GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

The next meeting of the Gloucestershire Hospitals NHS Foundation Trust Main Board will be held on **Wednesday 12 July 2017** in the **Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital** commencing at 9.00 a.m. with tea and coffee from 8.45 a.m. **(PLEASE NOTE DATE AND VENUE FOR THIS MEETING)**

Peter Lachecki
Chair

22 June 2017

AGENDA

				Approximate Timings
1.	Welcome and Apologies			09:00
2.	Declarations of Interest			
	Minutes of the Board	(subject to ratification by the Board and its relevant sub-committees)		
3.	Minutes of the meeting held on 7 June 2017	**PAPER**	**To approve**	09:02
4.	Matters Arising	**PAPER**	**To note**	09:05
5.	Chief Executive's Report July 2017	**PAPER** (Deborah Lee)	**To note**	09:10
6.	Quality and Performance Report:		**For Assurance**	09:20
	• Performance Management Framework Report - Update of the Chief Operating Officer	**PAPER** (Felicity Taylor-Drewe)		
	• Report of the Chair of Quality and Performance Committee meeting held on 28 June 2017	**PAPER** (Tracey Barber)		
	• Trust Risk Register	**PAPER** (Deborah Lee)		
7.	Financial Performance Report:		**For Assurance**	09:50
	• Report of the Finance Director	**PAPER** (Steve Webster)		
	• Report of the Chair of the Finance Committee meeting held on 29 June 2017	**PAPER** (Keith Norton)		
8.	Workforce Report:		**For Assurance**	10:10
	• Report of the Director of Human Resources and Organisations Development	**PAPER** (Dave Smith)		
	• Report of the Chair of the Workforce Committee on the meeting held on 9 June 2017	**PAPER)** (Tracey Barber)		
	Break			**10.30 - 10.40**
9.	Board Assurance Framework	**PAPER** (Deborah Lee)	**For Assurance**	10:40
10.	SmartCare Programme Board Report	**PAPER** (Sally Pearson)	**For Assurance**	10:50
11.	Research Update	**PAPER** (Sally Pearson)	**For Assurance**	11:00

12.	Organ Donation Executive Summary Reports	**PAPER/ PRESENTATION** (Mark Haslam)	**To Note**	11:10
13.	Minutes of the meeting of the Council of Governors held on 19 June 2017	**PAPER** (Peter Lachecki)	**To Note**	11:25
14.	Items for the Next Meeting and Any Other Business	**DISCUSSION** (All)	**To Note**	11:30
	Governor Questions			
15.	Governors Questions – A period of 10 minutes will be permitted for Governors to ask questions		**To Discuss**	11:35
	Staff Questions			
16.	A period of 10 minutes will be provided to respond to questions submitted by members of staff		**To Discuss**	11:45
	Public Questions			
17.	A period of 10 minutes will be provided for members of the public to ask questions submitted in accordance with the Board's procedure.			11:55
			Close	12:05
	Luncheon			**12.05 – 12.25**

Date of the next meeting: The next meeting of the Main Board will take place at on **Wednesday 13 September 2017** in the **Lecture Hall, Redwood Education Centre, Gloucester** at **9.00 am.**

Please note that the Main Board Meeting scheduled for 9 August 2017 has been cancelled.

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

Board Members

Peter Lachecki, Chair

Non-Executive Directors	**Executive Directors**
Tracey Barber	Deborah Lee, Chief Executive
Dr Claire Feehily	Maggie Arnold, Nursing Director
Tony Foster	Steve Webster, Finance Director
Rob Graves	Dr Sean Elyan, Medical Director
Keith Norton	Dr Sally Pearson, Director of Clinical Strategy
Vacancy	Dave Smith, Director of Human Resources and Organisational Development
	Arshiya Khan, Interim Chief Operating Officer

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE TRUST BOARD HELD IN THE SUBSCRIPTION ROOMS, GEORGE STREET, STROUD ON WEDNESDAY 7TH JUNE 2017 AT 9AM

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

PRESENT	Peter Lachecki	Chair
	Deborah Lee	Chief Executive
	Dr Sean Elyan	Medical Director
	Maggie Arnold	Director of Nursing
	Arshiya Khan	Interim Chief Operating Officer
	Dave Smith	Director of Human Resources and Organisational Development
	Sarah Stansfield	Acting Director of Finance
	Dr Sally Pearson	Director of Clinical Strategy
	Tracey Barber	Non-Executive Director
	Dr Claire Feehily	Non-Executive Director
	Tony Foster	Non-Executive Director
	Rob Graves	Non-Executive Director
APOLOGIES	Keith Norton	Non-Executive Director
IN ATTENDANCE	Catherine Boyce	Clinical Strategy Manager
PUBLIC/PRESS	Craig Macfarlane	Head of Communications
	Felicity Taylor-Drewe	Assistant Director Planning and Performance
	Steve Webster	Director of Finance Designate (from Item 5)
	Alan Thomas	Lead Governor
	Two members of the public	

The Chair welcomed all to the meeting.

133/17 PATIENT STORY **ACTIONS**

(Suzie Cro (Head of Patient Experience) attended the meeting for this item)

The Head of Patient Experience explained that the patient story originally scheduled would be presented at a later date. In its place, she presented the results of the National In-patient Survey.

Key points highlighted, included:-

- 530 responses with a response rate of 44%. This was lower than in 2015 (50%), but higher than the national average.
- The survey revealed a number of positive results, including:
    - 83% rated care as 7 or more out of 10
    - 80% felt "always" treated with dignity and respect
    - 80% always had confidence and trust in their doctors
    - 96% felt hospital rooms/wards were very or fairly clean
    - 88% said always had enough privacy when being examined or treated

The Head of Patient Experience then reflected the Trust's performance in a number of thematic areas, illustrating the findings

with both positive and negative feedback from patients.

- **Care from staff**
  80% of patients felt overall that they were treated with respect and dignity when they were in hospital**.**

  However, some examples of poor practice included: - slow response to call bells; a number of temporary staff on the night shift without a basic knowledge of medication and treating vulnerable older patients with disrespect; rough handling during one and only bed bath; lack of assistance in bath/shower, leaving patient in soiled clothing.

- **Confidence and trust**
  68% of patients had confidence and trust in the decisions made about their condition or treatment.

  Examples of poor experience included:- feeling just another number, shortage of night staff, agency staff who were not familiar with the hospital or procedures; constantly repeating medical history to everyone; not confident about agency staff knowledge of medication.

- **Information**
  75% patients felt were given the right amount of information. Poor experience included a lack of information about the reason for admission to hospital, how or why a condition had occurred, not being given information and no one to talk to leading to concerns and fear of reoccurrence and appointment with a specialist nurse only some weeks later.

  The Head of Patient Experience reported that she was working with the Library Services Manager on a quality improvement project to establish a “virtual library”, whereby patients or carers could e-mail the library, who could then undertake a search for them.

- **Communication**
  68% of patients felt they had answers from staff to important questions in a way they could understand.

  Patient feedback suggested in a number or cases particular difficulties in gaining access to doctors to discuss issues.

- **Planning**
  48% of patients felt that they were given enough notice about when they were to be discharged.

  Some examples of patient comments suggested that discharge systems were muddled, unplanned and required improvement; staff were overstretched, but some patients could assist by completing their own discharge forms; delay in being signed off by a doctor could reduce bed turnover.

- **Discharge**
  71% of patients felt staff explained the purpose of medicines they were to take home in a way which they understood.

  Examples of poor experience included a lack of information

about effects/side effects; conflicting/inconsistent advice; delays in writing up medication and in waiting for medication contributing to delays in discharge.

- **Self management**
  72% of patients were told how to take their medication in a way they could understand.

  Examples from patient feedback referred to rushed discharge leading to a lack of information on self-management or what to expect; a particular need for more information when first diagnosed; poor experience of lead up to self-manage in hospital resulting administering treatment for the first time only after discharge from hospital.

It was known that the score in the Staff Survey for the effective use of patient and service user feedback had been low. It was becoming widely recognised that bottom-up engagement in person-centred improvement could be motivating to frontline staff. Evidence also suggested that patient experience appeared better in wards with motivated staff. In this context, the Head of Patient Experience described the "Oxford Project" which was being undertaken on Ward 7A. Following a challenging period, and with the support of the Patient Experience Team, the ward had embarked on a programme of making small changes. Examples included the purchase of 13p hearing aid boxes, which avoided loss of aids and costly compensation and the introduction of whiteboards on lockers for patients to jot down ideas. Many now used them to capture points to raise with their doctor. The initiative had improved patient experience and had also had a beneficial impact on staff morale and team working. Next steps were for the project to be rolled out across more wards.

The Head of Patient Experience indicated that the in-patient survey data was now available through the CQC website: http://www.cqc.org.uk/provider/RTE/survey/3

The Chair thanked the Head of Patient Experience for her very helpful overview of the survey results and invited discussion.

- The Director of Human Resources and Organisational Development proposed that it would be helpful to triangulate results of the in-patient survey with relevant elements of the staff survey. The Head of Patient Experience advised that she was liaising with the Director of Nursing in this area of work and that before a project commenced in a ward, a team questionnaire was completed to provide an initial baseline position.

- Ms Barber enquired how the Trust's 44% response rate compared with the national figure, how the Trust could benchmark itself against other Trusts and whether there could be learning from action plans in other areas. The Head of Patient Experience indicated that the national average response rate was 41%. It was noted that the Trusts which performed most highly in the in-patient survey were generally specialist or single specialty Trusts. Amongst those Trusts providing a much broader range of services, our own Trust appeared to be relatively average.

The Head of Patient Experience also mentioned that a number of other Trusts had introduced real-time surveying, which brought the benefits of rapid feedback. The plan was to take this approach on selected wards.

- The Medical Director advised that research suggested that seeking detailed feedback from small numbers of patients, provided more valuable intelligence about what constituted a good service, than large-scale, post-discharge surveys. The Head of Patient Experience indicated that the plan was to run patient focus groups on individual wards involved in the Oxford Project.

- The Director of Clinical Strategy highlighted the importance of making a clear connection between action plans and the Trust's strategic objectives on which comments were currently being sought. Governors had indicated a wish to have a focus on improving patient experience in out-patients The Director of Clinical Strategy and the Head of Patient Experience would work together to agree an objective which addressed these concerns. The Chief Executive drew attention to two key themes. She asked the Director of Nursing why ward staff felt so very pressurised, when the Trust's staffing levels appeared better than in many similar organisations. She queried whether pressure might also come from what might be perceived as over-bureaucratic processes thus reducing the amount of direct patient contact time. The Director of Nursing explained that this pressure was not experienced consistently across all areas of service and tended to be associated with high levels of agency or bank staff. The Chief Executive enquired if it were possible to distribute agency staff more evenly across wards. The Director of Nursing explained that the site management teams endeavoured to do this, but sometimes the level of vacancies in one area meant that this was not possible. The Chief Executive proposed that consideration be given to reviewing the allocation of substantive posts to ensure no clinical area was left with excessive reliance on agency staff. **SP/SC** **MA**

- The second theme identified by the Chief Executive related to communications across all groups. This remained challenging and it would be important to continue to explore what needed to be done differently.

- Dr Feehily thanked the Head of Patient Experience for her presentation and recognised the value of having and listening to a variety of voices. Dr Feehily queried whether by taking an individual ward-based approach to improving patient care and experience, there was the potential danger of failing to recognise and address broader issues or core processes. The Head of Patient Experience indicated that the expectation was that work with individual wards would also draw out system wide issues. She expressed the view that in certain contexts a totally uniform approach could also be detrimental in enabling a more individualised approach to patients. Dr Feehily recognised the need for balancing autonomy, and a wider consistency of approach.

- The Chair felt that the project on Ward 7A was very valuable

and enquired if this could be rolled out at speed to encompass all wards within a year. The Head of Patient Experience indicated that the potential to roll out quickly would become more apparent from the experience gained in the early phases of the initiative. As well as encouraging wards to undertake Silver Quality and Safety Academy projects, ward sisters were being encouraged to become Gold Coaches, which should also help to make the approach more sustainable.

- The Chair also highlighted the importance of establishing a culture within the Trust, which was so strong that it was immediately and easily recognisable to everyone coming into the Trust, including agency staff. The Director of Nursing indicated that agency staff received an induction and that the Trust worked closely with agencies - where issues arose; these were fed back to them. The current move away from block contracts with agencies led to less consistency of agency staff. The Chief Executive asked whether there had been any success in encouraging agency staff to enrol with the bank and reducing the pay differential between agency and bank payments. The Director of Human Resources and Organisational Development expressed the view that with the current bank payment levels this transfer had probably peaked. The Chief Executive stressed the importance of the Trust ensuring that the majority of its staff was employed on a substantive basis.

- The Chair thanked the Head of Patient Experience again for her overview of the National In-patient Survey.

134/17 DECLARATIONS OF INTEREST

There were none.

135/17 MINUTES OF THE MEETING HELD ON 26 MAY 2017

A number of minor points were highlighted:

120/17 Patients Story (Page 2, third paragraph) **NJ**
The Chair felt that this had misrepresented what had been said. For purposes of clarity it was proposed the section be amended to read "Kim then became panicked and the situation escalated to her being sedated. The neck brace caused her to be very uncomfortable and restricted her movement for several hours."

124/17 Annual Accounts (Page 8, fifth paragraph) **NJ**
The first paragraph to be amended to read "The Director of Human Resources and Organisational Development queried the length …."

RESOLVED: That subject to the minor changes proposed, the minutes of the meeting held on 26 May 2017 be agreed as a correct record and signed by the Chair.

136/17 MATTERS ARISING

Current targets

In view of the very short period of time since the previous meeting of the Board, it was agreed that the matters arising from the meeting on 26 May would be updated at the July Board. **NJ**

Future targets 101/17 Patient Story

It was agreed that this could now be considered closed.

Completed targets 101/17 Patient Story

Dr Feehily queried how the action taken in relation to a particular item was recorded and whether there could be more visibility of this. For example, she had raised a safety issue in a previous meeting. This was shown as completed, but without any accompanying detail. The Medical Director offered reassurance that this was being monitored on an on-going basis through Trakcare, and regular monitoring of discharge summaries. DL agreed that the format of the "tracker" should be reviewed, recognising that this reflected more the detail of the minute, rather than the action undertaken. **DL/NJ**

137/17 CHIEF EXECUTIVE'S REPORT

The Chief Executive presented her report highlighting the following points:

- Her apologies for the delay in making the papers available on this occasion, due to the lack of a Board Secretary.

- Although periods of peak activity continued to be experienced particularly in the early part of the week, positive signs of improvement had been seen. These included exceeding the 90% 4 hour A&E wait standard despite the usual challenging Bank holiday period, and the success of working with partners and the Gallery Wing model to facilitate the discharge of medically stable patients.

- NHSI was due to review arrangements pertaining to Private Finance Initiatives (PFI). The Trust will remain alert to opportunities this might offer.

- A positive response had been received to the letter on a smoke free NHS sent to Duncan Selbie. This commended the Trust for the work it had done and continued to do. The response, missing from the papers, would be circulated. **NJ**

- Gloucestershire system partners recently met with Matthew Swindells, National Director for Commissioning Operations for NHS England who visited at the request of the Sustainability and Transformation Partnership (STP). The opportunity was taken to explore the vision for developing an Accountable Care System (ACS) model for Gloucestershire. Gloucestershire partners were encouraged to focus for now on addressing performance challenges before submitting a proposal to develop an ACS. Some work was underway to explore further how a 'shadow ACS' might develop as a means to addressing shortcomings in performance through even closer integration between the STP organisations. Mary Hutton would continue to lead the STP for the next period of tenure, including any emerging ACS model.

- Zack Pandor had recently joined the Trust on secondment from the County-wide IT Service (CITS) as Chief Information Officer. An early priority would be to develop the Trust's Digital Strategy in the context of the countywide Digital Strategy which had been presented recently. This was identified as a potential subject for a Board Seminar. **PL/ZP**

- Staff was being invited to comment on the Trust Strategic objectives. The aim was to ensure all staff recognised their contribution to the goals and to reflect this in appraisals and specifically when setting individual objectives.

- Steve Webster would start as Finance Director on 19th June. He was welcomed to the meeting as an observer.

- The appointment of a Chief Operating Officer, who would start in October, would be announced shortly,

- Chief Nurse Interviews were scheduled for 20th June.

- Following a successful eight years in the Trust, Dave Smith, Director of Human Resources and Organisational Development would be leaving the Trust in the autumn. The Board thanked him for leading a very successful and progressive function in the Trust and his contribution to Trust life more generally. Interviews were scheduled for 6th July.

- The final Care Quality Commission report had been delayed through illness in the CQC, but now expected from early July.

- The timescale for the publication of the final report of the independent Financial Governance Review was still uncertain, but June publication was now appeared unlikely.

- The Chief Executive had recently paid a visit to Ward 7A and had been very impressed by the impact of the patient experience project.

In the course of discussion a number of points were made:

- Dr Feehily mentioned how inspired she had been by the work and commitment of staff, and the involvement of patients, when she had visited the Gallery Wing. However, she had concerns about the availability of end of life care in the community.

- The Chief Executive describes the things in hand to try and expedite care for those on an End of Life pathway. She indicated that she had raised concern about the proposal to tender the service to a single provider and felt there were a number of good providers in the area. The Commissioners were currently reconsidering their approach and would respond shortly.

- The Director of Clinical Strategy mentioned that one of the national leads for tobacco control had suggested that in the

absence of legislation, Trusts should reframe their approach to smokers from an accusatory approach to one which placed the focus on what the hospital could do to support them to stop smoking. The Chief Executive indicated that following the election she would approach local MPs for their support to introduce legislation.

The Chair thanked the Chief Executive for her report.

RESOLVED: That the report be noted.

138/17 QUALITY AND PERFORMANCE

REPORT OF THE INTERIM CHIEF OPERATING OFFICER

The Interim Chief Operating Officer presented the report summarising key highlights and exceptions in Trust performance up until the end of April 2017. Key points were highlighted:

Performance against the 4-hour A&E waiting time standard improved by almost 5% relative to March. Delivery of the 60 minute time to see a doctor in A&E remained a challenge, exacerbated by the new rules governing the booking of locum doctors which meant staff shortages continued in middle grade rotas. Downward trends were seen in the number of medically stable for discharge patients and delayed transfers of care patients.

There were higher than average numbers of 2 week waits for colorectal referrals causing capacity issues in the outpatient clinics and for endoscopies. Increased demand, the reported incident of missing clinic letters and patient cancellations around Easter led to the Trust missing the target by 3%. This contributed to a deteriorating performance against the 31 day cancer pathway and would affect the 62 day cancer performance for May and June. However, in April performance (78%) had been almost 7% higher than in March and almost 3% over the plan agreed with NHSI.

Whilst the Trust continued to address backlogs in echocardiograms, the number of patients awaiting a diagnostic test after 6 weeks had increased. In April 7.2% patients were awaiting a diagnostic test after 6 weeks with increasing pressures in May and June. A recovery plan is in place with improvements expected from July onwards.

The Trust continued to face issues regarding data for the safety and effective domains which were not being reported at present due to TrakCare issues. It was hoped to re-establish reporting against some within the next month albeit with some data quality caveats. In the absence of 18 week referral to treatment data, close monitoring and management continued of patients waiting longer than 52 weeks. All but one of the 11 patients reported in April, had been treated in May. Some 52 week breaches were anticipated for the next few months whilst the post TrakCare validation exercise was completed and data quality issues addressed.

A number of metrics had been removed from the PMF from April 2017, as these were no longer relevant.

In June the Q&P would receive the first full draft version of the new

Quality and Performance Report.

- Ms Barber observed that it was a challenging report and reflected that whilst targets were central, the impact on patients was also key. She queried whether the Trust was getting better at anticipating the impact of planned external factors – for example new rules governing locum doctors.

- The Interim Chief Operating Officer indicated that the rule changes had been anticipated, but the full implications of external factors could not always be foreseen. In this case action had been taken swiftly. Weekly meetings took place with ED doctors on this issue.

- The Acting Director of Finance confirmed that there was awareness of the new rules, but that it was not always in the gift of the Trust to mitigate the impacts. The Director of Human Resources and Organisational Development drew attention to differential application of the rules by some organisations, despite strong exhortations from HR network chairs to organisations in their network to hold the line.

- The Chief Executive, on joining the Trust, had recognised the need for more effective environmental scanning, although there would always be unexpected factors. She welcomed the work which the Director of Clinical Strategy was doing in this respect and the recent appointment of an Associate Director Planning and Performance, who would support work in this area.

- Rob Graves observed that there was a tendency for reports to present "history". He would welcome greater clarity of the enablers which could be instrumental in making progress, recognising that there were also constraining factors. **DL/AK**

- The Chief Executive agreed that this approach could be helpful. She would work with the Interim Chief Operating Officer to identify more clearly, for the July report, the main underpinning issues and the key enablers which would lead, over time, to performance to driving itself.

- The Chair enquired what could be done differently to address the challenges of ED staffing. The Chief Executive drew attention to the role of the Sustainable Workforce Group and to work to explore new workforce roles which could be offered, and use of new models used elsewhere. She recognised the need to share some of this information with the Board and emerging thinking as it occurred.

- With regard to the 52 week standard, the Chair enquired if it were the case that the Trust could not identify these patients in advance. The Interim Chief Operating Officer responded that these patients could be identified in advance but not early enough to enable action to avoid a breach. These patients were, however, closely monitored and prioritised clinically. The Chief Executive indicated that other Trusts did identify these patients earlier. She was hopeful that the position would be better by the summer.

- The Chair enquired about the impact of patient choice on the achievement of targets. The Chief Executive indicated that the national target had been set in recognition of patent choice but that the Trust would continue to be alert to the impact of this.

The Chair thanked the Interim Chief Operating Officer for her report.

RESOLVED: That the report be noted as assurance that the Executive Team and Divisions fully understood current areas of poor performance and had action plans in place to improve the position.

TRUST RISK REGISTER

The Chief Executive presented the Trust Risk Register (TRR) providing oversight of the key risks within the Trust and assurance that the Executive Team was actively controlling and pro-actively mitigating risks as far as possible. Changes in the period since the previous report were highlighted.

Safety risks accepted to the risk register (12 and above)

- DSP2513PATH Risk to patient safety due to delayed diagnosis because of shortage of histopathology staff – this was especially highlighted by the Chief Executive as requiring close attention.

- M2488Card Risk of harm to patients as a result of delay in receiving essential cardiac interventions.

- M1746Diab Risk of patients having potentially avoidable procedures.

Quality risks accepted onto the risk register (15 and above)

- DSP2462OPD & DSP2460OPD - quality risks around the clinic operational management impacting on patient experience.

TC2501Paed/Gyn & S2455ALL linked to clinic operational management had also been considered. Income scored as a red financial risk in the relevant specialties for loss of at least 1% of expected income. Since the Trust level did not meet the 1% level for the overall Trust these would they stay as red risk at Divisional level and the Finance committee would consider the overall impact and review the finance income risk.

- F2515 Risk that the Trust does not agree a FY18 Control Total accepted on to the risk register as a finance risk (15 and above) **DL/AS**

In the course of discussion, the following points were made:

- In response to a point raised by Tony Foster, it was agreed to remove the figures in the “current” column to avoid confusion.

- Dr Feehily enquired about the appropriateness and effectiveness of risk training. The Chief Executive indicated that she felt that an understanding of the importance of risk issues was becoming better embedded within the new Trust culture, particularly amongst senior staff, but less amongst other staff.

The development of e-learning would enable improvement to be made in time.

- Dr Feehily recognised that individual risks were recognised, but enquired how broader risks associated with the Trust having to deal with a number of high risks at the same time were identified or considered.

- The Chief Executive indicated that the near miss reporting worked well and identified some wider issues. The Medical Director reflected on how in the absence of an exact science for risk, judgement would continue to play an important role. The Interim Chief Operating Officer agreed that this was a challenging area. Although effort was made to make connections between risks, this was not done formally in the way Dr Feehily had identified.

- Mr Graves recognised the role of judgement, but suggested that it would be helpful to explore whether other organisations had models which the Trust could consider, as this issue was likely to be common to many.

- The Chief Executive recognised the role which judgement played and cautioned against an over-scientific approach. Her judgement was that incident reporting was generally good in the Trust and that as a general rule levels of harm were relatively low. She proposed that, if necessary, the relevant Board sub-committee could be asked to undertake a deep dive exercise on a particular area.

- Mr Foster identified that a number of risks indicated that they were associated with poor patient experience. He queried whether these were likely to relate to a single patient or multiple patients and whether there were likely to be particular risks for certain groups of patients. The Chief Executive recognised that this was not made clear and would address this for future reports

The Chair thanked the Chief Executive for her report.

RESOLVED: That the report is noted as assurance that the Executive is actively controlling and pro-actively mitigating risks so far as possible and the changes to the Trust Risk Register should be approved.

REPORT OF CHAIR OF THE QUALITY AND PERFORMANCE COMMITTEE ON THE MEETING HELD ON 24 MAY 2917

The Chair of the Committee, Dr Feehily, presented the report of the meeting and highlighted a number of areas:

The Committee had had the opportunity to focus on issues relating to the Women and Children's Division. This had been very valuable, enabling greater understanding through open and detailed discussion, for example on the impact of Trakcare on patients and morale. This approach also provided the opportunity for challenge.

The Chair thanked Dr Feehily for her report, encouraging each Executive to attend this Committee from time to time.

RESOLVED: That the report of the meeting of the Quality and Performance Committee held on 25 May, 2017 be noted, indicating the non-Executive Director Challenges made and the assurance received for residual concerns and /or gaps in assurance,

139/17 FINANCIAL PERFORMANCE

REPORT OF THE FINANCE COMMITTEE ON 24 MAY 2017

In the absence of Keith Norton, Chair of the Finance Committee, Mr Foster presented this report and highlighted three elements.

- A month one position had been received, which was unusual. This identified an adverse position of £2m against plan, mainly associated with lower income associated with TrakCare implementation. It was hoped that this might be mitigated by confirming block contracts with key commissioners. This was an important area to keep under review.

- Thirty two of the 34 recommendations of the Deloitte Financial Reporting Review had been completed. There were no residual issues or gaps in control or assurance.

- The Cost Improvement Plan was £34.7m. RAG ratings had been applied to the likely success of each proposal being achieved. Monthly profiling was to be introduced to improve control.

- Mr Graves felt that monthly profiling was particularly important. He was concerned that, numerically, the plan looked risky and loaded to the year end. Mr Foster indicated that this had been discussed in detail at Finance Committee. The Chief Executive recognised that the level of the CIP was a risk. The year-end loading was mostly associated with large schemes which could not be achieved until quarter four or required lengthy work up. With regard to RAG rating of 53% of schemes, it was important that Divisions were not complacent about achieving CIP schemes due to deliver later in the year. The Acting Director of Finance indicated that a proportion of the schemes with high level risks related to cross-cutting schemes, for which there was an Executive lead. The newly appointed Director of PMO would contribute to improved monitoring mechanisms. Three Cost improvement Plan Delivery Managers had been appointed to support divisions.

- The Interim Chief Operating Officer reported that conversations were on-going about where risks were red and the nature of the help required.

The Chair thanked Mr Foster for his report.

RESOLVED: That the report, indicating the non-Executive Director Challenges made and the assurance received for residual concerns and /or gaps in assurance, be noted.

(The Board adjourned from 10.45 to 10:55)

140/17 AUDIT AND ASSURANCE

REPORT OF THE CHAIR OF THE AUDIT AND ASSURANCE COMMITTEE HELD ON 23 MAY 2017

Mr Graves, Chair of the Audit and Assurance Committee presented his report, drawing attention to a number of points.

The Finance Team had done excellent work for the year end accounts closure. The review of final accounts and associated processes had been undertaken and ratified by the Board at its last meeting. Whilst the numerical work had been excellent, it was recognised that some of the supporting documents had been delayed – an area for improvement next year.

Concern had been expressed as to why the number of outstanding recommendations associated with internal audit had increased so significantly.

Dr Feehily expressed the view that the communication routes and processes for internal audit reports were not effective. The CEO explained that a revised process was in place which was being followed. She added that the Risk Management audit had not been to Q&P as it was yet to go to Audit Committee. It was noted that new reports would contain more specific detail about dissemination routes and reporting.

The Chair thanked Mr Graves for his report.

RESOLVED: That the report, indicating the non-Executive Director Challenges made and the assurance received for residual concerns and /or gaps in assurance, be noted.

141/17 SMARTCARE PROGRAMME REPORT

The Director of Clinical Strategy presented the report on progress with the current operation of TrakCare and planned implementation of future phases. A number of points were highlighted.

There had been a significant improvement in the relationship with, and the responsiveness from, InterSystems. The newly appointed Business Intelligence deputy post had been identified to take the role of system owner for TrakCare and provide the lead point of contact with InterSystems, As a consequence there was more clarity about issues requiring escalation to InterSystems and those which could be locally addressed. The Programme Board had considered the Lessons Learnt Report from PWC (internal audit) and would develop an action plan. The number of open incidents had reduced markedly. Training had been extended to provide "Champion" sessions and some additional targeted training – for example, on discharge planning.

Planning was underway to prepare a confirmed proposal for implementation of the four components which comprised Phase 1.5 of the project, taking into account lessons learned previously. A rolling and evolutionary go-live approach across operational areas was proposed, rather than a *"big bang"* approach. Resources would be reprofiled to reflect the extended rollout.

The Medical Director asked about the likely sequencing for Phase

1.5 elements. The Director of Clinical Strategy indicated that this would be Radiology (Order Comms), Pharmacy (Stock Control and Dispensing), and Pathology (Order Comms and TrakCare Lab Enterprise). It was hoped that Pharmacy would follow within a month of Radiology, although work to implement pharmacy in other sites in the region might impact upon this. Software issues relating to the Pathology elements meant that timescales for this were not yet known.

Ms Barber enquired how the Trust communicated with staff on TrakCare issues and how feedback was captured. The Director of Clinical Strategy responded that Nicola Turner, the TrakCare Operational Lead, issued regular weekly bulletins. It was noted that engagement of many clinical teams had improved but further work was required. The Interim Chief Operating Officer drew attention to the TrakCare Operational Group which met weekly, to consider issues raised from Divisions. Training sessions also enabled good two way communication an opportunity to gain advance insight into future issues. The Director of Clinical Strategy reported that TrakCare was raised during safety visits and was a standing item on many agendas.

Dr Feehily sought clarification about whether a crisis event mentioned in the report had involved risk to patients. The Director of Clinical Strategy explained that this related to a situation whereby new patients could be added to lists before existing patients. This had now been technically resolved.

The Chair identified the need to balance past experience alongside the future benefits which TrakCare would bring. The Director of Clinical Strategy indicated that it was always known that the benefits would be more apparent to clinical teams as the later phases were implemented. The challenge lay in providing reassurance that future implementation plans were credible. Up front, end to end, testing was key. The Medical Director agreed that benefits to patient care were being felt as process issues were resolved. He also recognised the cultural change involved in moving to a very structured and integrated electronic system which removed the ability for the “workarounds” which so many staff had adopted over the years.

The Chief Executive indicated that she was reassured by the level of mapping and testing of the forthcoming systems. She also suggested that some TrakCare activities introduced extra time into the system and asked how this was being taken into account. The Director of Clinical Strategy recognised that this was the case in some areas. The challenge was to understand the impact of the need for additional resource, whilst at the same time understanding TrakCare would enable effort to be taken out of the system too. This was being explored in the planning of the new elements.

The Chair thanked the Director of Clinical Strategy for her report.

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

142/17 MEDICAL REVALIDATION REPORT

The Medical Director provided an annual review of the Appraisal and Revalidation processes for Senior Medical Staff. He was confident that the Trust had a robust process for appraisal, which was key to the revalidation of doctors. Quality assurance was provided through appraisee feedback, appraisers' annual meetings with the Appraisal Lead, use of a standard tool to assess a percentage of appraisal summaries, peer review of processes with another Trust and an independent verification visit from NHSE. Quarterly and year end reports were submitted to the NHSE. It was noted that the action plan included with the papers had since been updated and the actions addressed.

- In the course of discussion, Mr Foster asked whether performance review should be part of the appraisal. The Medical Director indicated that the GMC view was that appraisals should be separate from performance review. However, medical staff underwent a performance review with their specialty lead in advance of the appraisal and a summary form and personal development plan were included in the appraisal portfolio. Appraisal was undertaken by an appraiser from a different specialty. Each specialty had a series of key performance indicators, which were currently being reviewed.

- The Chair asked how medical staff with leadership ambitions and potential were identified for development. The Medical Director indicated that this was likely to feature on personal development plans and might also be identified during appraisal.

- The Director of Clinical Strategy recognised that there were good assurance processes for appraisal, but enquired about the process for the small number of doctors who were identified as having an unapproved, incomplete or missed appraisal and if they were still able to practise. The Medical Director indicated that these doctors had their revalidation deferred, with a requirement that within a designated period (4-12 months) the necessary paperwork would be produced. So far all doctors had fulfilled this requirement.

- Mr Graves asked about the number of appraisers. It was noted that there were currently 38 and that each was expected to undertake a minimum of 10 appraisals annually. Appraisers enjoyed their work, although it represented a significant commitment. The budget was now held centrally by the Medical Director.

- The Director of Clinical Strategy recognised the added value of appraisal by someone from another specialty

The Chair thanked the Medical Director for his report.

RESOLVED: that the report, providing assurance of the quality of the medical staff appraisal and revalidation in the Trust, be noted.

The Director of Nursing, who had left the room during this item, informed the Board that she had been notified that a Major Incident Exercise had been initiated.

143/17 APPOINTMENT OF SENIOR INDEPENDENT DIRECTOR

The Chair presented this report, explaining that the Board was required, in consultation with the Council of Governors, to appoint one of the Non-Executives to be the Senior Independent Director (SID) to provide a sounding board to the Chair and to serve as intermediary for other Directors or Governors when appropriate. Following discussion with Governors and others it was proposed that Mr Rob Graves be appointed to the role of SID. Mr Graves had expressed his willingness to undertake the role and the Chair expressed his thanks to him.

RESOLVED: that the appointment of Rob Graves, as Senior Independent Director, be approved.

144/17 MINUTES OF THE MEETINGS OF THE COUNCIL OF GOVERNORS HELD ON 5 APRIL 2017

The Chair indicated that these minutes were for information. Attention was drawn to a request for assurance by Mr Rob Randles that decisions of the Vacancy Control Panel were not having a detrimental clinical impact. The Chief Executive reported that she had had a conversation with Mr Randles and reassured him that where there were particular areas of difficulty, posts could be advertised and filled. It was noted that the work to progress the issue regarding over recruitment or nurses awaiting their PIN number was almost complete and would address the situation.

RESOLVED: that the minutes of the Council of Governors held on 5th April, 2017 be noted.

145/17 ITEMS FOR NEXT MEETING AND ANY OTHER BUSINESS

ANY OTHER BUSINESS:

No further items of business were raised.

ITEMS FOR THE NEXT OR FUTURE MEETINGS:

A number of potential items were identified for consideration at future meetings:

- Changes to the PFI arrangements, once known
- The Countywide Digital Strategy
- The annual report on Clinical Excellence Awards
- The GP Lead Employer Contract and its potential renewal
- The Education and Learning Report, following its consideration by the Workforce Committee

146/17 GOVERNOR QUESTIONS

The Chair invited questions from the Lead Governor.

The Lead Governor expressed disappointment that he was the only governor on this occasion. He would raise this at the next Council of

Governors. The Lead Governor welcomed the level and rigor of the challenge which he had witnessed in the course of the meeting and the openness of discussions for example, on TrakCare. He also welcomed the inclusion of the patient story item at the start of meetings and that that issues and actions were well reflected in the minutes.

The Lead Governor observed that discharge issues were not new to the Trust and enquired if the Board was confident that the Trust was learning from issues associated with and following discharge.

He raised concerns about arrangements relating to new Healthwatch provider, and their ability to provide a user perspective.

He also highlighted concerns about the impact on patients of long wait times and inconsistent information.

The Interim Chief Operating Officer expressed concern about this experience. She acknowledged that there were currently capacity issues resulting, for example, in extended waiting times for diagnostics. The Chief Operating Officer undertook to review the content of letters, and recognised the need to share information more widely with staff about extended waiting times so that they were aware. She would also explore the possibility of providing generic information in out-patient areas. The Chief Executive suggested that receptionists and volunteers might also be well placed to advise patients about likely waiting times. **AK**

The Chief Executive indicated that she welcomed the reports of Healthwatch, but recognised the need to consider how to gain optimum benefit from visits.

The Chair thanked the Lead Governor for his contribution to the meeting.

147/17 STAFF QUESTIONS

There were none.

148/17 PUBLIC QUESTIONS

There were none. However, the need to update contact details in the guidance for submitting questions was noted. **DL/NJ**

149/17 DATE OF NEXT MEETING

The next **Public** meeting of the **Main Board** would take place at **9am** on **Wednesday 12 July 2017** in the Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital, Gloucester.

150/17 EXCLUSION OF THE PUBLIC

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

The meeting ended at 12.15

Chair
12 July 2017

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – 12 JULY 2017

MATTERS ARISING

CURRENT TARGETS

Target Date	Month/Minute/Item	Action with	Issue	Action	Update
June 2017	May 2017 120/17 Patient Story	**TF**	Audiology Department and the calling of patient names	The Disability Equality Manager to contact the Charitable Funds Committee regarding resources to purchase visual electronic signage. Mr Foster explained that he would raise this with the charity team.	
June 2017	May 2017 120/17 Patient Story	**SE**	Communication between doctors and deaf patients	The Medical director asked that Kim Fletcher think about what three key signing messages should be taught to all doctors so that these could be introduced.	
June 2017	May 2017 120/17 Patient Story	**SC/ CM**	Communication between doctors and deaf patients	Disability Equality Manager to liaise with Jo Dutton (Advanced Hearing Therapist) to arrange to attend the Education and Early Development sub group to investigate how training could be developed.	
June 2017	May 2017 120/17 Patient Story	**SC/MA**	Communication between nurses and deaf patients	The Director of Nursing asked that Kim Fletcher and Victoria Banks attend an upcoming strategy day. The Head of Patient experience will link in with Fran Wilson (Matron for Outpatients) to discuss the outpatient forum.	

June 2017	May 2017 124/17 Annual Accounts	**CM**	Communications regarding the deficit	Head of Communications to develop clear and understandable communications regarding the deficit focusing on the £18m operational figure.	
June 2017	May 2017 125/17 Quality Report	**SP/SC**	Stakeholder feedback - Trust has not quite met expectations on reporting patient experience and data regarding type of engagement	The Director of Clinical Strategy to work with the Head of Patient Experience to strengthen the information taken and had discussed in Quality and Performance Committee looking at a more robust set of indices to give assurance on safety in the Emergency Department.	*Revised structure for Performance Reporting presented to the Quality and Performance committee. Associate Director of Performance and Planning working with the Head of Patient experience to include revised set of indicators for patient experience into the September reporting cycle.*
June 2017	May 2017 125/17 Quality Report	**DL**	Poor CCG Information Cascade from Quality Committee.	The Chief Executive will investigate this	*Completed.*
June 2017	May 2017 129/17 Any Other Business – Safety Walkabouts	**SC/AS**	Trends and issues raised during Safety Walkabouts	Head of Patient Experience to liaise with the Director of Safety and look at collating information. Director of Safety to bring issues regarding safety to the Quality and Performance Committee.	
June 2017	May 2017 129/17 Items for the next meeting – Staff Stories	**PL**	Staff Stories at Board as well as Patient Stories	The Chair agreed this was a good suggestion and would investigate having one staff story a year. The Medical Director noted that stories of staff experiences whilst patients themselves were also very helpful.	

