ITFF	19,958
Capital Loan	14,217
Distress Funding	99,409
Obligations under finance leases	4,052
Obligations under PFI contracts	17,680
Balance Outstanding	**155,316**
Total Balance Outstanding	**167,270**

The Trust has two major loans outstanding with the Independent Trust Financing Facility (ITFF).

The first loan was to facilitate improvements related to backlog maintenance and the second was for the build of the Hereford Radiotherapy Unit. These are included within the balance sheet within both current liabilities (for those amounts due within 12 months) and non-current liabilities (for balances due in over 12 months).

There are also borrowing obligations under finance leases and the PFI contracts.

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

Cashflow : September

Gloucestershire Hospitals NHS
NHS Foundation Trust

Cashflow Analysis	Apr-19 £000s	May-19 £000s	Jun-19 £000s	Jul-19 £000s	Aug-19 £000s	Sep-19 £000s
Surplus (Deficit) from Operations	**(3,464)**	**(5,470)**	**(1,626)**	**835**	**(1,700)**	**(305)**
Adjust for non-cash items:						
Depreciation	1,229	1,229	1,229	1,229	1,229	1,229
Other operating non-cash	0	4,918	0	0	0	0
Operating Cash flows before working capital	**(2,235)**	**677**	**(397)**	**2,063**	**(471)**	**924**
Working capital movements:						
(Inc.)/dec. in inventories	113	0	298	(202)	(28)	0
(Inc.)/dec. in trade and other receivables	1,444	2,810	92	(4,458)	(2,512)	(1,019)
Inc./(dec.) in current provisions	0	0	0	0	0	0
Inc./(dec.) in trade and other payables	(2,349)	916	154	16,467	(6,712)	(161)
Inc./(dec.) in other financial liabilities	0	(1,055)	0	0	0	0
Net cash in/(out) from working capital	**(792)**	**2,671**	**544**	**11,807**	**(9,252)**	**(1,180)**
Capital investment:						
Capital expenditure	(1,129)	(1,629)	(1,729)	(3,125)	(1,129)	(500)
Capital receipts	0	0	0	0	0	0
Net cash in/(out) from investment	**(1,129)**	**(1,629)**	**(1,729)**	**(3,125)**	**(1,129)**	**(500)**
Funding and debt:						
PDC Received	0	0	0	0	0	0
Interest Received	3	3	3	3	3	3
Interest Paid	(124)	(294)	(114)	(259)	(196)	(1,327)
DH loans - received	2,442	3,368	2,887	0	10,049	3,842
DH loans - repaid	0	0	0	0	(167)	(1,317)
Finance lease capital	(488)	(488)	(488)	(488)	(488)	(488)
Interest element of Finance Leases	(12)	(12)	(12)	(12)	(12)	(12)
PFI capital element	(68)	(68)	(68)	(68)	(68)	(68)
Interest element of PFI	(38)	(38)	(38)	(38)	(38)	(38)
PDC Dividend paid						(277)
Net cash in/(out) from financing	**1,715**	**2,471**	**2,170**	**(862)**	**9,083**	**318**
Net cash in/(out)	**(2,441)**	**4,190**	**588**	**9,883**	**(1,769)**	**(438)**
Cash at Bank - Opening	**7,317**	**4,876**	**9,065**	**9,653**	**19,537**	**17,768**
Closing	**4,876**	**9,065**	**9,653**	**19,537**	**17,768**	**17,330**

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

Cashflow Key movements:

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

The closing cash position includes £9.9m of committed cash:

Committed cash from 2018/19	£3.5m
Balanced of £10m capital loan	£3.8m
Accrued capital expenditure	£2.6m

The remaining cash balance of £7.4m represents Group working capital.

Year End Income and Expenditure Forecast

The plan for the 2019/20 financial year is for a £1.5m deficit assuming receipt of income for the Marginal Rate Emergency Threshold (MRET), Provider Sustainability Fund (PSF) and Financial Recovery Fund (FRF). The Trust remains committed to delivering this position but there are a number of risks that need to be highlighted. The table below summarises the forecast year end income and expenditure position for the Trust. This position reflects the forecast Cost Improvement Programme (CIP) gap £7.7m, and cost pressures identified within the Trust, notably within D&S for the hire of imaging equipment and external reporting, and within Medicine for medical staffing costs.

The table summarises the forecast reported to the Financial and Digital Committee on 31st October 2019. At month 6 the Trust is forecasting a control total deficit of £12.5m, a deficit to plan of £11m.

The forecast has improved from that reported in September by £1.4m, reflecting the receipt of national monies towards funding the medical staff pay award of £0.4m, increased patient care income of £0.4m, and run rate improvement of £0.6m.

Month 06 Forecast Outturn	FY PLAN £000s	M06 FoT £000s	FoT VARIANCE £000s
Total Income (exc. PSF/FRF)	**559,214**	**571,177**	**11,962**
PSF/FRF	**15,801**	**10,270**	**(5,531)**
Pay	**(368,128)**	**(375,315)**	**(7,186)**
Non Pay	**(182,303)**	**(192,409)**	**(10,105)**
EBITDA	**24,584**	**13,723**	**(10,861)**
Non Operating Costs	**(25,526)**	**(30,607)**	**(5,081)**
Surplus/(Deficit)	**(942)**	**(16,884)**	**(15,941)**
Fixed Asset Impairments	0	4,918	4,918
Surplus/(Deficit) after Impairments	**(942)**	**(11,966)**	**(11,024)**
Excluding Donated Assets	(558)	(562)	(4)
Controla Total Surplus/(Deficit)	**(1,500)**	**(12,528)**	**(11,027)**

The forecast would deliver the Quarter 3 control total, and Divisions are continuing to work on financial recovery actions to mitigate the £5.5m underlying gap (before PSF/FRF). If the gap is not resolved and the Trust does not deliver the £1.5m deficit year end control total it will lose PSF and FRF quarter 4 funding of £5.5m, resulting in a total gap from control total of £11m.

Closing The Year End Income and Expenditure Gap

Gloucestershire Hospitals NHS
NHS Foundation Trust

A series of initiatives to mitigate the forecast financial gap have been actioned or are under consideration as follows:

- Additional focus on run rate expenditure control
- Introduction of further grip and control measures, particularly around discretionary spend
- Revisiting current and proposed business cases
- Development of Divisional opportunities resulting in additional cost reduction delivery
- Year-end outturn income agreement with commissioners
- Review of Procurement delivery

Forecast Scenarios	Downside £m	Likely £m	Upside £m
Planned deficit (control total)	**(1.50)**	**(1.50)**	**(1.50)**
Forecast deficit at month 6	(12.53)	(12.53)	(12.53)
Month 6 FOT gap to control total	**(11.03)**	**(11.03)**	**(11.03)**
52 week fines imposed	(1.90)		
Additional winter expenditure	(0.50)	(0.50)	(0.50)
Gap to Control Total	**(13.43)**	**(11.53)**	**(11.53)**
Release of reserves	1.00	1.50	2.00
Increased patient care income		0.60	1.20
Improvement in Divisional forecasts		0.75	1.50
Revised Gap to Control Total	**(12.43)**	**(8.68)**	**(6.83)**
Quarter 4 PSF and FRF funding	5.53	5.53	5.53
Outstanding financial gap	**(6.90)**	**(3.15)**	**(1.30)**

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

The downside forecast assumes that 52 week wait fines are imposed, and all scenarios reflect the likelihood of additional winter costs to meet operational pressures .