June 2017	May 2017 129/17 Items for the next meeting – Workplan	**NJ**	Work Plan inclusion in Papers	Board Secretary to include Work Plan in next month's papers.	*Completed – Included.*
July 207	June 2017 133/17 Patient Story/ National Inpatient Survey	**SP/SC**	Governors had indicated a wish to have a focus on improving patient experience in out-patients	The Director of Clinical Strategy and the Head of Patient Experience to work together to agree an objective which addressed these concerns.	*Completed - Strategic Objective to reduce the number of complaints relating to outpatients now included.*
July 2017	June 2017 133/17 Patient Story/ National Inpatient Survey	**MA**	Even distribution of agency and substantive nursing staff	The Chief Executive proposed that consideration be given to reviewing the allocation of substantive posts to ensure no clinical area was left with excessive reliance on agency staff.	
July 2017	June 2017 135/17 Minutes of The Meeting Held on 26 May 2017	**NJ**	Minutes of the last meeting	A number of minor points were highlighted.	*Completed – Corrected.*
July 2017	June 2017 136/17 Matters Arising	**DL/NJ**	Matters Arising Format	DL agreed that the format of the "tracker" should be reviewed, recognising that this reflected more the detail of the minute, rather than the action undertaken.	Completed – Updated.
July 2017	June 2017 137/17 Chief Executive's Report	**NJ**	Smoke Free NHS Letter	A positive response letter on a smoke free NHS from Duncan Selbie to be circulated.	*Completed – Circulated.*

July 2017	June 2017 137/17 Chief Executive's Report	**PL/ZP**	Development of Trust's Digital Strategy	Develop the Trust's Digital Strategy in the context of the countywide Digital Strategy which had been presented recently. This was identified as a potential subject for a Board Seminar	
July 2017	June 2017 138/17 Report of the Interim Chief Operating Officer	**AK**	Reports and the inclusion of historic data	Greater clarity of the enablers which could be instrumental in making progress, recognising that there were also constraining factors to be included in the report in future	
July 2017	June 2017 138/17 Trust Risk Register	**SS**	Update of FY18 on Trust Risk Register	F2515 Risk that the Trust does not agree a FY18 Control Total accepted on to the risk register as a finance risk (15 and above)	*Completed*
July 2017	June 2017 146/17 Governor Questions	**AK**	Capacity issues and extended waiting times	The Interim Chief Operating Officer to review the content of letters, and share information more widely with staff about extended waiting times. To also explore the possibility of providing generic information in out-patient areas. The Chief Executive suggested that receptionists and volunteers might also be well placed to advise patients about likely waiting times.	
July 2017	June 2017 148/17 Public Questions	**DL/NJ**	Contact details within Guidance for submitting questions.	Board Administrator to update	*Completed – Updated.*

FUTURE TARGETS

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

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – JULY 2017

REPORT OF THE CHIEF EXECUTIVE

1. Current Context

1.1 Following a period of small respite, the operational pressures have returned with a vengeance. In the final two weeks of June, an additional 500 patients attended our A&E departments with more than 150 arriving by ambulance, reflecting the acuity of those presenting to the department. Extraordinary efforts have been displayed by staff throughout the Trust to ensure patient safety and experience have been maintained however, performance against the national four hour standard has been particularly challenged at times with the increasingly typical pattern of decent daytime performance and then very poor performance overnight at GRH - this reflects the longstanding and continuing difficulties with junior doctor staffing and resolving this is one of our most critical workforce challenges.

2. National

2.1 Following the tragic fire at Grenfell Tower, there has been much national focus on the estate and preparedness of NHS Trusts to prevent and respond to a similar issue. For our Trust, the Tower Block, due to its height and construction has been a major focus for review and risk assessment and I am pleased that this has not revealed any shortcomings. The Trust's Fire Prevention Team continues to work closely with the local fire service who, in turn are working in close concert with national fire officers. I am particularly grateful to Neil Jackson and his team for responding to a very short notice request to undertake additional, unplanned weekend assessments at the request of the Secretary of State.

2.2 For the first time, the number of nurses leaving the profession nationally has exceeded those joining. This is a very worrying trend and one that Gloucestershire Hospitals will not be immune to. Recruitment and retention is a key workforce priority for the Trust and we will be watching closely the national response to this concerning picture and ensure that we take advantage of any national initiatives aimed at addressing this issue.

3. Our System

3.1 System partners have been working closely to prepare for the next step in our efforts to redesign services for patients in the County. On the 6th July, STP leads will join NHS England to participate in a formal review of our plans for service reconfiguration. This is an exciting step in our efforts to ensure that patients across the County are able to access the very best healthcare locally, in centres of excellence for planned and urgent care, to ensure that recourse to regional services is only required by exception and does not become the rule locally.

4. Our Trust

4.1 This month saw the long awaited publication of the Care Quality Commission (CQC) report following their inspection of the Trust in January this year. I am delighted that the report reflects the continuing focus of staff to deliver increasingly high quality care to all of our patients. A further nine domains achieved improved ratings from the 2015 inspection which means the Trust can now be proud of the fact that 73% of ratings now reflect services that are either good or outstanding - of concern since last time three ratings have deteriorated and these are already areas where we have placed a particular focus in recent months such as fracture neck of femur care.

Although, this position still leaves the Trust with an overall rating of Requires Improvement, it is an exceptionally strong platform from which to launch our journey towards *good* and then onto *outstanding.*

I am immensely proud and grateful to our staff whose actions have resulted in these very significant improvements.

4.2 On Tuesday 4th July, the Trust hosted a visit from Powys Community Health Council. The Trust provides a number of services, particularly oncology services to this population. The visit was extremely well received by the visiting team and a report is expected in due course.

4.3 Activities to secure substantive directors to the Board continue. Steve Webster has now commenced as our new Finance Director and is already making a positive contribution. We have successfully recruited to the posts of Chief Operating Officer (COO) and Director of Quality & Chief Nurse (DQ&CN) and as such will be returning two locals to the County. Caroline Landon will be joining us as COO in early October from Epsom and St Helier Trust where she currently holds the COO post. Caroline was Divisional Director of Medicine in the Trust four years ago before leaving to take up her first Board appointment in East Hertfordshire and I know she is very much looking forward to re-joining the Trust and establishing herself in Gloucestershire again.

Steve Hams has been appointed to the DQ&CN post - another local very much looking forward to working, as well as living in the County. Steve brings an unusual breadth of experience having worked in public health, commissioning and nursing roles. Most recently, Steve has held Director of Quality and Nursing posts in Addenbrookes, Medway and Guernsey. Steve is expected to join us in mid-September.

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

4.5 Finally, as reported last month we are in the final stages of the independent Financial Governance Review. The final report will be received by the Board at an additional confidential meeting in July with the expectation that the key findings and recommendations will be published later this month. I very much hope that this represents the final chapter of this difficult time for the Trust; the report will enable us to provide answers to our staff and other interested stakeholders and assure all that we have learnt from the shortcomings of the past and are stronger and better governed as a result.

5. Seals of the Trust

The Trust seal has been applied to the following documents in the period:

- Agreement to Amend and Reinstate the Project Agreement (CEF Energy Infrastructure Project)
- Project for the Re-Provision of Energy and Energy Management Facilities at Gloucestershire Royal Hospital – Direct Agreement (GRH)
- Amendments and Reinstatement Deed – Direct Agreement (CGH)
- Deed of Variation to the Cheltenham General Hospital Lease

Deborah Lee

Chief Executive Officer

July 2017

PUBLIC BOARD MAIN BOARD – JULY 2017

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

Report Title
Quality and Performance Report
Sponsor and Author(s)
Sponsor: Arshiya Khan, Interim Chief Operating Officer Sponsor: Dr Sally Pearson, Director of Clinical Strategy Author: Felicity Taylor-Drewe, Associate Director of Planning and Performance

Executive Summary

Purpose

This report summarises the key highlights and exceptions in Trust performance up until the end of May 2017 for the financial year 2017/18.

Alongside the Performance Management Framework, the Quality and Performance (Q&P) committee will receive the Quality Performance Report (QPR) that will replace the existing reporting format. The QPR will include the SWOT analysis.

The committee is asked to note that an issue has been identified with the contextual indicators at the end of the report and the data is being reviewed.

Key issues to note

- For May the Trust did not meet any of the four national waiting trajectories for A&E 4 hour wait, 62 day cancer standard, 18 week referral to treatment (RTT) standard or 6 week diagnostic wait
- A&E 4 hour performance declined to 80.00% in May, 80.5% with GP ED included. The agreed operating plan trajectory for April was 89.5%. The recovery plan in place supports the areas of the ED workforce, front door pathways, and review of the ambulance profile, escalation processes and SAFER measurement
- Performance against the 15 minute time to triage standard has this month declined by 1.7% Trust wide the performance in May was 80.2% with GRH achieving 81.2% and CGH achieving 78.5%. 60 minute performance has deteriorated to 28.8% from 33.4% at the end of Quarter 4. Achievement of the latter will in part be influenced by recruitment to the full establishment of consultants and middle grades and for the former nursing staff training for triage. Improvement is not anticipated until July
- The Trust did not meet the 2 week wait cancer target in April as reported with the validated position as 91.4% against the target of 93%. For May, early indications are the 2 week wait position is positive with an un-validated position of 95.5%. Endoscopy capacity remains an underlying risk to delivery to some 2week wait pathways. Waiting list initiatives through Glanso are designed to support this recovery and commenced in May and continue in to June. Referral rates are 1.6% increase from this period last year, in particular Lower GI has seen a 8.7% increase. This has been raised with commissioners to target key practices with clear communication and an offer of additional triage support from primary care has been accepted by the Trust
- 31 days Diagnosis to Treatment performance did not meet the target in April as reported with the validated position of 94.9%. For May the un-validated position is reported as 95.5% against the target of 96%
- 62 days Referral to Treatment performance for April was 78.3% validated. For May the un-validated position is 73.6%

- In respect of RTT, concerns regarding data quality following the migration to TrakCare, resulted in a decision to cease RTT reporting until the quality of data can be assured. This remains in place until at least June
- The Trust did not meet the diagnostics target in May, mainly driven by underperformance in three areas; Colonoscopy with 163 breaches; Audiology with 104 breaches and Endoscopy with 59 breaches. Echo Cardiology as reported last month has recovered, operating at a sufficient run rate for sustainable performance. Recovery plans are in place for these diagnostic areas, an assessment of performance of all the diagnostic areas, capacity and individual recovery plans is being undertaken to assess the timing of full recovery. Performance for May, 5.58% is an improvement on the April position but significant remedial action is required to operate at the required 1%
- The Trust reported nine 52 week breaches in May. All patients have a Treatment date in May and June. Looking forward there are expected 52 week breaches in June

At the May Trust Board members received the breakdown of the reporting regime against each of the targets, in particular those that are reported quarterly or in arrears and those that we cannot at present report because of data quality issues. This will continue to be provided as an Appendix with due dates where known, for assurance purposes. This report does indicate a number where the dates for reporting are not yet known or target dates not estimated. This is being addressed through the Trak Care operational Group.

Conclusions

Key areas of focus remain the Urology speciality, the performance for the Trust is contingent on delivery in this speciality as it impacts, 2 week wait; 62 day; RTT and our long waiter breaches. Diagnostic recovery and underlying issues with Endoscopy remains an area of focus as it impacts other pathways delivery. Additional waiting lists undertaken by the Trust and through external parties will continue to support the Trust's recovery. Alongside this the Board level support for Central Booking Office and RTT validation will significantly positively impact teams to manage breaches and forward plan the required capacity ahead of breaches.

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

Implications and Future Action Required

Delivery of agreed action plans remains critical to restore performance back to the minimum expected standards.

Recommendations

The Board is requested to note the Integrated Performance Framework Report as assurance that the executive team and Divisions fully understand the current levels of poor performance and have action plans to improve this position.

Impact Upon Strategic Objectives

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

Impact Upon Corporate Risks

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

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

Finance		Information Management & Technology	
Human Resources		Buildings	
No change.			

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

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

Gloucestershire Hospitals NHS
NHS Foundation Trust

Quality and Performance Report

Reporting period June 2017

to be presented at July 2017 Quality and Performance Committee

Executive Summary

The following summarises the key successes in June 2017, along with the weaknesses, opportunities, risks and concerns for the Trust. Delivery of agreed action plans remains critical to restore operational performance to the expected levels. During May, the Trust did not meet the national standards or Trust trajectories for A&E 4 hour wait; 31 and 62 day cancer standard; 18 week referral to treatment (RTT) standard; and 6 week diagnostic wait. There is significant focus and effort from operational teams to support performance recovery. There is clinical review and oversight of patients awaiting care to ensure that patients do not come to harm due to delays in their treatment. The Key areas of focus remain within the Urology speciality, the performance for the Trust is contingent on delivery in this speciality as it impacts, 2 week wait; 62 day; RTT and our long waiter breaches. Diagnostic recovery and underlying issues with Endoscopy remains an area of focus as it impacts other pathway's delivery. Additional waiting lists undertaken by the Trust and through external parties will continue to support the Trust's recovery. Alongside this the Board level support for Central Booking Office and RTT validation will significantly positively impact teams to manage breaches and forward plan the required capacity ahead of breaches.

Key areas where additional reports have been provided for the Quality and Performance Committee are:

- Emergency care
- Trakcare Operational Recovery
- Access target recovery
- Mortality

Strengths

- 104 days performance improved for the second month in a row. All breaches in month have been analysed and trends shown.
- Medically fit at 55 and DTOC at 30, remain stable during this period.
- LOS for elective (2.7%) and non-elective (5.5%) are both decreasing, which is positive position and to be anticipated during the summer months.
- Reporting of the number of patient discharge summaries sent to GPs within 24 hours externally has recommenced. Whilst the performance is not at the required level, a daily report is now available to support management.
- The engagement of Glanso to deliver 4 endoscopy waiting list initiatives in May has been a success and further lists are planned in June in a number of RTT specialities.
- Board approval for the additional recruitment of Bank and substantive administration support for three areas: RTT validation; speciality support and Central Booking Office – work has commenced on employment
- Overall clinic slot utilisation is positive, this is still an area for further development but good progress has been made.
- Echo-Cardiology have recovered the in-month position with3 breaches and a smaller waiting list as a result of waiting list clinics which continue in June.
- Performance in the majority of the additional quality measures has been good; the three exceptions remain the same this month as last.

Weaknesses

- Due to the implementation of the new EPR system we cannot report the number of patients waiting 18 weeks from referral to treatment.
- Patient Treatment Lists (PTLs) are not cleansed and data quality issues remain which continues to impact management of patient journeys. This will be addressed through the deployment of additional clerical staff as approved at May Board. Despite this, teams are focused on reviewing patients >35 weeks and predicting potential breaches on a more routine basis.
- Achievement of the national standard for % of patients spending 4 hours or less remains below the national and NHSI standard and below the operating Plan target of 89.5% at 80% for May.
- A number of statutory returns and reporting requirements are not able to be reported due to issues with TrakCare. Separate assurance through the Appendix detailing the reporting areas and the return to reporting due date will be provided on a monthly basis.
- Two never events are reported this months both involving joint implants, a review is being conducted based on the early Failure Mode Evaluation.

Opportunities

• Development of Standard Operating Procedures (SOP) for key areas being developed across teams. This will provide action cards supporting staff to enter it right first time and to provide corporate guidance on operating procedures e.g. DNA's. There is some evidence that we are not operating our Access Policy in full and this has led to some breaches which will be addressed through the development of SOPs. This will be managed through the Planned Care Programme Board.
• The South West Cancer Alliance is providing some additional funding, full details yet to be realised which will be designed to support 62 day delivery. The Trust has provided feedback in addition with commissioners of the best way to target this funding stream.
• Support from commissioners has been sought in relation to cancer across a number of areas: - Referral rate increases – CCG to support communication to targeted practices in the CGH area. - Project support for advice and guidance for Upper and Lower GI commences in July. - Clinical support for triage of 2ww pathway patients in Lower GI supporting communication with Primary Care on appropriate pathway utilisation.
• Confirmation from local Commissioners that they will support escalation of late cancer referrals to neighbouring Trusts. It is recognised that these are small in number but have caused breaches in the 62 day pathway for patients.

Risks & Threats

• Delivery hampered by capacity issues to achieve agreed national target by July and risk to meeting 62 days until October 2017 continue. Un-validated performance for May has shown a decline from the April position. Issues remain of endoscopy, imaging and histology and surgical capacity remain. July recovery has been identified as a risk area.
• The speciality of Urology despite significant service re-configuration with the MAD clinic has surgical capacity barriers. Additional support from Glanso and waiting list clinics are being delivered. This pathway impacts on a number of the Trusts key constitutional targets.
• The Diagnostic target, while reduced from April's reported position is higher (-ive) than performance last year (where we failed to deliver against the 1% of patients to wait over 6 weeks). This was mainly attributable to Colonoscopy (163 breaches; Audiology (104 breaches); Gastro (59 breaches).

Performance Against STP Trajectories

* = unvalidated data

Indicator		Month											
		Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Cancer - 31 Day Diagnosis To Treatment (First Treatments)	Trajectory	96.40%	96.20%	96.10%	96.20%	96.20%	96.10%	96.10%	96.20%	96.10%	96.30%	96.10%	96.30%
	Actual	94.90%	95.50%*										
Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	Trajectory	98.40%	100.00%	98.70%	98.10%	100.00%	98.40%	98.00%	98.00%	100.00%	100.00%	100.00%	98.40%
	Actual	100.00%	100.00%*										
Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	Trajectory	95.30%	95.70%	96.40%	94.90%	94.50%	94.90%	94.10%	94.60%	94.40%	94.40%	94.10%	94.20%
	Actual	98.50%	100.00%*										
Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	Trajectory	94.90%	94.80%	94.00%	95.80%	94.50%	95.20%	94.10%	94.90%	94.70%	94.10%	94.50%	94.10%
	Actual	90.00%	91.40%*										
Cancer - Urgent referrals Seen in Under 2 Weeks	Trajectory	93.00%	93.00%	93.00%	93.10%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%
	Actual	91.40%	90.40%*										
Cancer 62 Day Referral To Treatment (Screenings)	Trajectory	92.00%	94.40%	90.00%	94.70%	91.20%	91.90%	92.90%	92.90%	90.50%	92.90%	92.90%	90.50%
	Actual	86.30%	89.10%*										
Cancer 62 Day Referral To Treatment (Upgrades)	Trajectory	100.00%	80.00%	100.00%	87.50%	80.00%	91.70%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Actual	100.00%	100.00%*										
Cancer 62 Day Referral To Treatment (Urgent GP Referral)	Trajectory	77.70%	79.40%	80.10%	85.40%	85.20%	85.20%	85.30%	85.50%	85.30%	85.40%	85.40%	85.20%
	Actual	78.30%	73.60%*										
Diagnostics 6 Week Wait (15 Key Tests)	Trajectory	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%
	Actual	7.22%	5.58%*										
ED Total Time in Department - Under 4 Hours	Trajectory	87.70%	89.50%	89.20%	88.30%	92.20%	91.00%	90.00%	88.10%	77.40%	80.00%	80.00%	83.50%
	Actual	82.85%	79.96%										
Max 2 Week Wait For Patients Referred With Non Cancer Breast Symptoms	Trajectory	93.40%	93.00%	93.10%	93.50%	93.00%	93.50%	93.10%	93.10%	93.30%	93.20%	93.20%	93.30%
	Actual	90.40%	95.50%*										
Referral To Treatment Ongoing Pathways Under 18 Weeks (%)	Trajectory	73.80%	75.00%	76.10%	77.20%	78.40%	79.50%	80.60%	81.80%	82.90%	84.00%	85.20%	86.30%
	Actual	*											

Summary Scorecard

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

QUALITY

Adult Inpatients who received a VTE Risk Assessment	C.Diff Cases - Rate
C.Diff Cases - Variance from Plan	Emergency C-Section Rate
Emergency Readmissions Percentage	Friends and Family Test Score - ED % Positive
Friends and Family Test Score - Inpatients % Positive	Friends and Family Test Score - Maternity % Positive
Hospital Standardised Mortality Ratio (HSMR)	Hospital Standardised Mortality Ratio (HSMR) - Weekend
MRSA Bloodstream Cases - Cumulative Totals	Number of Breaches of Mixed Sex Accommodation
Potential Under-Reporting of Patient Safety Incidents	Rate of Patient Complaints
Staff Friends and Family Test and Recommended Care	Summary Hospital Mortality Indicator (SHMI) - National Data

OPERATIONAL PERFORMANCE

Cancer 62 Day Referral To Treatment (Screenings)

Cancer 62 Day Referral To Treatment (Upgrades)

Cancer 62 Day Referral To Treatment (Urgent GP Referral)

Diagnostics 6 Week Wait (15 Key Tests)

ED Total Time in Department - Under 4 Hours

Referral To Treatment Ongoing Pathways Under 18 Weeks (%)

FINANCE

Achieved Planned Income and Expenditure Position at Year End

Aggressive Cost Reduction Plans

Performance against CIP - % QIA's from PMO completed

LEADERSHIP AND DEVELOPMENT

Executive Team Turnover

Sickness Rate

Staff Engagement Indicator (as Measured by the Annual Staff Survey)

Workforce Turnover Rate

STRATEGIC CHANGE

Trust Scorecard

* = unvalidated data

Category	Indicator	Target	Month											Quarter				Annual	
			Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	16/17 Q1	16/17 Q2	16/17 Q3	16/17 Q4	16/17	17/18
Key Indicators - Quality																				
Friends and Family Test Score	Friends and Family Test Score - ED % Positive		95.4%	87.7%	87.7%	85.4%	84.7%	88.0%	78.4%	85.7%	80.3%	85.5%	86.9%	84.4%	92.5%	87.0%	84.8%	83.9%	86.5%	85.7% *
	Friends and Family Test Score - Inpatients % Positive		95.3%	93.4%	94.6%	95.3%	95.2%	92.0%	90.1%	88.9%	100.0%	91.6%	89.3%	92.2%	94.9%	94.4%	93.0%	93.5%	94.0%	90.7% *
	Friends and Family Test Score - Maternity % Positive		100.0%	100.0%	85.7%	100.0%	97.8%	98.2%	100.0%	100.0%	100.0%	98.9%	94.5%	96.8%	99.3%	92.3%	98.2%	99.1%	98.6%	95.9% *
Infections	MRSA Bloodstream Cases - Cumulative Totals	0	1	1	1	1	1	1	1	2	2	3	0	0	1	1	1	3	3	0 *
Mixed Sex Accommodation	Number of Breaches of Mixed Sex Accommodation	0	7	5	4	0	0	5	0	3	0	3	4	11	19	9	5	6	39	15
Mortality	Hospital Standardised Mortality Ratio (HSMR)	Dr Foster confidence level	108	109.7	110.3	111.8	113	112.9	115.2	115.5	113.5				108	111.8	115.2			
	Hospital Standardised Mortality Ratio (HSMR) - Weekend	Dr Foster confidence level	117.3	118.6	119.4	119.5	119.9	117.4	119.3	118.7	116.8									
	Summary Hospital Mortality Indicator (SHMI) - National Data	Dr Foster confidence level	112.4			115.6									112.4	115.6				
Readmissions	Emergency Readmissions Percentage	Q1<6%Q2<5.8%Q3<5.6%Q4<5.4%	6.8%	7.0%	6.3%	6.2%	6.4%	*	*	*	*	*	*	*	6.7%	6.5%	*	*	*	*
Venous Thromboembolism (VTE)	Adult Inpatients who received a VTE Risk Assessment	>95%	94.0%	93.2%	93.2%	93.9%	93.1%	92.2%	*	*	*	*	*	*	93.6%	93.7%	*	*	*	*
Key Indicators - Operational Performance																				
Cancer (62 Day)	Cancer 62 Day Referral To Treatment (Screenings)	>=90%	95.0%	100.0%	89.9%	100.0%	85.7%	97.0%	100.0%	82.8%	92.3%	95.5%	86.3%	89.1% *	90.6%	96.0%	96.0%	85.7% *		
	Cancer 62 Day Referral To Treatment (Upgrades)	>=90%		0.0%	100.0%	100.0%	50.0%			100.0%		100.0%	100.0%	100.0% *	100.0%	71.4%	71.4%	100.0% *		
	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	>=85%	81.2%	73.6%	79.0%	76.8%	72.9%	79.2%	72.0%	62.7%	70.0%	70.7%	78.3%	73.6% *	79.0%	76.9%	76.9%	66.3% *		
Diagnostic Waits	Diagnostics 6 Week Wait (15 Key Tests)	<1%	1.4%	0.5%	0.5%	1.5%	1.8%	0.9%	1.5%	1.2%	1.8%	4.6%	7.2%	5.58% *	2.6%	0.8%	1.4% *	2.5% *		
ED - Time in Department	ED Total Time in Department - Under 4 Hours	>=95%	87.21%	86.16%	90.71%	88.97%	86.05%	86.67%	74.12%	74.75%	76.96%	77.86%	82.85%	79.96%	86.90%	88.48%	82.40%	76.56%		81.36% *
Referral to Treatment (RTT) Performance	Referral To Treatment Ongoing Pathways Under 18 Weeks (%)	>=92%	92.0%	90.9%	90.9%	90.2%	89.9%	87.0%	*	*	*	*	*	*	92.0%	90.7%	84.4% *	74.3% *		
Key Indicators - Finance																				
Finance	Achieved Planned Income and Expenditure Position at Year End		18.2	18.2		-23.8	-23.9	-18.7	-18	-18	-18 *				18.2	-23.8	-18			

Key Indicators - Leadership and Development

Sickness	Sickness Rate	G<3.6% R>4%	3.8%	3.7%	3.9%	3.8%	3.9%	3.9%	3.9%	3.9%	3.9%	4.0%	4.0%	3.9% *	3.8%	3.8%	3.9%	3.9%		
Staff Survey	Staff Engagement Indicator (as Measured by the Annual Staff Survey)	>3.8	.04	.04	.04	.04	.04	.04	.04	.04	3.71	3.71	3.71	3.71	.04	.04	.04	.04		
Turnover	Executive Team Turnover									40	36	40	40	27 *						
	Workforce Turnover Rate	7.5% - 11%	11.7%	12.0%	11.6%	11.1%	12.0%	11.5%	11.7%	11.8%	12.0%	11.5%	12.1%	12.0% *	11.6%	11.5%	11.7%	11.8%		

Detailed Indicators - Quality

Dementia	Dementia - Fair question 1 - Case Finding Applied	Q1>86%Q2 >87%Q3>8 8%Q4>90%	90.0%	89.6%	88.5%	86.3%	88.6%	90.4%							88.1%	88.3%				
	Dementia - Fair question 2 - Appropriately Assessed	Q1>86%Q2 >87%Q3>8 8%Q4>90%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%							100.0%	100.0%				
	Dementia - Fair question 3 - Referred for Follow Up	Q1>86%Q2 >87%Q3>8 8%Q4>90%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%							100.0%	100.0%				
Fracture Neck of Femur	Fracture Neck of Femur - Time To Treatment 90th Percentile (Hours)		51	66.9	50.6	68	49.2	40.5	49.1						48.6	63.7	46.9			
	Fracture Neck of Femur Patients Seeing Orthogeriatrician Within 72 Hours		98.3%	94.6%	98.6%	96.2%	100.0%	95.8%	100.0%						98.4%	96.6%	98.0%			
	Fracture Neck of Femur Patients Treated Within 36 Hours		61.7%	60.0%	75.4%	67.3%	68.3%	81.7%	63.5%						75.8%	67.2%	71.6%			
Infections	C.Diff Cases - Cumulative Totals	17/18 = 37	10	15	16	20	21	25	27	34	34	42	1	5	10	20	27	42	42	5 *
	MSSA Cases - Cumulative Totals	No target	26	37	50	59	71	79	90	95	105	114	6 *		26	59	90 *	114 *	114	6 *
Maternity	Percentage of Spontaneous Vaginal Deliveries		66.2%	66.7%	60.3%	63.3%	63.1%	61.1%	61.3%	60.0%	61.1%	*	*	*	63.8%	63.5%	61.8%	*	*	*
	Percentage of Women Seen by Midwife by 12 Weeks	>90	87.8%	85.9%	90.8%	91.5%	91.6%	90.6%	*	*	*	*	*	*	87.2%	92.3%	*	*	*	*
Medicines	Rate of Medication Incidents per 1,000 Beddays	Current mean	3.6	4.1	3.2	3.6	3.6	2.9							3.2	3.6				
Never Events	Total Never Events	0	0	1	0	0	1	0	0	0	0	0	0	2	0	1	1	0	2	2 *
Patient Falls	Falls per 1,000 Beddays	Current mean	6.2	5.1	6.1	6.7	5.6	6.2							5.8	6				
	Total Number of Patient Falls Resulting in Harm (moderate/severe)													5 *						
Patient Safety Incidents	Number of Patient Safety Incidents - Severe Harm (major/death)		3%	1%	3%	3%	3%	8%	1%	4%	0%			1% *	3%	2%	4%			
	Number of Patient Safety Incidents Reported		1,168	1,099	932	962	909	986	1,064	1,285	1,162			1,268	997	998	986			
	Patient Safety Incidents per 1,000 Beddays		40.9	37.6	32.9	33.7	31.1	34.5							34.8	34.7				

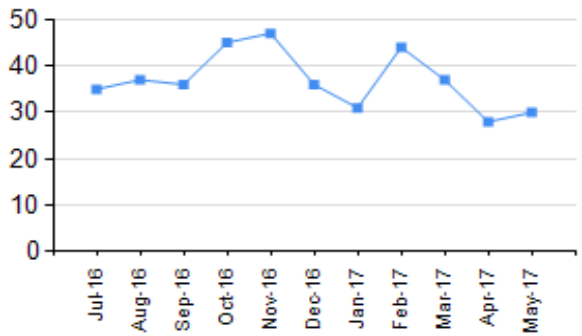
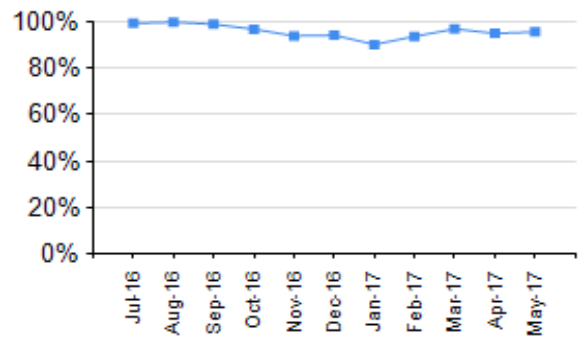
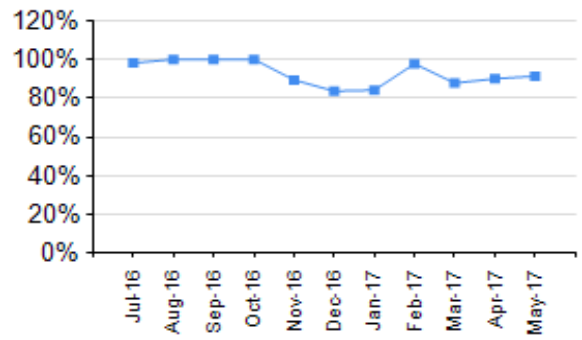
Performance Initiation & Delivery	Performance in Delivery: Recruiting to Time for Commercially Sponsored Studies														44.4%	33.3%	27.3%			
	Performance in Initiation: Percentage of Studies that are Eligible to Meet 70 Day Target														47.6%	50.0%	66.7%			
Pressure Ulcers Developed in the Trust	Pressure Ulcers - Grade 2	R:=1% G:<1%												123.00%						
	Pressure Ulcers - Grade 3	R: = 0.3 G: <0.3%												12.00%						
	Pressure Ulcers - Grade 4	R: =0.2% G: <0.2%												12.00%						
Research Accruals	Research Accruals	17/18 = >1100	183	160	120	126	104	144	66	90	64	78	123	176	134	135	104	88	3,045	299 *
RIDDOR	Number of RIDDOR	Current mean	2	1	1	1	0	0	4	1	5	2	2	2	2	1	1	3	2	2
Safer Staffing	Safer Staffing Care Hours per Patient Day		7	7	7	7	7	7	11	7	7	7	7	7 *	7 *	7	8	7 *	8	7 *
Safety Thermometer	Safety Thermometer - Harm Free	R<88% A 89%-91% G>92%	92.7%	93.0%	93.5%	92.9%	92.9%	92.8%	91.4%	91.4%	90.6%	91.3%	94.0%	92.4%	93.4%	93.1%	92.4%	0.0% *		
	Safety Thermometer - New Harm Free	R<93% A 94%-95% G>96%	97.5%	98.7%	97.6%	97.8%	97.8%	97.7%	95.4%	96.7%	97.1%	97.0%	97.7%	95.8%	98.1%	98.0%	97.0%	0.0% *		
Sepsis Screening	2a Sepsis – Screening	>90%	96.0%	98.0%	96.0%	98.0%	98.0%	98.0%	96.0%	100.0%	98.0%	96.0%		88.0% *	96.0%	97.0%	97.0%	96.0%		
	2b Sepsis - treatment within timescales (diagnosis abx given)	>50%	43.0%	52.0%	42.0%	41.0%	60.0%	65.0%	69.0%	44.0%	70.0%	64.0%			55.0%	45.0%	64.0%	0.0% *		
Serious Incidents	Number of Serious Incidents Reported		4	2	1	3	4	4	2	1	2			5	3	2	3			
	Percentage of Serious Incident Investigations Completed Within Contract Timescale		100%	100%	100%	100%	100%	100%	100%	100%	100%			100%	100%	100%	100%			
	Serious Incidents - 72 Hour Report Completed Within Contract Timescale		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			100.0%	100.0%	100.0%	100.0%			
Staff Safety Incidents	Rate of Incidents Arising from Clinical Sharps per 1,000 Staff	Current mean	2.5	1.3	2.5	1.2	2.2	1.8	2.4	2.2	1.4	2.1	1	1.2	2.3	1.7	2.1	1.9		
	Rate of Physically Violent and Aggressive Incidents Occurring per 1,000 Staff	Current mean	5	3.9	3.1	3	2.7	1.8	1.9	2.7	1.9	2.6	2.3	3.1	4.3	3.3	2.1	2.4		
Stroke Care	High Risk TIA Patients Starting Treatment Within 24 Hours	>=60%	69.8%	65.9%	79.5%	63.9%	65.4%	70.4%	85.2%	75.9%	68.2%	68.4%	64.0%	41.9%	66.2%	69.8%	73.8%			51.8% *
	Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	>=50%											33.3% *	32.5% *						32.8% *
	Stroke Care: Percentage Spending 90%+ Time on Stroke Unit	>=80%	83.8%	86.2%	96.2%	88.9%	88.8%	93.3%	84.3%	83.6%	87.3%	66.1%	81.8%		85.1%	90.0%	88.6%	0.0% *		81.8% *
Time to Initial Assessment	ED Time To Initial Assessment - Under 15 Minutes	>=99%	78.1%	76.9%	80.8%	78.2%	77.7%	79.8%	48.8%	57.9%	68.5%	80.2%	81.9%	80.2%	75.3%	78.6%	69.0%	69.1%		81.1% *
Time to Start of Treatment	ED Time to Start of Treatment - Under 60 Minutes	>=90%	46.0%	43.9%	49.4%	44.9%	46.8%	49.1%	27.6%	35.4%	34.0%	31.2%	29.5%	28.8%	47.1%	46.0%	41.3%	33.4%		29.1% *

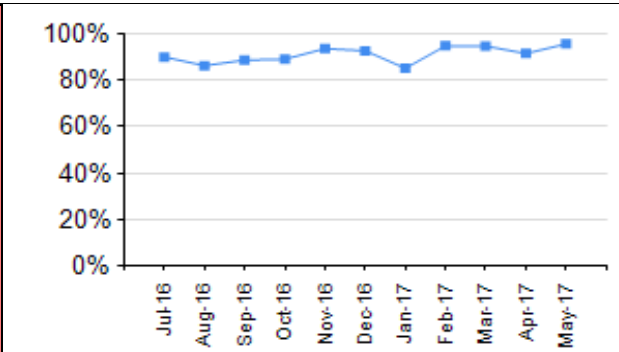
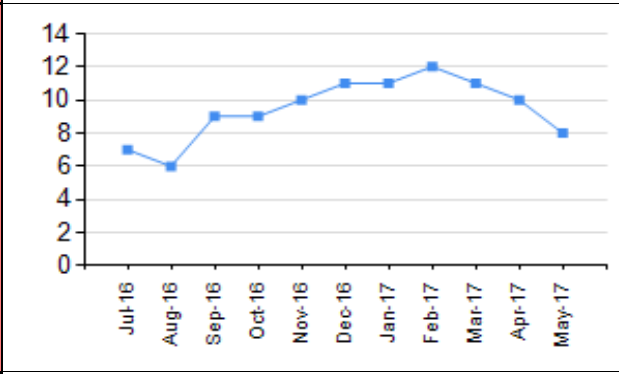
Detailed Indicators - Operational Performance