The upside scenario assumes the release of central funds, an increase in patient care income, and improvement in Divisional forecasts.

All scenarios assume as a minimum the delivery of existing Divisional forecasts.

Capital Programme

The table below summarises capital expenditure at month 6 and the forecast outturn for 2019/20.

Capital Programme Expenditure Summary position at 30th September 2019

Capital Summary	Internal YTD Plan £k	YTD Spend £k	YTD Var £k	19/20 Full Year Plan £k	FOT 19/20 Spend £k	Forecast Variance £k
Health & Safety Projects	1,038	2,106	1,068	2,605	2,825	220
Environmental Works	139	24	(115)	350	350	0
Non Health & Safety Projects	474	567	93	975	1,088	113
Committed Schemes	185	900	715	460	482	22
Service Reconfiguration	4	0	(3)	9	9	0
Major Equipment Replacement	8	99	91	1,020	1,021	1
IM&T	4,292	4,653	361	9,883	9,883	0
MEF	995	245	(750)	2,490	2,490	0
Other Schemes	2,087	574	(1,513)	6,908	4,470	(2,438)
Contingency/Leases Capitalisation	316	0	(316)	1,300	3,882	2,582
Overspend/(Underspend)	**9,537**	**9,169**	**(368)**	**26,000**	**26,500**	**500**

Points to note:

- The work within the Women's Centre to replace the carbon steel piping completed in early October.
- The Trust received confirmation during October that its capital financing application of £4.95m has been approved and will be available for draw down shortly. The funding will be used for the replacement of emergency and essential medical equipment, essential estate backlog maintenance, and to fund priority health & safety schemes. The funding will be spent by the end of March 2020.
- The Trust has also been allocated £0.5m for winter planning and this is reflected in the forecast outturn value of £26.5m.
- Following a successful bid, the Trust has been awarded £0.7m to install energy efficient LED lighting across the two hospital sites.

Recommendations

Gloucestershire Hospitals NHS
NHS Foundation Trust

The Board is asked to note:

- The Trust is reporting a year to date actual income and expenditure deficit on a control total basis of £11.7m at September 2019. This is £0.6m favourable against plan.
- The actions being taken to mitigate the forecast gap to delivery of the Trust's control total, and associated forecast scenarios, with consideration of risks to delivery.

Author:	**Tony Brown, Senior Finance Advisor**
Presenting Director:	**Jonathan Shuter, Acting Director of Finance**
Date:	**November 2019**

REPORT TO TRUST BOARD – November 2019

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

This report describes the business conducted at the People and Organisational Development Committee on 21 October 2019 indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Risk Register	Inclusion of surgery risks from Trust Risk Register highlighted and a link to the overall / hierarchy of risks explained			
	Reported GMS Employee Relations risks and its need to be validated by the GMS Board.	Are we assured that staff morale has not been impacted	There is an active staff engagement forum, OD work on values, behaviours and mission. All Employee Relations issues are being overseen and managed and business continuity plans are in place.	
	New risk added 'IRMER' compliance with CQC and HSE notices discussed and issues with engagement at a task and finish group level	What were the issues; what do we do differently; what is the learning?	Issue was not involving the divisional Tri at an early enough stage to ensure assurance through the executive review process.	
	Trust secretary risk update discussed and updates provided.			

Freedom to Speak Up Quarterly return and strategy	Additional resources have been secured as Guardians. Fewer cases than previously reported. Trend remains staff issues specifically poor behaviours. October is Freedom to speak up month and a list of Comms and Engagement plans were shared alongside the strategy. Committee were assured by update	Are there any system, process, structure changes required as a consequence of the F2SU concerns? What are the Trusts plan to support managers and teams in relation to rudeness and the impact that has on teams? Do Guardians record demographics and is there a link suggesting poorer experiences for BAME colleagues?	Most changes relate to behaviours The People and OD and Patient experience team have held 8 engagement events and an online survey on behaviours. • Draft behaviour framework created • Civility saves lives is a means for clinical delivery • Need to plan interventions / embed into operational activities and practice • Need to be open about the next task of how to embed where we can • Consider training and development; human factors and use of simulation Demographics are not recorded but details of the incidents do not suggest a theme at present.	. Agreed to add a demographics form to the survey sent post Freedom to speak up guardian support.

				Agreed to approach chaplaincy, Diversity Network or persons on the 'stepping up' national BAME programme to become Guardians to widen cover of protected characteristics.
		Can we give case studies of speaking up, what happened and what improved as a result?	This is part of a planned Podcast to highlight two stories and the 'so what'	
		How can we be assured that Guardians are responded to in a timely manner?	Timelines agreed with person doing each case.	Timelines to be added in next report.
Freedom to speak up self-assessment board audit	The national tool to self-assess Freedom to Speak Up provision was presented. The committee agreed with the content.	Where are GMS on the self-assessment?	Freedom to Speak up does not extend to GMS formally but GMS have been asked to consider setting up a Guardian service.	
		Are the actions to take similar to other Trusts and where will assurance come from that they will be delivered?	If you look at the National Guardians Office actions and case studies the Trust is doing well against peers.	

Health and Safety Objectives (half year update)	The objectives were discussed and updates provided assurance on progress. At present stress and MSK are not divided into work and non-work categories. Sharps have reduced in some departments significantly and reflects the safer sharps introduction e.g. cannula / insulin / blade. Domestic and Sterilisation services injuries are up. Investigations: reviewing improvements to improve quality including Datix Reporting. RIDDOR reporting is improving and reports are coming down.	The committee raised concern about the level of risk and the funding available at 2020 for Health and Safety resources. What benefit is there of knowing whether its work related stress vs personal and can further triangulation with employee relation issues and freedom to speak up be given?	The People and OD function is looking for funding to assist in the interim if early recruitment commences. The data can be triangulated and is during executive review. Knowing the split of work and non-work gives the Trust the ability to influence work related stress issues and give targeted action. Hub would support regardless of the issue.	Reporting to separate figures from work vs personal and provide trends.
Update on HSE/CQC inspections	Radiation safety committee terms of reference changed with an exec led. 7 out of 9 areas have submitted their documents and 2 are outstanding. An extension on the CQC requirements will be requested			