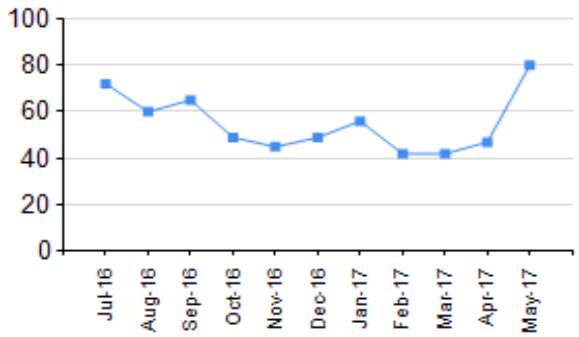
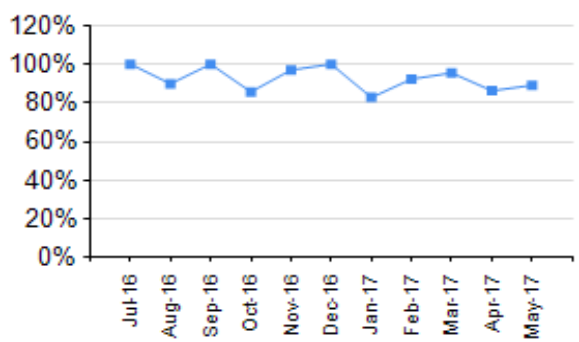
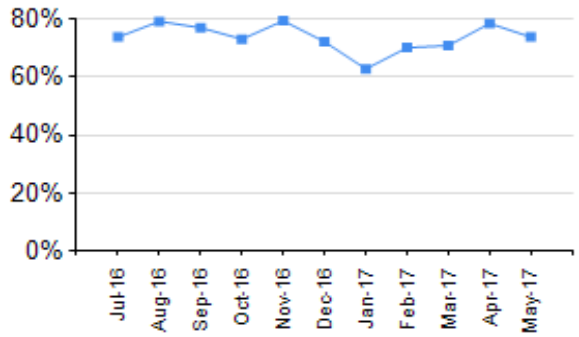
Ambulance Handovers	Ambulance Handovers - Over 30 Minutes	< previous year	155	199	155	187	186	99	189	201	104	47	34	54	517	541	474	352	1,884	88 *
	Ambulance Handovers - Over 60 Minutes	< previous year	0	0	1	0	1	0	13	7	1	0	1	0	3	1	14	8	26	1 *
Cancelled Operations	Number of LMCs Not Re-admitted Within 28 Days	0	8	4	4	2	3	0	*	*	*	*	*	*	35	10	*	*		*
Cancer (104 Days)	Cancer (104 Days) - With TCI Date	0	9	7	6	9	9	10	11	11	12	11	10	8						
	Cancer (104 Days) - Without TCI Date	0	80	72	60	65	49	45	49	56	42	42	47	80						
Cancer (2 Week Wait)	Cancer - Urgent referrals Seen in Under 2 Weeks	>=93%	90.3%	89.9%	86.2%	88.6%	89.0%	93.5%	92.6%	85.1%	94.7%	94.6%	91.4%	90.4% *	84.9%	88.2%	91.7%	90.1% *		
	Max 2 Week Wait For Patients Referred With Non Cancer Breast Symptoms	>=93%	90.5%	91.2%	93.4%	96.4%	95.7%	92.5%	88.3%	89.4%	95.0%	97.1%	90.4%	95.5% *	93.1%	93.7%	92.0%	92.2% *		
Cancer (31 Day)	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	>=96%	99.0%	99.2%	99.7%	98.8%	96.7%	93.8%	94.1%	90.1%	93.6%	96.8%	94.9%	95.5% *	99.1%	99.2%	94.9%	91.9% *		
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	>=98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0% *	100.0%	100.0%	100.0%	100.0% *		
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	>=94%	100.0%	100.0%	100.0%	98.3%	100.0%	100.0%	95.0%	98.4%	100.0%	98.6%	98.5%	100.0% *	100.0%	99.5%	98.6%	99.2% *		
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	>=94%	100.0%	98.1%	100.0%	100.0%	100.0%	89.4%	83.7%	84.2%	97.7%	87.8%	90.0%	91.4% *	99.4%	99.4%	90.7%	90.0% *		
Delayed Discharges	Acute Delayed Transfers of Care - Patients	<14	16	35	37	36	45	47	36	31	44	37	28	30	16	36	36	37		
Diagnostic Waits	Planned / Surveillance Endoscopy Patients Waiting at Month End		441	528	479	405	350	375	*	*	*	*	*	*	441	405	*	*	*	*
Discharge Summaries	Patient Discharge Summaries Sent to GP Within 1 Working Day	>=85%	85.7%	87.8%	89.5%	87.6%	88.9%	86.6%	*	*	*	*	*	*	85.7%	88.3%	*	*	*	*
ED - Time in Department	CGH ED - Percentage within 4 Hours	>=95%	92.98%	93.30%	97.29%	96.09%	91.32%	94.36%	84.33%	87.47%	88.42%	88.50%	91.80%	92.30%	92.44%	95.46%	92.79%	88.00% *	91.60%	92.10% *
	GRH ED - Percentage Within 4 Hours	>=95%	84.08%	82.12%	86.97%	84.81%	83.08%	82.38%	68.47%	67.83%	70.56%	71.80%	77.90%	72.90%	83.49%	84.49%	82.64%	70.00% *	79.20%	75.40% *
Length of Stay	Average Length of Stay (Spell)		5.53	5.16	5.43	5.55	5.39	5.67	*	*	*	*	*	*	5.41	5.38	*	*	*	*
	Length of Stay for General and Acute Elective Spells	<=3.4	3.7	3.51	3.84	3.65	3.52	3.5	*	*	*	*	*	*	3.34	3.69	*	*	*	*
	Length of Stay for General and Acute Non Elective Spells	Q1/Q2<5.4 Q3/Q4<5.8	5.99	5.54	5.81	6.03	5.87	6.32	*	*	*	*	*	*	5.89	5.79	6.24 *	6.36 *	6.08 *	5.59 *
Medically Fit	Number of Medically Fit Patients Per Day	<40	74	70	77	73	76	83	73	75	84	68	59	55	69	73	73	75		57 *
Referral to Treatment (RTT) Performance	Referral to Treatment Number of Ongoing Pathways Over 18 Weeks		4,008	4,510	4,527	4,850	4,978	6,574							12,063	13,887				

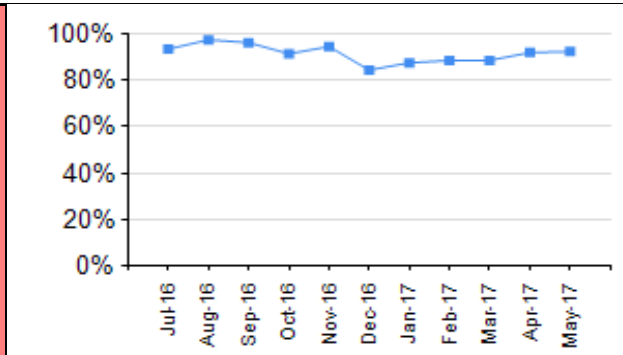
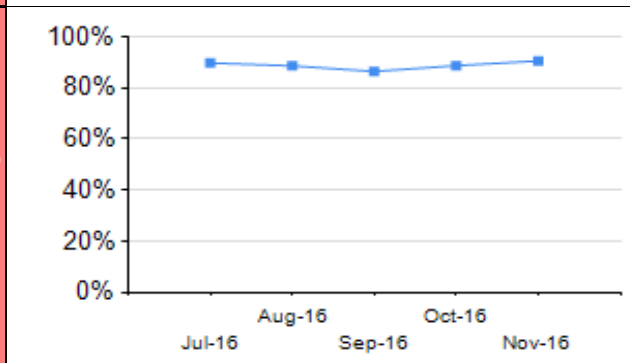
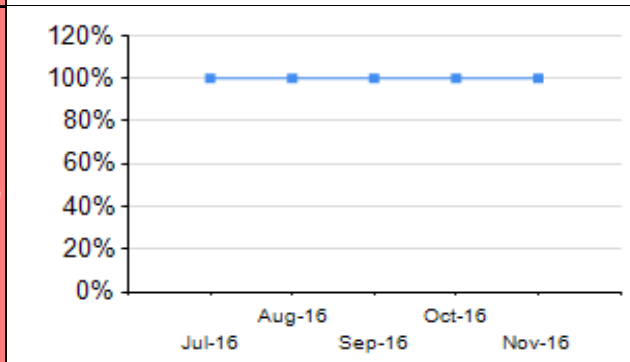
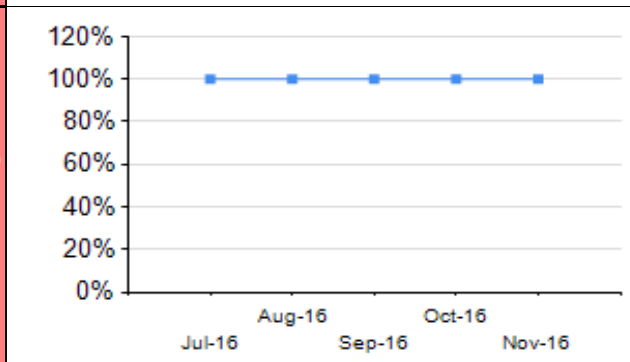
Referral to Treatment (RTT) Wait Times	Referral To Treatment Ongoing Pathways 35+ Weeks (Number)		407	475	419	476	536	579							1,114	1,367				
	Referral To Treatment Ongoing Pathways 40+ Weeks (Number)		163	200	193	250	215	250							431	643				
	Referral To Treatment Ongoing Pathways Over 52 Weeks (Number)	0	2	3	1	3	4	3							7	7				
SUS	Percentage of Records Submitted Nationally with Valid GP Code	>=99%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			100.0%	100.0%	100.0%	100.0%		
	Percentage of Records Submitted Nationally with Valid NHS Number	>=99%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%			99.8%	99.8%	99.8%	99.8%		
Trolley Waits	ED 12 Hour Trolley Waits	0	0	0	0	1	0	0	1	0	0	0	0	0	0	1	1	0	2	0 *
Detailed Indicators - Finance																				
Finance	NHSI Financial Risk Rating	3	2	2	1	1	1	1	1	1	1				2	1	1			
	Total PayBill Spend		27400	27000	28700	27400	28000	27900	27466	26998	27240				77422	83100	83346			
Detailed Indicators - Leadership and Development																				
Appraisals	Percentage of Staff Having Well Structured Appraisals in Last 12 Months	>3.8	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3		
	Staff who have Annual Appraisal	G>89% R<80%	83.0%	80.0%	81.0%	80.0%	80.0%	80.0%	80.0%	80.0%	82.0%	82.0%	80.0%	79.0%	83.3%	80.3%	80.0%	81.6%		
Staff Survey	Improve Communication Between Senior Managers and Staff (as Measured by the Annual Staff Survey)	>38%	34.0%	34.0%	34.0%	34.0%	34.0%	34.0%	34.0%	34.0%	34.0%	34.0%	34.0%	34.0%	34.0%	34.0%	34.0%	34.0%		
Staffing Numbers	Total Worked FTE		7,088	7,156	7,295	7,299	7,290	7,226	7,200	7,238	7,239 *				7,088	7,299	7,200			
Training	Essential Training Compliance	>=90%	92%	91%	92%	91%	91%	89%	89%	89%	89%	90%	89%	89%	92%	91%	90%	89%		

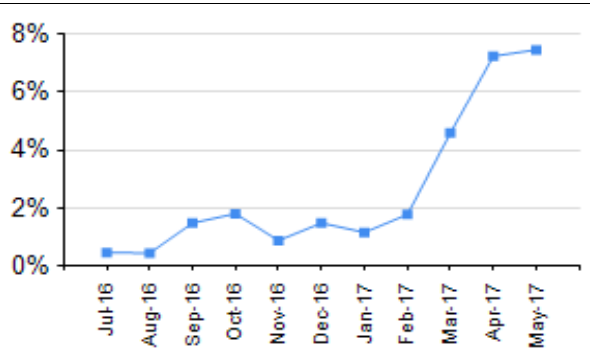
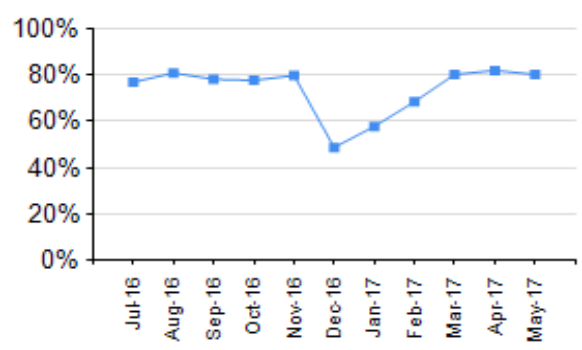
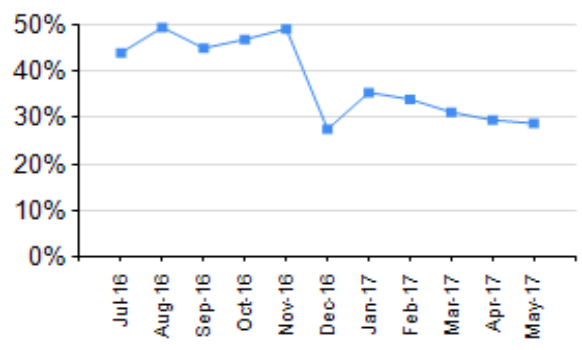
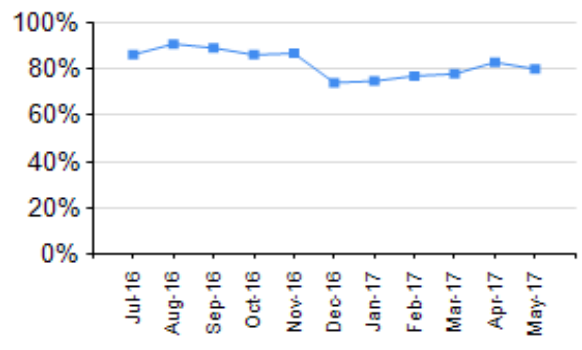
Exception

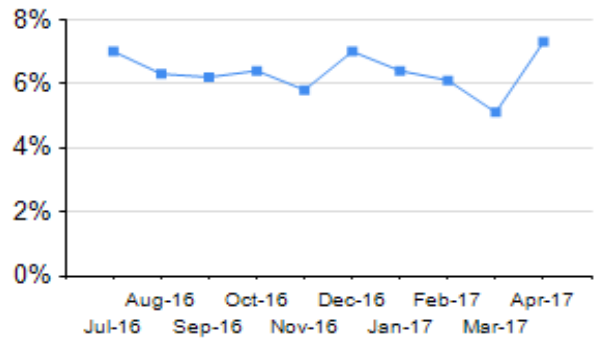
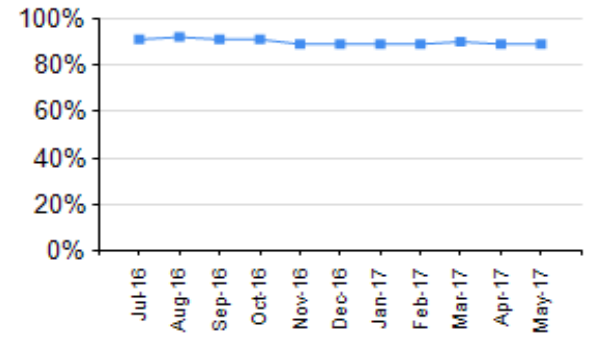
Metric Name & Target	Trend Chart	Exception Notes	Owner	
Acute Delayed Transfers of Care - Patients **Target: <14**		DTOC and Medically fit remain a priority for the Trust as it impacts the overall bed availability of the Trust. Work with partner agencies continues particularly the development of Discharge to Assess, Pathway 1. The SAFER programme and delivery of the Red/ Green day programme works to support every patient journey. The medically fit ward continues to operate well. Supporting this partner agencies are working through a 'pull model' across the Trust.	Deputy Chief Operating Officer	
Cancer - 31 Day Diagnosis To Treatment (First Treatments) **Target: >=96%**		The performance for May 17 was 95.5% against a target of 96% (253 treatments and 12 breaches). All 12 breaches were due to surgical capacity. 10 of these cases were in Urology. Actions to improve the position are included in the wider Cancer Waiting Times recovery plan, but specifically in Urology: • Additional consultant capacity is now in place and will start to have an impact • The service is moving to generic pre-assessment – implementation began in April • The Urology admissions team is now in post and having a positive impact • The pooling of theatre lists has begun and is ongoing	Deputy Chief Operating Officer	
Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery) **Target: >=94%**		Actions as per metric Cancer - 31 Day Diagnosis To Treatment (First Treatments) The performance for Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)May 17 was Performance: 91.4% against a target of >=94% Mitigating actions to improve the position are included in the wider Cancer Waiting Times recovery plan, but specifically in Urology: • Additional consultant capacity is now in place and will start to have an impact • The service is moving to generic pre-assessment – implementation began in April • The Urology admissions team is now in post and having a positive impact • The pooling of theatre lists has begun and is on-going	Deputy Chief Operating Officer	

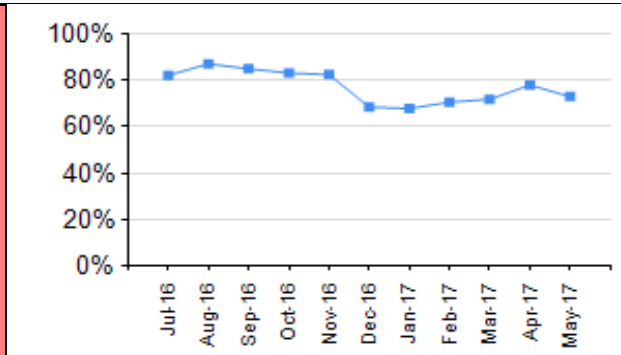
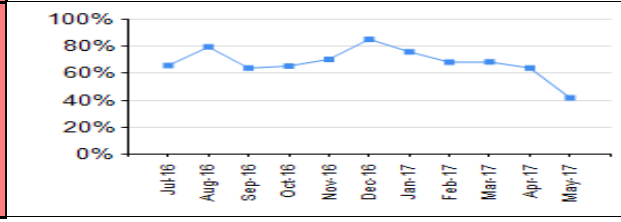
Cancer - Urgent referrals Seen in Under 2 Weeks **Target: >=93%**		Upper GI increased referral rate has been identified with the CCG. An upward trend in referrals from Cheltenham GP's. Communication to primary care in place on appropriate use of referrals to a 2WW pathway.	Deputy Chief Operating Officer	
Cancer (104 Days) - With TCI Date **Target: 0**		There are currently 27 patients waiting over 104 days with a TCI, 24 of whom are urology patients. The trajectory for Urology shows recovery by July 2017 as the backlog is cleared. 15 of these patients have already been treated, but treatments outcomes are not yet available (in some cases, due to the clearance of the Histology backlog).	Deputy Chief Operating Officer	

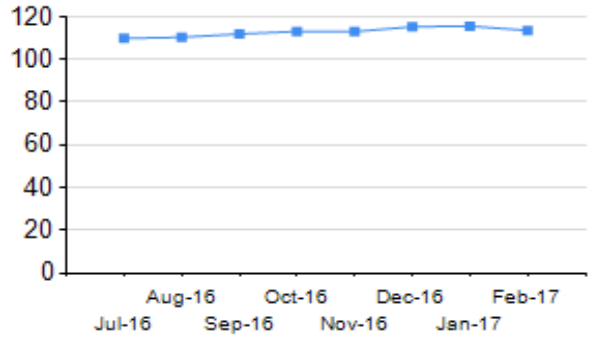
Cancer (104 Days) - Without TCI Date **Target: 0**		There are currently 23 patients waiting over 104 days without a TCI, 12 of whom are urology patients. The trajectory for Urology shows recovery by July 2017 as the backlog is cleared. Of the non-urology patients, all were waiting due to complex pathways, or patient choice or because they were not fit for treatment.	Deputy Chief Operating Officer	
Cancer 62 Day Referral To Treatment (Screenings) **Target: >=90%**		Performance: 89.1% against a target: >=90% The issues are similar as for the overall 62 day performance. with regards diagnostic and surgical capacity, the Trust has a Cancer Waiting Times action plan to recover the overall 62 day position to include screening referrals.	Deputy Chief Operating Officer	
Cancer 62 Day Referral To Treatment (Urgent GP Referral) **Target: >=85%**		April's validated position is 78.5%, against a standard of 85% and against a trajectory of 79.4%. There were 62 fewer treatments than projected (130 as opposed to 192) and 11.5 fewer breaches than projected (28 as opposed to 39.5). 5 of these breaches were the result of backlog clearance in Urology and there were 6 breaches where the histology backlog was a contributory factor. The backlog has since been cleared (as of 12.06.17) and there is a plan to sustain this position using outsourcing and locums until permanent appointments can be made to increase capacity in Histology. Overall the issues are diagnostic capacity (endoscopy, imaging and histology) and surgical capacity. The Trust has an agreed revised trajectory to recover the 62 day performance by July 2017 following Trakcare operational issues and delays in implementing multi-assessment and diagnostic clinics in Urology. This plan has been shared with Gloucestershire CCG, NHS England and NHS Improvement and it has been approved. All Trakcare operational issues are being addressed, but remain a risk to recovery as well as the delivery of the full urology recovery to plan to timescale. 2ww capacity, particularly in Endoscopy, is also a risk to recovery as demand exceeds capacity. There are further risks due to consultant vacancies in Head and Neck and Haematology	Deputy Chief Operating Officer	

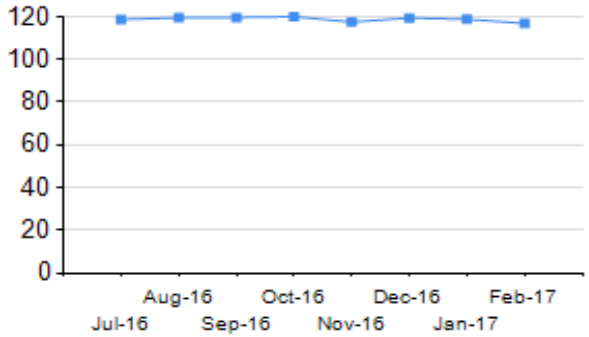
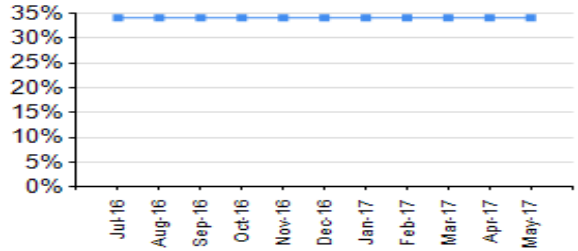
CGH ED - Percentage within 4 Hours **Target: >=95%**		Over the month performance at 92.3% against the national target of 95% in CGH this has improved from April by 0.5%. Performance is impacted upon when diverts from GRH have to be accommodated. however; we acknowledge there is room for improvement in process and plans via the unscheduled care senior leaders meeting are being implemented in tandem with renewed focus on potential breaches from 2 hours.	Deputy Chief Operating Officer	
Dementia - Fair question 1 - Case Finding Applied **Target: Q1>86%Q2>87%Q3>88%Q4>90%**		Data previously was collected via the Infoflex Discharge Summary. Since the introduction of Trakcare, this functionality has been lost. Currently discussion as on-going to enable an assessment page of Trakcare, which will, within Urgent Care, capture the Case Finding Question. However, ideally the full element of the Dementia dataset would need re-establishing within the Discharge element of Trakcare, including an automised process to alert the patient's GP to any potential new diagnosis of Dementia.	Deputy Nursing Director & Divisional Nursing Director - Surgery	
Dementia - Fair question 2 - Appropriately Assessed **Target: Q1>86%Q2>87%Q3>88%Q4>90%**		Data previously was collected via the Infoflex Discharge Summary. Since the introduction of Trakcare, this functionality has been lost. Currently discussion as on-going to enable an assessment page of Trakcare, which will, within Urgent Care, capture the Case Finding Question. However, ideally the full element of the Dementia dataset would need re-establishing within the Discharge element of Trakcare, including an automised process to alert the patient's GP to any potential new diagnosis of Dementia.	Deputy Nursing Director & Divisional Nursing Director - Surgery	
Dementia - Fair question 3 - Referred for Follow Up **Target: Q1>86%Q2>87%Q3>88%Q4>90%**		Data previously was collected via the Infoflex Discharge Summary. Since the introduction of Trakcare, this functionality has been lost. Currently discussion as on-going to enable an assessment page of Trakcare, which will, within Urgent Care, capture the Case Finding Question. However, ideally the full element of the Dementia dataset would need re-establishing within the Discharge element of Trakcare, including an automised process to alert the patient's GP to any potential new diagnosis of Dementia.	Deputy Nursing Director & Divisional Nursing Director - Surgery	

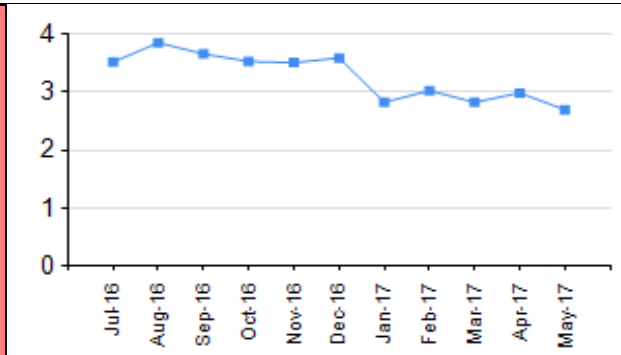
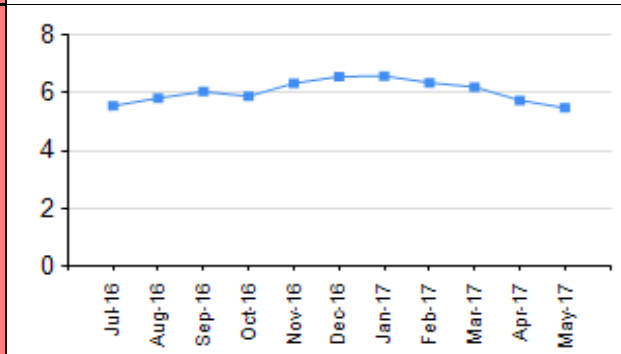
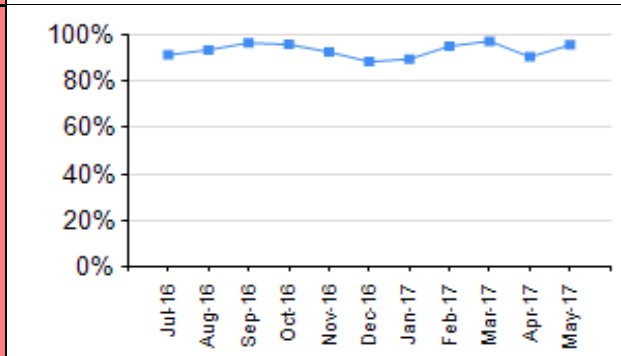
Diagnostics 6 Week Wait (15 Key Tests) **Target: <1%**		The Trust did not meet the diagnostics target in May, mainly driven by underperformance in three areas; Colonoscopy with 163 breaches; Audiology with 104 breaches and Endoscopy with 59 breaches. Echo Cardiology as reported last month has recovered, operating at a sufficient run rate for sustainable performance. Recovery plans are in place for these diagnostic areas, an assessment of performance of all the diagnostic areas, capacity and individual recovery plans is being undertaken to assess the timing of full recovery. Performance for May, 5.58% is an improvement on the April position but significant remedial action is required to operate at the required 1%.	Deputy Chief Operating Officer	
ED Time To Initial Assessment - Under 15 Minutes **Target: >=99%**		Trust wide Performance: 80.2% against a Target: >=99%. The reason for this is the number of nurses able to triage. Currently in mitigation we are training a further 9 nurses in triage, this is a 3 month programme that will enable a greater pool of staff who can triage and support at peak times.	Deputy Chief Operating Officer	
ED Time to Start of Treatment - Under 60 Minutes **Target: >=90%**		Performance 28.8% against a target: >=90% GP patients coming through ED late afternoon early evening have put pressure on the capacity of the dept. Currently the department does not operate a RAT model, however; the department have piloted a similar model over a 9 day period in late May using PDSA cycles. the outcomes are currently being reviewed. We have made changes to Trak care which will enable the first point of contact by a senior clinician to be recorded as the senior Dr who assesses the patient to order the relevant diagnostic tests. We anticipate an impact in July however; this will be subject to having 3 consultants in ED with one being allocated to overview the department.	Deputy Chief Operating Officer	
ED Total Time in Department - Under 4 Hours **Target: >=95%**		The overall Trust performance against the 4 hour national standard of 95% for May was 80.5%	Deputy Chief Operating Officer	

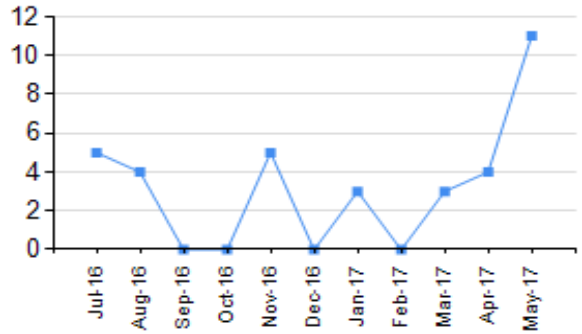
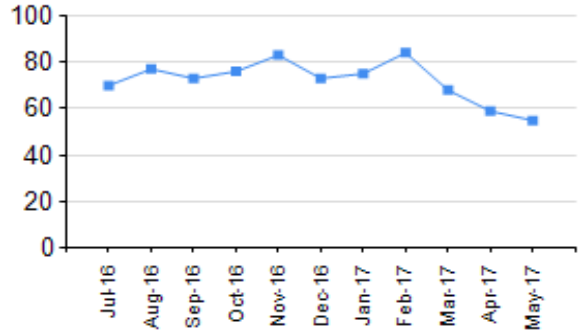
Emergency Readmissions Percentage **Target: Q1<6%Q2<5.8%Q3<5.6%Q4<5.4%**		Readmissions are an important indicator as a balancing measure in our PMF. We will continue to monitor this closely and review readmissions to ensure any learning from these cases is used to improve patient care. Due to the implementation of a new EPR system emergency readmissions are still under intense validation because of a variety of reasons, e.g. patients have been incorrectly categorised as elective, day case or non-elective admissions on Trak; 1,000+ inpatient records are not being extracted into the data warehouse from Trak and are therefore not available for the coders to code; theatre patients are not always having their theatre episode correctly finalised and these patients cannot then be discharged. These issues are all in the process of being resolved and previously incorrect data is being corrected.	Deputy Chief Operating Officer	
Essential Training Compliance **Target: >=90%**		This is all about focus and targeting the areas/staff groups with non-compliance. Cost centre managers are provided with robust data monthly enabling them to identify departments, individuals and subjects with low completions. These are also highlighted in the monthly divisional executive reviews as well as in the Education, Learning and Development operations sub-group.	Director of Human Resources and Operational Development	

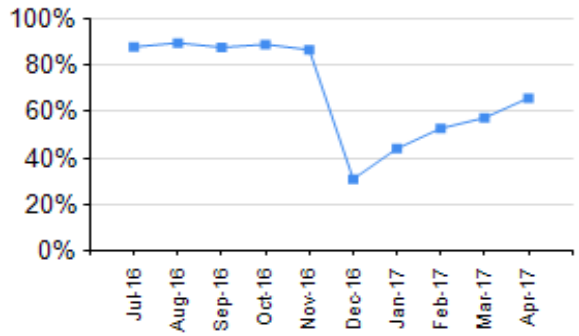
GRH ED - Percentage Within 4 Hours **Target: >=95%**		Gloucester did not achieve the 4 hour 95% national standard reporting at 79.96% Issues in relation to Medical rota gaps, peaks in attendances from 16:00 and bed flow have impacted. Mitigations to address these issues have been put in place or are planned: Recruitment plan for middle grades Transfer policy to Cheltenham to improve flow between sites from ACU GRH to appropriate medical wards CGH Recruitment to floor coordinators in ED to enable constant focus, early and proactive escalation Joint refocus on any potential breaches from 2 hours by site team 2 hourly pull from ED by the AEC consultant or ANP Nominated medical Dr for ED to support flow in front door	Deputy Chief Operating Officer	
High Risk TIA Patients Starting Treatment Within 24 Hours **Target: >=60%**		We failed to achieve the standard for this measure in May 2017, recording 18 breaches. A detailed investigation is underway, but returns collated suggest that this was linked to a lack of TIA capacity on 5 separate days. Provisional findings suggest this is due to reduced consultant cover in May, but a thorough review is being undertaken and findings will be reported at the June COTE service review, along with an action plan to deliver this moving forwards.	Director of Operations - Medicine	

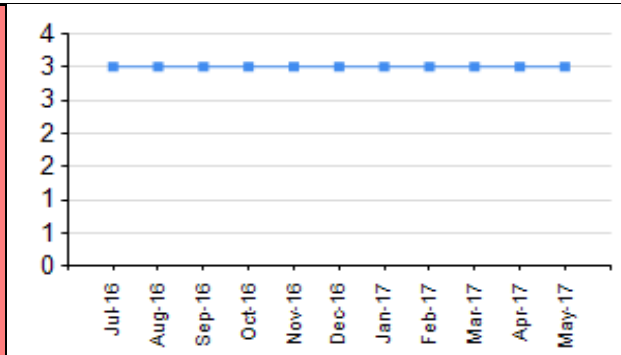
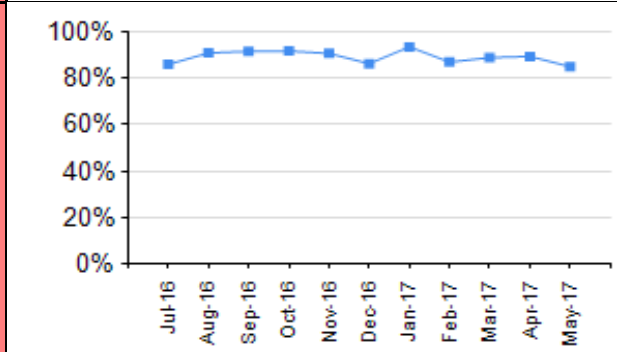
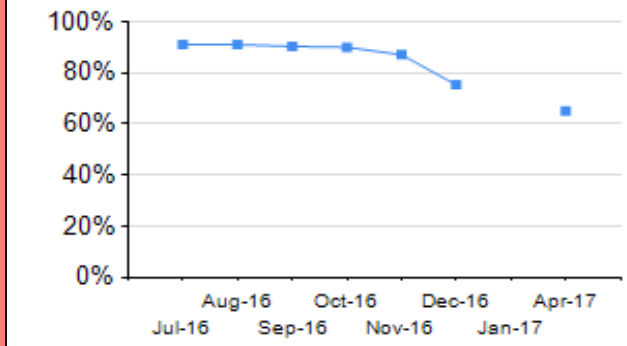
Hospital Standardised Mortality Ratio (HSMR) **Target: Dr Foster confidence level**		The performance against the Dr Foster HSMR indicates a higher than expected mortality. There is a downward trend in HSMR since October 2016. Issues with Trak Care are thought to be affecting this data. Both indicators include patients who have died within Gloucestershire Hospitals NHSFT and Community Hospitals in Gloucestershire. SHMI data suggests there is a negative impact from deaths in community hospitals and the Executive is asked to support collaborative system-wide work to unpick this. The actions taken to review Mortality Indicators and Alerts are detailed below. All inpatient deaths within GHNHSFT are reviewed independently by the Medical Examiner and concerns are discussed with the Coroner. All elective deaths, deaths due to fractured neck of femur, child, neonatal and maternal deaths, deaths in ED and DCC, deaths in patients with a Learning Disability have a second line review by a clinical reviewer. A subset of all inpatient deaths are reviewed at clinical Specialty level. All deaths within diagnostic groups which flag as an outlier within Dr Foster have an on-line review of history by the Clinical Co-ordinator for Mortality and the Hospital Mortality Group. This is a review of data, coding, co-morbidities, procedures and risks. Any patients with a potential care concern are referred for a clinical notes review by the Specialty. Any care concerns from the Medical Examiner reviews are referred for scoping under the current governance systems. Any complaints by bereaved families are signposted via Bereavement services and the Medical Examiner to PALS or via the Datix system. Any coding concerns are reviewed by the Director of Clinical Coding in collaboration with the Consultant. Work to correct discrepancies in Palliative Care coding has resulted in changes which should show an impact on the data during the current financial year. A database is under construction which should facilitate more contemporaneous reviews of inpatient deaths by Specialties. Database will be piloted by adult divisions over summer 2017 and will fulfil reporting	Medical Division Audit and M&M Lead	

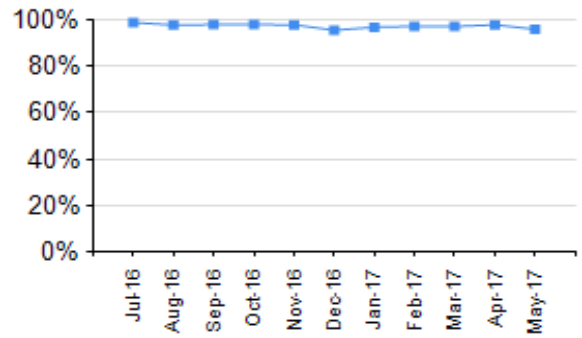
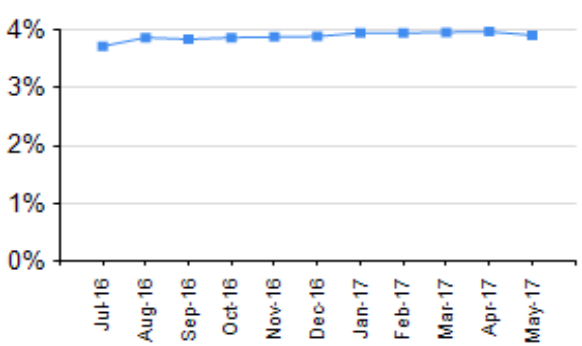
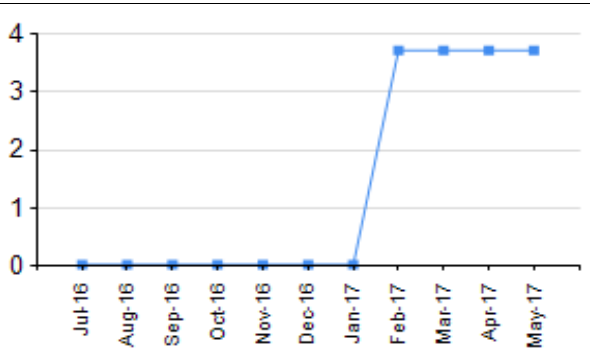
Hospital Standardised Mortality Ratio (HSMR) - Weekend **Target: Dr Foster confidence level**		The performance against the Dr Foster HSMR indicates a higher than expected mortality. There is a downward trend in HSMR since October 2016. Issues with Trak Care are thought to be affecting this data. Both indicators include patients who have died within Gloucestershire Hospitals NHSFT and Community Hospitals in Gloucestershire. SHMI data suggests there is a negative impact from deaths in community hospitals and the Executive is asked to support collaborative system-wide work to unpick this. The actions taken to review Mortality Indicators and Alerts are detailed below. All inpatient deaths within GHNHSFT are reviewed independently by the Medical Examiner and concerns are discussed with the Coroner. All elective deaths, deaths due to fractured neck of femur, child, neonatal and maternal deaths, deaths in ED and DCC, deaths in patients with a Learning Disability have a second line review by a clinical reviewer. A subset of all inpatient deaths are reviewed at clinical Specialty level. All deaths within diagnostic groups which flag as an outlier within Dr Foster have an on-line review of history by the Clinical Co-ordinator for Mortality and the Hospital Mortality Group. This is a review of data, coding, co-morbidities, procedures and risks. Any patients with a potential care concern are referred for a clinical notes review by the Specialty. Any care concerns from the Medical Examiner reviews are referred for scoping under the current governance systems. Any complaints by bereaved families are signposted via Bereavement services and the Medical Examiner to PALS or via the Datix system. Any coding concerns are reviewed by the Director of Clinical Coding in collaboration with the Consultant. Work to correct discrepancies in Palliative Care coding has resulted in changes which should show an impact on the data during the current financial year. A database is under construction which should facilitate more contemporaneous reviews of inpatient deaths by Specialties. Database will be piloted by adult divisions over summer 2017 and will fulfil reporting	Medical Director	
Improve Communication Between Senior Managers and Staff (as Measured by the Annual Staff Survey) **Target: >38%**		The actual score (based on the raw data scores) moved from 34% to 37% therefore the reported metric is out of date. This is an annualised score and there will be no change to the reported figures until March of next year. Improving communication between senior managers and staff was established as a priority by the Trust Board in 2016 and in particular, fostering an open and transparent environment. Early feedback through the last staff survey and subsequent listening events has been positive with staff wishing us to continue with this as one of our identified priorities for 2017	Director of Human Resources and Operational Development	

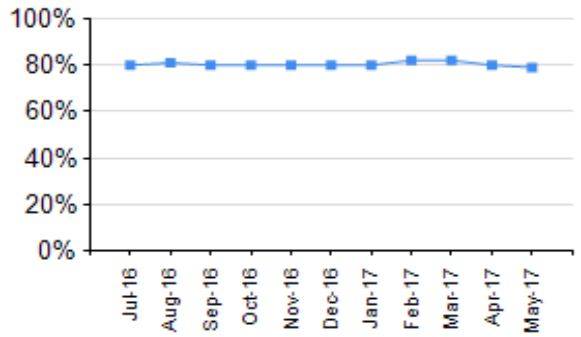
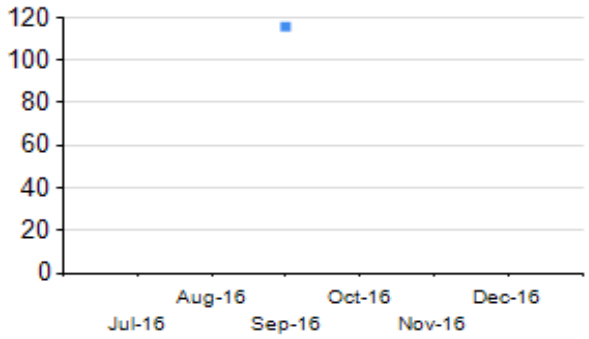
Length of Stay for General and Acute Elective Spells **Target: <=3.4**		The trend in Length of Stay has improved since the winter months. This has been aided by the decrease in the number of DTOC's.	Deputy Chief Operating Officer	
Length of Stay for General and Acute Non Elective Spells **Target: Q1/Q2<5.4 Q3/Q4<5.8**		The trend in Length of Stay has improved since the winter months. This has been aided by the decrease in the number of DTOC's.	Deputy Chief Operating Officer	
Max 2 Week Wait For Patients Referred With Non Cancer Breast Symptoms **Target: >=93%**		Performance for May was 90.4% against the 93% target. The Breast service have had a reduction in screening capacity from radiology due to vacancies.	Deputy Chief Operating Officer	

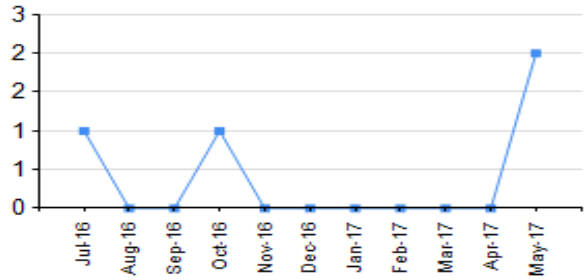
Number of Breaches of Mixed Sex Accommodation **Target: 0**		The routine mixing of sexes in inpatient clinical areas is unacceptable and must only happen in exceptional circumstances. A total of 11 breaches affecting 18 patients was declared by the Trust for the month of May 2017. The analysis shows that all 11 breaches were within the Critical Care departments with the split being 9 at GRH and 2 at CGH. All breaches were due to the inability to move patients out of Critical Care areas once they had been made wardable. This is particularly prevalent at the GRH site where the operational OPEL status is often at level 3 (red) or 4 (black) and bed availability poor. The key issue to address is how to ensure movement of patients from both DCCs when they are declared wardable and no longer require level 2 or 3 critical care. Patients that require transferring to wards are discussed at the 0800 Site Handover Meeting; a member of DCC staff is generally present to provide this information. This enables the Site Management Teams to consider those movements along with ensuring flow from ED, repatriations from other Acute sites (including MTCs) and ward moves. The impact that this key action is expected to show is an improvement in mixed sex breach numbers throughout June 2017. The risks to the actions are a potential of a reduction in 4hr ED performance due to the balance of breach management in both Critical Areas and EDs. The overall confidence level to achievement an improvement over the May 2017 figures is medium. The mitigating actions to the risks are to maintain the safety of all patients pathways, protect the 4hr ED performance wherever possible and look at each potential mixed sex breach on a case by case basis.	Head of Capacity and Patient Flow	
Number of Medically Fit Patients Per Day **Target: <40**		DTOC and Medically fit remain a priority for the Trust as it impacts the overall bed availability of the Trust. Work with partner agencies continues particularly the development of Discharge to Assess, Pathway 1. The SAFER programme and delivery of the Red/ Green day programme works to support every patient journey. The medically fit ward continues to operate well. Supporting this partner agencies are working through a 'pull model' across the Trust. The Trust are also designing a daily navigation meeting to review patients MFFD in lie with reporting of MFFD patients against core standards both internal and external for shared learning and joint holding partner agencies to account.	Deputy Chief Operating Officer	

Patient Discharge Summaries Sent to GP Within 1 Working Day **Target: >=85%**		Discharge summary performance is not currently at the required level (85%). However since the introduction of Trak in December the performance overall has improved from 51% to 65% and a lot of work is under way to address both the contemporaneous delivery of discharge summaries and to clear the backlog. The new process for discharge summaries has built in pharmacy checks, ward nurse checks and doctor approval prior to sending the summary. Review of the discharge summaries not sent show that the vast majority of summaries are completed but are just awaiting final approval. Ultimately this process will address a number of issues that arose with the previous discharge summaries but these new systems have required additional training which was not anticipated. A daily report is now sent to Speciality Directors with the current state and clear instructions to reduce these numbers.	Medical Director	

Percentage of Staff Having Well Structured Appraisals in Last 12 Months **Target: >3.8**		This is reported via the annual staff survey and scores are on a 5 point scale (1-5 where 5 scores high). Our performance is 3 (a 0.03 improvement on the prior year) against a national average of 3.11, with a national best performance of 3.49. A target of 3.8 is therefore unrealistic within this timeframe and should be recalibrated at 3.2 for this year. Notwithstanding this, the focus has been on appraisal completion and despite changes to the appraisal paperwork in the last year (simplification and reduction), this remains an issue. Whilst the scores are acceptable in nursing and midwifery, Health Care Assistants and Allied Health Professionals, there are challenges across the remainder of the workforce, most notably with doctors and healthcare scientists. Our education leads are working with the professional leads in these areas to determine how performance can be improved.	Director of Human Resources and Operational Development	
Percentage of Women Seen by Midwife by 12 Weeks **Target: >90**		The Booking data is currently inaccurate. Since implementation of TRACK data concerning date of booking has not been consistently entered onto the system as this is not a Mandatory Filed .The Division are looking to address this by issuing clear standard operating procedures to assist midwives in ensuring all the necessary fields are completed. Plans are in place to enter this data retrospectively from April to support accurate data analysis in future.	Divisional Nursing and Midwifery Director	
Referral To Treatment Ongoing Pathways Under 18 Weeks (%) **Target: >=92%**		Due to inconsistent use of the current EPR there are large quantities of poor data being created and retained on this list. Current estimates based on ongoing assessments is that 40-50% of the pathways (at aggregate level, this differs per specialty) are data quality issues. Due to the level of poor data it is not possible to accurately define which areas are truly pressured and which areas have data quality issues caused by insufficient processes. The current validation resource is unable to maintain or improve the current volume of pathways requiring validation which is causing a steady decline in the performance. There is currently a business case in production to increase the resource within the validation team with a focus to; clearing the backlog, monitoring RTT data quality, improving pathway quality through training and providing proactive management of RTT pathways. There are also external	Deputy Chief Operating Officer	

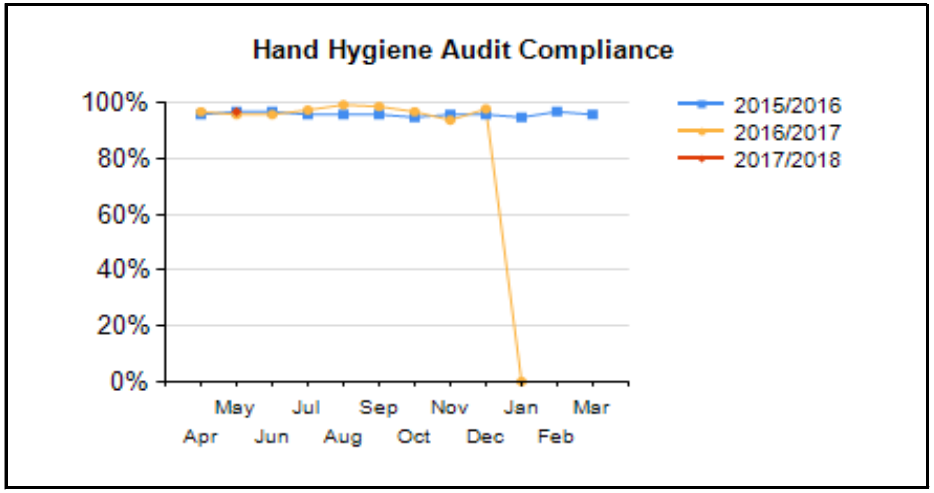
Safety Thermometer - New Harm Free **Target: R<93% A 94%-95% G>96%**			Director of Safety	
Sickness Rate **Target: G<3.6% R>4%**		Our sickness rate of 3.94% (annualised) is above our target of 3.60% albeit the 'in-month' performance was better than target. We also frequently beat the national average for the NHS of 4.30. We expect this annualised rate to reduce marginally over the summer months as we do witness seasonal fluctuations. Sickness data is reviewed at both a trustwide level (within the Staff Health and Wellbeing Group) and divisionally. There is a balance of managing absence and promoting healthy activities such as the 'One You' campaign which encourages staff to make pledges towards improving and maintaining their own health. We are also working towards accreditation under the Workplace Wellbeing Charter and several CQINS this year are linked to health promotion, improved diet and food content, reductions in stress levels and a reduction in musculo-skeletal injuries.	Director of Human Resources and Operational Development	
Staff Engagement Indicator (as Measured by the Annual Staff Survey) **Target: >3.8**		Staff engagement disappointingly did not move forward in the year (a similar phenomenon happened nationally)and following presentations/feedback following the 2016 staff survey, a four point corporate priority list has been produced; 1. Complete the travel plan to incorporate additional parking and travel to work options (carried forward) 2. Promote and role model openness and transparency through words and action 3. Demonstrate listening/learning from patients 4. Greater management visibility. A full action plan is being developed for Workforce Committee regarding these priorities whilst divisions are also developing a suite of localised actions	Director of Human Resources and Operational Development	

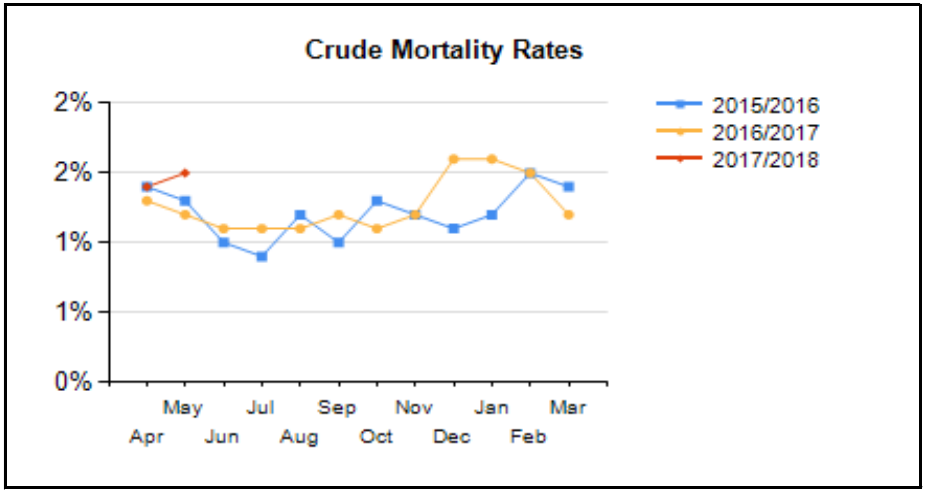
Staff who have Annual Appraisal **Target: G>89% R<80%**		Appraisal rates have reduced to an unacceptable level. Particular focus is being placed on Medicine Division and we received very recent assurance from this division that they are expecting action plans to be established and delivered against every under-performing cost centre. A similar focus will be placed on the 'Facilities' part of the Estates and Facilities Division where performance is now less than 60%. This will also be addressed via the ELD Operational Group. This is a key topic for discussion in the monthly divisional executive reviews.	Director of Human Resources and Operational Development	
Summary Hospital Mortality Indicator (SHMI) - National Data **Target: Dr Foster confidence level**		The performance against the SHMI indicates a higher than expected mortality. Both indicators include patients who have died within Gloucestershire Hospitals NHSFT and Community Hospitals in Gloucestershire. SHMI data suggests there is a negative impact from deaths in community hospitals and the Executive is asked to support collaborative system-wide work to unpick this. The actions taken to review Mortality Indicators and Alerts are detailed below. All inpatient deaths within GHNHSFT are reviewed independently by the Medical Examiner and concerns are discussed with the Coroner. All elective deaths, deaths due to fractured neck of femur, child, neonatal and maternal deaths, deaths in ED and DCC, deaths in patients with a Learning Disability have a second line review by a clinical reviewer. A subset of all inpatient deaths are reviewed at clinical Specialty level. All deaths within diagnostic groups which flag as an outlier within Dr Foster have an on-line review of history by the Clinical Co-ordinator for Mortality and the Hospital Mortality Group. This is a review of data, coding, co-morbidities, procedures and risks. Any patients with a potential care concern are referred for a clinical notes review by the Specialty. Any care concerns from the Medical Examiner reviews are referred for scoping under the current governance systems. Any complaints by bereaved families are signposted via Bereavement services and the Medical Examiner to PALS or via the Datix system. Any coding concerns are reviewed by the Director of Clinical Coding in collaboration with the Consultant. Work to correct discrepancies in Palliative Care coding has resulted in changes which should show an impact on the data during the current financial year. A database is under construction which should facilitate more contemporaneous reviews of inpatient deaths by Specialties. Database will be piloted by adult divisions over summer 2017 and will fulfil reporting requirements of the National Standards for Mortality Review.	Medical Division Audit and M&M Lead	

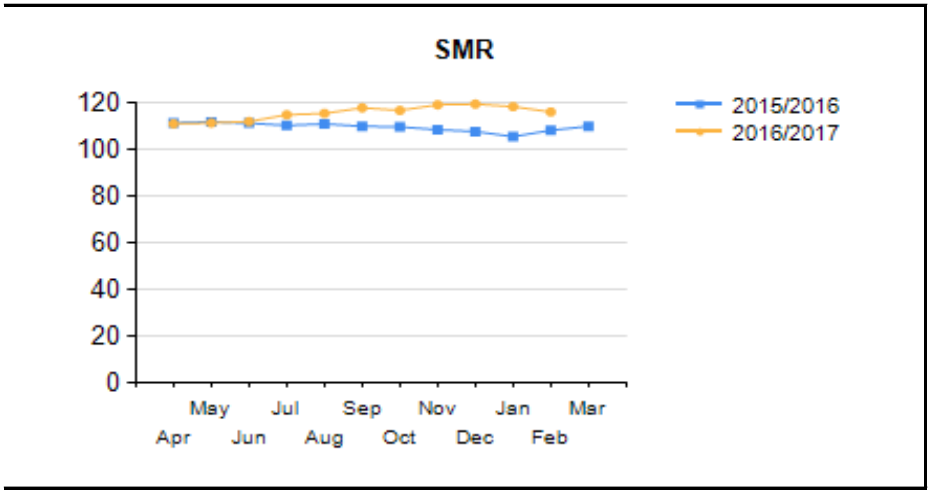
Total Never Events **Target: 0**		Two Never Events were reported with the Never Events classification of "insertion of wrong implant" both involved joint implants. The two cases occurred approximately a year apart, the first case was discovered on re-admission with a complication the second case was identified whilst the patient was still in the theatre environment. The Never Event investigation is progressing as per contractual requirements. A further high level review will be conducted linking to a T&O programme to reduce variation of practice, the work will be based on an early Failure Mode Evaluation and analysis exercise.	Director of Safety	

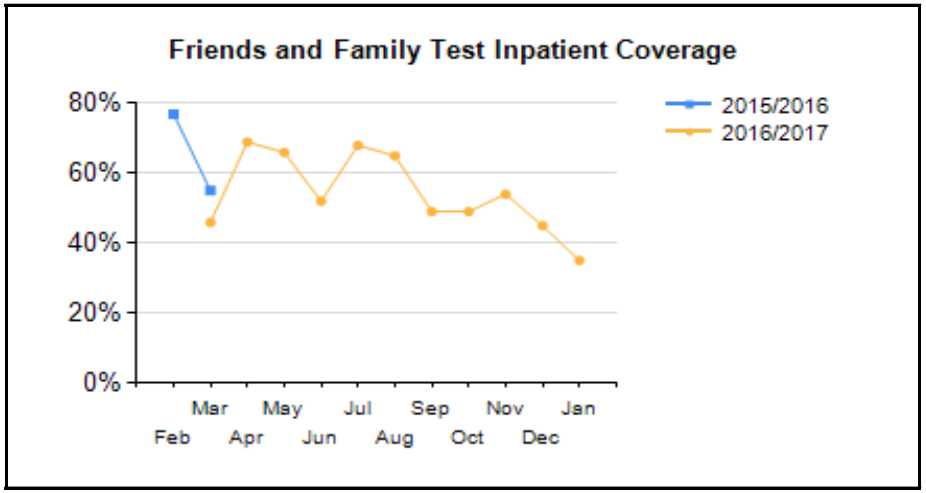
Contextual Indicators

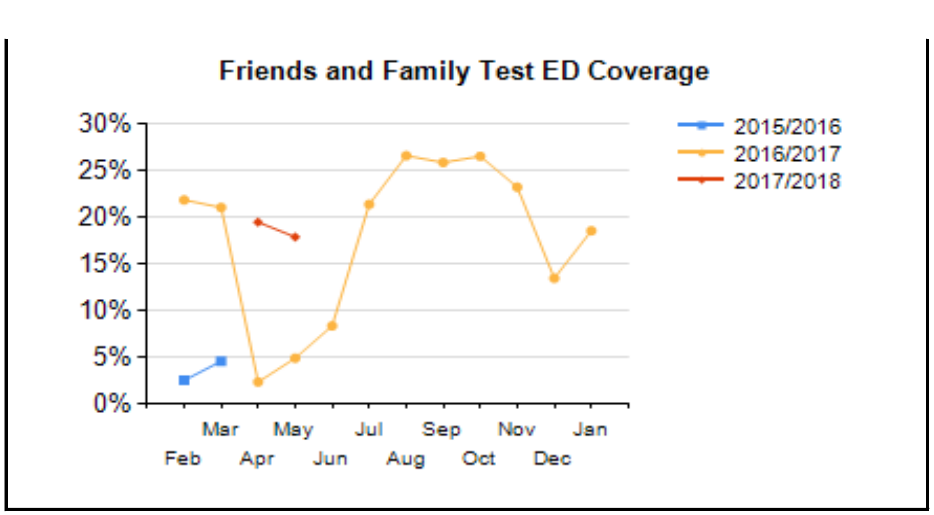
This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, relative to that of previous months and years.

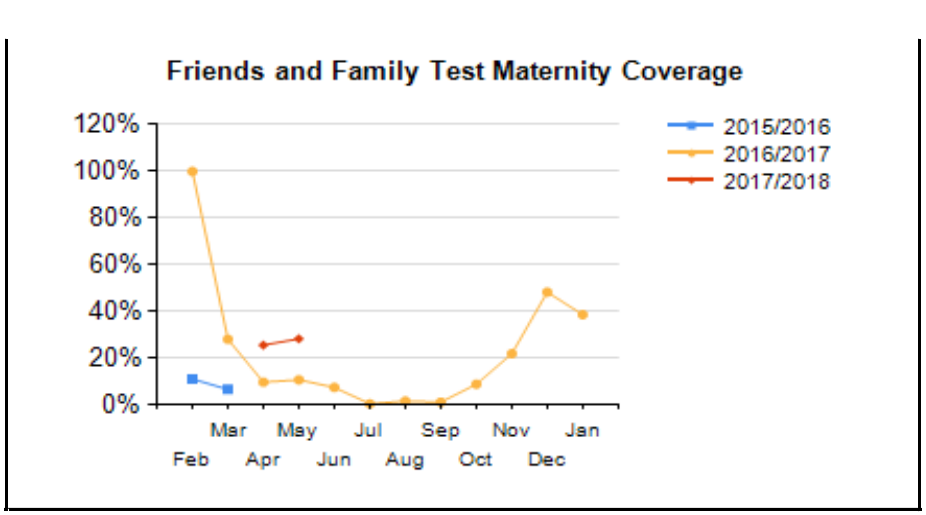




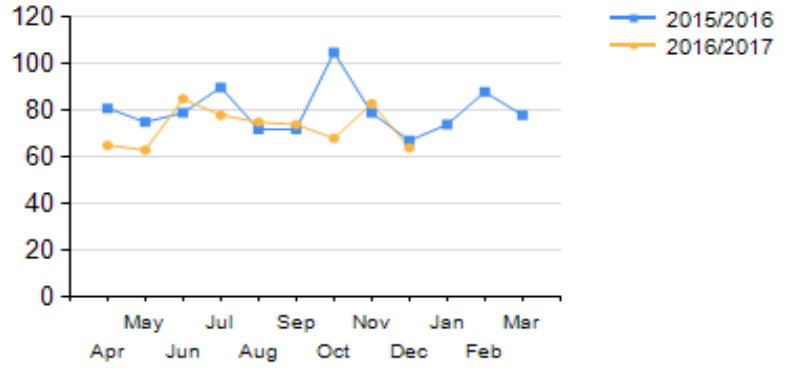




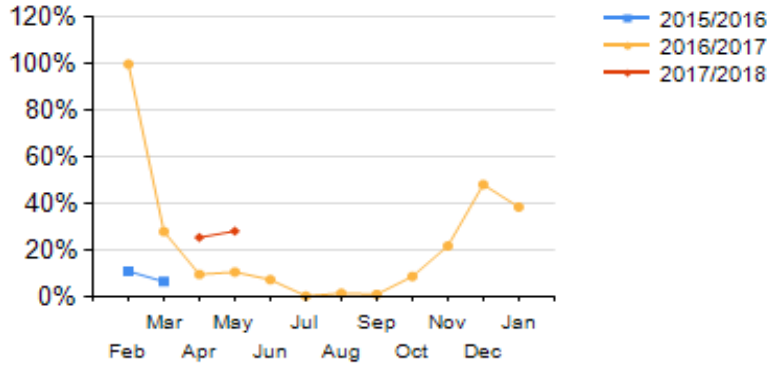

Friends and Family Test ED Coverage
30%
25%
20%
15%
10%
5%
0%
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
2015/2016
2016/2017
2017/2018


Friends and Family Test Maternity Coverage
120%
100%
80%
60%
40%
20%
0%
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
2015/2016
2016/2017
2017/2018

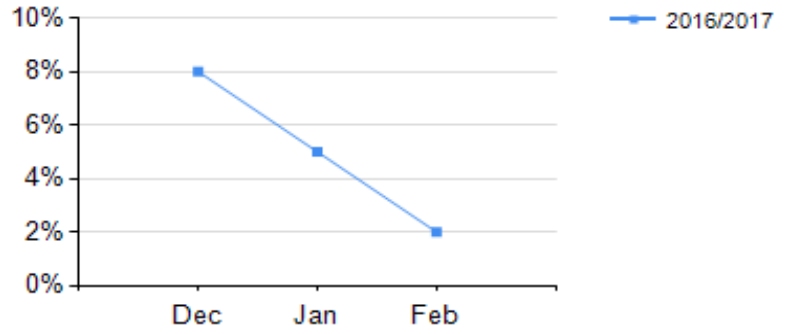
Number of Patient Complaints



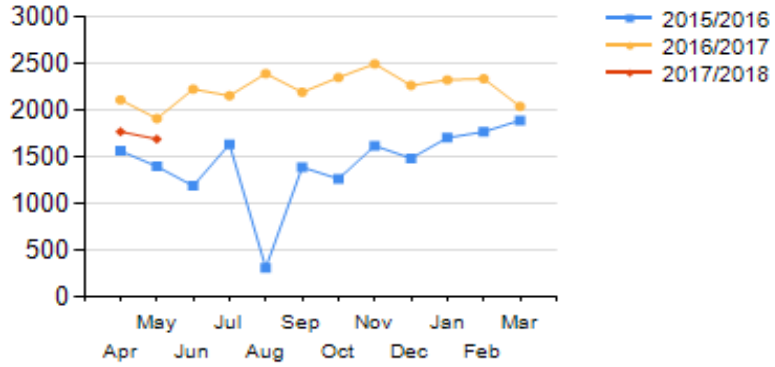
Complaints Responeded to Within Trust Timeframe



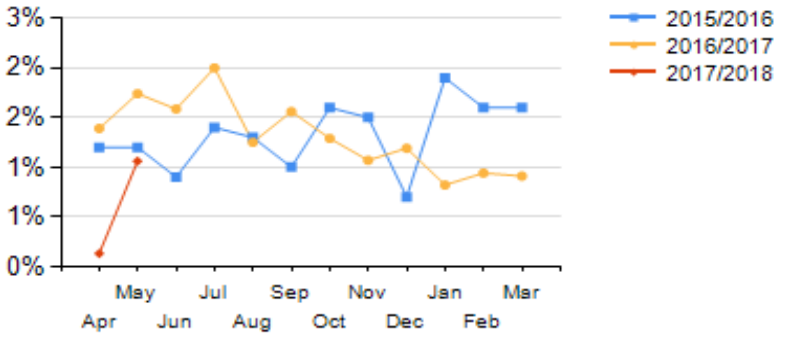
Percentage of Responses where Complainant is Dissatisfied



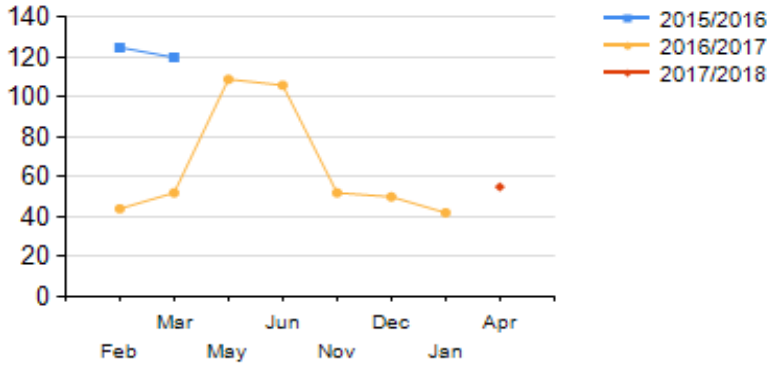
Beddays Occupied by Medically Fit Patients

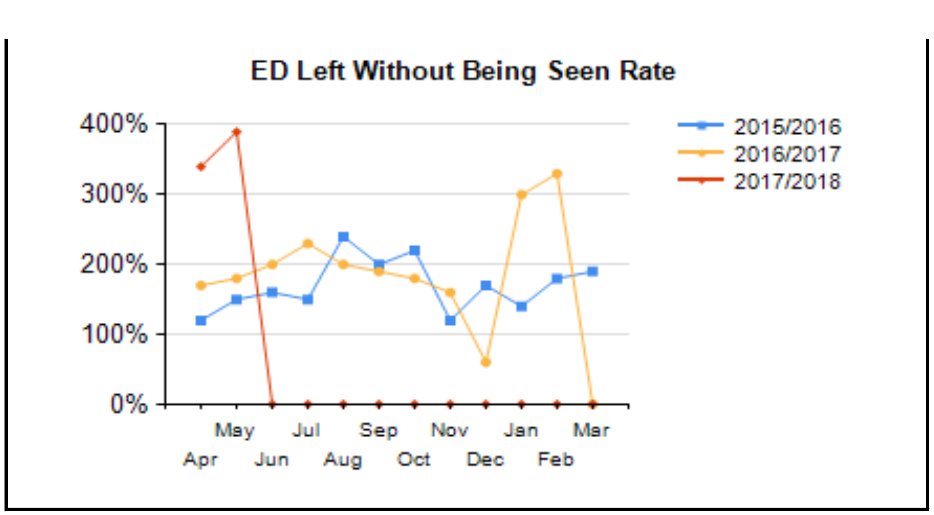


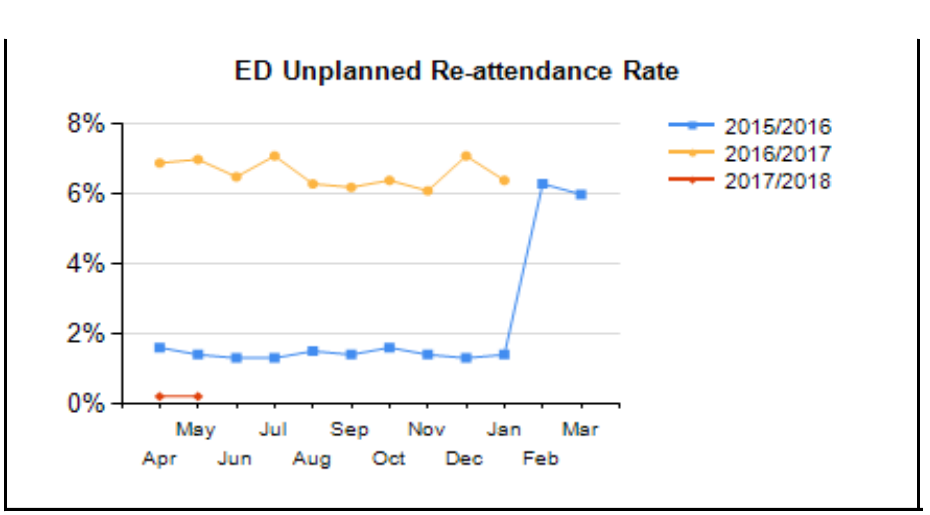
Last minute Cancelled Operations - Percentage of Admissions



Number of Last Minute Cancelled Operations




ED Left Without Being Seen Rate
400%
300%
200%
100%
0%
May
Jul
Sep
Nov
Jan
Mar
Apr
Jun
Aug
Oct
Dec
Feb
2015/2016
2016/2017
2017/2018


ED Unplanned Re-attendance Rate
8%
6%
4%
2%
0%
May
Jul
Sep
Nov
Jan
Mar
Apr
Jun
Aug
Oct
Dec
Feb
2015/2016
2016/2017
2017/2018

REPORT TO MAIN BOARD – July 2017

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

This report describes the business conducted at the Quality and Performance Committee on 29th June 2017 indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Matters arising	A new format for Matters Arising to be brought to the committee with actions explained and closed in advance of the meeting where viable.	We need to ensure pace and ownership.	Revised reporting led by Board Administrator.	
Estates and facilities Report	A presentation and paper were presented to the committee. Of note were the requirements for the Capital plan to deliver to ensure improvements in the quality of the estate. In addition the number of falls in kitchen areas and mitigating actions taken to re place kitchen flooring. In addition the impact of the new telephone system.	In relation to telephony, how are we taking learnings from Trakcare and ensuring the organisation is behind the changes and understand the impact? How are we addressing the anecdotal issue of portering and the ongoing issues on appraisals and training?	The OD element of telephony would be referred to Workforce and learnings from Trakcare built into an implementation plan.	Telephony referred across to Workforce committee. The Chair agreed to work with the Exec lead to improve the quality of the written narrative particularly in the cover sheets specifically to highlight key issues, solutions to address and assurance available.
Quality and Performance report	A new format was presented for Performance oversight. This was discussed at length by the committee and agreed that it should be implemented moving forward.	We need to ensure that the reporting framework delivers both a historical perspective and indicates the levers to be used to instigate change. Step two would be real time assessment. It was stressed	A number of processes in place to provide assurance on the quality of data supporting the reports, including validation activity, supported by additional resources and within scope	Test and learn across the committees. Specific deep dive into Urology to be brought to the next Committee. Ownership of the Urology report to sit

		that the quality of the narrative needed to be guided and reviewed and that an audit structure should be in place to test the veracity of the numbers.	of the work commissioned from Cymbio.	with the Divisional Director to start to embed control into the organisation.
Mortality report	The only report received other than verbal assurance and a copy of the minutes and an update of the Mortality Review Action Plan.	Here is the evidence and interrogation into what has changed since the last report, what are the figures telling us against Dr Fosters? What has deteriorated in which areas and why?		Report to next meeting to include: • Monthly Mortality report. • Governance arrangements • Action plan to implement requirements of learning from deaths guidance
CQC actions response	Summary received.	Approved.		
Trakcare	The committee received an update on Trakcare.	How are we prioritising? What will impact short term and long term be and how are we tracking that the right things are happening? There appears to be no understanding of how this is working within the organisation	Cymbio will be used to map progress and a report brought to the next committee.	

SUIs	The committee received the overview of SUIs.	Are we seeing the failure of another electronic system? Given the two never events, is there a correlation? How are we taking learnings from the high level review and tracking effectiveness of actions?	Further response from Andrew Seaton into Board.
Cancer Waiting times	The committee received details of cancer waiting times and actions taken to address.	How are we interrogating cancer appointments? If we are aware of capacity issues, are we clear that the back log will be cleared by outsourcing to fill back log. How are we managing clinical safety and risk specifically in urology? Can we understand if there is more scrutiny on impact of waiting times on safety? How do we triangulate and understand cause and effect? How are we managing the patient experience and the impact of waiting?	Work taking place to look at patient choice and impact and we have verified and recorded harm reviews. This will be reviewed in further reports.
Emergency care pathways	The committee received a report on emergency care where the anecdotal impact of IR35 and Medical rota gaps were identified	Are we clear whether the implication of IR35 is anecdotal or factual and how much of an impact is the cultural morale issue?	Response from workforce on IR35 and Medical gaps.

Safeguarding	The committee received a presentation on safeguarding and noted the work being done both within the organisation and across partner organisations on both adults and children safeguarding.		
Safer staffing	The committee noted that another review is likely post-budget assessment to ensure safer staffing is as accurate as possible.		
52 weeks	The committee received the deep dive into 52 week breaches	How are we prioritising impact of what we are doing and monitoring success?	All over 44 week breaches are reviewed to identify actions to both address individual pathways and system process errors.
Health and safety	The Trust has been issued with a material breach notice by the Health and Safety Executive relating to an aspect of our water management systems. An action plan is in place to address the issues identified.		

Specific items for Board

Urgent Need for Mortality Report and deep dive

New Performance Management Framework to be activated

Continued poor performance across all key indicators – specifically A&E – and we need to look further at effective solutions owned across the Exec team and within the organisation

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

PUBLIC BOARD MAIN BOARD – JULY 2017

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

Report Title
TRUST RISK REGISTER

Sponsor and Author(s)
Author – Bev Williams, Trust Risk Register Sponsor – Deborah Lee, Chief Executive

Audience(s)									
Board members	√	Regulators		Governors		Staff		Public	

Executive Summary

Purpose

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

Key issues to note

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

Changes in Period
S2045 – As agreed at TLT this risk downgraded following review of mortality data by T&O CG.