	Wheelchair incident was discussed and the 4 issues the coroner wants to explore were outlined. A Jury will be convened.			PFD Review to be completed and submitted to People and OD Committee.
Temporary staffing update	A positive report well received which indicated a reduction in spend and improvements in agency use (decreased) and bookings (decreased) with an increase in bank use.	Are the key priorities right - to make more savings / improvements? Is the new recruitment lead delivering? What extent are messages regarding temporary staffing rules followed?	By reducing spends we reduce demand. The nurse recruitment and retention lead is a good start and a dedicated resource to assist. Overall good engagement in nursing. Medical roles require more engagement as not usually challenged on booking so requires a culture shift.	Layout statistical analysis on a single page to capture the significant progress more easily.
Silver QI exit project	Exit interview process is a Silver QI project with a task and finish group across the divisions. Compliance to exit interview process is still low. However overall retention has improved and is best in class against model hospital, peers and university hospital Trusts.	Is the Trust assured that without this data they have a view on the reasons staff leave? Are conducting Exit Interviews part of a supervisors Job Description? The percentage compliance is less of a concern than implementation. It should	The many sources of data received outside of the exit interview questionnaire give a good picture of why people leave the Trust. People management is in Job Descriptions. Executive reviews continue to focus on retention at divisional level.	

		matter to managers.		
Engagement and comms strategy update	Draft strategy and intention shared for early engagement. 3 pillars described: involving those who care (staff); involving our communities (people) involving our partner.	Is the definition of stakeholder clear and the language consistent throughout? Ensure description of care is about 'compassion' not just clinical intervention. Document has many 'buzz' words but what do they mean? What is the direction of travel? Who is the document for? Who is 'us'?		The strategy to be updated and a further version presented.
University hospital status update	Update shared and progress noted including the challenges relating to in year investments where benefits had been ill defined.	How will the Board be assured of progress?	The December Board seminar will be updated on progress.	
Performance dashboard	New format provided to link with the People and OD strategy and well received.	Can the committee see data as SPC Charts with upper and lower controls? Can the committee receive as narrative exception reports on the operational measures	Divisional exception reports will come to People and OD Committee once the	Trajectory of travel to be added to each item with historical data where possible. To add an executive summary on the report.

		linked to the dashboard?	dashboard for the divisions has been devised and interrogated. The new dashboard reflects the People and OD strategy priorities and measures.	
Work place race and disability equality standard	Benchmarking reviewed and the Trust position against peers noted.	Is it easy to look for organisations who are excelling?	Not all data is published which makes comparisons difficult to make easily	
ICS update	An update on activity was received including a review of groups reporting to the Local Workforce Advisory Board. Not all groups are meeting regularly	How do we get assurance that people not attending meetings are getting the information they need?	Minutes are distributed from meetings and Trust initiatives and impact are discussed at the People and OD Delivery Group and TLT as an Exception report.	

Board note/matter for escalation

The capability of Datix and its future to be considered as part of the digital agenda in Finance and Digital

Balvinder Kaur Heran Chair of People and OD Committee, 31 October 2019

TRUST MAIN BOARD – NOVEMBER 2019
THE LECTURE HALL, REDWOOD EDUCATION CENTRE, GRH
commencing at 12.30pm

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

Purpose

To provide assurance to the board and detail on the performance dashboard presented at the People and OD Committee on 21 October 2019. The report is the first draft of a new dashboard, aligned to the recently released People and OD Strategy. Key performance indicators detailed within are benchmarked (where appropriate) to Model Hospital Peer rates and University Hospital/ Teaching Peer rate. The indicators include:

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

The Board is advised that there are a variety of other strategic and operational measures contained within the strategy for which performance is more appropriately measured in narrative/ more detailed report form (i.e. Bullying and Harassment, Equality, Diversity and Inclusion measures, Staff Engagement, ICS). These have been mapped accordingly in **Appendix 1** and will feature, or continue to feature, as part of the overarching People and OD Committee work plan.

Key issues to note

Turnover and Retention
Non Registered nursing turnover has decreased to below 2018 levels; **Medicine Division** has the highest Turnover rate for non-registered nursing staff at 21.27%. The next highest Division is Surgery at 13.83%.
When we benchmark our Registered Nurse retention rate against Model Hospital Peers (rate **86.8%) and** University/Teaching Peer (rate **87%**) The Trust outperforms with a retention rate of 88.70%.

Sickness Absence
Trust annual sickness absence rates are stable (3.90%) and sit below both Model Hospital Peers (rate 4.01%) and University/Teaching Peer (rate 4.05%).

Vacancy levels
Vacancy levels within Non Registered Nursing and Doctors has decreased. With medical vacancies reducing dramatically over the summer months. Staff Nurse vacancies continue to be of concern at 13.08%, reflecting the national picture relating to staff nurse recruitment. Efforts continue to find innovative ways to attract and recruit Nursing staff from both domestic and international pipelines.

Appraisal
Appraisal compliance has declined and remains an area of concern. Divisions are challenged via the executive review process to report on specific action plans to improve compliance and their progress.

Mandatory Training
Compliance is achieved at 92% against a target of 90%. Only Medicine Division is below the target at 89%. By Staff Group, Additional Clinical Services and SAS Doctors are at 86%, Training Grade Medical staff is at 70%. All other groups are over target. Information Governance training is highlighted as an exception due to the decline in compliance. It is recognised that the anniversary of this training requirement means some slippage may occur however Divisions will now be challenged to focus on local improvement plans to improve and meet the required 95% target.

Recommendations

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

The Board are asked to note the Assurance Map in Appendix 1 approved by the People and OD Committee as sufficient to enable meaningful discussion for assurance purposes.

Impact Upon Strategic Objectives

Reflects known pressures and priorities relating to the delivery of a compassionate, skilful and sustainable workforce, organised around the patient that describes us as an outstanding employer who attracts, develops and retains the very best people.

Impact Upon Corporate Risks

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

Regulatory and/or Legal Implications

The reports proposed in Appendix 1 are designed in such a way to provide assurance that the Trust are operating in accordance with:
National reporting requirements associated with Equality, Diversity and Inclusion
Freedom to Speak Up best practice
NHSI/E requirements
Best practice and employment legislation, including the Equality Act.

Equality & Patient Impact

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

Resource Implications

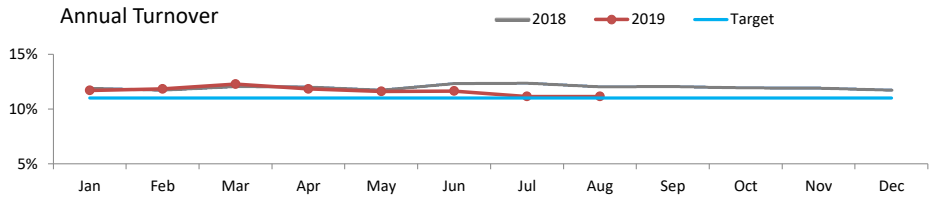
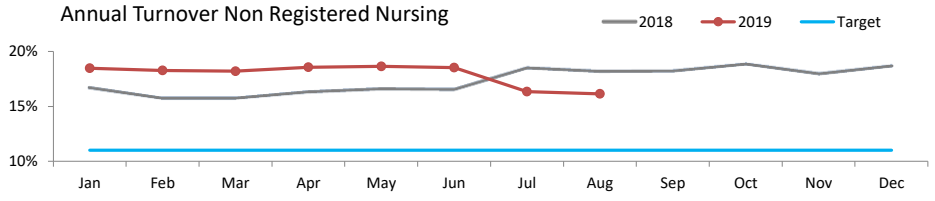
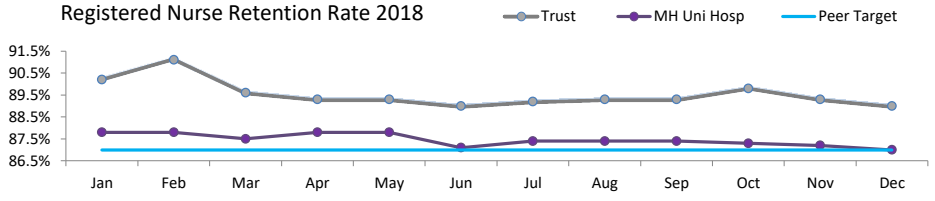
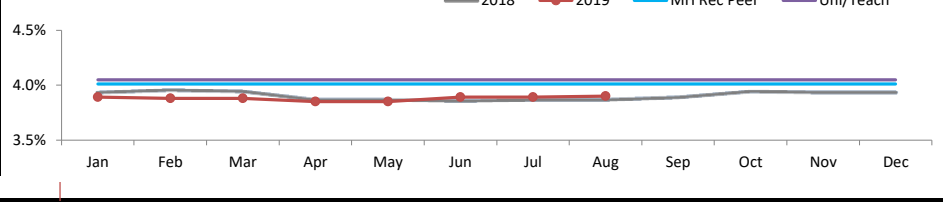
Finance	✓	Information Management & Technology	
Human Resources	✓	Buildings	

Action/Decision Required

For Decision		For Assurance	✓	For Approval		For Information	✓

Date the paper was presented to previous Committees						
Quality & Performance Committee	**Finance Committee**	**Audit & Assurance Committee**	**People and OD Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
			21 October 2019			
Outcome of discussion when presented to previous Committees						
The People and OD committee requested that data be presented as SPC charts with upper and lower controls and a trajectory of travel provided with historical data where possible. An executive summary will be added to the report alongside any exceptions relating to operational performance as linked to the dashboard and evaluated during Executive Reviews.						

Gloucestershire Hospitals NHS Foundation Trust - P&OD DASHBOARD , Oct 2019

Measure	Description	Aug-18	Aug-19	Trend	Variation
12 Month Rolling Turnover	Turnover is the no of leavers (in fte) expressed as a % of the ave numbers (fte)over the period. It is based on permanent contracts only.Trust target 11% Model Hospital only reports monthly figures. Latest avail Mar 19 - Trust 1.28%/Uni_Teach 1.21%, MH Rec ommended 1.30%	12.01%	11.15%		AHP's as a Staff Group have the highest turnover to Aug 19 at 15.71%. All other Staff Groups with the exception of Additional Clinical Services (13.85%) are below the 11% threshold. Medicine & Corporate Division are above the threshold, at 13.23% & 12.69% respectively.
Non- Reg Nursing 12 Month	Non - registered nursing includes HCAs, Apprentice HCAs, Trainee Nursing Assistants. Threshold 11% This figure not available from MH.	18.21%	16.16%		**Medicine Division** has the highest Turnover rate for non registered nursing staff at 21.27%. The next highest Division is Surgery at 13.83%. The Nurse Recruitment and Retention Lead (appointed Summer 2019) continues to work with the Recruitment and Retention Group and Divisional colleagues to address. The Trust has also joined the NHSI Retention Collaborative, a clinically led initiative.
Nurse Retention Rate %	The percentage of nursing and health visitors that remained stable over 12 months period. Latest data from Model Hospital is Dec 18. University/Teaching Peer rate was **87%**, MH recommended Peer rate **86.8%** (NB excludes Midwifery)	89.30%	88.70%		Model Hospital data is calculated slightly differently to ESR, resulting in a figure approx 0.5% higher. The latest available from MH is December 18. The Aug 19 figure shown has been calculated by applying an uplift of 0.5% to the Aug 19 ESR figure . This demonstrates that the Trust in outperforming when compared to Model Hospital peers.
Annual Sickness Absence %	Sickness Absence is expressed as a percentage of fte lost /available fte. The Uni/Teaching Hospital Peer rate from MH is 4.05%. MH recommended peer rate is 4.01%	3.87%	3.90%		Trust annual sickness absence is relatively stable. No Division is at the threshold, Corporate is closest at 3.69%. Diagnostics Div has the highest rate at 4.17%. By Staff Group, Nursing & Midwifery 4.34% and Additional Clinical Services (HCAs etc) 4.54% have the highest rates whilst Add Prof Sci Tech, AHPs, Health Scientists & Medical & Dental staff are below the threshold.

Enabling Pillar: Workforce Sustainability

We need to ensure that in our ambitions to place patients at the heart we are mindful of future needs, demands and service changes. As such we must make sure our workforce is future proofed and the Trust focuses on attraction, developmemt and retention of current and future staff. This means we need to work on some key inititatives around Recruitment, Retention, Role Development, Career Pathways, Learning and Development, Continuous Professional Development, Coaching and Workforce planning (succession planning).