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

Conclusions

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

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

Recommendations

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

Impact Upon Strategic Objectives
Supports delivery of a wide range of objectives relating to safe, high quality care and good governance
Impact Upon Corporate Risks
The Trust risk register is included in the report
Regulatory and/or Legal Implications
None
Equality & Patient Impact
None

Resource Implications			
Finance		Information Management & Technology	
Human Resources	X	Buildings	

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

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

July Trust Risk Register

Ref	Division	Highest Scoring Domain	Execute Lead title	Title of Assurance / Monitoring Committee	Inherent Risk	Controls in place	Adequacy	Consequence	Likelihood	Score	Current	Action / Mitigation	Review date
S1851	Surgical Services Division	Quality	Chief Operating Officer	Quality & Performance Committee	A risk that patients receive poor quality care as a consequence of demand for beds exceeding the beds available which could include cancelled operations, being cared for on a non-specialty ward or being cared for in an escalation area	1. Extended site management - Silver rota 2. Escalation policy and procedures for use of extra beds 3. Risk assessments evaluating the change in function of the areas.	Inadequate	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Major	Delivery of Winter plan Easter Bank Holiday Plan	17/08/2017
DSP2462 OPD	Diagnostics and Specialties Division, Medical Division, Surgical Services Division, Women's and Children's	Quality	Chief Operating Officer	Divisional Board	Risk of compromised quality and patient experience due patients being unable to be offered an appointment within expected waiting times because of increased workload growth in CBO following introduction of Trakcare.	Recruited additional bank and agency staff to help with the workload Additional staff training Identify issues that causes additional workload and report to the Trakcare team to identify a permanent solution by releasing the booking service manager from her current role to work with the Trakcare team. Work with the learning and development team to improve staff morale	Inadequate	Major (4)	Likely - Weekly (4)	16	15 - 25 Major	To complete a Business Case - Recommending additional work force Learning & Development Escalate to executive director to agree further escalation	25/08/2017
M2488 Card	Medical Division	Safety		Divisional Board, Specialty Meeting	Risk of Harm to patients as a result of delay in receiving essential, required cardiac interventions.	Efficiency review of cath lab provision suggesting means of increasing throughput which has been actioned. Plan to progress to using GLANSO. Active recruitment strategy to fill consultant posts.	Inadequate	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	Business case	28/07/2017
M1746 Diab	Diagnostics and Specialties Division, Medical Division, Surgical Services Division	Safety		Divisional Board, Quality Committee, Specialty Meeting	Risk of patients having potentially avoidable procedures (minor or major) due to the lack of a designated Multidisciplinary Footcare Team.	Clinical assessment as required through clinical assessment Referral to specialty in hospital teams on assessment Follow up by surgical specialty team	Inadequate	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	NHSE bid	01/08/2017
F1609	Corporate Division, Diagnostics and Specialties Division, Estate and Facilities, Medical Division, Surgical Services Division, Women's and Children's	Quality	Director of Nursing	Quality & Performance Committee	Risk of poor continuity of care and overall reduced care quality arising from high use of agency staff in some service areas.	1. Pilot of extended Bank office hours 2. Agency Taskforce 3. Bank incentive payments and weekly pay for bank staff 4. General and Old Age Medicine Recruitment and Retention Premium 5. Master vendor for medical locums 6. Temporary staffing tool self assessment 7. Daily conference calls to review staffing levels and skill mix. 8. Ongoing Trust wide recruitment drive 9. Divisions supporting associate nurse and CLIP programme. 10. Initiatives to review workforce model, CPN's, administrative posts to release nursing time	Adequate	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Major	Monitoring at Workforce Committee Establish Quality Impact Assessment for project Overseas recruitment programme	28/07/2017
DSP2460 OPD	Diagnostics and Specialties Division, Medical Division, Surgical Services Division, Women's and Children's	Quality	Director of Strategy	Divisional Board	Risk of reduced quality and patient experience as a result of errors in clinic templates leading patient attending the wrong clinic.	Central Booking Office staff, identify and fix any errors identified To restart the clinic validation exercise by working with the specialities, Central Booking Office, Trakcare clinic build team and the Trakcare team. This is led by the Trakcare operational lead	Adequate	Major (4)	Likely - Weekly (4)	16	15 - 25 Major	To rebuild clinic templetes for all specialities Escalation to the Trust Risk register through executive director for Trakcare	24/08/2017
DSP2404 Haem	Diagnostics and Specialties Division	Safety	Medical Director	Divisional Board	Risk of reduced quality care as a result of inability to effectively monitor patients receiving haematology treatment and assessment in outpatients due to a lack of clinical capacity and increased workload.	Telephone assessment clinics Locum and WLI clinics Reviewing each referral based on clinical urgency Pending lists for routine follow ups and waiting lists for routine and non-urgent new patients.	Inadequate	Major (4)	Likely - Weekly (4)	16	15 - 25 Major	Develop Business case to meet capacity demand	28/07/2017

F1339	Corporate Division, Diagnostics and Specialties Division, Estate and Facilities, Medical Division, Surgical Services Division, Women's and Children's	Finance	Director of Finance	Finance Committee	Risk that the Trust does not achieve the required cost improvement resulting in failure to deliver the Financial Recovery Plan for FY18	PMO in place to record and monitor the FY18 programme Monthly monitoring and reporting of performance against target Monthly executive reviews	Adequate	Catastrophic (5)	Possible - Monthly (3)	15	15 - 25 Major		28/07/2017
F2515	Corporate Division, Diagnostics and Specialties Division, Estate and Facilities, Medical Division, Surgical Services Division, Women's and Children's	Finance	Director of Finance	Finance Committee	Risk that the Trust does not agree a FY18 Control Total with NHS Improvement resulting in no access to the Sustainability & Transformation Fund and is also subject to contractual fines and penalties	Regular NHSI FSM meetings	Adequate	Catastrophic (5)	Possible - Monthly (3)	15	15 - 25 Major		28/07/2017
F2511	Corporate Division, Diagnostics and Specialties Division, Estate and Facilities, Medical Division, Surgical Services Division, Women's and Children's	Finance	Director of Finance	Finance Committee	Risk that the Trust's expenditure exceeds the budgets set resulting in failure to deliver the Financial Recovery Plan for FY18	Monthly monitoring, forecasting and reporting of performance against budget by finance business partners Monthly executive reviews Performance management framework		Catastrophic (5)	Possible - Monthly (3)	15	15 - 25 Major		28/07/2017
DSP2513 Path	Diagnostics and Specialties Division, GP Services / NHS England, Medical Division, Surgical Services Division, Women's and Children's	Safety	Trust Medical Director	Divisional Board	Risk to patient safety due to delayed diagnosis because of shortage of Histopathology Staff	Locum laboratory staff in place Permanent staff recruitment in progress Locum consultant approved Outsourcing of reporting organised	Inadequate	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	fill vacant histopathologist post complete business case for Histopathology including workforce plan	09/08/2017
WF2335	Corporate Division, Diagnostics and Specialties Division, Estate and Facilities, Medical Division, Surgical Services Division, Women's and Children's	Finance	Director of HR & OD	Workforce Committee	The risk of excessively high agency spend in both clinical and non-clinical professions due to high vacancy levels.	1. Agency Programme Board receiving detailed plans from nursing, medical, workforce and operations working groups. 2.Increase challenge to agency requests via VCP 3. Convert locum\agency posts to substantive 4. Promote higher utilisation of internal nurse and medical bank.	Inadequate	Major (4)	Almost certain - Daily (5)	20	15 - 25 Catastrophic	Establish Workforce Committee Complete PIDs for each programme Reconfiguring Structures	04/08/2017
S1748	Surgical Services Division, Women's and Children's	Statutory	Chief Operating Officer	Quality & Performance Committee	The risk of failing national access standards including RTT and Cancer	1. Weekly meetings between AGM and MDT Coordinators to discuss pathway management and expedite patients as appropriate. 3. Performance Management at Cancer Management Board 4. Escalation procedure in place to avoid breaches 5. Performance trajectory report for each pathway	Inadequate	Major (4)	Almost certain - Daily (5)	20	15 - 25 Catastrophic	Re establish Planned care board Interim action plan to recover position	04/07/2017
M2473	Medical Division	Quality	Director of Nursing	Quality & Performance Committee	The risk of poor quality patient experience during periods of overcrowding in the Emergency Department	Identified corridor nurse at GRH for all shifts; ED escalation policy in place to ensure timely escalation internally; Cubicle kept empty to allow patients to have ECG / investigations (GRH); Pre-emptive transfer policy patient safety checklist up to 12 hours Monitoring Privacy & Dignity by Senior nurses	Inadequate	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Major	CQC action plan for ED	10/08/2017

S2045	Surgical Services Division	Safety	Medical Director	Quality & Performance Committee	The risk of poorer than average outcomes for patients presenting with a fractured neck of femur at Gloucestershire Royal	Prioritisation of patients in ED Early pain relief Admission proforma Volumetric pump fluid administration Anaesthetic standardisation Post op care bundle – Haemocus in recovery and consideration for DCC Return to ward care bundle Ward move to improve patient environment and aid therapy Supplemental Patient nutrition with employment of nutrition assistant Increased medical cover at weekends OG consultant review at weekends Increased therapy services at weekends Senior DCC nurses on secondment to hip fracture ward for education and skill mix improvement Review of all deaths	Adequate	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	Deliver the agreed action fractured neck of femur action plan	27/07/2017

PUBLIC BOARD MAIN BOARD – JULY 2017

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

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

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

Executive Summary

Purpose

This report provides an overview of the financial performance of the Trust as at the end of Month 02 of the 2017/18 financial year. It provides the three primary financial statements along with detailed analysis of the variances and movements against the budgeted position. It also provides a summary of the variance against the planned position to NHS Improvement (this differs from budget from a phasing view only and will be resubmitted in early July).

Key issues to note

- The financial position of the Trust at the end of Month 02 of the 2017/18 financial year is an operational deficit of £10.2m. This is a favourable variance to the budgeted position of £0.1m.
- Forecasting will be produced in detail for next month's report after a full quarter of financial data is available to operational teams.
- The NHSI plan contains a different phasing than that used in the budget and the position against that plan is an adverse variance of £2.3m. This should be resolved in future months by resubmission of the NHSI Plan.

Conclusions

The financial position for M02 shows a favourable variance to budget of £0.1m, with an adverse variance to NHSI plan of £2.3m.

No STF funding has been assumed in the actual position given that the Trust has not agreed a control total for the 2017/18 financial year.

Implications and Future Action Required

The variance to financial plan for the year-to-date will mean an increased scrutiny of the Trust financial position and an increased focus on cost recovery in the form of both Cost Improvement Programmes and notably agency expenditure reductions.

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

Resource Implications			
Finance	✓	Information Management & Technology	
Human Resources		Buildings	

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

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

Gloucestershire Hospitals NHS
NHS Foundation Trust

Financial Performance Report
Month Ended 31st May 2017

© Copyright Gloucestershire Hospitals NHS Foundation Trust

LISTENING HELPING EXCELLING IMPROVING UNITING CARING BEST CARE FOR EVERYONE

Gloucestershire Hospitals NHS
NHS Foundation Trust

Introduction and Overview

The Trust Board approved budgets on 10th May 2017. The budget is for a deficit of £14.631m. This budget is in line with that submitted to NHSI in March as part of the normal planning process. However, during April, as part of the detailed budget reconciliation and review process and in support of agreeing a reflective control total the profiling of Income, Expenditure and CIP was considered and it was concluded that the monthly outturn profiles should be changed, the outturn deficit of £14.631m was not changed. As a result of this the Month 2 deficit in budget is £5.31m (£10.22m cumulative), the NHSI Plan deficit for the month is £4.08m (£7.89m cumulative). This report outlines performance against both budget and NHSI plan for the month.

Statement of Comprehensive Income (Position Against Budget)

2016/17 Outturn £000s	Month 02 Financial Position	Annual Budget £000s	M02 Cumulative Budget £000s	M02 Cumulative Actual £000s	M02 Cumulative Variance £000s
433,665	SLA & Commissioning Income	440,028	68,578	66,190	(2,388)
4,604	PP, Overseas and RTA Income	4,771	773	730	(44)
66,388	Operating Income	60,292	9,921	10,095	175
504,657	**Total Income**	**505,091**	**79,272**	**77,015**	**(2,257)**
329,809	Pay	333,133	57,126	55,190	1,936
174,906	Non-Pay	161,703	28,211	28,305	(94)
504,716	**Total Expenditure**	**494,837**	**85,337**	**83,496**	**1,841**
(59)	**EBITDA**	**10,254**	**(6,066)**	**(6,481)**	**(416)**
(0.0%)	**EBITDA %age**	**2.0%**	**(7.7%)**	**(8.4%)**	**(0.5%)**
21,135	Non-Operating Costs	24,885	4,156	3,673	482
(21,193)	**Surplus/(Deficit)**	**(14,631)**	**(10,221)**	**(10,154)**	**67**
3,225	STF Funding				
(17,968)	**Surplus/(Deficit)**	**(14,631)**	**(10,221)**	**(10,154)**	**67**

In May the Trust has delivered a deficit position of £4.29m and a cumulative deficit of £10.15m

This represents a favourable variance to **budget** in the month of £1.02m.

Cumulatively the variance is £0.07m favourable to **budget**.

The Month 1 position against the NHSI Plan is shown in detail on page 7.

© Copyright Gloucestershire Hospitals NHS Foundation Trust

Detailed Income & Expenditure

Gloucestershire Hospitals NHS
NHS Foundation Trust

Annual Budget £000s	Month 02 Financial Position	M02 Cumulative Budget £000s	M02 Cumulative Actual £000s	M02 Cumulative Variance £000s
440,028	SLA & Commissioning Income	68,578	66,190	(2,388)
4,771	PP, Overseas and RTA Income	773	730	(44)
60,292	Operating Income	9,921	10,095	175
505,091	**Total Income**	**79,272**	**77,015**	**(2,257)**
	Pay			
305,093	Substantive	51,961	50,780	1,181
10,903	Bank	1,843	1,616	227
17,138	Agency	3,322	2,794	528
333,133	**Total Pay**	**57,126**	**55,190**	**1,936**
	Non Pay			
57,096	Drugs	9,702	9,828	(126)
40,219	Clinical Supplies	6,777	6,603	174
64,388	Other	11,732	11,874	(142)
161,703	**Total Non Pay**	**28,211**	**28,305**	**(94)**
494,837	**Total Expenditure**	**85,337**	**83,496**	**1,841**
10,254	**EBITDA**	**(6,066)**	**(6,481)**	**(416)**
2.0%	**EBITDA %age**	**(7.7%)**	**(8.4%)**	**(0.5%)**
24,885	Non-Operating Costs	4,156	3,673	482
(14,631)	**Surplus/(Deficit)**	**(10,221)**	**(10,154)**	**67**
	STF Funding			
(14,631)	**Surplus/(Deficit)**	**(10,221)**	**(10,154)**	**67**

The table opposite shows the detailed income and expenditure position.

SLA and Commissioning Income – a £2.4m under-recovery. This shortfall is believed to be largely linked to TrakCare data completeness/quality issues and operational impacts on booked activity.

Operating Income – includes education, training and research flows and other income (which includes staff recharges for CITS, Shared services etc.). This shows a small over-recovery as at Month 2.

Pay – expenditure is showing a favourable variance of £1.9m against budgeted levels. This is largely driven by a 'time to hire' saving against budget profile.

Non-Pay – Sub-categories of non-pay show small favourable and adverse variances but is largely in line with plan overall.

© Copyright Gloucestershire Hospitals NHS Foundation Trust

CIP Plan 2017/18 and Actual Delivery At Month 2

Gloucestershire Hospitals NHS
NHS Foundation Trust

Annual NHSI CIP Plan £000s	CIP Scheme Type	M02 NHSI CIP Plan £000s	M02 Actual £000s	M02 Variance against NHSI Plan £000s
2,304	Agency	400	319	(81)
0	Central Vacancy Factor	0	1,359	1,359
500	Income Improvement (Comorbidities)	30	42	12
2,500	Income Improvement (Repatriation)	0	0	0
0	Length of Stay	0	0	0
11,395	Local Divisional schemes	888	1,177	289
2,057	Medical Productivity	0	5	5
812	Medicines Optimisation	19	19	0
650	Non Pay Workstream - Discretionary spend	108	77	(31)
135	Nursing/AHP Productivity	0	1	1
3,500	Operational Growth Margin	0	0	0
1,110	Outpatients	0	0	0
314	Private Patients	0	0	0
2,243	Procurement	104	89	(15)
5,315	Stretch	0	477	477
692	Theatre	56	100	44
1,166	Workforce Pay Grip	211	44	(167)
34,693	**Total**	1,816	3,711	1,895

There is an over-delivery of £1.9m against the NHSI plan at month 2 as the additional Vacancy Factor identified is profiled to deliver in the early months of the year.

Action:

- Divisions need to have a more realistic approach to reporting with less conservatism both about reporting actuals and forecast CIP delivery at month end.
- PIDs for new and mitigating schemes to be developed with momentum and pace.
- Currently £2.8m of forecast relates to the vacancy factor of new posts agreed in budget setting but not fully appointed to. Work needs to be undertaken with Divisions to allocate the £2.8m from the overarching scheme down to divisional level .

© Copyright Gloucestershire Hospitals NHS Foundation Trust

Balance Sheet(1)

Gloucestershire Hospitals NHS
NHS Foundation Trust

Trust Financial Position	Opening Balance 31st March 2017 £000	Balance as at M2 £000	B/S movements from 31st March 2017 £000
Non-Current Assests			
Intangible Assets	7,393	7,393	0
Property, Plant and Equipment	296,272	294,800	(1,472)
Trade and Other Receivables	4,668	4,623	(45)
Total Non-Current Assets	**308,333**	**306,816**	**(1,517)**
Current Assets			
Inventories	7,400	8,368	968
Trade and Other Receivables	17,697	21,608	3,911
Cash and Cash Equivalents	7,974	3,043	(4,931)
Total Current Assets	**33,071**	**33,019**	**(52)**
Current Liabilities			
Trade and Other Payables	(44,355)	(50,467)	(6,112)
Other Liabilities	(2,089)	(5,017)	(2,928)
Borrowings	(5,356)	(5,356)	0
Provisions	(182)	(182)	0
Total Current Liabilities	**(51,982)**	**(61,022)**	**(9,040)**
Net Current Assets	**(18,911)**	**(28,003)**	**(9,092)**
Non-Current Liabilities			
Other Liabilities	(7,612)	(7,612)	0
Borrowings	(83,126)	(82,672)	454
Provisions	(1,524)	(1,524)	0
Total Non-Current Liabilities	**(92,262)**	**(91,808)**	**454**
Total Assets Employed	**197,160**	**187,005**	**(10,155)**
Financed by Taxpayers Equity			
Public Dividend Capital	166,519	166,519	0
Reserves	70,501	70,501	0
Retained Earnings	(39,860)	(50,015)	(10,155)
Total Taxpayers' Equity	**197,160**	**187,005**	**(10,155)**

The table shows the M2 balance sheet and the variance between movements from the 2016/17 closing balance sheet, supporting narrative is on the following page.

© Copyright Gloucestershire Hospitals NHS Foundation Trust

Balance Sheet(2)

Gloucestershire Hospitals NHS
NHS Foundation Trust

Commentary below reflects the Month 2 balance sheet position against the 2016/17 outturn

Non-Current Assets

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

Current Assets

- Inventories show an increase of £0.9m The movement reflects increases in drug stocks. These are charged to the I&E on issue and so this change reflects a movement between inventories and creditors.
- Trade receivables are now £3.9m above their closing March 17 level. This is an improvement of £1.1m compared to Month 1. Invoiced debt has increased by £2.8m Month 2 SLA Payments not settled by month-end (now largely settled) and accrued debt has reduced by £1.7m, related to 16/17 accruals now settled.
- Cash has reduced since the year-end.

Current Liabilities

- Trade payables have increased by £6.1m above their closing March level. This includes a payment from HEE of £3.4m as a payment in advance for 3 months of the hosted GP trainees – the cash has since been received for this .

BPPC	Financial Year 2017/18		Current Month May '17	
	Number	£'000	Number	£'000
Total Bills Paid Within period	20,297	37,450	10,729	19,765
Total Bill paid within Target	18,939	28,048	9,933	13,235
Percentage of Bills paid within target	93%	75%	93%	67%

BPPC performance is shown opposite and currently only includes those invoices that are part of the creditors ledger balance. Performance reflects invoices processed in the period (both cumulative and in-month) rather than the invoices relating to that period. It should be noted that whilst driving down creditor days as far as possible we are not compliant with 30 day terms across all suppliers

Non-Current Liabilities

- Borrowings have reduced slightly in line with monthly payments.

Reserves

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

© Copyright Gloucestershire Hospitals NHS Foundation Trust

Cashflow : Month 2

Gloucestershire Hospitals NHS
NHS Foundation Trust

Cashflow Analysis	Apr-17 £000s	May-17 £000s	YTD - M2 £000s
Surplus (Deficit) from Operations	**(4,958)**	**(3,284)**	**(8,242)**
Adjust for non-cash items:			
Depreciation	946	1,719	2,665
Impairments within operating result	0	0	0
Gain/loss on asset disposal	0	0	0
Provisions	0	0	0
Other operating non-cash	(58)	(59)	(117)
Operating Cash flows before working capital	**(4,070)**	**(1,624)**	**(5,694)**
Working capital movements:			
(Inc.)/dec. in inventories	(150)	(1,118)	(1,268)
(Inc.)/dec. in trade and other receivables	(5,066)	1,200	(3,866)
(Inc.)/dec. in current assets	0	0	0
Inc./(dec.) in current provisions	0	0	0
Inc./(dec.) in trade and other payables	4,930	328	5,258
Inc./(dec.) in other financial liabilities	(520)	3,448	2,928
Other movements in operating cash flows	835	(995)	(160)
Net cash in/(out) from wokring capital	**29**	**2,863**	**2,892**
Capital investment:			
Capital expenditure	(148)	(989)	(1,137)
Capital receipts	0	0	0
Net cash in/(out) from investment	**(148)**	**(989)**	**(1,137)**
Funding and debt:			
PDC Received	0	0	0
Interest Received	4	3	7
Interest Paid	0	(162)	(162)
DH loans - received	0	0	0
DH loans - repaid	0	0	0
Other loans	0	0	0
Finance lease capital	(20)	(20)	(40)
PFI/LIFT etc capital	(181)	(181)	(362)
PDC Dividend paid	0	0	0
Other	0	0	0
Net cash in/(out) from financing	**(197)**	**(360)**	**(557)**
Net cash in/(out)	**(4,386)**	**(110)**	**(4,496)**

Cash at Bank - Opening	**7,539**	**3,153**	**7,539**
Closing	**3,153**	**3,043**	**3,043**

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

Key movements:

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

Current Assets – Debtor balances have increased in month due to delayed commissioning and education payments in Month 2.

Trade Payables – increased in May which reflects a balance of income received on account over and above activity recorded which has been provided for

© Copyright Gloucestershire Hospitals NHS Foundation Trust

Gloucestershire Hospitals NHS
NHS Foundation Trust

Financial Performance Against NHSI Plan
Month Ended 31st May 2017

© Copyright Gloucestershire Hospitals NHS Foundation Trust

Performance Against NHSI Plan

In May the Trust has delivered a deficit position of £4.29m and a cumulative deficit of £10.15m.

This represents an adverse variance to **NHSI Plan** of £0.21m in the month and £2.27m cumulatively.

During April as part of the budget setting process and with a view to agreeing a control total, the Trust has undertaken a review of the profiling of Income, Expenditure and CIP and this review concluded the budget deficit to Month 2 to be £10.15m– an adverse change to the deficit compared to plan of £2.33m. Income reduction being £0.52m, Pay increase £1.09m and Non Pay reduction £0.43m.

The plan also reflected an earlier CIP categorisation which changed the allocation between income and costs.

Statement of Comprehensive Income Position Against NHSI Plan

2016/17 Outturn £000s	Month 02 Financial Position	Annual NHSI Plan £000s	M02 Cumulative NHSI Plan £000s	M02 Cumulative Actual £000s	M02 Cumulative Variance £000s
433,665	SLA & Commissioning Income	432,884	69,095	66,190	(2,905)
4,604	PP, Overseas and RTA Income	4,404	729	730	1
66,388	Operating Income	67,026	11,085	10,095	(990)
504,657	**Total Income**	**504,314**	**80,909**	**77,015**	**(3,894)**
329,809	Pay	329,890	56,031	55,190	841
174,906	Non-Pay	164,318	28,640	28,305	335
504,716	**Total Expenditure**	**494,208**	**84,671**	**83,496**	**1,175**
(59)	**EBITDA**	**10,106**	**(3,762)**	**(6,481)**	**(2,719)**
(0.0%)	**EBITDA %age**	**2.0%**	**(4.6%)**	**(8.4%)**	**(3.4%)**
21,135	Non-Operating Costs	24,737	4,126	3,673	453
(21,193)	**Surplus/(Deficit)**	**(14,631)**	**(7,888)**	**(10,154)**	**(2,266)**
3,225	STF Funding				
(17,968)	**Surplus/(Deficit)**	**(14,631)**	**(7,888)**	**(10,154)**	**(2,266)**

The table summarises (at a high level) the Trust position for Month 2 of the 2017/18 financial year against the plan as submitted to NHSI in March.

© Copyright Gloucestershire Hospitals NHS Foundation Trust

NHSI Single Oversight Framework

Gloucestershire Hospitals NHS
NHS Foundation Trust

	YTD Plan	YTD Actual
Capital Service Cover	(1.57)	(3.27)
Metric		
Rating	4	4
Liquidity	(21.21)	(26.61)
Metric		
Rating	4	4
I&E Margin	(9.70%)	(13.20%)
Metric		
Rating	4	4
I&E Variance from Plan	0.00%	(3.50%)
Metric		
Rating	1	4
Agency	47.60%	39.90%
Metric		
Rating	3	4
Use of Resources rating	4	4

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

The performance reported here reflects that for M02 against the new framework.

© Copyright Gloucestershire Hospitals NHS Foundation Trust

Recommendations

Gloucestershire Hospitals NHS
NHS Foundation Trust

The Committee is asked to note:

- The financial position of the Trust at the end of Month 2 of the 2017/18 financial year is an operational deficit of £10.15m. This is an favourable variance to budget of £0.07m, and an adverse variance to NHSI Plan of £2.27m

- At this stage of the year the Trust is forecasting a deficit of £14.631m for the year.

Author: **Sarah Stansfield, Director of Operational Finance**

Presenting Director: **Steve Webster, Director of Finance**

Date: **June 2017**

© Copyright Gloucestershire Hospitals NHS Foundation Trust

REPORT TO MAIN BOARD - July 2017

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

This report describes the business conducted at the Finance Committee held 28th June 2017, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Financial Performance Report	Month two: £2m improvement on Month 1 to take a £1m cumulative deficit at Month 1 to a balanced position against the budget at the end of Month 2. Forecast remains at £14.6m. Two key areas of improvement: • £1.8m income improvement on Month 1 (£2.1m deficit M1 to £0.3m deficit M2) • £0.5m improvement in pay (£0.7m fav in M1 to £1.2m fav in Month 2).	Grip on Medical spend.	Assurance was sought on the timescales for block arrangements on agreement with the principle commissioners. More work on understanding the impact of accounting and coding issues on activity and associated income, and action to improve.	Grip on Medical spend to be reviewed at the next meeting. Assurance regarding forecast and more detailed phasing will be produced and further backing detail to support the forecast. Key areas are income including blocking impact, pay underspend, and CIPs (Cost Improvement Programmes).

Capital Programme Update	The deferral of items and expenditure that could not be delivered in 17/18 was noted. Proposals for funding the element of the capital spend that cannot be funded internally were supported being a balance between Department of Health loan support and leasing.	Which will be the most productive route in terms of funding?	That we will seek from both sources.	Impact of the revised capitol programme and funding sources on income expenditure and cash would be clarified and included in the refresh of the plan.
Workforce Update	Agency spend in Month 2 was higher than the very low Month 1 numbers but still improved on recent trends. Key driver for agency remains delayed hire. The Medical staff area is more complex	Does the Medical area have the same grip as nursing? Challenge to present a more integrated view on workforce spend that takes account of the interrelationship between permanent staff and bank and agency.	Further investigations will take place and the committee will review the whole of the Medical area which will include those points.	Will return to July Committee.
Cost Improvement Programme Update	£12.8m in red category still and particular risks to the growth margin item and repatriation items as a consequence of both the Trakcare issues and uncertainty issues around capacity.	What is the quality of current leadership?	Medical productivity CIP to be reviewed at the next meeting.	Will return to July Committee. Is there sufficient grip?

	Medical productivity and the need to develop more granular action plans for improving Medical productivity were highlighted.			
Regulatory Review Update	Letter from Stephen Hay endorsing (for financial special measures monitoring purposes) the Trust's £14.7m plan deficit.	How soon/if we can agree a control total.		Are we still able to agree a control total?
Financial Risk Register	Unchanged from previous month.			
Theatre Managed Service Update	The committee were assured on three key questions raised by the Board with one further outstanding regarding NHSi approval requirements.			Governor Consultation and any NHSi approval requirements.
Hereford Radiotherapy Update	Substantial report received on income expenditure and cash flow implications of continuing versus terminating the Hereford Radiotherapy Unit. Committee supported the recommendation that it was in the best interests			

	of the Trust to continue the current service and to sign associated contracts with Wye Valley.			
Estates Return & Information Collection	Committee endorsed the submission.			The Committee would be interested in comparative benchmarking of Estates and Facilities services through the ERIC return.
Divisional Attendance	The question regarding what form divisional attendance should take was resolved by decision to take forward issue by issue. If we do bring people along an executive briefing is needed first. Three Chairs to work together to agree which topics will be covered to avoid duplication.			Agreeing what is done.
Finance Committee Work Plan	Amendments to be made: • Divisional attendance for July to be noted			

	as Medicine. • Theatre Efficient Update to be removed. The Work Plan stands with these amendments.			
Matters to be Escalated to the Board	None.			
Governors Comments	Governors reinforced the importance of Safer Staffing arrangements. Lead Governor noted the discussion on grip around consultant leadership and management. Raised the meaning of deferral of Emergency Department improvements and asked for clarification as to whether this was in conflict to service improvement plans in ED. Assurance given that			Governor consultation on the Theatre MS which may necessitate an extraordinary meeting of Governors.

	it was not in conflict.			
Papers for Circulation to Governors	None.			
Committee Reflection	• Successful meeting. • Unitary board with plenty of challenge • Greater Exec sharing of views leading up to the meeting would be beneficial			
Any Other Business	No other business.			

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

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

Report Title
Workforce Report – Period to 30th April 2017
Sponsor and Author(s)
Authors and Sponsoring Director: David Smith, Director of Human Resources and Organisational Development
Executive Summary

Purpose

This report presents progress on control of pay spend, fte numbers and agency expenditure

Key issues to note

- The paybill increased by circa £160k in month, however still reflected a saving in excess of £700k against budget
- The increase in spend was largely driven by the accrual of the 1%pay settlement (circa £250k) and the application of the Apprenticeship Levy reflecting 0.5% of the paybill (circa £128k
- The variance to budget was driven by the budget lines containing approved posts which have not been recruited to as yet and not being completely offset by temporary staff expenditure
- Agency spend pleasingly reduced in the month on both nursing and medical, with medical being below the run rate required to hit the NHSI target on reduced spend this year of £1.157m
- Part of the reduction may be explained by reduced supply of both nursing and medical locums during the Easter period and the impact of IR35

Conclusions

It is too early in the year to draw meaningful conclusions on the progress against either pay or agency, albeit on both fronts we go into this year with much stronger controls and a clearer sighting of the issues and levers.

Implications and Future Action Required

Continued strong governance and scrutiny of these issues is vital. The lack of supply occasioned recently is vital to understand if it is short term or permanent and forces us also to accelerate issues such as the development of alternative roles to cover gaps in our medical rotas. This work is being taken through the Specialty Director group and the Sustainable Workforce Group under the sponsorship of the Medical Director.

Recommendations
The Committee is asked to note the early positive variance to budget recognising that firmer conclusions maybe drawn after month 2.
Impact Upon Strategic Objectives
It remains vital that we continue to operate within the financial envelope as well as making progress on the design of new roles.
Impact Upon Corporate Risks
Agency expenditure is currently rated as one of the Trusts highest risks to achieving financial balance.
Regulatory and/or Legal Implications
NHSi will continue to scrutinise our performance, particularly in relation to medical agency spend.
Equality & Patient Impact
N/A

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

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

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

Gloucestershire Hospitals NHS
NHS Foundation Trust

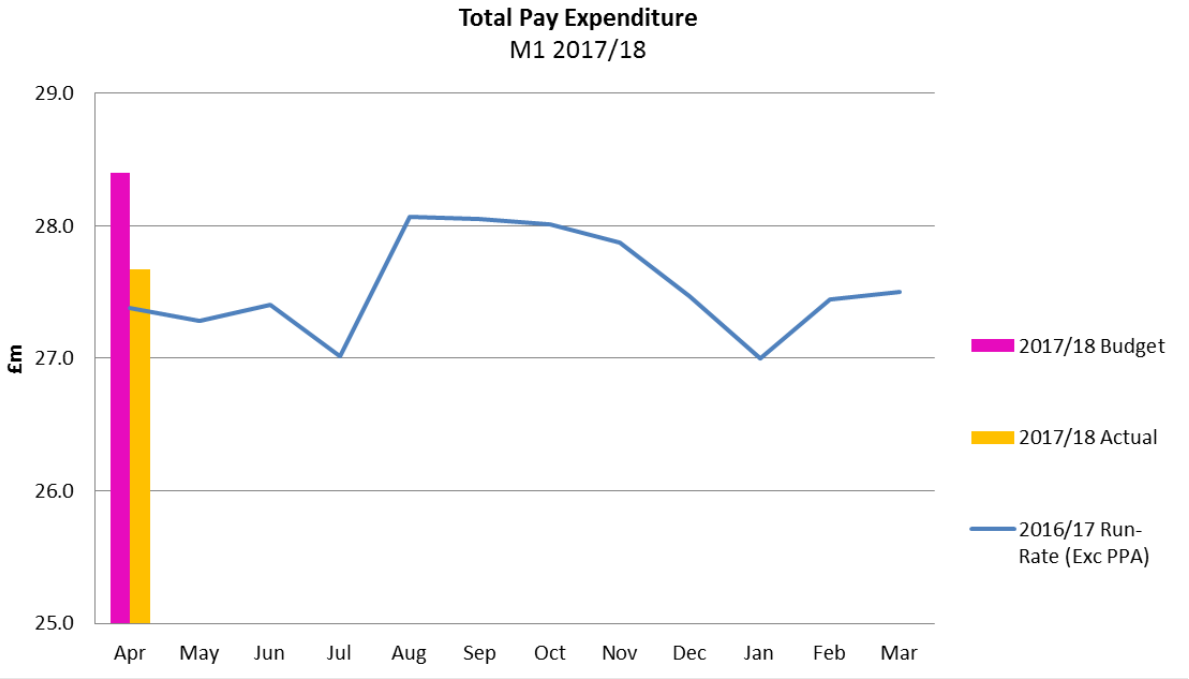
Workforce Report
Period to 30th April

© Copyright Gloucestershire Hospitals NHS Foundation Trust

Introduction and Overview

The purpose of this presentation is to provide an overview for the Finance Committee of our current position in terms of Workforce expenditure and other relevant Performance Indicators. It will include a breakdown of current pay along with a description of actions being taken to address any concerns.

Pay Expenditure



Pay expenditure reflects the total expenditure across the Trust, including bank and agency. It includes all hosted and shared services.

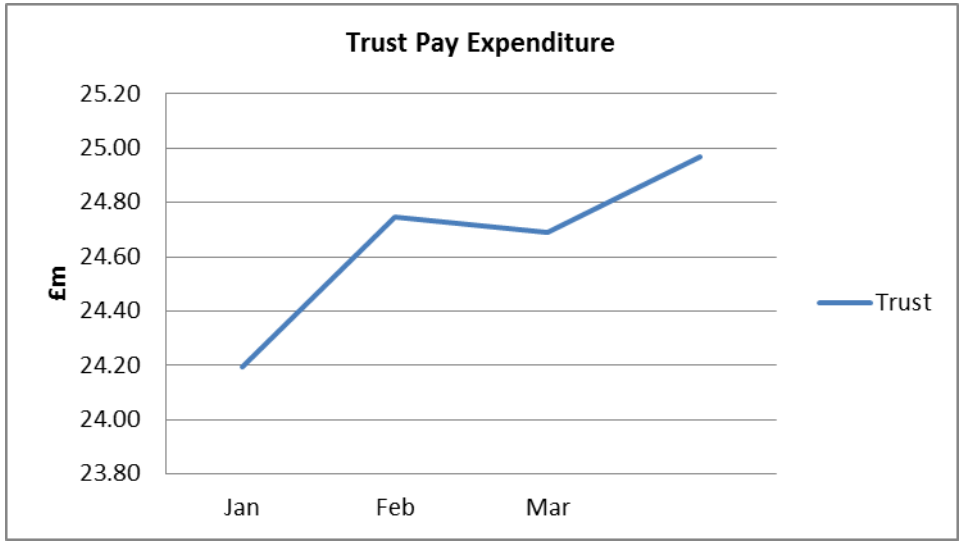
Total pay expenditure showed a marginal increase in month 1 of £170k (see overleaf) however was still some way below budget by £736k.

This is primarily as a consequence of the time lag between the approval of posts at VCP which have been built into the 2017/18 budget and their actual recruitment. This benefit will clearly lessen as new starters come on board and the high vacancy factor reduces.

© Copyright Gloucestershire Hospitals NHS Foundation Trust

Pay Expenditure – detailed analysis

	Jan	Feb	Mar	April	Movement M10-M11	Movement M11-M12	Movement M12 - M1
	£m	£m	£m	£m	£m	£m	£m
2017/18 Actual	**27.00**	**27.45**	**27.50**	**27.67**	**0.45**	**0.06**	**0.16**
Medicine	6.10	6.44	6.28	6.06	0.34	(0.16)	(0.23)
Surgery	7.08	7.43	7.34	7.27	0.36	(0.09)	(0.08)
Women and Children	2.84	2.79	2.87	2.82	(0.05)	0.08	(0.05)
Corporate Services	1.87	1.58	1.85	1.82	(0.30)	0.27	(0.03)
Diagnostics & Specialist	5.08	5.15	5.27	5.34	0.07	0.11	0.07
Estates and Facilities	1.11	1.13	1.12	1.17	0.02	(0.01)	0.06
Hosted Services - GP	2.37	2.29	2.32	2.24	(0.08)	0.03	(0.08)
Other (inc. Trustwide & SS)	0.55	0.63	0.45	0.95	0.08	(0.18)	0.50
Trust	**24.20**	**24.75**	**24.69**	**24.97**	**0.55**	**(0.06)**	**0.28**
Hosted	**2.80**	**2.70**	**2.81**	**2.70**	**(0.10)**	**0.11**	**(0.12)**
Total	**27.00**	**27.45**	**27.50**	**27.67**	**0.45**	**0.06**	**0.16**



The increase in the overall paybill was primarily driven by the application of the Apprenticeship Levy. As from April 2017, 0.5% of the paybill is paid into a central fund to encourage the recruitment of apprenticeships by major employers. This amounted to circa £128k of the expenditure in month, reflecting our annual liability of circa £1.5m. Our opportunity to draw back this levy is by employing more apprentices however we are only able to draw back their training costs. The other factor contributing to the increase was the accrual of the 1% annual payrise which whilst not physically paid to staff in April was accrued for. Both of these expenditures sit in the 'Other' line, as opposed to divisional lines

© Copyright Gloucestershire Hospitals NHS Foundation Trust

Pay expenditure by Division

Pay Analysis Divisional	Budget £000's	Substantive £000's	Bank £000's	Agency £000's	Total £000's	Variance £000's
Surgery	7,499	6,810	251	205	7,266	232
Medicine	6,454	4,875	309	875	6,059	396
D&S	5,321	5,191	83	63	5,337	(16)
W&C	2,956	2,695	78	46	2,819	137
EFD	1,181	1,115	54	4	1,174	7
Corporate*	4,993	4,871	84	59	5,014	(21)
Total Pay	**28,404**	**25,557**	**859**	**1,252**	**27,668**	**736**

* Includes Trustwide and hosted services

Notwithstanding the explanations overleaf, considerable efforts are continuing both corporately and divisionally to control and reduce pay costs. This project currently includes 8 work streams, all of which are overseen by the Executive Director of HR and OD:

1. Executive Authorisation of non-clinical overtime
2. Review of HR Policies and extension of Salary Sacrifice opportunities
3. Review of annual leave accrual
4. Review of RRP
5. Nursery income generation
6. Change of notice periods for Band 5 staff (increase to 8 weeks)
7. Increase in number of apprenticeships
8. Recruitment income generation

.All of these work streams have specific target reductions set against them which are either centrally owned (annual leave accrual, nursery income generation or recruitment income) or divisionally allocated, reflecting where the expenditure happens. Eg. The recruitment of apprentices , key to recouping the levy and building a sustainable workforce, requires divisional support and an equitable allocation.

© Copyright Gloucestershire Hospitals NHS Foundation Trust

Staff in Post

The net difference between our funded establishment [7,473] and contracted establishment [7,002] is 471 WTE and reflects the incorporation of additional posts into divisional plans at the beginning of the year through the budget setting process, creating a temporary benefit in terms of pay as described earlier in the report.

Perhaps unsurprisingly the gap between funded and contracted establishment is bridged by the additional 178 WTE incorporated within the worked WTE category. Work continues to attract and retain permanent staff with a view to reducing reliance on temporary staffing arrangements. Whilst an appropriate vacancy factor is an integral part of the CIP programme for this year, recruitment of the budgeted posts ensures that the individual cost per WTE is not inflated.

The Vacancy Control Panel (VCP) chaired by the Executive Director of HR and OD continues to sit each week to scrutinise every request for recruitment and continues to see relatively high levels of requests. The Workforce Committee have asked for a review of this process to ensure that effectiveness is considered not purely in terms of cost control but also the impact on other factors such as safety, quality and strategic development of the workforce..

The high "paid" figure in the table below relates to the enhancement issue as previously referenced.

Division - Establishment - Month 1	Funded WTEs	Contracted WTEs	Worked WTEs	Paid WTEs	Funded less contracted WTEs
Surgery	1,788	1,746	1,790	1,898	42
Medicine	1,546	1,312	1,457	1,513	234
D&S	1,638	1,599	1,618	1,615	39
W&C	738	705	698	761	33
EFD	540	426	453	581	114
Corporate*	1,223	1,213	1,164	1,177	10
Total WTEs	**7,473**	**7,002**	**7,180**	**7,545**	**471**

* Includes Trustwide and hosted services

The table shows the current M12FTE data against the establishment

Definitions:

- **Funded**– the FTE value held within the financial ledger to reflect budgeted establishment
- **Contracted WTE** – reflects the number of contracted substantive WTE
- **Worked WTE** – reflects WTEs worked within the month, includes bank and agency
- **Paid WTE** – reflects WTEs paid within the month (includes premiums, unsocial hours payments etc. – converted to WTE)

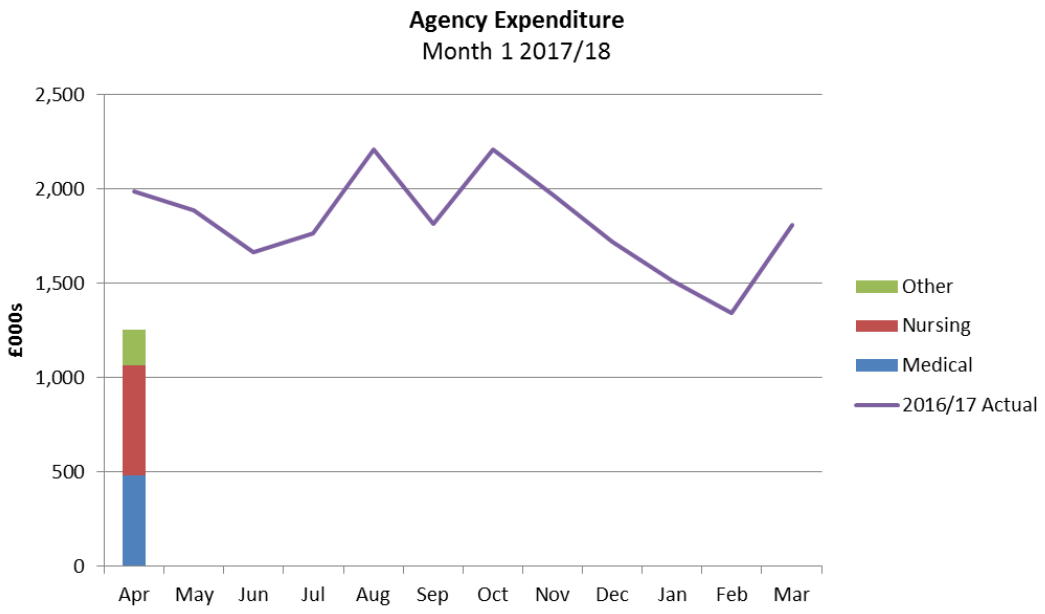
© Copyright Gloucestershire Hospitals NHS Foundation Trust

Gloucestershire Hospitals NHS
NHS Foundation Trust

Agency Spend

A significant reduction was witnessed in Month 1 which is pleasing however may not be completely sustainable. Medical locum expenditure reduced and this is a mixture of increasing control, but also driven by reduced supply. Medical division occasioned the biggest drop in this space owing to the annual leave of two expensive (and budgeted locums) who will return to the run rate. We are also assessing the impact of IR35 on supply which at this stage anecdotally suggests that some locums are withdrawing from the market..

Agency Spend by Staff Group													
	Apr £000s	May £000s	Jun £000s	Jul £000s	Aug £000s	Sep £000s	Oct £000s	Nov £000s	Dec £000s	Jan £000s	Feb £000s	Mar £000s	Total £000s
Medical	481												481
Nursing	585												585
Other	187												187
Total	1,252	0	0	0	0	0	0	0	0	0	0	0	1,252
2016/17	1,988	1,891	1,663	1,764	2,211	1,816	2,209	1,971	1,721	1,516	1,345	1,812	21,906



Nursing agency expenditure also saw a pleasing reduction and the number of both agency and bank shifts reduced significantly in the month. This may also be in large part to the lateness of the Easter break and holidays being taken in the month. This may have impacted the supply of agency staff. It will be important to balance out the expenditure on both pay and agency over the first couple of months as no significant conclusions should be drawn at this stage.

© Copyright Gloucestershire Hospitals NHS Foundation Trust

Recommendations

Gloucestershire Hospitals NHS
NHS Foundation Trust

The Committee are asked to :

- NOTE the contents of this paper and APPROVE the actions being taken

Author:	**Dave Smith, Director of Human Resources and Organisational Development** **Sarah Stansfield, Acting Director of Finance**
Presenting Director:	**David Smith , Director of Human Resources and Organisational Development**
Date:	**May 2017**

© Copyright Gloucestershire Hospitals NHS Foundation Trust

REPORT TO MAIN BOARD – July 2017

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

This report describes the business conducted at the Workforce Committee on 9th June 2017 indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Workforce report	The Finance focused Workforce report came to this committee as due to timings it had not been to Finance and was referred to Workforce. It is not intended that this retrospective report is received by Workforce Committee in future unless so directed by other committees on the basis of timings.	How are we managing the implications of IR 35? How are we mapping the enablers and leading indicators to drive forward the Workforce strategy? Have we the assurance that we are both proactive and reactive on staff resource across nursing and medical staffing with regards summer and winter capacity?	Nursing Director and Medical Director Operational Plans with HR support	Still need to be clearer on active resource mapping against known events
Workforce priorities and focus against Workforce strategy for	A full and comprehensive presentation was given reminding the committee of the Workforce strategic pillars and then mapping against each of these pillars the	Are we clear on the must dos and how are we measuring success	New format Workforce dashboard and Annual Agenda plan. Sub Group Committee structure mapped against KPIs and Strategy	

2017/8	priorities, the KPIs, the deliverables, the risks and how we were mapping assurance		
Annual Agenda Plan	The Annual Agenda Plan will be reviewed in light of the Workforce Strategy presentation and shared at the next meeting	Are we focusing our energy on the right areas?	We will return to Monthly meetings of the Committee.
VCP	The Committee received a recommended approach and methodology for reviewing the effectiveness of the VCP	How are we assessing the financial effectiveness of the VCP .	Findings to August meeting
Staff Survey Action Plan	The Committee discussed the findings from the Staff Survey and the top 4 items for the current year including 2 'carried forward' items and 2 new ones. A selection of divisional priorities were also highlighted	Should we retain existing targets given their importance and impact on staff?	Existing focus on two indicators would remain until completion and detailed objectives for the additional items picked up across the Trust and within individual directorates

A and C Listening Event	The committee received an update on the A and C listening event – part of a series of listening events across the Trust	How are we taking these learnings particularly around Trakcare and feeding back into other initiatives?
Risk	The committee highlighted the Risk of IR 35 and changes to taxation , plus STP impact	

Items for the Board to specifically note:

The excellent presentation of the focus for Workforce to deliver the Strategic Pillars, how it's going to be done, by when and how we are tracking performance and risk

The methodology proposed to evaluate the Vacancy Control Panel

PUBLIC BOARD MAIN BOARD – JULY 2017

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

Report Title
COMBINED BOARD ASSURANCE FRAMEWORK
Sponsor and Author(s)
Author(s) – Executive Directors Sponsor - Deborah Lee, Chief Executive

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

Executive Summary

Purpose

The Board Assurance Framework is the means through which the Board receives assurance in respect of the delivery of its stated annual objectives through the oversight of risks which have the potential to undermine delivery of the objectives. The BAF sets out the controls to mitigate the potential risks and provides assurance that the controls are effective or describes further actions to strengthen the controls and mitigate the risk.

The BAF also provides a narrative on the progress towards achievement of the objective.

Key issues to note

- The Board has recently reviewed and refreshed its strategic objectives (SO) for the period 2017-2019 and these are now reflected in the Board Assurance Framework.
- The Framework documentation has been revised to include information on supporting strategies and enablers, oversight responsibility and progress against delivery of the objective.
- The work to complete this new style BAF has been significant and further work is still required to complete this. Currently two objectives still require completion and this is in hand. These relate to our aim to be in the upper quartile for operational efficiency and work to develop integrated teams as part of the STP work underway in key clinical pathways.
- Delivery of objective 20 requires achievement of objectives 1, 3 and 16 and as such a separate proforma has not been produced.
- Updates will be provided to the Board quarterly with monthly reporting by exception from sub-committees should the risk profile of any objective change materially. Further work is required to ensure the approach to assessing progress is consistent across all the SO owners.

Conclusions

This revised BAF is a significant step in developing a more robust approach to oversight of progress and risks in respect of the Trust's Strategic Objectives. The picture at quarter one reflects a number of risks to these objectives, with few currently assessed as GREEN and on target – in part this reflects the need to further refine and agree the approach to RAG rating progress.

Implications and Future Action Required

Further refinement and completion of the BAF and iteration of the approach as requested by the Board following review of this first quarterly report.

Recommendations
To receive the report for assurance that the Executive is sighted on and actively controlling the potential risks to achievement of the Trust's objectives.
Impact Upon Strategic Objectives
The report identifies the risk and mitigation to the Strategic objectives
Impact Upon Corporate Risks
Links between risk to delivery of strategic objectives aligned to known corporate risks
Regulatory and/or Legal Implications
There are no specific regulatory or legal implications arising from this report.

Resource Implications			
Finance		Information Management & Technology	
Human Resources	x	Buildings	

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

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

Gloucestershire Hospitals NHS Foundation Trust

Board Assurance Framework

Q1 Update

5th July 2017

Gloucestershire Hospitals
NHS Foundation Trust

Our vision: Best care for everyone

Our mission: Improving health by putting patients at the centre of excellent specialist health care

Our goals

Our patients will

- Be safe in our care
- Be treated with care and compassion
- Be treated promptly with no delays
- Want to recommend us to others

Our staff will

- Put patients first
- Feel valued and involved
- Want to improve
- Recommend us as a place to work
- Feel confident and secure in raising concerns

Our services will

- Make best use of our two sites
- Be organised to deliver centres of excellence for our population
- Promote health alongside treating illness
- Use technology to improve

Our organisation will

- Use our resources efficiently
- Use our resources effectively
- Be one of the best performing trusts
- Be considered to be a good partner in the health and wider community

Our Strategic Objectives

Our patients

By April 2019 we will...

- Be rated good overall by the CQC
- Be rated outstanding in the domain of Caring by the CQC
- Meet all national access standards
- Have a hospital standardised mortality ratio of below 100
- Have more than 35% of our patients sending us a family friendly test response, and of those 93% would recommend us to their family and friends
- Have improved the experience in our outpatient departments, reducing complaints to less than 30 per month

Our staff

By April 2019 we will...

- Have an Engagement Score in the Staff Survey of at least 3.9
- Have a staff turnover rate of less than 11%
- Have a minimum of 65% of our staff recommending us as a place to work through the staff survey
- Have trained a further 900 bronze, 70 silver and 45 gold quality improvement coaches
- Be recognised as taking positive action on health and wellbeing, by 95% of our staff (responding definitely or to some extent in staff survey)

Our services

By April 2019 we will...

- Have implemented a model for urgent care that ensures people are treated in centres with the very best expertise and facilities to maximise their chances of survival and recovery
- Have systems in place to allow clinicians to request and review tests and prescribe electronically
- Rolled out Getting it Right First Time Standards across the target specialities and be fully compliant in at least two clinical services
- Have staff in all clinical areas trained to support patients to make healthy choices

Our organisation

By April 2019 we will...

- Be in financial balance
- Be among the top 25% of trusts for efficiency
- Have worked with partners in the Sustainability and Transformation Partnership to create integrated teams for respiratory, musculoskeletal conditions and leg ulcers
- No longer subject to regulatory action
- Be in segment 2 (targeted support) of the NHSI Single Oversight Framework

(1.1) Strategic Objective - To Be Rated Good Overall in Our CQC Rating

Principle Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk that our Trust will not be rated Good overall post CQC inspection.	Director of Nursing Quality & Performance Committee	1. Divisional /Executive Monthly monitoring. 2. Divisional reviews / presentations to Quality and Performance Committee 3. SNMC 4. CCG Quality rand contracting reviews 5. Regular monitoring and analysis of data of key themes at Patient Experience Committee 6. Quarterly meetings with Governors with specific focus on quality topics.	1. Divisional Quality Report 2. Matron Audit reports to their divisional quality committees	1. Quarterly in real time audits/ reviews	3 x 4 = 12
				Gaps in Assurance	Direction of Travel
				1. Reliable data for actual performance surveys not reported in real time	↔

Potential Risk Exposure	Related risks on Trust Risk Register		
• Improvement in ED reliant on improved capacity and flow throughout our trust and wider county providers • Staffing and vacancies may impact on abilities to maintain consistency and release of staff to undertake quality improvement reviews.			3x4 =12

Actions Agreed for any gaps	By Whom	By When	Update
Meetings scheduled throughout year to undertake quality improvement reviews	MDT	4 per year	One undertaken; using mainly matrons and band 7 ward managers using NHSE checklists
Action plan for improvement within in ED in place and implementation being overseen by ECB	Medical Division Nursing Director	June 2017	Monthly reports to main ECB

Patient Experience improvement plans in clinical areas working with Oxford university and our trust academy	Divisional Nursing Directors & Patient experience improvement team.	March 2018	Ward 7a process now completed reported to Q&P and SNMC ready for roll out to other wards.
Enabling Strategy	Oversight Committee	Executive Group	
Patient Experience Strategy	Patient Experience Committee	Quality & Performance Committee	
Quarterly Progress Report Against Delivery			RAG Rating
One quality /review undertaken, with staff trained in process supported by NHSI/ NHSE. Action formed and shared at SNMC Awaiting final published CQC report from their inspection in January 2017 , expected first week in July Care and compassion noted to be good overall and significant improvement in care of the dying. Experience of patient in ED still of concern as capacity and high attendances impacting on flow throughout our organisation			

(1.2) Strategic Objective - To be Rated Outstanding in our CQC Rating For Caring

<table>
<tr><th>Principle Risks to Achievement of the Objective</th><th>Risk Owner (Executive Director & Committee)</th><th>Key Controls</th><th>Assurance on Controls</th><th>Current Assurances</th><th>Risk Rating (Likelihood x Impact)</th></tr>
<tr><td rowspan="3">Risk that our Trust will not be rated Outstanding in our CQC rating for Caring</td><td rowspan="3">Director of Nursing

Quality & Performance Committee</td><td rowspan="3">1. Divisional /Executive Monthly monitoring.
2. Divisional reviews / presentations to Quality and Performance Committee
3. SNMC
4. CCG Quality rand contracting reviews
5. Regular monitoring and analysis of data of key themes at Patient Experience Committee
6. Quarterly meetings with Governors with specific focus on quality topics.
7. Reports to Q&P on complaints and concerns.</td><td>1. Divisional Quality Report

2. Matron Audit reports to their divisional quality committees</td><td>1. Quarterly in real time audits/ reviews</td><td>3 x 4 = 12</td></tr>
<tr><td></td><td>Gaps in Assurance</td><td>Direction of Travel</td></tr>
<tr><td></td><td>1. Reliable data for actual performance surveys not reported in real time</td><td>↔</td></tr>
<tr><td>Potential Risk Exposure</td><td colspan="3">Related risks on Trust Risk Register</td><td></td><td></td></tr>
<tr><td colspan="5">• Improvement in ED reliant on improved capacity and flow throughout our trust and wider county providers
• Staffing and vacancies may impact on abilities to maintain consistency and release of staff to undertake quality improvement reviews.</td><td>3x4 =12</td></tr>
</table>

Actions Agreed for any gaps	By Whom	By When	Update
Meetings scheduled throughout year to undertake quality improvement reviews. Contact trust that are already rated outstanding to under peer review	MDT DoN	4 per year July 2017	One undertaken; using mainly matrons and band 7 ward managers using NHSE checklists CNO in Bristol contacted and ideas gathered likewise great Western Hospital has given information regarding their improved plan for their ED department which are deemed excellent by NHSI
Action plan for improvement within in ED in place and implementation being overseen by ECB	Medical Division Nursing Director	June 2017	Monthly reports to main ECB
Patient Experience improvement plans in clinical areas working with Oxford university and our trust academy	Divisional Nursing Directors & Patient experience improvement team.	March 2018	Ward 7a process/ plan now completed reported to Q&P and SNMC; ready for roll out programme to other wards.
Enabling Strategy	Oversight Committee	Executive Group	
Patient Experience Strategy	Patient Experience Committee	Quality & Performance Committee	Draft strategy agenda item for patient experience committee 3/7/17
Quarterly Progress Report Against Delivery			RAG Rating
One quality /review undertaken, with staff trained in process supported by NHSI/ NHSE. Action formed and shared at SNMC Awaiting final published CQC report from their inspection in January 2017 , expected first week in July Care and compassion noted to be good overall and significant improvement in care of the dying. Experience of patient in ED still of concern as capacity and high attendances impacting on flow throughout our organisation.			

(1.3) Strategic Objective(S) – Meet All National Access Standards and No Longer Subject to Regulatory Action for the Four Hour A&E Standard

Principle Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Failure to recover A&E performance sufficiently to enable current Enforcement Undertakings to be removed	Chief Operating Officer Trust Board	Monthly MDT Emergency Care Operational Group chaired by the Specialty Director for Emergency Medicine Emergency Care Operational Group provides assurance to the trust board via the Emergency Care Programme Board chaired by the CEO. A weekly 14+ LoS meeting with system partners is in place. System wide A&E Delivery Board.	An integrated Emergency Care Improvement Plan and an integrated KPIs dashboard is in place and actions are reviewed at the weekly multi-disciplinary seniors meeting with monthly updates to the Operational Group and the Emergency Care Programme Board. Emergency Care report to the Quality and Performance Committee. System wide A&E Delivery action plan	Monthly reporting to the trust Q&P And the system Delivery Board	4x3=12
				Gaps in Assurance	Direction of Travel
			System wide control mechanisms are reactive rather than proactive to the emerging issues. Slow progress against key actions due to staffing, activity flow	None	↓

Principle Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Failure to deliver the national access standards for RTT and Cancer	Chief Operating Officer Trust Board	Weekly PTL meetings Monthly Planned Care Board Monthly Cancer Services Board	RTT waiting list validation recovery plan in place Cancer and capacity and recovery plans in place	Performance reports to the Q&P	4x3=12
			Gaps in Control	Gaps in Assurance	Direction of Travel
			Demand out strips capacity plans Lack of clean PTLs Lack of demand and capacity plans for RTT delivery (post track) Divisional oversight and drive	RTT reporting	↓

Potential Risk Exposure	Related risks on Trust Risk Register				
Demand continues to outstrip capacity STP does not deliver the expected benefits	Risk Ref no and detail	Risk Ref no and detail			

Actions Agreed for any gaps	By Whom	By When	Update
Review of the A&E system action plan	COO	October 2017	
Support from ECIP	COO	July 2017	
Validation of all PTLs, establish RTT reporting , complete demand and capacity modelling and recovery plans for delivering 18 w RTT	COO	Dec 2017	
Enabling Strategy	Oversight Committee	Executive Group	
Clinical strategy , STP	Q&P	Emergency Care Programme Board, Planned Care Board	
Quarterly Progress Report Against Delivery			RAG Rating
To the trust board via the Q&P.			

(1.4) Strategic Objective: Have a Hospital Standardised Mortality Ratio Below 100

Principle Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk that changes to process and clinical pathways do not achieve an HSMR below 100	Medical Director Hospital Mortality Group	1. Regular monitoring of mortality indicators though Hospital Mortality Group 2. Close working with Dr Fosters to report on HSMR, identify factors driving high rates and investigate the drivers behind these 3. Agreed areas of clinical pathway work to identify improvements in care, coding and pathways 4. Regular reporting by division to the HMG 5. Mortality dashboard reporting to divisional and speciality level 6. Monitoring through Q+P and with partners through CCG quality monitoring group and through the joint NHSI and NHSE Quality Improvement Group 7. # Neck of femur group monitoring action plan for improved care. Similar model to be applied for other care pathways as appropriate.	Mortality Dashboard to Q+P committee	Reporting to the Q+P committee	2X4=8
			Gaps in Control	Gaps in Assurance	Direction of Travel
			Data capture in Trak of number of episodes of inpatient care results in risk of	Reporting and detail of oversight at Q+P and Trust Board to be finalised Inability to model the impact of changes on HSMR	Dr Foster shows improvement in HSMR

Potential Risk Exposure	Related risks on Trust Risk Register				
Reliability of admission diagnosis and clinical linkage to coding	S2045 The risk of poorer than average outcomes for patients presenting with fractured neck of femur at Gloucestershire Royal Hospital				

Actions Agreed for any gaps	By Whom	By When	Update
Approach to reporting for Q+P in development in conjunction with Dr Foster and Trust Information team	Medical Director	September 2017	
Enabling Strategy	**Oversight Committee**	**Executive Group**	
Mortality Strategy	Quality and Performance Committee	Hospital Mortality Group	
Quarterly Progress Report Against Delivery			**RAG Rating**
Reporting schedule to be established			

(1.5) Strategic Objective – To Have More Than 35% of Our Patients Responding to our Family Friendly Tests and of Those at Least 93% Would Recommend Us

Principle Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk that our trust will not meet our stretch target of more than 35% of patients responding to the FFT and of those responding at least 93 % would recommend us to their friends and family	Director of Nursing Quality & Performance Committee	1. Divisional /Executive Monthly monitoring. 2. Divisional reviews / presentations to Quality and Performance Committee 3. SNMC 4. CCG Quality rand contracting reviews 5. Regular monitoring and analysis of data of key themes at Patient Experience Strategic Group 6. Quarterly meetings with Governors with specific focus on quality topics. 7. Reports to Q&P on complaints and concerns.	1. Divisional Quality Report 2. Matron Audit reports to their divisional quality committees	1. Quarterly in real time audits/ reviews	4 x 4 = 16
				Gaps in Assurance	Direction of Travel
				1. Reliable data for actual performance surveys not reported in real time	↔

Potential Risk Exposure	Related risks on Trust Risk Register		
• Patients have previously been able to respond using methods such a 'token as used in supermarkets' which appeared to improve Responses especially in ED. This method has now been stopped by NHSE . • Our trust data had previously already indicated we were ahead of national benchmark • Texting methodology recently implemented had compensated for loss of Token system; however implementation of track care has restricted the texting methodology. A solution is being sought.			4x3=12

Actions Agreed for any gaps	By Whom	By When	Update
Reports are sent regularly to clinical areas to ensure continual focus is given.	Head of Patient Experience improvement	Monthly	

Enabling Strategy	Oversight Committee	Executive Group	
Patient Experience Strategy	Patient Experience Strategic Group	Quality & Performance Committee	Draft strategy agenda item for patient experience Strategic Group 3/7/17
Quarterly Progress Report Against Delivery			RAG Rating
FFT numbers awaited for first quarter			

(1.6) Strategic Objective – To Have Reduced the Number FF Complaints Received Regarding Care and Experience in our Outpatients Departments by 25% By 2019

Principle Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk that our trust will not have reduced the complaints received regarding the care in our outpatient departments by 25% by 2019	Director of Nursing Quality & Performance Committee	1. Divisional /Executive Monthly monitoring. 2. Divisional reviews / presentations to Quality and Performance Committee 3. SNMC 4. Outpatient department forum 5. Regular monitoring and analysis of data of key themes at Patient Experience Strategic Group 6. Quarterly meetings with Governors with specific focus on quality topics. 7. Reports to Q&P on complaints and concerns.	1. Quality & Performance committee	1. Complaints review	3 x 3 = 9
				Gaps in Assurance	Direction of Travel
					↔

Potential Risk Exposure	Related risks on Trust Risk Register		
• None			4x3=12

Actions Agreed for any gaps	By Whom	By When	Update
Reports are sent regularly to clinical areas to ensure continual focus is given.	Head of Patient Experience Improvement	Monthly	
Enabling Strategy	**Oversight Committee**	**Executive Group**	
Patient Experience Strategy	Patient Experience Strategic Group	Quality & Performance Committee	Draft strategy agenda item for patient experience Strategic Group 3/7/17
Quarterly Progress Report Against Delivery			RAG Rating

(2.1) Strategic Objective – Have an Engagement Score in the Staff Survey of at Least 3.9

Principle Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk of static or reduced engagement with staff which negatively impacts on our vision and movement towards Best Care for Everyone	Director of HR & OD Workforce Committee	1. Trust wide survey action plans 2. Divisional action plans 3. Staff Listening Events 4. Involve sessions 5. Executive Walkabouts 6. Trust Leadership Team	1. Quarterly review of trust wide survey plans at Workforce Committee 2. Scrutiny of divisional plans at executive reviews	1. Plans have been developed	2x4=8
			Gaps in Control	Gaps in Assurance	Direction of Travel
				1. Plans not implemented to gain sufficient traction. 2. Need to develop/ procure real time feedback tool.	↔

Potential Risk Exposure	Related risks on Trust Risk Register				
1. Inability to attract/ retain key staff, leading to an over-reliance on agency staff at premium cost.	WF2335 The risk of excessively high agency spend in both clinical and non-clinical professions due to high vacancy levels.				

Actions Agreed for any gaps		By Whom	By When		Update
1. Plans to be presented at TLT		Abby Hopewell/Dave Smith	Wednesday 5th July		
Enabling Strategy		Oversight Committee	Executive Group		
Workforce Strategy		Workforce Committee			
Quarterly Progress Report Against Delivery					RAG Rating
Plans presented and adopted at TLT and now to be communicated more widely. Two of the four work streams are carried forward from last year (travel solutions, openness and transparency) and have a number of actions already in train. Divisional Engagement plans are also showing strong traction, particularly in W+C and D+S where engaging on staff on the key issues which matter to them have really been adopted. Listening events will continue and the presentation of the CQC and FGR reports will demonstrate the emphasis on openness and transparency. The development and launch of the new Patient Strategy will help with ensuring that we demonstrate active listening to our patients and there are also a number of actions work streams attached to the identified priority of greater visibility of managers. The 100 Leaders event on the 7th July also affords an opportunity to reinforce the leadership required in this space					

(2.2) Strategic Objective - Have a Staff Turnover Rate of Less Than 11%

Principle Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Reduced workforce supply, high vacancy rates, and turnover across the NHS make further reductions challenging	Director of HR&OD Workforce Committee	1. Workforce plans being produced for each division/specialty in alignment with operational plans 2. Countywide Workforce Planning Group overseeing combined Workforce Plan 3. Exit interviews 4. New Starter Questionnaires 5. Staff focus groups	1. Recruitment strategy group analysing data and trends 2. Divisional Boards reviewing localised data 3. Reward Strategy Group reviewing effective recruitment and retention strategies 4. Divisional Executive Reviews 5. Reward Strategy Group reviewing Recruitment and Retention premium (RRP)	1. Data on turnover by staff group and division readily available	3x3=9
			Gaps in Controls	Gaps in Assurance	Direction of Travel
			1. Limited compliance with exit interviews	1. Limited evidence of local plans/solutions to address	↔

Potential Risk Exposure	Related risks on Trust Risk Register				
Shortages develop in specific occupations impacting on our ability to deliver services	DSP2513pa Risk to patient safety due to delayed diagnosis because of shortage of Histopathology Staff				

Actions Agreed for any gaps	By Whom	By When	Update
1. Implement default that exit interviews are mandatory	DS/MA/AK	Immediate	
Enabling Strategy	**Oversight Committee**	**Executive Group**	
Workforce	Workforce Committee	Recruitment Strategy Group	

Quarterly Progress Report Against Delivery	RAG Rating
Reward Strategy Group reviewed RRP's from Pharmacy and Pathology, agreeing to a re-banding exercise for certain Pharmacy positions and whilst agreeing continuation of Pathology RRP's, requested division work with HRBP to develop longer term plans. Assistant Director of Workforce due to lead work on collating best practice Reward strategies. New Starter questionnaires to be implemented in Nursing from August.	

(2.3) Strategic Objective - Have a Minimum Of 65% of Our Staff Recommending Us as a Place to Work Through The Staff Survey

Principle Risks to Achievement of the Objective	Risk Owner (Executive Director& Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Staff feeling that they are not being heard/listened to Staff feeling that patients are not being heard/listened to Potential for miscommunication of key strategic decisions	Director of HR&OD Workforce Committee	1. Staff Survey Action Plans (local and trust wide) 2. Staff Listening events 3. Involve 4. Divisional Engagement groups 5. Quality Improvement Groups 6. Patient Experience Group 7. 100 Leaders 8. This Week messages	1. Staff feedback on variety of issues	1. Engagement on parking/travel options 2. Engagement on models of care 3. Feedback on staff listening events	2x4=8
			Gaps in Control	Gaps in Assurance	Direction of Travel
				1. Lack of real time engagement tool. 2. Rumour mill working as fast as official channels	↔
Potential Risk Exposure	Related risks on Trust Risk Register				
Staff not willing to act as positive advocates could impact attraction and retention of key staff going forward					

Actions Agreed for any gaps	By Whom	By When	Update
1. Increase visibility of line managers 2. Provide opportunities for staff voice to be heard at Board	1. Leadership Team (key action in this year's staff survey response) 2. Chair/CEO/Dir HR&OD	1. Immediately (some actions in train already) 2. September 2017	
Enabling Strategy	Oversight Committee	Executive Group	
Workforce	Workforce Committee	Trust Leadership Team	
Quarterly Progress Report Against Delivery			RAG Rating
Challenging but hugely informative listening events held with A+C staff with full report and actions/responses. Ownership of A+C group and sponsor at Board identified as COO. Exercise to be repeated with other staff groups. Further communications/feedback sessions scheduled on CQC report and FGR. Further engagement sessions required on travel and parking options.			

(2.4) Strategic Objective: Have Trained a Further 900 Bronze, 70 Silver and 45 Gold Quality Improvement Coaches

Principle Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk that target numbers will not be achieved as staff will not be able to access training due to operational pressure preventing release to attend	Medical Director Gloucestershire Quality Improvement Academy	1. Monitoring of numbers trained through the GSQIA 2. Identification of those for higher training through projects in line with strategic objectives 3. Training programme agreed 4. Performance against programme monitored	Monitoring of training numbers	Report of progress to Trust Board	2x2=4
			Gaps in Control	Gaps in Assurance	Direction of Travel
			None	Regular reports on progress to the Q+P and TMT	

Potential Risk Exposure	Related risks on Trust Risk Register				
Operational pressures prevent training	none				

Actions Agreed for any gaps	By Whom	By When	Update
Reporting schedule to GQIA	Medical Director	September 2019	
Enabling Strategy	**Oversight Committee**	**Executive Group**	
Quality Improvement Strategy	Q+P	GSQIA	
Quarterly Progress Report Against Delivery			RAG Rating

(2.5) Strategic Objective - To Be Recognised as Taking Positive Action on Health and Wellbeing by 95% Of Our Staff (Responding 'Definitely' Or 'To Some Extent' in the Staff Survey)

Principle Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
1. Failure to engage staff sufficiently in activities to help them improve and maintain their wellbeing 2. Increase in stress/mental health issues linked to high demand and workforce shortages	Director of HR & OD Workforce Committee	1. Quarterly sickness data by reason, staff group and division 2. Both long and short term sickness managed locally by divisions supported by HR Advisors 3. Key programmes of work promoting health linked to CQINS 4. Flu vaccination campaign launched early to drive up numbers 5. Collaboration and promotion across county on specific programmes such as 'One You' 6. Collaboration with Catering Department on 'healthy eating' 7. Development of Health and Wellbeing web pages with signposting to resources	1. Staff Health and Wellbeing Group 2. Trust Health and Wellbeing Group 3. Establishment of STP Health and Wellbeing Group 4. Positively received sessions on 'resilience' and 'identifying mental health' 5. Current sickness levels (including stress/mental health) below national levels 6. Awaiting assessment under the Workplace Wellbeing Charter	1. Work programmes and data frequently reviewed	2x3=6
			Gaps in Control	Gaps in Assurance	Direction of Travel
				1. An understanding from staff as to what would truly engage them 2. Limited current availability of healthy options out of hours	↔

				3. Improvements in flu vaccination numbers encouraging but insufficient to hit targets.	
Potential Risk Exposure	Related risks on Trust Risk Register				
Increased staff sickness could reduce key workforce supply at critical times					

Actions Agreed for any gaps	By Whom	By When	Update
1. Nursing Director chairing Flu Action Plan Group 2. Relaunch of timetable for 'resilience' and 'identifying/managing mental health sessions 3. Launch survey to staff ascertaining views on those programmes that would engage them to improve their health 4. Confirmation of plans for out of hours vending to be received and publicised	Maggie Arnold Dave Smith/Leslie Morrison Dave Smith/Staff Health and Wellbeing Group Neil Jackson	6th July July 31st September 30th July 31st	
Enabling Strategy	Oversight Committee	Executive Group	
Staff Health and Wellbeing Strategy/Workforce Strategy	Workforce Committee		
Quarterly Progress Report Against Delivery			RAG Rating
Positive progress on redesign of web pages to create links to health and wellbeing activities and signposting to support services. Positive support for the 'Gloucestershire One You' campaign with participation and pledges from senior leaders. An STP group has also been recently established to focus on Health and Wellbeing with a particular focus on stress/mental health (ensuring current resources are shared). Engaging staff with what matters to them and in particular, those programmes that they would be interested in is key activity for the next quarter as will be shifting the perception that this is a management agenda rather than a shared focus			

(3.1) Strategic Objective: Have a Model For Urgent Care That Ensures People Are Treated In Centres with the Very Best Expertise and Facilities to Maximise Their Chances of Survival And Recovery

Principle Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
The risk that the proposals will not secure the support of key stakeholders preventing implementation	Director of Clinical Strategy Main Board	1. Development of proposals through clinical leadership model 2. Staff engagement plan 3. Alignment of proposals within STP Case for Change plans 4. Creation of high quality consultation material 5. Clinical leadership of engagement activities	NHSE Assurance Process SW Clinical Senate Assurance process	Strategic Outline Case June 2017	2X4-8
			Gaps in Control	Gaps in Assurance	Direction of Travel
			None	None	↔
Principle Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
The risk that the proposals cannot be implemented without impacting on operational performance or quality of care	Director of Clinical Strategy Main Board	Detailed implementation plan with modelling of impact of service change Impact Assessment and Quality Impact Assessment of all proposals Risk assessments for operational processes	Full Business Case including impact assessments	Strategic Outline Case June 2017	2x4=8
			Gaps in Control	Gaps in Assurance	Direction of Travel
			None	None	↔

Potential Risk Exposure	Related risks on Trust Risk Register				
National political processes Unexpected increase in demand for services	S1748. The risk of failing national access standards	S1851. The risk that patients receive poor quality care as a consequence of the demand for beds exceeding the beds available	S2045. The risk of poorer than average outcomes for patients presenting with fractured neck of femur	M2473. The risk of poor quality patient experience during periods of overcrowding in the ED	
Enabling Strategy		Oversight Committee	Executive Group		
New Clinical Model Strategic Outline Case		Main Board	New Clinical Model Programme Board		
Quarterly Progress Report Against Delivery					RAG Rating
Programme reports monthly to the Main Board. No slippage against programme plan to date					

(3.2) Strategic Objective: Have Systems in Place to Enable Clinicians to Request and Review Tests And Prescribe Electronically

Principle Risks to Achievement of The Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk that the functionality of the software is not sufficiently well developed leading to delays in deployment and continuing dependency on old platform	Director of Clinical Strategy Main Board	1. Implementation plan with critical plan for software releases 2. Rigorous testing of applications prior to deployment 3. Collaboration with other live sites	Authority to Proceed gateways	Monthly reports to Main Board on contract performance	2x4=8
			Gaps in Control	Gaps in Assurance	Direction of Travel
			None	None	↔

Principle Risks to Achievement of The Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Service is not operationally prepared for go live, delaying deployment	Director of Clinical Strategy Main Board	1 Rigorous process to identify "as is" and "to be" processes 2 Engagement of TrakCare Operational Group 2.Comprehensive role based training programme 3.Sign off by Trakcare Operational Group of operational readiness	Authority to Proceed gateways	Monthly reports to Main Board on contract performance	3x4=12
			Gaps in Control	Gaps in Assurance	Direction of Travel
			None	None	

Potential Risk Exposure	Related risks on Trust Risk Register				
Delays beyond February 2019 impacting on central funding	F1339. Risk that the Trust does not achieve the required cost improvement resulting in failure to deliver the financial recovery plan				

Enabling Strategy	Oversight Committee	Executive Group	
Smartcare Business Case. Will be covered by emerging Digital Strategy	Main Board	Smartcare Programme Board	
Quarterly Progress Report Against Delivery			RAG Rating
Monthly reports to Main Board from Programme Board Project set to amber as deployment dates for subsequent phases not yet agreed			

(3.3) Strategic Objective: Rolled Out Getting it Right First Time Standards in all Target Specialties and be Fully Compliant in at Least 2 Clinical Services

Principle Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk that resources are not available to achieve compliance	Director of Clinical Strategy Quality and Performance Committee	1. Programme of target specialities identified 2. Priority services for full compliance identified 3. Action plans in place to achieve compliance developed in each service 4. Business cases			3x3=9
			Gaps in Control	Gaps in Assurance	Direction of Travel
			GIRFT action plans in each specialty	No current formal reporting on GIRFT programme	↔
Principle Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk that actions to secure compliance will constitute significant service change delaying implementation	Director of Clinical Strategy Quality and Performance Committee	1. Development of proposals through clinical leadership model 2. Staff engagement plan 3. Early discussions with commissioners 4. Creation of high quality consultation material 5. Clinical leadership of engagement activities			3x3=9
			Gaps in Control	Gaps in Assurance	Direction of Travel
			GIRFT action plans in each specialty	No current formal reporting on GIRFT programme	

Potential Risk Exposure	Related risks on Trust Risk Register				
none	S2045. The risk of poorer than average outcomes for patients presenting with fractured neck of femur	F1339. Risk that the Trust does not achieve the required cost improvement .resulting in failure to deliver the financial recovery plan			

Actions Agreed for any gaps	By Whom	By When	Update
GIRFT action plans to be item on agenda for Surgical Division Executive Review	COO	July 2018 meeting cycle	
GIRFT to be regular reporting item on Q&P committee	Director of Clinical Strategy	July 2018 meeting cycle	
Enabling Strategy	Oversight Committee	Executive Group	
New Clinical Model Strategic Outline Case	Quality and Performance committee	New Clinical Model Programme Baord	
Quarterly Progress Report Against Delivery			RAG Rating
Formal reporting to be established			

(3.4) Strategic Objective: Have Staff in all Clinical Areas Trained to Support Patients to Make Healthy Choices

Principle Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk that staff will not be able to access training due to lack of availability or difficulty being released from roles	Director of Clinical Strategy Health and Wellbeing Group	1. Identification of target staff in all clinical areas 2. Training offer clarified with ICE Creates 3. Training programme agreed 4. Performance against programme monitored		High level reports to Health and Wellbeing Group	2x2=4
			Gaps in Control	Gaps in Assurance	Direction of Travel
			None	Regular reports on progress to the Health and Wellbeing Group	
Potential Risk Exposure	Related risks on Trust Risk Register				
none	none				

Actions Agreed for any gaps	By Whom	By When	Update
Reporting schedule to Health and Wellbeing Group	Director of Clinical Strategy	September 2017	
Enabling Strategy	Oversight Committee	Executive Group	
Health and Wellbeing Strategy	Trust Leadership Team	Health and Wellbeing Group	
Quarterly Progress Report Against Delivery			RAG Rating
Reporting schedule to be established			

(4.1) Strategic Objective – Be in Financial Balance by April 2019

Principle Risks to Achievement of the Objective	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk that the Trust does not deliver the required savings and budgetary efficiencies resulting in failure to deliver the Financial Recovery Plan	Director of Finance Finance Committee	1. Regular NHSI FSM meetings 2. Monthly monitoring, forecasting and reporting of performance against budget by finance business partners 3. PMO in place to record and monitor the FY18 programme (including monitoring and reporting of performance against target) 4. Weekly Turnaround Implementation Board 5. Monthly executive reviews 6. Regular monitoring and analysis of data completeness (and quality) and income recovery	1. Finance Report 2. Audit reports 3. CIP Report 4. Performance reporting	1. NHSI agreement to Financial Recovery Plan 2. Initial Deloitte review and implemented actions	3 x 5 = 15
				Gaps in Assurance	Direction of Travel
				1. Reliable data for activity impacting billing and income recovery	↔

Potential Risk Exposure	Related risks on Trust Risk Register	
• Risk that the Trust does not achieve the required cost improvement resulting in failure to deliver the Financial Recovery Plan for FY18		5 x 3 = 15
• Risk that the Trust does not exit Financial Special Measures in a timely way and as a result is subject to interest charge "penalties"		4 x 3 = 12
• Risk that the Trust's expenditure exceeds the budgets set resulting in failure to deliver the FY18 Financial Recovery plan		5 x 3 = 15
• Risk that FY18 income recovery will be reduced as a result of being unable to submit accurate data to commissioner to support payment, arising from current issues associated with TrakCare implementation		4 x 3 = 12

Actions Agreed for any gaps	By Whom	By When	Update
PMO works with divisions to recover slippage and identify new schemes. TIB used as escalation forum for issues that cannot be resolved at divisional level	Director of CIP PMO	Ongoing	CIP programme showing favourable variance to plan for period to end May

Finance business partners work with divisions to recover slippage and identify mitigating actions Escalation to DoF where Executive intervention required (part of Executive reviews)	Director of Operational Finance	Ongoing	Expenditure budgets showing favourable variance to plan overall for period to end May
Ongoing discussions with Commissioners regarding blocking contract elements to mitigate cashflow impacts with regular risk assessment of income position	Director of Finance	July 2017	Discussions ongoing
Enabling Strategy	Oversight Committee	Executive Group	
	Finance Committee	Turnaround Improvement Board and Trust leadership team	
Quarterly Progress Report Against Delivery			RAG Rating
The overall I&E position to end May is showing a £0.1m favourable variance of £0.1m against budget, but with an adverse variance of £2.3m to the NHSI plan, largely as a result of an income shortfall which is believed to be largely related to the issues with TrakCare implementation. The short term action to recover this is to seek to reach block funding agreements with principal commissioners for the first 6 months of the financial year. A key next step is to undertake a more detailed financial forecast for 2017/18 as at the end of Q1, incorporating in particular an assessment of CIPS delivery, and identifying any further actions needed to deliver the planned CIPS for the year or mitigate any shortfall. This will be reported to the July Finance Committee			

PUBLIC BOARD MAIN BOARD – JULY 2017

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

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

Audience(s)									
Board members	**X**	Regulators		Governors		Staff		Public	

Executive Summary

Purpose

To provide assurance to the Board, from the Smartcare Programme Board, on progress within the continued operation of TrakCare and planned implementation of Phases 1.5 and 2.