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

Planning	Trust Key Initiatives						
Ser ref	Key Initiatives	Year 1-2 Milestones	Years 3-4 Milestones	Year 5	PODC Assurance (Type)	Frequency	Responsible
	Embed a strong unique employer brand to attract the best talent and embed value based recruitment	Ensure recruitment services are maximised to ensure time to hire is in the top quartile	Increase applications for medical grade roles by 10% in hard to fill areas.	Be regarded by our peers as the best hospital to work for in the South West	Resourcing Report	6 monthly	Mel Murrell
		Innovate to recruit for behaviours and competencies, not just skill. Intergrate Human Rights principles in recruitment, appraisal and development.	Develop innovative ways to attract staff and assess them		Resourcing Report	6 monthly	Mel Murrell
		Improved supply routes to the Trust for key roles and build more bank networks. Improved attraction and pipeline that looks to improve supply by 5-10% annually. Ensure colleagues are recruited for their values and managers developed to role model the right behaviours.	Close the gap to ensure the proportion of BAME colleagues employed in Leadership roles is consistent with local demographic data and BAME workforce percentages.		Resourcing Report	6 monthly	Mel Murrell
					Equality Report (Yr 3-4 Milestone)	Annual	Abigail Hopewell
		Identify, publish and commence delivery of targets for BAME representation across Junior, Middle and Senior Level Leadership roles.			Equality Report	Annual	Abigail Hopewell
	Recognise the talent of colleagues and retain	Improve nurse retention by 1%. Reduce vacancy factor for nurses 0.75 - 1% per annum	Improve Nurse retention by 1% Reduce vacancy factor for Nurses 0.75 - 1% per annum	Improve Nurse retention by at least 2% in line with NHS Long Term Plan and Vacancy Factor of 5%	Performance Dashboard	Bi-Monthly	Alison Koeltgen
		Reduce overall Trust turnover to benchmark with peers in the top quartile.		Reduce overall Trust turnover to be the best in top quartile.			
		Reduce turnover in Health Care Assistants and Admin and Clerical roles by at least 1% per annum to ensure parity with other Trusts.		Reduce turnover in Health Care Assistant roles by at least 5% and Admin and Clerical by 3%.			
		Improve retention measured by stability index by 1% each year. Embed and improve the visibility of our talent pools and Accelerated Development pool		Improve retention measured by stability index. Aim to be in top quartile of good and outstanding large University Status Trusts.			
	Develop new roles and career pathways	Delivery of grow your own / succession planning schemes			Sustainable Workforce Review	6 monthly	Alison Koeltgen & Dee Gibson-Wain
		Grow Nursing Associates (50 per annum) and Chief Nurse Fellows (5-15 per annum)	Have at least 2 Nursing Associates on each ward by 2023	Trust will have developed at least 25 colleagues through the Chief Nurse Fellowship route.			
		Develop 'step on' Nurses degree pathways to BSc	Expand the number of Nursing Associates stepping onto the BSc Nursing Degree Pathway		Education Report	6 Monthly	Dee Gibson-Wain
		Co-design MSc modules with Higher Education Institutes for Advanced Clinical Practitioner (ACP) roles and align supply with the workforce plan.	Have a ready supply of professional colleagues educated to a Masters level in Advancing Clinical Practice.		Sustainable Workforce Review	6 monthly	Ali Koeltgen & Dee Gibson-Wain
		ACP role development and delivery into roles in stroke, ICU, frailty and acute response team.	Have a developed and embedded ACP role and plan for 5 yeats	See the consistent use of advanced clinicians in roles more traditionally filled by medics.			
		Implement Associate Specialist roles in Acute Medicine.	Implement Associate Specialist role in Audiology, Pathology, Theatre/Operating department Practitioners and Radiography.				
		Develop and deliver an Assistant General Manager to General Manager to Director of Operations career pathway.	Reduce the vacancy position in Radiography and have a sustainable succession pathway				
		Commence radiography in-house training programmes	At least 5% of staff will be in the Accelerated Development pool and there will be a fair representation of diversity and protected characteristics				
		Embed talent development processes					
		Co-design Assistant Practitioner opputunities and Health Care Scientists with Integrated Care System (ICS) partners.	Increase the number of higher level apprenticeships to meet Assistant Practitioner and Healthcare Scientist vacancy levels	Increase the number of staff accessing these pathways for career development opputunities.			

Understand supply changes and demands and analyse current and future needs.	Develop a 5 year workforce plan which establishes gaps, future gaps	Reduce agency spend to meet NHSI control total	Efficient use of resources rated as outstanding by NHS Improvement (NHSI)			
Develop and implement new workforce models within the Trust with partners.	Improve attraction and pipeline for hard to fill roles - Doctors in training, consultant posts in Care of the Elderly (COTE), Acute, Radiographers, Cardiac Physiologists, Paediatric Nurses	Have a confident social media and online presence as a prospective employer		Resourcing Report	6 monthly	Mel Murrell
	Consider alternative methods for attraction and develop sources of supply.					
	Grow apprenticeships by at least 10% and add 5 new standards per annum to our offer	Achieve national target for apprentices by 2021		Education Report	6 monthly	Dee Gibson-Wain
	Spend/transfer levy available to ensure none is unused.	Maximise levy spend for internal use. Become and end point assessor organisation				
	Develop the Apprenticeship hub model with Health Education England.	Achieve an Integrated Care System Apprenticeship Hub	Achieve provider status for standards such as Business and Admin, Health and Social Care and Assistant Practitioner			
Integrated Care System (ICS) education and workforce collaboration	Deliver an education 'plan on page' for year one. Deliver upon programmes of work together with Health Education England (Nursing Associates, Leadership skills and toolkits, OD Skills, Advanced Clinical Practitioners)	Deliver upon ICS priorities of shared procurement for education and development programmes and commissions	Deliver the 5 year ICS local Workforce and advisory board plans for workforce development and sustainability	ICS Report	6 Monthly (+Monthly Verbal)	Emma Wood (& Senior Team)
	Deliver upon an Integrated Care System (ICS) workforce plan and commence solution building to work in partnership rather than competition.	Deliver workforce models and career development together ensuring partners to develop skills required across organisational boundaries e.g. ICS need for GPs to recruit roles traditionally found in other providers				
	Implement the ICS Pilot High Potential Scheme to encourage colleagues with aspirations to become Directors.					
	Take action to encourage BAME colleagues to participate in organisation and ICS-wide Leadership Development Programmes.					
Placement capacity and student experience	Increase adult nursing placements by 10%	Increase placement capacity by further 15%	Continue to work with Higher Education Institutes to maximise numbers of locally trained healthcare professionals.	Education Report	6 Monthly	Dee Gibson-Wain
	Improve student experience of placements by 10%	Implement recommendations from the National RePAIR project to improve the experience of students on placement.				
	Bid for Health Education England funds to improve student experience					
	Improve collaboration with Higher Education Institutes to ensure local educational provision meets the Trust and Integrated Care System (ICS) 5 year workforce plan			Sustainable Workforce Review	6 monthly	Ali Koeltgen & Dee Gibson-Wain
	Participate in the national RePAIR project relating to the retention of our older professional workforce, particularly in creation of alternative roles towards the end of careers and post-retirement.	Implement recommendations from RePAIR relating to the more experienced workforce.				