Key issues to note

- The programme is set at amber status due to the persistence of some system issues impacting on operational performance and delayed implementation of phase 1.5
- Performance against contracted services is being monitored and reported in line with service level agreement based reporting and delivery of contracted functionality.
- Key high priority system related issues are identified and reported with current status.
- Contractual and functional review of the system meeting output based specification requirements under way.
- Regular Service Reviews implemented with contractual support from Procurement.
- Proposed Programme Delivery plan for Phase 1.5 and Phase 2 components is to be presented to the Programme Board on 3rd July.
- Risk to Phase 2 proposed go-live for Oncology including Chemotherapy prescribing is the adherence to the proposed planned go-live of Pharmacy in November.
- A full review of project financial forecast is required upon acceptance of the agreed revised plan.
- Training progressing with focussed sessions for Maternity planned and extended team membership is set to enhance delivery. Preparation for Phase 1.5 is under way with Radiology Order Comms.
- Trust ownership and responsibility for Training as a whole is to be reviewed at a meeting on 7th July.

Conclusions

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

Implications and Future Action Required

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

Recommendations
The Board is asked to note this report as a source of assurance that the programme to identify issues within the respective operational and support areas to achieve a satisfactory recovery for Phase 1 and planning for subsequent phases is robust.
Impact Upon Strategic Objectives
Contributing to ensuring our organisation is stable and viable with the resources to deliver its vision, through harnessing the benefits of information technology
Impact Upon Corporate Risks
Implementation of phase 2 of Smartcare will reduce the risk on the corporate risk register associated with the instability of the Oncology Prescribing system
Regulatory and/or Legal Implications
The implementation is covered by a contractual agreement with InterSystems. At present the delays to implementation are not impacting on the contract but a full review will be undertaken in respect of the revised timescales from the re-planning exercise.
Equality & Patient Impact
The patient benefits from the implementation of Smartcare will be realised across all patient groups

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

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

Date the paper was presented to previous Committees					
Quality & Performance Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**
				5 July 2017	SmartCare Programme Board
Outcome of discussion when presented to previous Committees					
Endorsed for submission to Board					

This document may be made available to the public and persons outside of the Trust as part of the Trust's compliance with the Freedom of Information Act 2000

PROGRESS REPORT SmartCare			
Date completed:	28/06/17	**Version**	1.0
Project Sponsor:	**Dr Sally Pearson**	**TRUST RAG Status**	**AMBER**
Project Manager:	Gareth Evans		

SmartCare Progress Report – July 2017

Executive Summary & Programme Status

An overall Trust RAG status of **AMBER** as deployment dates for subsequent phases are still to be confirmed
This report identifies performance and progress in the following Phases:

- Phase 1
- Phase 1.5
- Phase 2

Phase 1

Contract performance

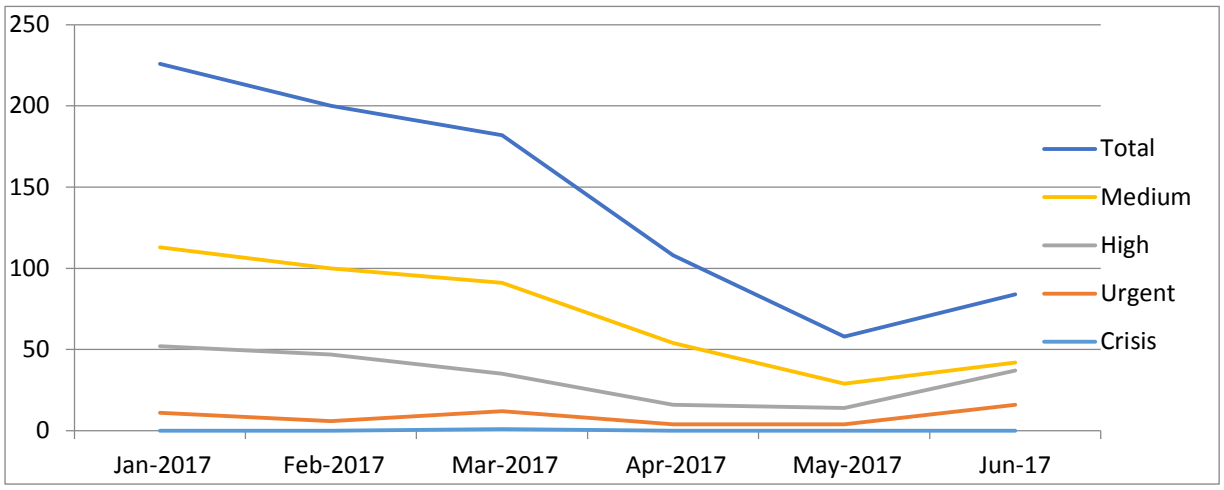
Contract Performance is measured against Incident call statistics against the InterSystems Call Centre (TRC) and availability of TrakCare to end users. Current trends and ongoing totals provided below.

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

TRC Incident reporting Summary: Jan – Jun 2017

Incidents Opened YTD:	438
Incidents Closed YTD:	374
Incident Closure (%):	85
Open Incidents:	156

Trend for Open Incidents



There are number of TrackCare Service Requests (TRCs) that the Trust and ISC have deemed as high priority

© Gloucestershire Hospitals NHS Foundation Trust Copyright 2007

which needed to be addressed as matter of urgency.

- Trust Vacant Slot Report – Review of clinic rebuild is a dependency for the correct use of this report. Follow-up ISC on-site review of clinic build related elements is to be held on 28/29 June. Subsequent update from this review session will be presented to the July Programme Board. Locally produced Vacant Slot report continues to be in use across divisions.
- Slot Utilisation Report – In progress with BI.
- Resolution of postcode issues QAS TRUD files. – Work-round provided and in full review with PAS support team for acceptable use of the back-office resolution.

Overall TRC use has increased slightly in the last month with a number of inappropriate TRC's being raised either in terms of content provision or priority. It is essential that the Trust Support owner is engaged with ISC at the earliest time possible in order for an overall review of support utilisation to be made and progress toward an acceptable level of TRC use.

Status reporting of all identified 'system' issues relating to Operational Impact is provided in the Operational Impact Log.

System Deliverables

A review of the Output Based Specification (OBS) provided in the SmartCare procurement has been undertaken by the project team and is pending further review with ISC to identify any agreed omissions from the planned delivery of Phase 1 implementation that are not covered by contract change notes.

Contract Payment schedule and any variance from plan

There are no reported variances to the contracted milestone payments.

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

Note that any changes to the milestone structure and associated payment needs to be identified to SLCS to confirm funding requirement for the next period. Next funding request required to be submitted by 11th August.

Service Review

Confirmation of the Trust support owner is to be established and introductions made with the InterSystems Support Management Team headed by Luke Ridding.

A meeting with KA and LZ has been established for 3rd July to review support arrangements with the output informing the Board and ISC.

The Support Owner will establish a regular Service Review process with the corresponding attendance from within the support team. GE will represent the programme attendance and invitation for Contract Management included.

A suggested request for ISC to attend operational Review meeting on a monthly basis has been proposed in order for an appreciation of operationally impacting issues to be presented first-hand and subsequent understanding of priorities made. This needs to be discussed with ISC and the Trust support owner as it is an additional request outside of contracted commitments.

A request for a monthly Service Review call to cover general information and any call escalation is proposed. The first monthly review will be arranged for July.

Update releases

The Update Release required for implementation has been revised from MR6.3 to MR7ENXX1. This is in line with

© Gloucestershire Hospitals NHS Foundation Trust Copyright 2007

the revised planning that is due to be reported to the July Programme Board for delivery of outstanding phase 1.5 and Phase 2 components.

This has been delivered to the Scratch environment with initial regression testing requested to be completed across all functional areas by 4th July.

Next stage regression testing in Base and subsequently in Test is due to take place from 12th July – 21st July. Currently planned live operation of MR7ENXX1 is 28th July.

Delivery of MR7ENXX1 is required for progressing Phase 1.5 implementation including the Labs code table resolution and associated re-baseline of environments that is planned for 21-25 August. The MR release will also include the security patch and fixes to operational issues identified from the release notes as well as a large number of Labs related Jira fixes. This will expedite the progress with migrating from Infoflex.

Radiology Order Comms will be scheduled for go-live with the 2016.2 MR7 release initially in ED on NN September. Roll-out to other areas across the Trust will take place with completion due by NN October.

Pharmacy Stock Control requires a minimum release of 2017.2 MR2. The upgrade to 2017.2 MR2 is currently planned for 18th October go-live followed by proposed Pharmacy go-live on 4th November. A further MR release to 2017.2 MR4 will be necessary and is planned for 17th November. It should, however, be noted that the proposed go-live for Pharmacy is considered a risk in that there are known issues with Pharmacy and its contributing formulary (FDB) that are expected to be resolved in go-lives at Yeovil and Northern Devon. Any delay in achieving successful go-live arrangements could impact the Pharmacy timescale.

Phase 1.5

Preparation and planning

Phase 1.5 deliverables are dependent upon the resolution of the deployment issue with TrakCare Labs Enterprise (TCLE) and subsequent re-baselining of the environments. Timing for this has been provided above.

Following the re-baselining exercise across all environments, TCLE can continue with build through to mid-September prior to the upgrade to 2017.2 in Base and Test which will enable further functional progress including Pharmacy stock Control.

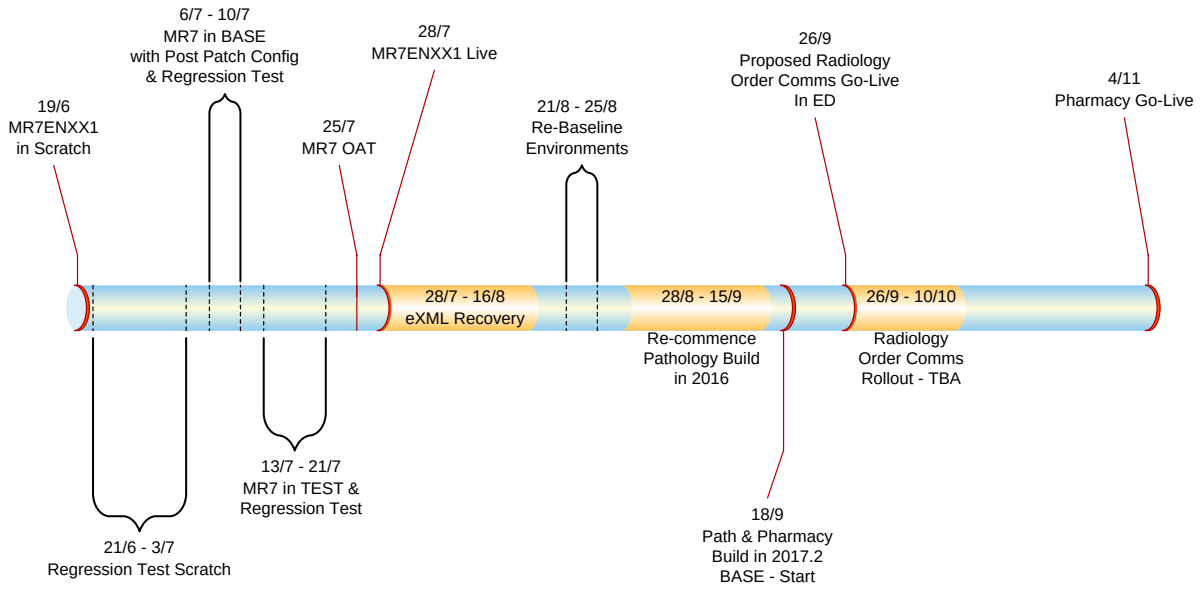
InterSystems will present an overall plan at the July Programme Board covering the Phase 1.5 functionality and Phase 2 components determined to be required in 2017/18.

The plans take into account lessons learned from phase 1 deployment and will cater for sufficient notice and preparation of Training and the use of a ‘Technically Live’ environment for all users to use against identified changes in process after completing training (whether e-learning or classroom based). The ability for users to make use of such a ‘play’ environment is key to the successfully prepared operational use and will form a key component of the Authority To Proceed processes.

The proposed timeline for the plan to be included at the Programme Board presentation is included below for preliminary information. It does not assume acceptance of the plan.

Proposed Timeline for key Phase 1.5 component delivery.

© Gloucestershire Hospitals NHS Foundation Trust Copyright 2007



Overall Phase 1.5 Planning

Phase 1.5 consists of four distinct components in respect of go-live re-planning:

- Radiology Order Comms
- Pharmacy Stock Control and Dispensing
- Pathology Order Comms
- Pathology (TrakCare Lab Enterprise)
- Consult Orders (brought forward due to delay to TCLE)

Phase 2 has been reviewed in respect of the planned delivery of functionality in parallel with Phase 1.5 functionality where possible.

The elements to be covered in the proposed plan for Phase 2 include the items listed below. Note that some of these items will require completion of operational assessments before dates may be confirmed.

- ePMA
- Oncology – SACT/COSD & OPMAS replacement
- Advanced Clinical Noting (Infoflex retirement)
- Medical Device Integration
- Theatre Clinicals
- Mortuary

The jointly prepared implementation plan is to be presented at the July Programme Board. There will be requirements for all workstreams to review and potentially revise progress trackers in line with the overall plan. There is a further proposal to migrate local progress tracker information to a joint ISC and Trust document that would be hosted on the ISC SharePoint site and in a format that both may monitor and report upon.

Following the June Programme Board, workstreams have been requested to ensure that Trust based Progress Trackers contain correct date ranges for completion of activities.

There is a significant amount of detailed planning required for Phase 2 that will be prioritised in relation to the overall planned delivery of functionality.

© Gloucestershire Hospitals NHS Foundation Trust Copyright 2007

Phase 2 component delivery.

Initial Phase 2 functional delivery is based upon Oncology in order to provide Chemo prescribing and medicines administration together with the ability to record and report data for SACT and COSD. This will also effect the replacement of OPMAS. The date proposed for live delivery of the Oncology element is April 2018. This is dependent upon the implementation of Pharmacy Stock Control in November 2017 and the expansion to include ePMA.

Essentially this brings ePMA into an operational perspective together with advanced clinical information.

The scope for full Oncology deployment is pending provision of an identified InterSystems capability scope and review against Trust requirements. A subsequent planning exercise may then be carried out to determine full oncology implementation timescales.

Risks to Planned Phase 1.5 & 2 Timelines

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

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

The requirements for the delivery of Phase 1.5 and 2 are currently under review internally by InterSystems to maximise the opportunities for delivery across the whole of the SmartCare Programme. The Trust Programme Management Team have contributed to the identification of the of the "windows of opportunity" where the programmes deliverables may go live taking into account known dependencies and aversion to risk InterSystems

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

Current estimation of required resources for the Phase 1.5 and Phase 2 elements planned is provided in the Resource Schedule. Any identified gaps in resource availability will be escalated to the appropriate senior management for both the Trust (SRO) and InterSystems (ML/CI).

Phase 1 Deployment Lessons Learned

The Action Plan required to be produced against the lessons learned report is to be established in line with the agreed Programme plan.

Order Communications Update

Order Communications maintains progress within Radiology. The previously advised dependencies on MR6.3 have been overtaken by the current deployment into the test process of MR7. The proposal for go-live with Radiology Order Comms is still proposed to commence with ED but with a currently estimated enhanced level of progress to other operational areas.

Training material preparation includes the process mapping of 'To Be' elements.

Once the plan has been agreed, notification of the training, UAT and go-live arrangements will be distributed.

Pharmacy Update

The plan for Pharmacy go-live with Stock Control is proposed as 4th November. Any delay to this would move into the period required for Pharmacy to prepare for the winter/Christmas period and would not present an opportunity to

© Gloucestershire Hospitals NHS Foundation Trust Copyright 2007

go-live in this calendar year.

A request for additional ISC Pharmacy resource to be available was raised. The resource plan provide by InterSystems indicates a significant improved amount of time required for the ISC personnel.

The implementation of Pharmacy also has a dependency of go-live being completed at Yeovil and NDH. Yeovil was reported as preparing for Pharmacy go-live in August but discussion held with YDH on 28/6 has indicated a deferral to September. It is not known if this will impact the subsequent go-live for NDH or GHT.

NOTE: Go-live of Pharmacy stock control against the proposed plan is a dependency for the implementation of ePMA and Oncology in April. This includes the replacement of OPMAS and the provision of SACT & COSD reporting.

Pathology Update

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

The completion of this work is re-planned for 25th August 2017, as against the original scheduled date of 18th April 2017. Pathology build activity will recommence on 29th August 2017.

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

PHASE 2

The delivery of Phase 2 functionality is to be completed within the 4-year contract period for funding with NHSE. The end date for this is 4th February 2019.

Initial planned timescales for functional delivery of Phase 2 components requires additional detailed planning which is dependent upon completion of operational Assessments against each deliverable component. The Operational Assessment will also determine a detailed resource requirement to include clinical representation from both clinicians and nursing representation as well as operational administrative resource. This is essential to ensure that clinical safety and workflow is determined in line with the build and configuration with resultant To Be processes analysed and confirmed as appropriate.

JB and PD visited the Bristol Royal Infirmary to assess operational use and clinical safety of Qualcomm Life's Capsule™ Medical Device Information System. Detailed planning of the approach for Medical Device integration is to be confirmed with CR and InterSystems.

Detailed delivery planning of Oncology is progressing and the initial delivery schedule for April 2018 is to include OPMAS replacement functionality that will enable the collection and reporting of data for SACT and COSD in line with required levels of reporting to ensure funding stream is maintained. The functionality will include elements of complex ePMA.

Consult Orders were originally deemed to be part of Phase 2 but due to the delayed implementation of Labs, this is required to be brought forward into Phase 1.5 deliverables for Order Comms.

Advanced Clinical Noting is being undertaken within the Infoflex replacement activity. Updated information pertaining to this element is highlighted below:

Project PID and Plan –

- First InfoFlex Steering Group(ISG) meeting has taken place on 26th May 2017. In ISG meeting Project PID, Project plan and work plan were reviewed and subsequently approved.

Migration Work Plan –

- InfoFlex(Ifx) Clinical system migration task order list has been agreed,(order list is based on complexity and high license usage), subsequently clinical letter production systems were chosen to be first to be migrated

© Gloucestershire Hospitals NHS Foundation Trust Copyright 2007

over to TrakCare(TC) in the work plan.

OP Clinical Letter(noting) TrakCare Developments Update –

- Meeting held on 6th June 2017 with Les Smith(LS),Paul Downie(PD) and Thomas Kus(TK)-clinical stakeholder to discuss new TrakCare MR6.3 new(now MR7 version) OP clinical letter production features,Meeting outcomes resulted in drawing out a draft specifications for clinical systems(CS) team.
- CS team have begun undertaking OP clinical letter prototype production on TC Scratch off Paediatric Haematology & Dermatology Clinical letter templates.
- As per the draft specs proposals Andy T(AT) has turned off Diagnosis , Medications, Procedures and Observations functionality on Scratch.

Training

Training is continuing both face to face and via e-learning. E-learning is now available through the LMS, so accessible from more locations, and work is continuing to ensure e-learning modules are linked job roles. A communication to users would benefit from confirming that the e-learning modules relate to the access according to TrakCare roles so although staff may feel they don't/won't perform certain tasks within a role, they may be required to do so and should therefore complete the training in full.

Focussed sessions have been organised for Maternity within the Maternity departments at GRH and Stroud (Mat) from mid-July.

Focussed Discharge Summary (IP) sessions for nursing staff has had **50** attendees across 14 sessions offered over 6 dates.

Training team have welcomed one new starter (Vicky) and a second (Ellen) is starting 28th June so train the trainer process is underway and will continue through to readiness for the next phase of deliverable functionality as well as maintaining current training needs.

Process mapping is underway for preparation of e-learning, lesson plans and supporting documentation for next phase components with a concentration on Radiology Order Comms. Liaison with the respective department leads is ensuring relevant material is produced ready for the technical go-live and training schedule.

A meeting to review the overall Trust provision of training encompassing Phase 1 elements together with clinical training and ongoing e-learning development and maintenance is scheduled for 7th July.

Programme Resourcing

The re-planning exercise for phases 1.5 & 2 includes a resource profile plan that has to be supported in order to meet the requirement for delivery.

The resource structure will present challenges to both the Trust and InterSystems.

The use of contract resources will be limited to those necessary to complete the implementation tasks where Trust substantive resource is not available to meet the scheduled delivery. All requirements will need to progress through the Vacancy Control Panel and associated procurement activity so a clear understanding of external resource requirement is required urgently.

Two currently identified areas of resource that are required to be supported either by the Trust as substantive resource or through the use of contract engagement are the roles of Interface Developer and Test Team membership (4). The Test Team is proposed to become part of the BI restructuring. The role of an Interface Developer to take on the development and maintenance of HealthShare (Ensemble) is currently being covered by SPi but the workload relevant to overall delivery is such that SPi's availability is no longer sustainable and a substantive requirement is seen as necessary in order to provide ongoing development, management and support. Support for current interfacing technologies is contracted to a third-party that does not include all of the TrakCare development so this would be a form of benefit in cash terms.

Support related resourcing as illustrated in the previous report continues to be a challenge and is pending the results of internal discussion scheduled for 3rd July.

© Gloucestershire Hospitals NHS Foundation Trust Copyright 2007

Finance

A full review of resource allocation and corresponding cost forecast will be necessary to revise the financial forecast upon acceptance of the revised delivery plan. Assuming the proposed plan is accepted, the financial review will take place in July.

Programme Risks

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

Operational Activity

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

Next Planned activities

Re Baselined Plan for Phase 1.5 to be presented to July Programme Board for review and subsequent approval by all parties.

Development of the initial Phase 2 Scope and associated delivery plan to be presented to July Programme Board for review and subsequent approval by all parties.

Initial resource plan to be issued to the July Programme Board for both ISC and Trust resources in accordance with the proposed plans.

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

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

Status against communications plan

Continuation of communications with all stakeholders regarding TrakCare – both from Programme and Operational perspectives via regular global updates.

Upon agreement of the Phase 1.5 & 2 delivery plans, it is proposed to communicate this to all stakeholders staff at the earliest appropriate time.

Progress
(against project plan / project brief)

Tasks/Milestones completed

Task	Start	Finish/ % comp.	Comments
Detailed implementation Plan		31/03/15	Version 1.0 Completed for payment milestone confirmation.
Project Initiation Document		29/04/15	Version 1.0 Completed for payment milestone confirmation.
Phase 1 Operational Assessment Stage Complete		31/05/15	Milestone Achievement Certificate Issued.
Phase 1.5 Operational Assessment		30/09/15	Milestone Achievement Certificate Issued.

© Gloucestershire Hospitals NHS Foundation Trust Copyright 2007

Complete			
Phase 1 Build Milestone		17/07/16	Milestone Achievement Certificate to be Issued from Programme Board 07/11/16.
Phase 1 ATP Complete (Technical Live)		25/10/16	Milestone Achievement Certificate to be Issued from Programme Board 07/11/16 on basis of Technically LIVE system being available and supported.
Revised Milestone Plan pending InterSystems CCN		Dec 16	CCN has been completed and signed off.
Phase 1 ATP Complete (Operationally Live)		5 Dec 16	System Live
Phase 1 Deployment Verification Complete		6 Mar 17	Completed

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

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

NOTE: All risks under review in line with Issue Management

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

© Gloucestershire Hospitals NHS Foundation Trust Copyright 2007

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

Report Title
Up-date on Research in Gloucestershire Hospitals NHS Foundation Trust
Sponsor and Author(s)
Author – Julie Hapeshi, Associate Director of Research and Development Sponsor – Sally Pearson, Director of Clinical Strategy
Executive Summary

Purpose

To provide an up-date for the board on the current status of research activity within the Trust

Key issues to note

Research activity within the trust is significant and compares favourably to other Trusts in the West of England Clinical Research Network.

Our performance against the national metrics is variable (largely due to small numbers of trials included in the measures) but there is an action plan in place to secure improvements

The income for research comes from streams that are independent of the main health care budgets. The value of research activity in the trust approaches £2m but the non-recurring nature of the funding streams makes management of this budget challenging. Comparative figures suggest that we deliver value for money from this income in terms of number of patients recruited into trials

There is a strong history of joint working to support research across the health and social care organisations in Gloucestershire. This will be further strengthened by the recent Memorandum of Understanding between these organisations and the University of Gloucestershire.

Conclusions

Research is an important aspect of the day to day business of the NHS and provides the organisation, it patients and its staff with access to new drugs, devices and developments in the delivery of care that it would otherwise have to wait for. Reporting to the board provides an opportunity to improve the visibility of this important area of the Trust's work.

Implications and Future Action Required

Research activity is reported monthly to the Quality and Performance Committee as part of the Quality and Performance report. Activity and performance is scrutinised at the quarterly Research and innovation Forum.
It is proposed that the Board receives quarterly update reports to provide assurance of the performance and governance of research within the Trust

Recommendations
The Board is asked to accept this report as assurance of the performance and governance of research within the Trust.

Impact Upon Strategic Objectives
Impact Upon Corporate Risks
None.
Regulatory and/or Legal Implications
Research activity is covered by specific regulatory framework administered by the Medicines and Health regulatory Authority. The MHRA are due to visit the Trust in September.
Equality & Patient Impact
Research studies are accessible to all patients who meet the criteria of the studies.

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

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

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

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – JULY 2017

UP-DATE ON RESEARCH IN GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

1. Aim

To provide the board with an up-date on the current research activity and finance relating to the delivery of research studies.

2. Background

Under the NHS Constitution (2009) it is expected that research is a core part of the business of the NHS which enables the NHS to improve the current and future health of the people it serves. NHS organisations must do all they can to ensure that patients are made aware of research that is of particular relevance to them. To enable studies to recruit, conclude and report in a timely way we need to promote research to staff and patients. The Government intends us to give patients more information on research studies that are relevant to them, and more scope to join in if they wish. Patients should be encouraged to enroll into research studies on the basis that it is the best way of improving treatment options.

Research activity in the NHS is managed through the National Institute for Health Research (NIHR), which was established in April 2006. It provides the framework by which the Department of Health fund the research, research staff and research infrastructure of the NHS in England as a national research facility. The NIHR also actively encourages partnerships with the commercial sector and this is a key area of income generation for the Trust.

3. The Local Context

The Trust currently hosts in excess of 300 studies which are open to recruitment or in follow-up. These studies form part of the NIHR portfolio of adopted studies and a list of studies that are currently recruiting new participants can be found in annex A to this paper. Many of these are multi-centre studies that originate from outside the organisation for which we are a centre for recruitment, treatment and follow-up. We have a much smaller portfolio of locally generated studies, some funded by NIHR and other funders but also student projects undertaken by members of our staff. We also have around 15-20 commercial studies open at any one time.

Support for non-NIHR funded studies is provided by the Gloucestershire Research Support Service (GRSS) via an SLA with the NHS research active organisations in the county and including Public Health in Gloucestershire County Council. Funding described in the SLA supports the Research Management and Governance, design and delivery of non-NIHR portfolio studies including local service evaluation projects and student projects. The GRSS hosts the Gloucester office of the NIHR Research Design Service South West (NIHR RDS SW) which provides a free support service for study design and applications for funding to approved NIHR funders.

4. Key Messages

Research Activity

The Trust receives funding from the NIHR via the West of England Clinical Research Network (WE CRN) which supports the infrastructure to deliver hosted studies that are adopted by the NIHR. Research activity fluctuates depending on the studies we have available to us to recruit to and the number of participants can be heavily distorted by one or two high recruiting studies. The annual recruitment since 2007/08 can be seen in figure 1. The target for 2017/18 is 1100 based on studies that are currently open. Our research activity compared with the other Partner organisations in the WE CRN area is in Table 1.

Figure 1. Annual recruitment to research studies since 2007 (data extracted 3.7.17)

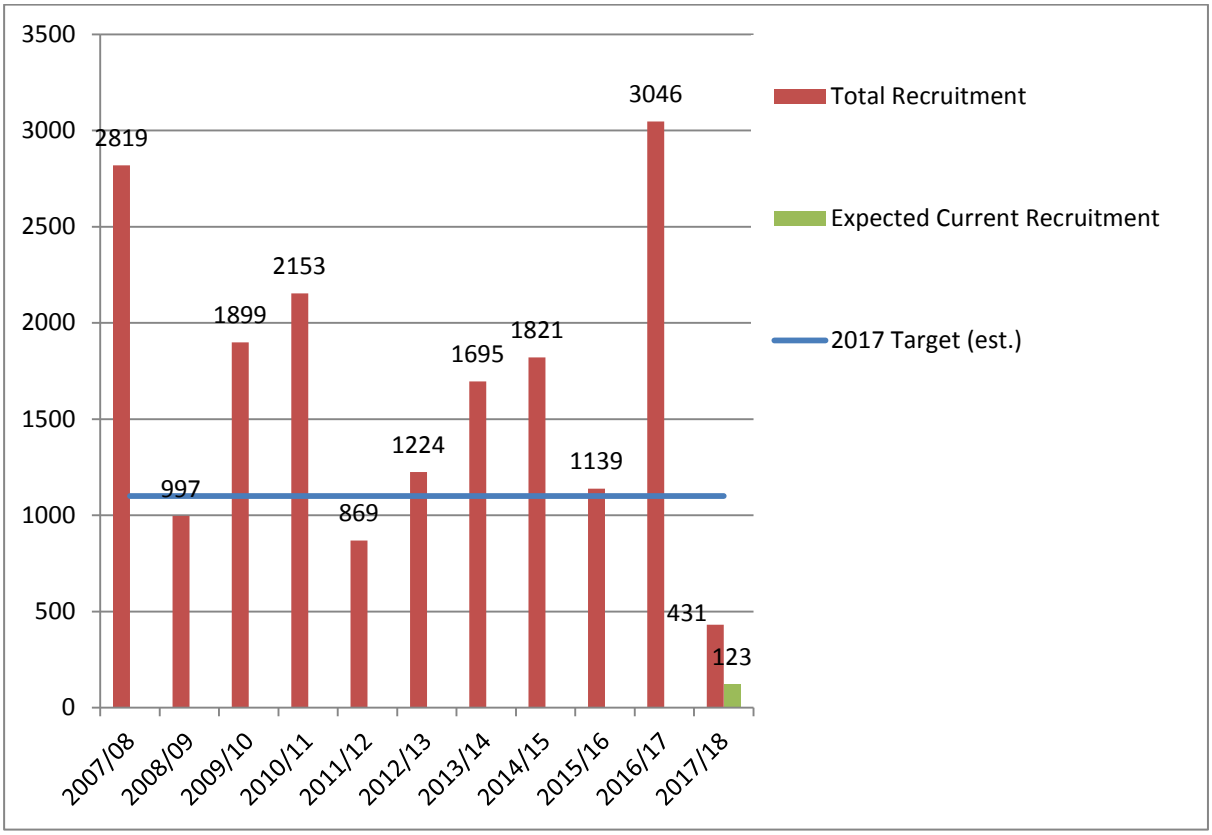
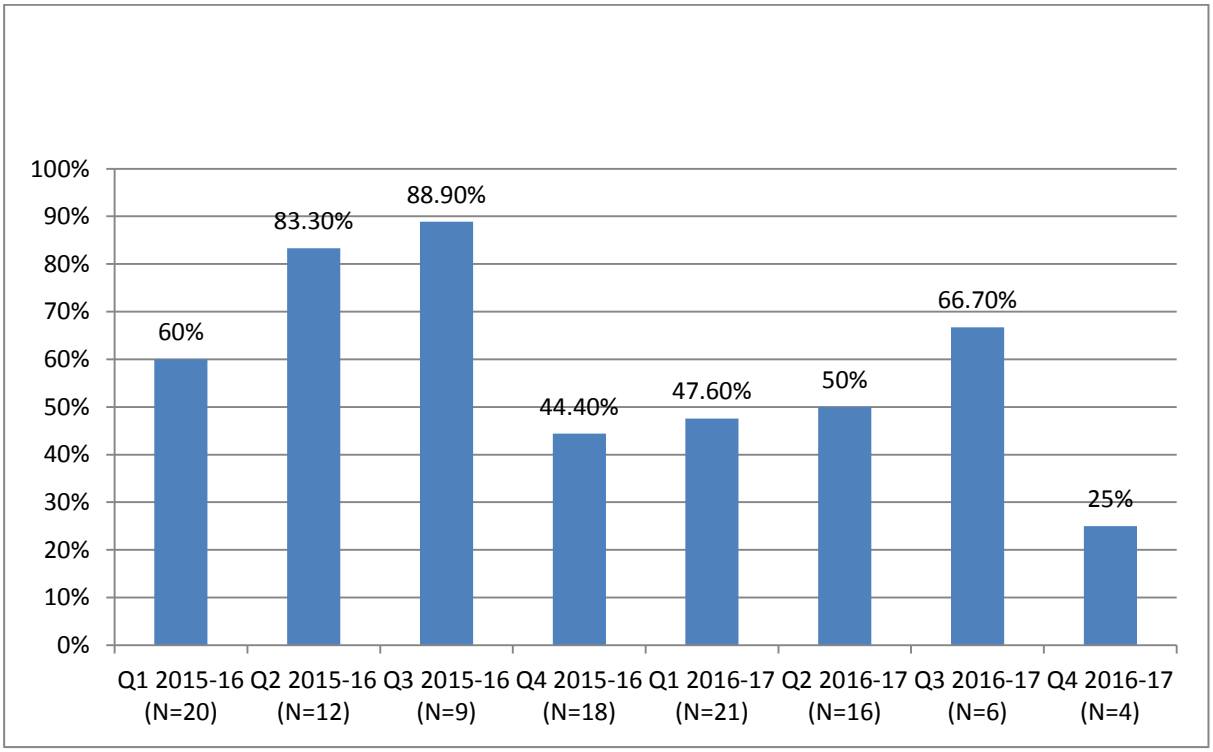


Table 1. Research activity in West of England CRN partner organisations (data extracted 6.6.17)

Trust	Commercial recruitment	Non-commercial recruitment	Total	Weighted recruitment (ABF)	% year-to-date recruitment goal achieved
2Gether NHS Foundation Trust	0	29	29	214.0	174.00%
Avon And Wiltshire Mental Health Partnership NHS Trust	1	45	46	140.0	84.40%
Gloucestershire Care Services NHS Trust	0	7	7	77.0	560.00%
Gloucestershire Hospitals NHS Foundation Trust	6	163	169	758.0	176.35%
Great Western Hospitals NHS Foundation Trust	0	76	76	683.5	101.33%
North Bristol NHS Trust	31	365	396	1940.0	135.77%
Primary Care	33	192	225		38.57%
NHS Bath And North East Somerset CCG	12	11	23	113.5	
NHS Bristol CCG	0	55	55	135.0	
NHS Gloucestershire CCG	2	34	36	256.5	
NHS North Somerset CCG	3	12	15	42.0	
NHS South Gloucestershire CCG	4	59	63	549.0	
NHS Swindon CCG	7	1	8	11.0	
NHS Wiltshire CCG	5	20	25	110.0	
Royal United Hospitals Bath NHS Foundation Trust	11	83	94	643.0	62.67%
University Hospitals Bristol NHS Foundation Trust	17	361	378	1906.0	90.72%
Weston Area Health NHS Trust	0	15	15	27.5	76.60%

We are performance managed on a number of high level objective set by the NIHR, including study set up times (figure 2) and recruiting to time and target (figure 3). Over the last 18 months, R&D Approval Processes have been undergoing a period of transition from the old, site-based systems, to a centralised Health Research Authority Approval (HRA) Process and the NIHR reporting systems have been constantly changing. In addition to this, the recent Work Force review of the local delivery team led to a number of studies being delayed in set-up due to resource issues and this has had an adverse effect on recent quarterly outcomes. Now the transition period (and Workforce Review) has come to an end, it is expected that the results of the quarterly report will improve as the R&D Team now has a better understanding of how the results are calculated and how best to process new studies to ensure compliance with the new system.

Figure 2. The percentage of studies recruiting the first patient within 70 days of site selection (Target 80%)



The measure of how commercial studies that have closed recruited participants on time and to target (figure 3) is more difficult to achieve because if a study does not meet its recruitment target, even by one participant, it will be RAG rated red. This includes studies closed early by the company which we have no control over, or studies closed by us because they are non-viable. We are trying to improve this performance by more stringent feasibility and by declining studies that we do not feel have realistic targets.