Enabling Pillar: Colleague Experience

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

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

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

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

Planning	Trust Key Initiatives						
Ser ref	Key Initiatives	Year 1-2 Milestones	Years 3-4 Milestones	Year 5	PODC Assurance (Type)	Frequency	Responsible
	Develop a culture where our values are well embedded in all our practices and policy	Ensure recruitment services are maximised to ensure time to hire is in the top quartile of peers	Improve experience indicators as measured by staff survey to be the best of Acute Trusts	To be recognised nationally as an employer of choice via national awards	Staff Survey (&Action Plan)	(& 6 month u	Abigail Hopewell
		Tailor pulse surveys to determine colleague experience			*Enagement Strategy	*tbc	*tbc
		Agree new models of communication and listening into action methodologies					
		Improve experience indicators as measured by staff survey to be in top quartile of Acute Trusts			Staff Survey (&Action Plan)	(& 6 month u	Abigail Hopewell
		Embed our values and define the associated behaviours. Launch 'Civility Saves Lives' and			Employee Relations Report	6 Monthly	Ali Koeltgen
					Freedom to Speak Up Review	Quarterly	Emma Wood
	Secure equity for all	Workplace, Disability, Equality Standard first report published	Closure of Workforce, Race, Equality Standard and Workplace, Diversity, Equality Standard experience gaps	Annual reports indicate no experiential discrepancies between staff groups	Equality Report	Annual	Abigail Hopewell
		Improve reported experience gaps as measured by the Workplace Race Equality	Closure of gaps in Gender Pay reporting		WRES Report,	Annual	Abigail Hopewell
					Gender Pay Gap Report	Annual	Ali Koeltgen
		Reduce divisional reports of inequitable treatment relating to protected characteristics			Employee Relations Report	Annual	Ali Koeltgen
		Embed the Diversity Network further			Equality Report	Annual	Abigail Hopewell
		Colleagues recognise that they can have a say in matters relating to them and influence change			Staff Survey	Annual	Abigail Hopewell
	Remove violence and aggression, bullying and harrassment from colleagues' working lives.	Improved reporting of bullying and harassment resolution and ensure faster resolution of cases.	Reduce year on year in grievances relating to bullying and harassment.	Colleagues have confidence that the Trust has a zero tolerance approach to violence, aggression, bullying and harassment	Employee Relations Report	6 Monthly	Ali Koeltgen
		Improve in staff survey results relating to violence and aggression, bullying and harassment to meet top quartile of Acute Trusts	Improvements in staff survey relating to violence and aggression, bullying and harassment to best of Acute Trusts		Staff Survey	Annual	Abigail Hopewell
	Promote health, safety and wellbeing	Deliver and embed the staff support and advice hub. Embed processes for reasonable workplace adjustments and requests	Expand the staff support and advice hub to more proactive campaigning and ICS inclusion.	Be recognised nationally for health, safety and wellbeing services.	Colleague Health and Wellbeing Report	Annual	Abigail Hopewell
		Reduce colleague absence specifically for Multiskeletal and mental health illnesses	Closure of the gaps in Gender Pay Report				
		Absence rates to match model hospital best peers	Be recognised as having improved and safe systems of work for colleagues		Performance Dashboard	Bi-Monthly	Ali Koeltgen
		Reduce safety incidents involving colleagues in key areas: sharps, manual handling and incident rates per 100 staff in line with peer Trusts.	Achieve full compliance with the workplace Wellbeing Charter		Colleague Health and Wellbeing Report	Annual	Abigail Hopewell
			Improve staff survey results to show disabled staff report the same experience as their non-disabled colleagues		Staff Survey (&Action Plan)	Annual (& 6 month update)	Abigail Hopewell
	Embed new leadership and management practice	Deliver new education and development standards for managers and leaders.	Ensure no people manager is in post without the prerequisite training and development	Ensure all peoples managers are professionally qualified in people management skills	Employee Relations Report	6 Monthly	Ali Koeltgen
		Improve on boarding for management colleagues	Improve and embed a coaching and mentoring offer for managers and staff.	The Trust has a coaching and mentoring culture			
		Improve the ratings in the following NHS Staff Survey Themes: immediate manager, Quality of Appraisals and Staff Engagement.			Staff Survey	Annual	Abigail Hopewell

Enabling Pillar: Transformation

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

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

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

Planning	Trust Key Initiatives						
Ser ref	**Key Initiatives**	**Year 1-2 Milestones**	**Years 3-4 Milestones**	**Year 5**	**PODC Assurance (Type)**	**Frequency**	**Responsible**
	Deliver the best professional education, learning and development	Ensure continuous improvement of education content, material and methods of delivery.	Deliver upon the education requirements of nurse, midwifery, Allied Health Professionals and Health care scientist career pathways.	be recognised as a learning organisation	Education Report	6 Monthly	Dee Gibson-Wain
		Support and develop programmes which enable colleagues to develop personal skills via either accredited or non- accredited means		To be recognised as having an embedded coaching and improvement culture			
		Target the needs of colleagues as linked to the workforce plan and plan programmes which span pre-employment, new starters and ongoing development.					
	Deliver new patient pathways within the Trust and the Integrated Care System	Ensure colleagues are engaged and contribute to changes in service delivery	Colleagues will transition into new pathways and services with ease	Colleagues will reflect that the change processes for them was engaging and well managed	Employee Relations Report (Includes Management of Change)	6 Monthly	Ali Koeltgen
		Colleagues will report in the staff survey an improvement in their views on quality of care and their ability to deliver this to match national averages	Nursing Assessment and Accreditation Service (NAAS) ratings are blue	Colleagues will report in the staff survey an improvement in their views on quality of care and their ability to deliver this to match best in class Acute Trusts	Staff Survey	Annual	Abigail Hopewell
		Nursing Assessment and Acrreditation Service (NAAS) ratings are all green			Assurance to Q&P Committee		
	Deliver digital and technological efficiencies for people processes	Deliver upon a tecnological solution for temporary staffing.	Technological solutions for temporary staffing and the Employee Relations tracker have		Resourcing Report	6 monthly	Mel Murrell
					Employee Relations Report	6 Monthly	Ali Koeltgen
		Introduce an Employees relation tracker to enable HR Advisory services to better support staff and managers with grievances, sickness management and disciplinary cases.	Implement further self service and Manager modules on ESR		Employee Relations Report	6 Monthly	Ali Koeltgen
		Deliver improved demographic data capture relating to protected characteristics on ESR to enable improved reporting on staff experience.			Equality Report	Annual	Abigail Hopewell
		Safer staffing levels are consistently achieved at ward level			Assurance to Q&P Committee		
		Improve job planning compliance			Resourcing Report	6 monthly	Mel Murrell
		Broaden electronic rostering to all front line clinicians			Resourcing Report	6 monthly	Mel Murrell
	Deliver upon University Hospital Status	Scope the opportunity, benefits and requirements for becoming a University Hospital	Develop additional research projects with a focus on education	Maximise the opportunities presented by being an Accredited University Hospital	University Hospital Update	Quarterley	Simon Lancely
		Develop further research funding sources					

REPORT TO THE MAIN BOARD – NOVEMBER 2019

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

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

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

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

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

Mike Napier
Chair of Gloucestershire Managed Services Committee
3 September 2019

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

TRUST MAIN BOARD – NOVEMBER 2019
THE LECTURE HALL, REDWOOD EDUCATION CENTRE, GRH
commencing at 12.30pm

Report Title
A REPORT ON THE TRUST'S EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE ARRANGEMENTS
Sponsor and Author(s)
Author: Rachel Minett, Emergency Planning and Resilience Manager Sponsor: Rachael de Caux, Chief Operating officer
Executive Summary

Purpose

The aim of the paper is to provide the Trust board with assurance, following annual self- assessment against national standards for emergency and resilience preparedness. In addition, the paper provides an overview of the emergency planning and resilience programme and events for the past year.

Key issues to note

Self- assessment against national standards for emergency planning and resilience preparedness.

The Trust self -assessment report has been interrogated by Gloucestershire CCG and accepted as part of the overall system wide report for submission to NHSE in August 2019.
The official report is expected from NHSE in November 2019. No issues have been raised thus far.
It is acknowledged due to staff turnover, training of staff will be a continuous action.

Annual Programme Plan

A rolling programme to review emergency plans and training is in place. Debriefing sessions and lessons learned are shared with teams following incidents and events.
Improvements have been made with Business Continuity and Business Impact Assessments (BIAs) across critical and essential services along with IT resilience and testing of the IT Cyber plans with IT shared community CITS (County wide IT Systems).

Elements of the Major Incident Plan have been tested through a variety of exercises, testing major incident response plans and action cards and their coordinated response in specific areas. Exercise Barracuda tested Critical Care, Theatres and Pathology Department. Exercise Paper Weight tested the revised cyber response plans and action cards, and Exercise Astralbend tested the Emergency Department major incident response to Chemical, Biological ,Radiological ,Nuclear (CBRN), the Trust Incident Coordination Centres and the Decontamination CBRN team responsiveness.

Conclusions

The Trust is compliant against national core standards for EPRR with the acknowledgment it is a

challenge to provide continuous refresher updates and training to all staff and acknowledging a report from NHSE is expected. A planned programme of review and training will remain a continuous process. Planned exercises will be held regularly to test front line staff in their preparedness and resilience in responding to unforeseen events.

Implications and Future Action Required

An action plan is being monitored through the Emergency Planning Resilience and Preparedness Group to ensure national standards and training needs are maintained.

Recommendations

The Board is asked to:

- Accept this report as assurance of the Trust's compliance with EPRR standards and annual planned programme.

Impact Upon Strategic Objectives

Failure to meet the national EPRR standards will impact on the operational resilience of the Trust in response to all incidences.

Impact Upon Corporate Risks

Non-compliance will directly impact the Trust effectiveness and safety of patients visitors and staff in an incident response.

Regulatory and/or Legal Implications

The Trust has a duty as category one responders under the Civil Contingencies Act 2004 and Health and Social Care Act 2012 to have plans in place and maintain our preparedness through training and exercises.

Equality & Patient Impact

No specific patient group is affected by the issues addressed in this report

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)
						Emergency Planning and Resilience Group (EPRG)

Outcome of discussion when presented to previous Committees

EMERGENCY PREPAREDNESS RESILIENCE AND RESPONSE 2019

1. Aim

The aim of the paper is to provide the Trust board with assurance, following an annual self- assessment against national standards for emergency planning and resilience preparedness. In addition, the paper provides an overview of the emergency planning and resilience programme and events for the past year.

2. Background

Each year the Trust Emergency Preparedness Resilience and Response (EPRR) is reviewed through the NHS England assurance process.
http://www.england.nhs.uk/ourwork/eprr/.
The process is an evidence-based internal self-assessment against nationally defined standards. The Trust assessment has been reviewed in detail by Gloucestershire Clinical Commissioning Group (CCG). A system wide report of which GHFT report is included was submitted to NHS England area team in August 2019 by the CCG. The official report from NHSE is due in November 2019. However the CCG have already approved the Trust self- assessment prior to submission to NHSE.

The Emergency Preparedness Resilience and Response annual work plan is identified as part of the review. Following feedback from the assurance process key actions are identified and monitored through the Emergency Planning and Resilience Group. They will include training and exercises to ensure staff are fully compliant against the national standards.

3. Governance

The attached Appendix is a copy of the Trust self–assessment, evidence, RAG rating and Actions required to become fully compliant. Training and updates is a continuous challenge due to staff turnover and therefore meeting full compliance is not always achievable and therefore this element is rated partial compliance.
Changes to the national standards have been made since last year and do not directly correlate to last year's self- assessment.

4. Planned Annual Programme

A rolling timetable for reviewing of emergency plans and training is in place along with debriefing sessions and lessons learned from training exercises.
Listed below are the plans reviewed so far this year:

- Business Continuity Management (BCM) plan - The template for the business impact assessments which are part of the BCM plan has been updated to reflect NHSE national guidance.
- The Trust Major Incident (MI) plan has been reviewed with no significant changes. A quick access MI summary document will be available from November for on -call

managers and the Site team. A similar easy access document appropriate for ward staff has been developed and is being rolled out.

- Shelter and Evacuation plans have been revised and updated.
- Local fire plans across the Trust with standardised fire information folders are now being implemented.
- County wide Health IT resilience and incident response has been tested (Exercise paperweight).
- The Pandemic Flu plan is under review by the infection control team. This dovetails into the Trust Infection Control plans and the Local Resilience Forum (LRF) plans which are County wide.
- The Adverse Weather Plan will be revised and updated with LRHP (Local Resilience Health partnership) with a completion date of mid -November. The 4x4 LHRP/LRF transport plan worked well last winter across health partners and is being further revised for this winter.
- The CBRN (Chemical Biological Radiation Nuclear) decontamination plan was updated in March 2019 and will have a further review following the recent exercise Astralbend held in September 2019.
- The Trust Human Resources Business Continuity policy is under review in line with and dove tails into the Local Health Resilience Partnership (LHRP) Mutual Aid Plan.
- The Trust Mass prophylaxis / Mass casualties plan is being reviewed and once approved a walk through exercise will be planned in the key areas involved.

5. Business Continuity

As expected there has been a lot of focus this year on Brexit preparation with key department heads identified to lead preparedness for their areas as part of the Brexit working group and in line with national directives. The group will be continually monitoring and responding to NHS Brexit guidance and will have the required plans in place. No significant issues have been raised by GHFT.

There is a continual drive and rolling training programme for Business Continuity Management. All key departments have Business Continuity leads working with their teams to ensure plans and action cards are up to date so that staff are familiar with each action card. The focus now is on the BCM for the Electronic Patient Record (EPR) with clinical champion engagement.

GHFT IT with the county wide CITS (County Wide IT systems) have worked collaboratively on IT systems and cyber resilience upgrades and updating plans as part of the process. Testing exercises were held in March 2019 and August 2019.

Procurement and Estates have updated their BCM plans and as part of the exercise and have sought assurance from companies with which the Trust have contracts so they align to the ISO 22301 standards and have their own BCM plans in place.

6. CBRN

The Trust has maintained the Chemical, Biological, Radiological Nuclear /Hazardous Materials (CBRN/HAZMAT) preparedness which is now bolstered by new PHE (Public Health England) CBRN guidance documentation. All specialist CBRN suits have been

replaced under Government Issue. Equipment identified for replacement such as CBRN tents has been replaced.

A SWAST CBRN audit undertaken in March 2019 on behalf of NHSE as part of the assurance process received a Red rating for lack of evidence of CBRN trained staff on duty 24/7 in the Emergency Department (ED). This has been addressed by targeting identified staff to ensure there are trained staff on each shift evidenced on the duty roster. A repeat audit will take place this month.

CBRN e-learning will now be rolled out to nursing staff.

Plans are also being developed with the Fire Service and GHFT for better countywide

CBRN resilience.

In September 2019 the Trust participated in a multiagency CBRN radiation exercise Astralbend using actors as patients to exercise in as real a situation as possible. The exercise was deemed a success despite ED staff having to respond to competing operational pressures which made the exercise more realistic and more challenging to complete.

7. **Fire evacuation**.

Fire evacuation training with local level walk through continues with the standardisation of ward fire folders. Training fire evacuation kit is now part of mandatory manual handling training

8. Training updates

Staff Training requirements are documented within the Emergency Planning and Resilience Response (EPRR) training matrix which is aligned to the Local Health Resilience Partnership group (LHRP) training matrix.

Training needs for operational on call Silver and Gold which is via a self-assessment document and signposting to training for identified gaps has been revised.

Testing Exercises

The Major Incident Plan was tested in parts over the last year in particular Exercise Barracuda held on 25 January 2019 which tested the MI response and action cards for Theatre teams, Critical care teams and Pathology Department.

Cyber Exercise Paper Weight was a cyber desktop exercise which was held on 19 July 2019 with clinical and non- clinical staff and IT teams.

CBRN/contamination exercise Astral Bend was held on 11 September 2019.

Local and Major Incident plans and action cards were reviewed and updated from lessons learned as part of the EPRR exercise work plan for the summer.

Exercises planned.

CBRN training exercise is biannual with the next exercise planned for March 2020 prior to the Gold Cup Festival week so that staff are freshly rehearsed.

Walk through of Mass prophylaxis/ Mass Casualty Plan for GRH Outpatient department is being planned for this later year

A Major incident exercise is being planned for next summer to incorporate theatres, Department of Critical Care (DCC), ED and other relevant parts of the hospital.

Resources

The Trust will maintain all decontamination and emergency response kit such as decontamination tents, dis-robe and re-robe kits and waste water storage containers. The requirements will be driven by the recommendations of the audit of CBRN compliance performed by SWAST which is expected in November 2019.

Review of resources have now been agreed to support the Trusts EPRR requirements in relation to training, exercising and admin/EPRR support.

Author: Rachel Minett, Emergency Planning and Resilience Manager
Presenting Director: Rachel de Caux, Chief Operating Officer
November 2019

MAIN BOARD – NOVEMBER 2018
Lecture Hall, Redwood Education Centre commencing at 09:00

Report Title
Strategic Objective Amendment: Driving Research
Sponsor and Author(s)
Author: Simon Lanceley, Director of Strategy & Transformation Sponsor: Deborah Lee, Chief Executive
Executive Summary
Purpose To propose an amendment to one of the Trusts ten Strategic Objectives following feedback from colleagues. Key issues to note Any change will need to be communicated to colleagues and reflected in a range of online and printed materials. Conclusions There are three options to consider.
Recommendations
To approve option 3: Agree this change to the Delivering Research objective now, but do not communicate or action until we complete an end of year 1 review of all ten strategic objectives in April 2020, at which point we may want to make changes to other objectives. Communication and material updates would be completed in one go during April 2020
Impact Upon Strategic Objectives
Updates current Driving Research Objective
Impact Upon Corporate Risks
None
Regulatory and/or Legal Implications
None
Equality & Patient Impact
None

Resource Implications			
Finance		Information Management & Technology	
Communications	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 & Assurance Committee	Workforce Committee	Remuneration Committee	Trust Leadership Team	Other (specify)
Outcome of discussion when presented to previous Committees						
Paper has come direct to Board.						

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD NOVEMBER 2019

Strategic Objective Amendment: Driving Research

1 Background

In June 2019 Main Board approved the Trusts new five year strategy which includes ten strategic objectives (appendix 1).

Through the communication, cascade and implementation of these objectives feedback from colleagues suggests we have not fully captured our current strength and future ambition in relation to teaching and learning.

Our commitment and ambition to teaching and learning is incorporated within the workforce sustainability pillar of our People & OD Strategy, but it is felt this should be made more explicit by incorporating teaching and learning into one of our ten strategic objectives.

2 Proposal

Given the link to our University Hospital ambition, the proposal is to amend the Driving Research objective from:

Driving Research – We are research active, providing innovative and ground breaking treatments; staff from all disciplines contribute to tomorrow's evidence based, enabling us to be one of the best University hospitals in the UK.

To:

Driving Research and Teaching – We are a research and teaching active Trust, delivering innovative and ground breaking approaches to treatment and learning; staff from all disciplines contribute to tomorrow's evidence base and skilled workforce enabling the Trust to be one of the best University Hospitals in the UK.

The People & OD strategy was approved by Main Board in August 2019 and the Research Strategy in October 2019. The annual refresh of these strategies in 2020 will need to reflect this amended objective and define the actions being taken by both strategies to progress our teaching and learning ambition.

This change will need to be communicated to colleagues and reflected in a range of materials, for example:

- Animated video (although this is an opportunity to amend the introductory narrative to make it clearer the objectives describe a future state e.g. "By 2024 we will….")
- On-line materials: Internet, Intranet, Trust strategy, enabling strategies, training materials
- Printed materials: Posters, pocket guides
- Trust processes: appraisal materials, induction materials, Datix, business case templates.

3 Options

Option 1: No change – teaching and learning ambition to be progressed through the workforce sustainability pillar of the People & OD strategy.

Option 2: Make the change to the Delivering Research objective with immediate effect.

Option 3: Agree this change to the Delivering Research objective now, but do not communicate or action until we complete an end of year 1 review of all ten strategic objectives in April 2020, at which point we may want to make changes to other objectives. Communication and material updates would be completed in one go during April 2020.

Author & Presenting Director: Simon Lanceley, Director of Strategy & Transformation

14th November 2019

Appendix 1: Trust Strategic Objectives

Our Strategic Objectives for 2019–2024

ITEM 15

GOVERNOR QUESTIONS

VERBAL

ITEM 16

STAFF QUESTIONS

VERBAL

ITEM 17

PUBLIC QUESTIONS

VERBAL

ITEM 18

NEW RISKS IDENTIFIED

VERBAL

ITEM 19

ITEMS FOR THE NEXT MEETING

VERBAL

ITEM 20

ANY OTHER BUSINESS

VERBAL