Figure 3. The percentage of closed, Commercially-Sponsored studies recruiting to "Time and Target" (Target 80%)

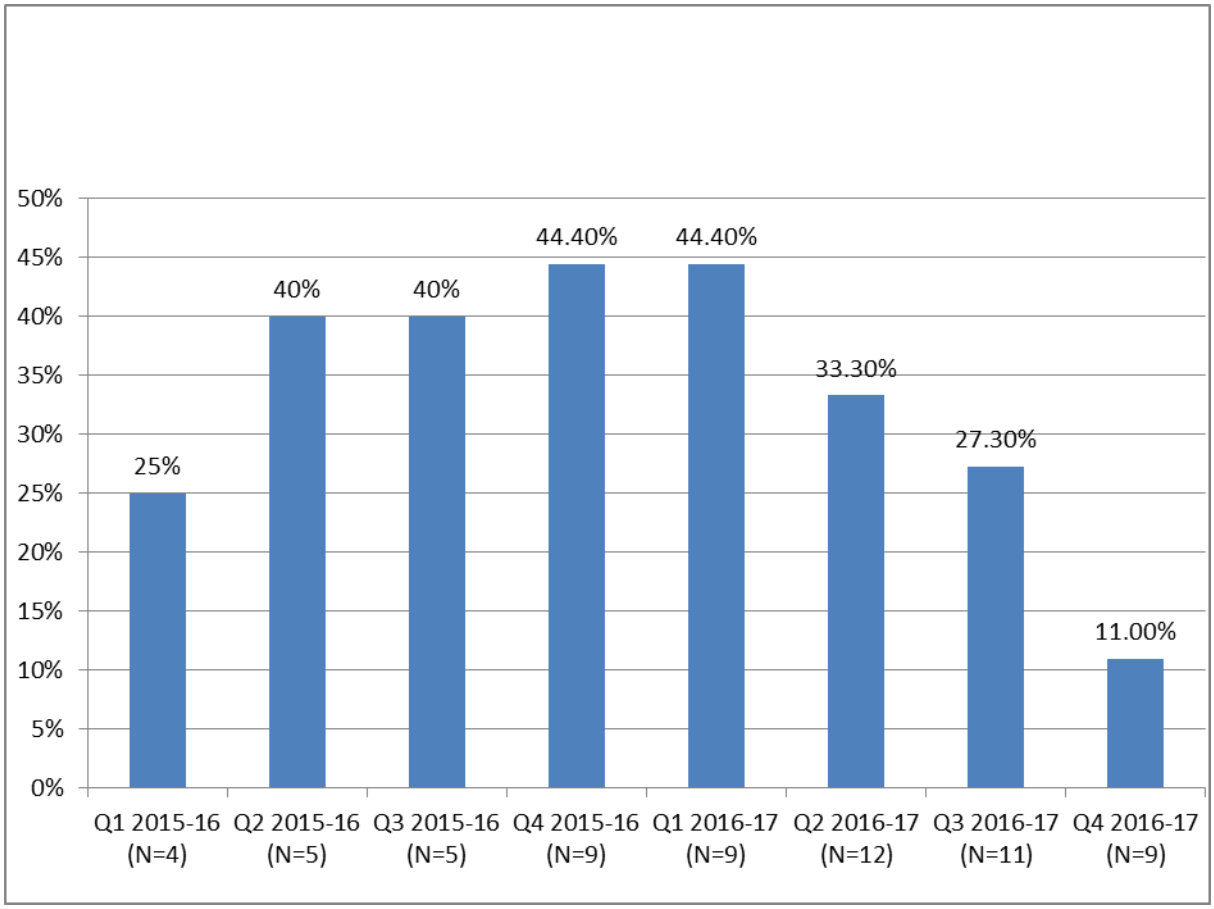
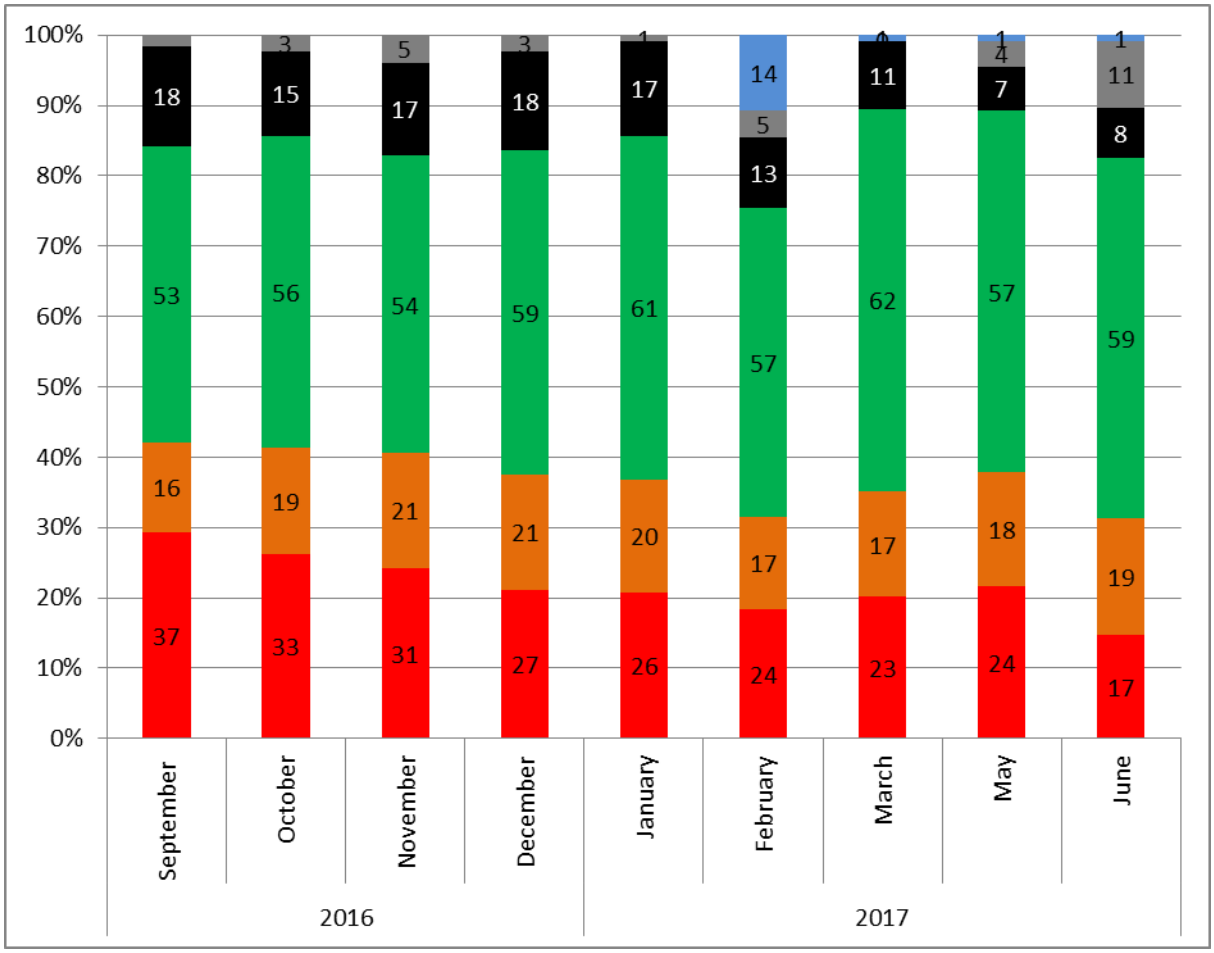


Figure 4 illustrates “Recruitment to Time and Target” live tracking of open studies within GHNHSFT. Although data is missing for April, there is a clear trend that indicates a reduction in the number of studies that are failing to recruit the number of patients agreed at the start of the project

One year ago we saw an approximately one third split across the red, amber and green categories and set about acting on this. We focused on reducing the number of studies rated red by closing some studies that were unlikely to deliver and redoubling our efforts on others. However, this consolidation of our portfolio by closing a number of red rated studies in a short time frame did have a knock on effect on our Performance in Delivery report which we hope will improve. We also now review the amber studies each month to try and move these from amber to green, especially if they are within six months of closing to recruitment.

Figure 4. The "RAG" rating for recruitment into all trials.



RAG Definitions		
BRAG	Open studies	Closed studies
Black	Study not reported recruitment or study has not recruited	Study not reported recruitment or study has not recruited
Red	% Recruitment is more than 30 behind % time elapsed, i.e. Difference < -30	Site recruitment is less than Project Site Target
Amber	% Recruitment is less than 30 behind % elapsed time but more than 0 behind % elapsed time, i.e. -30 < Difference < 0	
Green	% Recruitment is equal to or greater than % elapsed time, i.e. Difference >= 0	Site recruitment is equal to or greater than Project Site Target
Grey	Unable to calculate RAG due to record missing at least one data point	Unable to calculate RAG due to record missing at least one data point
Blue	Recruitment target of zero with no recruitment	Recruitment target of zero with no recruitment

Funding

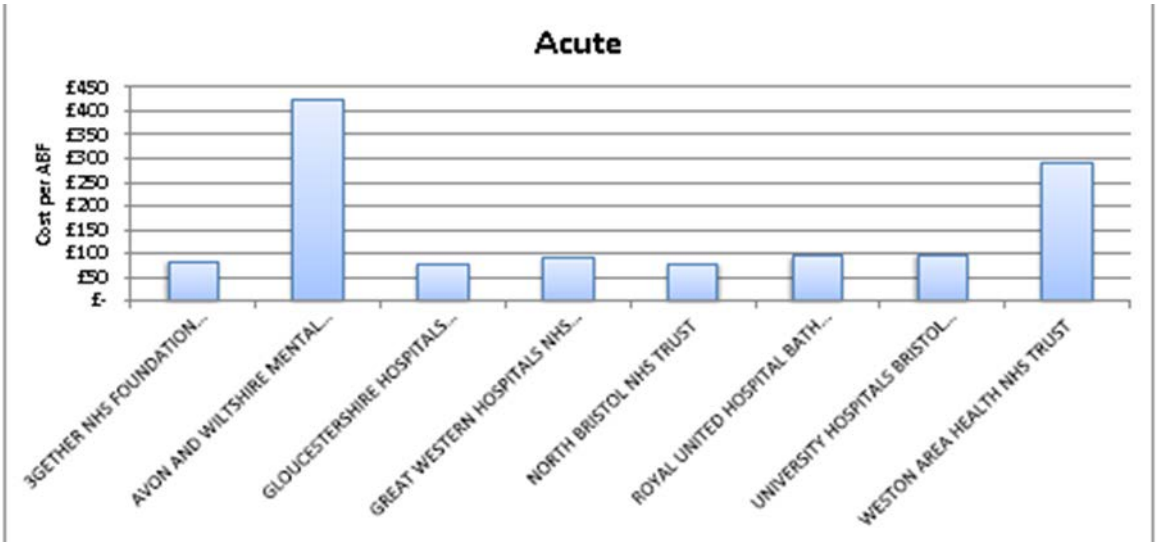
Research is funded from income streams that are independent of the other NHS budgets. The main source of income is from the WE CRN allocation of just over £1m in 2017/18. The NIHR utilises an activity based funding (ABF) model, based on the number of recruited subjects and weighted depending on the complexity of the study. However, this is not a direct "pass through" model where we receive a fixed amount per participant recruited. Although there is a protective "cap and collar" of 5% in the WE CRN allocations this has caused issues, with some trusts in the region being funded at higher rates per ABF point than others (see table 2 and figure 5 below).

Table 2. Cost per ABF point of WE CRN Partner Organisations

ABF Performance 2016/17 Q4 Data Cut

Organisation	2016/17 Q1 to 4 Allocation	ABF Activity	Cost per ABF
Acute			
3GETHER NHS FOUNDATION TRUST	£ 195,057	2,324	£ 83.95
AVON AND WILTSHIRE MENTAL HEALTH PARTNERSHIP NHS TRUST	£ 805,794	1,900	£ 424.10
GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST	£ 1,112,830	14,190	£ 78.43
GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST	£ 592,384	6,455	£ 91.77
NORTH BRISTOL NHS TRUST	£ 2,141,785	26,843	£ 79.79
ROYAL UNITED HOSPITAL BATH NHS FOUNDATION TRUST	£ 1,155,337	12,094	£ 95.53
UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST (DELIVERY)	£ 3,689,921	37,487	£ 98.43
WESTON AREA HEALTH NHS TRUST	£ 314,246	1,082	£ 290.56
Primary Care			
NHS BATH AND NORTH EAST SOMERSET CCG	£ 82,038	3,243	£ 25.30
NHS BRISTOL CCG	£ 366,062	8,445	£ 43.35
NHS GLOUCESTERSHIRE CCG	£ 100,545	2,026	£ 49.63
NHS NORTH SOMERSET CCG	£ 142,699	1,803	£ 79.17
NHS SOUTH GLOUCESTERSHIRE CCG	£ 76,209	2,791	£ 27.31
NHS SWINDON CCG	£ 30,877	339	£ 91.22
NHS WILTSHIRE CCG	£ 138,880	1,166	£ 119.11
Host			
UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST (HOST)	£ 1,867,754	N/A	N/A
	£ 12,812,418		

Figure 5. Comparison of acute Trusts' funding per ABF point for 2016-17



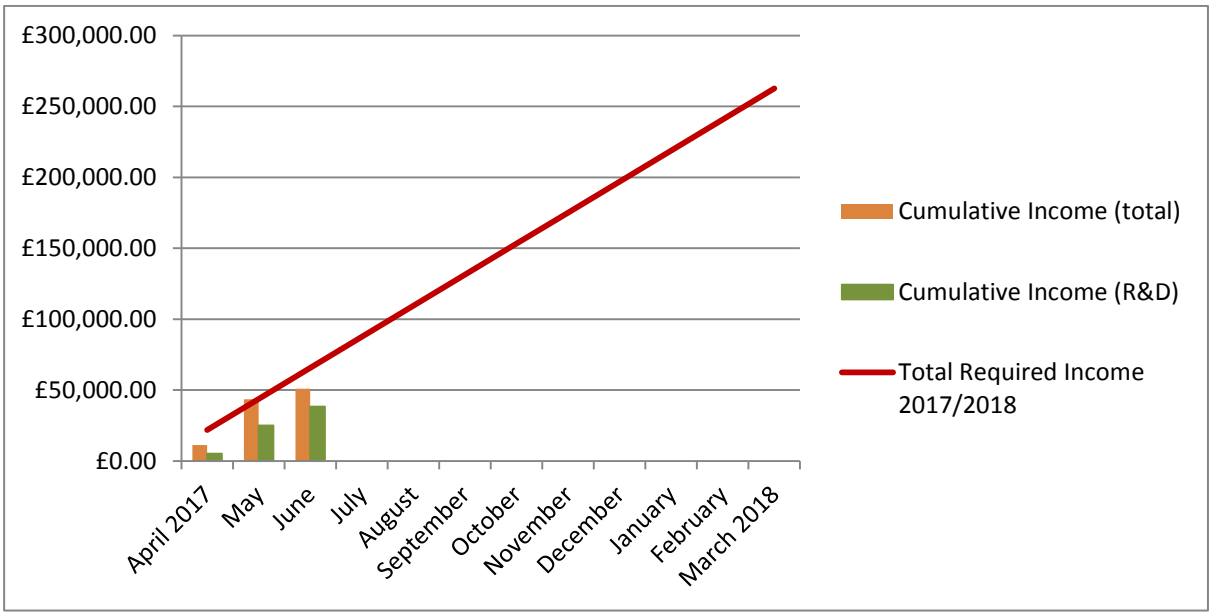
This source of funding does not generate surplus income for the trust and is non-recurring, which makes the annual planning cycle problematic. Small amounts of additional non-recurring funding come directly from the NIHR (around £30k per annum). We have clear accounting mechanisms for research income and expenditure streams with a single research income stream to allow for accurate accounting of income. All research budgets are presented to the Trust's Research and Innovation Forum including the budget from the account that holds income generated from research surpluses. A summary of R&D income and expenditure is in annex B.

Additional income is secured through delivery of commercial trials which are reimbursed according to a nationally agreed funding template. These studies are fully funded and accompanied by additional income which is used to support and further develop the infrastructure. We need to identify new and emerging areas for future studies by providing clinicians and their patients with information as soon as these opportunities are known. We currently have a commercial income target of £262.6K

which is required for the Research budget to break even. Although this seems quite daunting at times, we have achieved this in previous years.

The Trust's income target compared with actual income is shown in figure six, below.

Figure 6. R&D Income target



The Trust's research income has reduced in more recent years, mostly due to a falling allocation from the WE CRN and fewer locally awarded grants. To improve our efficiency we have just completed a full workforce review and re-structure of the research delivery team to ensure that we have the right staff doing the right job. This has resulted in an increase in administration staff, a reduction in some staff grades and posts lost through natural wastage.

It is acknowledged that in times of financial constraint research may be seen as a luxury which the Trust cannot afford but by ensuring that research is fully funded from the appropriate funding streams, patient care budgets are not compromised. In addition, research can be seen as a desirable activity for many clinicians, making job vacancies easier to fill as a result.

Research culture

The Trust has a number of well-established areas of research with large portfolios of research trial activity, in ophthalmology, stroke, oncology, renal, gastroenterology and emergency medicine; with other areas undertaking smaller number of studies. However, there are a number of high-prevalence disease areas where there is no culture of participating in research and staff who do not recognise research as core activity.

We also have active investigators in Biophotonics, Ophthalmology, Gastroenterology and Neurology conducting their own primary research which is funded from a variety of national and local sources. The recent signing of a statement of intent to work more closely with the University of Gloucestershire will also help to form productive grant writing partnerships to further this activity.

We offer novice researchers placements with established research teams so that they can learn some of the practical aspects of research including informed consent and good clinical practice. This includes providing opportunities for medical students to spend their elective placement in a research setting and work experience students from local schools considering careers in the NHS.

5. Reporting

The recruitment of patients to trials (activity) and the performance in initiating and delivering research against the NIHR targets is reported directly, every quarter, to the Trust Chief Executive by the NIHR Coordinating centre. In addition, the activity is reported to the Trust's Quality and Performance Committee and the Research and Innovation (R&I) Forum along with other clinical research meetings.

We would propose that a report be submitted each quarter to the Board to provide a summary of trial activity, finance and any additional noteworthy items.

6. Conclusion

Research is an important aspect of the day to day business of the NHS and provides the Trust, its patients and its staff with access to new drugs, devices and developments in the delivery of care that they would otherwise have to wait for.

We would value the opportunity to report key research messages directly to the board on a regular basis to improve the visibility of this important area of the Trust's work and receive feedback that might influence the strategic direction research might take.

Author: **Dr Julie Hapeshi, Associate Director of R&D**

Sponsor: **Dr Sally Pearson, Director Clinical Strategy**

July 2017

Annex A.

NIHR Portfolio Studies currently open and recruiting

Project Title	Principal Investigator	Directorate - GHNHSFT Only	Project type	Disease area	Project site date open to recruitment	Project site planned recruitment end date	Project site target participants
US-PEx: Understanding how frontline staff use patient experience data	Beer, Heather	Corporate	Non-commercial portfolio	Generic Relevance & Cross Cu	20/05/2016	31/01/2018	0
FAST-Forward	Bowen, Dr Jo	Diagnostic and Specialist	Non-commercial portfolio	Cancer	27/06/2012	01/03/2018	5
LungCAST - Does smoking status after a diagnosis of lung cancer affect outcomes?	Raghuran, Dr Ananthakrishnan	Diagnostic and Specialist	Non-commercial portfolio	Cancer	16/12/2013	31/03/2019	24
PROCLIPI	Benstead, Dr Kim	Diagnostic and Specialist	Non-commercial portfolio	Cancer	10/12/2015	01/06/2020	9
AML19	Rye, Dr Adam	Diagnostic and Specialist	Non-commercial portfolio	Cancer	06/01/2016	04/06/2021	25
RAIDER	Jenkins, Dr Peter	Diagnostic and Specialist	Non-commercial portfolio	Cancer	10/06/2016	01/03/2018	12
CANC - 3263 ADONIS	Farrugia, Dr David	Diagnostic and Specialist	Commercial portfolio	Cancer	31/08/2016	31/10/2017	8
DARS	Cook, Dr Audrey	Diagnostic and Specialist	Non-commercial portfolio	Cancer	03/10/2016	19/05/2018	8
UK Genetic Prostate Cancer Study	Cook, Dr Audrey	Diagnostic and Specialist	Non-commercial portfolio	Cancer	19/06/2009	31/12/2017	56
NIMRAD (NIMorazole/placebo plus RADiotherapy in head and neck cancer)	Grant, Dr Warren	Diagnostic and Specialist	Non-commercial portfolio	Cancer	13/02/2015	09/04/2018	13
STAR Standard vs Modified Drug Therapy in Renal Cancer	Farrugia, Dr David	Diagnostic and Specialist	Non-commercial portfolio	Cancer	25/02/2015	31/10/2017	16
Add-Aspirin Trial	Benstead, Dr Kim	Diagnostic and Specialist	Non-commercial portfolio	Cancer	05/10/2015	28/02/2021	30
CANC - 4705	Robson, Dr Philip	Diagnostic and Specialist	Commercial portfolio	Cancer	08/01/2016	30/09/2017	10
IMRiS	Candish, Dr Charlie	Diagnostic and Specialist	Non-commercial portfolio	Cancer	15/04/2016	04/03/2018	10
39039039STM4001 (RIVA / CASSINI)	Farrugia, Dr David	Diagnostic and Specialist	Commercial portfolio	Cancer	02/06/2016	30/12/2017	9
OvPSYCH 2	Cook, Dr Audrey	Diagnostic and Specialist	Non-commercial portfolio	Cancer	16/11/2016	30/06/2017	7
STAMPEDE	Bowen, Dr Jo	Diagnostic and Specialist	Non-commercial portfolio	Cancer	31/03/2011	31/12/2020	14
MDSBio	Lush, Dr Richard	Diagnostic and Specialist	Non-commercial portfolio	Cancer	23/07/2009	24/06/2021	32
Bridging the Age Gap in Breast Cancer	Vestey, Sarah	Diagnostic and Specialist	Non-commercial portfolio	Cancer	11/07/2013	30/06/2017	30
RAPPER	Bowen, Dr Jo	Diagnostic and Specialist	Non-commercial portfolio	Cancer	13/09/2011	31/08/2018	15
ICON8 and ICON8B - ICON8 Trial Programme	Cook, Dr Audrey	Diagnostic and Specialist	Non-commercial portfolio	Cancer	08/02/2013	07/01/2019	6
PANTS-E	Dunckley, Dr Paul	Medical	Non-commercial portfolio	Oral and Gastrointestinal	08/06/2015	30/06/2017	12
RESTART study	Dutta, Dr Dipankar	Medical	Non-commercial portfolio	Stroke	11/11/2013	31/05/2018	4
STOP-ACEi	Moriarty, Dr Jim	Medical	Non-commercial portfolio	Renal and Urogenital	03/06/2015	31/12/2017	20
STRO 3595 NAVIGATE ESUS	Dutta, Dr Dipankar	Medical	Commercial portfolio	Stroke	09/06/2015	30/09/2017	20
I--CARE - IBD Cancer and Serious Infections in Europe	Shaw, Dr Ian	Medical	Non-commercial portfolio	Oral and Gastrointestinal	07/10/2016	01/12/2017	22
TICH2	Dutta, Dr Dipankar	Medical	Non-commercial portfolio	Stroke	16/09/2013	30/09/2017	12
StartRight (Main Study)	Beames, Miss Sue	Medical	Non-commercial portfolio	Diabetes	28/11/2016	31/03/2018	30
Airway Management in cardiac arrest patients (AIRWAYS-2)	Benger, Prof Jonathan R	Medical	Non-commercial portfolio	Emergency Medicine	29/04/2015	01/07/2017	0
Novel use of TXA to reduce the need for nasal packing in epistaxis	De Weymarn, Dr Tanya	Medical	Non-commercial portfolio	Injuries & Emergencies	17/05/2017	31/07/2018	38
DRN 552 (Incident and high risk type 1 diabetes cohort - ADDRESS-2)	Abitha Kujambal, Dr VC	Medical	Non-commercial portfolio	Diabetes	07/01/2013	31/12/2017	10
RIGHT-2	Dutta, Dr Dipankar	Medical	Non-commercial portfolio	Stroke	24/06/2016	02/01/2018	4
HALT-IT	De Weymarn, Dr Tanya	Medical	Non-commercial portfolio	Injuries & Emergencies	01/11/2016	30/11/2017	24
LoTS2Care Feasibility Study	Ward, Mrs Deborah	Medical	Non-commercial portfolio	Stroke	17/02/2017	31/10/2017	20
Developing an activity pacing framework for chronic pain/fatigue	Ashworth, Polly	Surgical	Non-commercial portfolio	Musculoskeletal	05/06/2017	02/10/2017	
Care.Know.Do Pilot: Version 1	Boddana, Dr Preetham	Surgical	Commercial non-portfolio	Renal and Urogenital	02/01/2017	30/04/2017	30
OMASPECT	Mohamed, Mr Quresh	Surgical	Commercial portfolio	Eye		31/12/2017	6
FASBAT	Fletcher, Dr Emily	Surgical	Non-commercial portfolio	Eye	29/09/2016	09/04/2018	5
Burden of Illness in Geographic Atrophy in the UK, Germany and Ireland	Mohamed, Mr Quresh	Surgical	Commercial portfolio	Generic Relevance & Cross Cu	16/03/2017	01/07/2017	9
OPHT 4824	Scanlon, Prof Peter	Surgical	Commercial portfolio	Eye	14/07/2016	04/07/2017	25
Predict-CAT	Scanlon, Prof Peter	Surgical	Non-commercial portfolio	Eye	19/04/2016	31/03/2018	250
The CVI Project: Prevalence Study	Bishop, Miss Estelle	Surgical	Non-commercial portfolio	Eye	06/02/2017	01/07/2017	240
(FADES) Feeding and Autoimmunity in Down's syndrome Evaluation Study	Williams, Dr Georgina	Women and Children	Non-commercial portfolio	Paediatrics	01/05/2014	01/09/2017	7
DRN100 (TrialNet)	Matthai, Dr Susan	Women and Children	Non-commercial portfolio	Meds for Children	27/10/2010	01/09/2019	200
IMox study	Swingler, Rebecca	Women and Children	Non-commercial portfolio	Obstetrics & Gynaecology	21/05/2015	31/07/2018	360
VESPA Study	Easton, Karen	Women and Children	Non-commercial portfolio	Reproductive Health			150

Annex B

Research & Development Projected Income & Expenditure 2017/18

	£
Projected Expenditure	
Pay	1,822,253
Non Pay	54,479
Overheads to Trust (CLRN, RCF & RDS Contracts)	76,951
Overheads to Trust (Commercial studies) tbc	32,360
Total Projected Expenditure 2017/18	**1,986,043**
Projected Income:	
WoE CLRN Contract	1,043,367
Research Capability Allocation	31,912
Charity Allocation (LINC)	25,000
HTA Grant - BOSS Study	94,458
Bio photonic Grants	95,610
RDS Contract	62,945
GRSS SLA	45,250
GRSS SLA -GHNHSFT Contribution	25,999
Confirmed Income from open studies	269,318
Deferred Income carried forward form from 2016/17	29,523
Total Projected Income	**1,723,382**
R&D Commercial Income target	**262,661**

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

Report Title
ORGAN DONATION REPORT 2016/2017
Sponsor and Author(s)
Author: NHS Blood and Transplant: UK Transplant Registry Presenter: Dr Mark Haslam Sponsor: Dr Sean Elyan
Executive Summary

Purpose

To update the Board on the positive progress in respect of organ donation activities.

Key issues to note

- Management of the Donation after Brain Death (DBD) pathway achieved 100% for all stages to consent this year.
- The pathway involving patients as Donors after Circulatory Death (DCD) shows an increased referral rate year on year and is now up to 84%.
- Our specialist nurse involvement rate for family support in the DCD group was 100%

Conclusions

Consideration of organ donation is becoming integral to the management of End Of Life Care in the Emergency and Critical Care Departments. Challenges include targeting 100% referral rate and community engagement to improve consent rate.

Implications and Future Action Required

Continue to promote organ donation to the families of those patients who are potential donors and ensure staff are adequately trained and supported to have such conversations with families.

Recommendations
The Board is asked to receive this report as a source of assurance regarding the quality of organ donation activities in the Trust.
Impact Upon Strategic Objectives
N/A
Impact Upon Corporate Risks
N/A
Regulatory and/or Legal Implications
Organ donation activities are governed by NHS Blood and Transplant

Equality & Patient Impact
Organ donation has the potential to affect all patients and the progress described in this report benefits all patients. Some patient groups are at greater risk of organ failure.

Resource Implications			
Finance		Information Management & Technology	
Human Resources	X	Buildings	

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

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

Executive Summary
Actual and Potential Organ Donors
1 April 2016 - 31 March 2017

NHS Blood and Transplant

Gloucestershire Hospitals NHS Foundation Trust

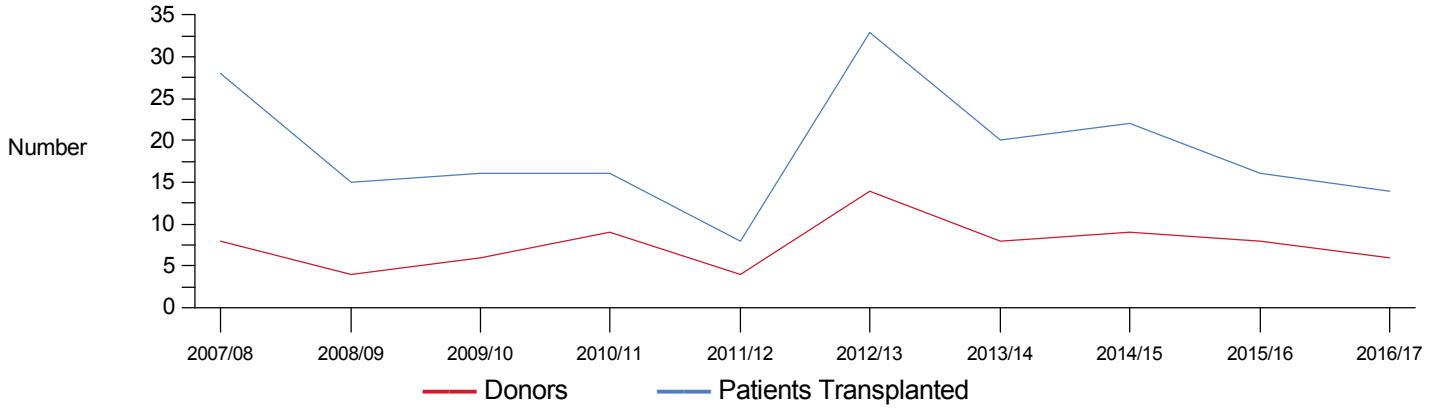
Donor outcomes

Between 1 April 2016 and 31 March 2017, your Trust had 6 deceased solid organ donors, resulting in 14 patients receiving a transplant. Further details are provided in the table and chart below. If you would like further information, please contact your local Specialist Nurse - Organ Donation (SN-OD).

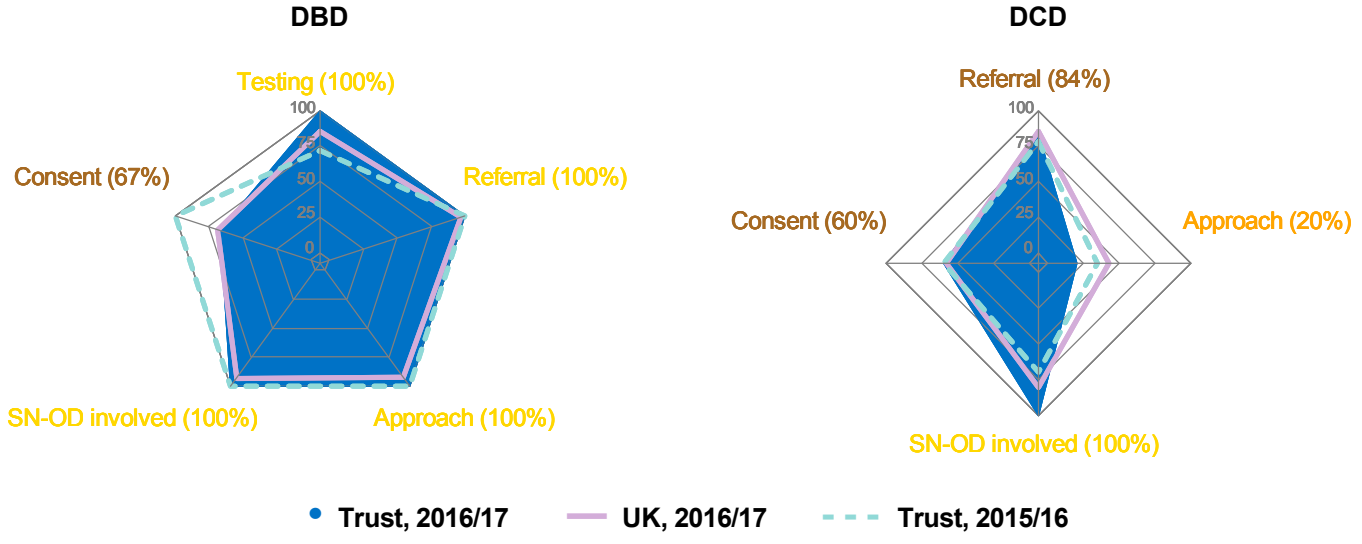
Donors, patients transplanted and organs per donor, 1 April 2016 - 31 March 2017 (1 April 2015 - 31 March 2016 for comparison)

	Number of donors		Number of patients transplanted		Average number of organs donated per donor Trust		UK	
Deceased donors	6	(8)	14	(16)	3.5	(3.1)	3.4	(3.4)

Number of donors and patients transplanted each year



Radar charts of key rates, 1 April 2016 to 31 March 2017



The blue shaded area represents your Trust's rates for 2016/17. The latest UK rates and your Trust's rates for the equivalent period in the previous year are superimposed for comparison. The fuller the blue shaded area the better. The colour of the rate label on each of the radar charts indicates the Trust performance as shown in the appropriate funnel plot (included in the detailed report) using the gold, silver, bronze, amber, and red (GoSBAR) scheme. Additionally, the funnel plots in the detailed report can be used to identify the maximum rates currently being achieved by Trusts with similar donor potential.

Key numbers and rates

There are nine measures on the Potential Donor Audit (PDA) which are most likely to affect the conversion of potential donors into actual donors. A comparison against funnel plot boundaries has been applied by highlighting the key rates for your Trust as gold, silver, bronze, amber, or red. Funnel plots can be found in the detailed report. Between 1 April 2016 and 31 March 2017, your Trust met a statistically acceptable level in 8 of these measures. Of the 10 potential DBD donors with suspected neurological death, 5 proceeded to donation and 5 did not proceed. Of the 25 eligible DCD donors, 1 proceeded to donation and 24 did not proceed. Further details are provided below. Caution should be applied when interpreting percentages based on small numbers.

	DBD					DCD				
		2016/17		2015/16			2016/17		2015/16	
	Target	Trust	UK	Trust	UK	Target	Trust	UK	Trust	UK
Patients meeting organ donation referral criteria[1]		10	1,775	7	1,747		37	6,204	54	6,500
Referred to SN-OD		10	1,728	7	1,684		31	5,308	42	5,402
Referral rate %		G *100%*	*97%*	*100%*	*96%*		B *84%*	*86%*	*78%*	*83%*
Neurological death tested		10	1,522	5	1,477					
Testing rate %		G *100%*	*86%*	*71%*	*85%*					
Eligible donors[2]		9	1,444	5	1,404		25	4,237	29	4,205
Family approached		9	1,329	5	1,296		5	1,815	10	1,942
Approach rate %		G *100%*	*92%*	*100%*	*92%*		A *20%*	*43%*	*34%*	*46%*
Family approached and SN-OD involved		9	1,236	5	1,180		5	1,460	7	1,511
% of approaches where SN-OD involved		G *100%*	*93%*	*100%*	*91%*		G *100%*	*80%*	*70%*	*78%*
Consent ascertained		6	917	5	891		3	1,055	6	1,113
Consent rate %	*72%*	B *67%*	*69%*	*100%*	*69%*	*68%*	B *60%*	*58%*	*60%*	*57%*
Expected consents based on ethnic mix		6		3			3		6	
Expected consent rate based on ethnic mix %		*70%*		*66%*			*61%*		*61%*	
Actual donors from each pathway		5	819	5	786		1	565	3	564
% of consented donors that became actual donors		*83%*	*89%*	*100%*	*88%*		*33%*	*54%*	*50%*	*51%*
Colour key - comparison with funnel plot confidence limits		G *Gold* A *Amber*		S *Silver* R *Red*			B *Bronze*			

[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

Note that from 1 April 2016 to 31 March 2017 there were 2 eligible DCD donors for whom consent for donation was ascertained who are not included in this section because they were either over 80 years of age or did not die in a unit participating in the PDA.

Further Information

- A detailed report for your Trust accompanies this Executive Summary, which also contains definitions of terms, abbreviations, table and figure descriptions, targets and tolerances, and details of the main changes made to the PDA on 1 April 2013.
- The latest Activity Report is available at https://www.organdonation.nhs.uk/supporting-my-decision/statistics-about-organ-donation/transplant-activity-report/
- The latest PDA Annual Report is available at http://www.odt.nhs.uk/odt/potential-donor-audit/
- Please refer any queries or requests for further information to your local Specialist Nurse - Organ Donation (SN-OD).

Source

NHS Blood and Transplant: UK Transplant Registry (UKTR), Potential Donor Audit (PDA) and Referral Record.
Issued May 2017 based on data reported at 8 May 2017.

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE COUNCIL OF GOVERNORS HELD IN THE LECTURE HALL, SANDFORD EDUCATION CENTRE, KEYNSHAM ROAD, CHELTENHAM ON MONDAY 19TH JUNE 2017 AT 5.30PM

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	Mr R Baker	Staff, Oncology
Governors/	Mr G Cave	Public, Tewkesbury
Constituency	Mr G Coughlin	Public, Gloucester City
	Mrs A Davies	Public, Cotswold
	Prof Chris Dunn	Public, Stroud
	Mrs P Eagle	Public, Stroud
	Ms C Graves	Healthwatch
	Mr R Graves	Non-Executive Director
	Mr C Greaves	Appointed, Clinical Commissioning Group
	Mrs J Hincks	Public, Cotswold
	Dr P Jackson	Public, Forest of Dean
	Mr N Johnson	Staff, Research
	Dr T Llewellyn	Staff, Medical and Dental
	Mr J Marstrand	Public, Cheltenham
	Mrs A Lewis	Public, Tewkesbury
	Mrs D Powell	Public, Gloucester City
	Mr R Randles	Staff, Nursing and Midwifery
	Mr A Thomas	Public, Cheltenham (Lead Governor)
Directors	Mr P Lachecki	Chair
	Dr C Feehily	Non-Executive Director
	Mr T Foster	Non-Executive Director
	Ms D Lee	Chief Executive
	Mr K Norton	Non-Executive Director
IN ATTENDANCE	Ms L Courtier	Corporate Governance Administrator
	Mr Z Pandor	Chief Information Officer
	Mr S Webster	Finance Director
APOLOGIES	Ms T Barber	Non-Executive Director
PRESS/PUBLIC	None	

The Chair welcomed members of the Council and thanked Governors for attending.

036/17 DECLARATIONS OF INTEREST

There were none.

037/17 MINUTES OF THE MEETING HELD ON 22ND FEBRUARY 2017

Minor amendments to be made to p.4. Otherwise minute agreed as correct and accurate reflection of the meeting.

038/17 MINUTES OF THE MEETING HELD ON 5TH APRIL 2017

Minor amendments to be made to p.2. Otherwise minute agreed as

correct and accurate reflection of the meeting.

039/17 MATTERS ARISING

005/17 VACANCIES ON THE COUNCIL OF GOVERNORS: The Chief Executive reported that arrangements had been made with the 2gether Trust for their Trust Secretary to act as Returning Officer for the staff governor elections with the administration being undertaken within our Trust. Details of the vacancies were published on 2 April 2017 with the closing date for nominations on 24 April 2017. If there were more nominations than vacancies then an election will be held.

The Lead Governor referred to the Healthwatch vacancy on the Council of Governors. He said that it was important for the appointed Governor to be representative of patients and Healthwatch fulfilled this requirement. There was a consensus that the Wiltshire Healthwatch (the successor body covering Gloucestershire) should be invited to appoint a Governor when the new structure for Gloucestershire became clearer. The Chair said that he would purse this with Healthwatch.

RESOLVED – This action is now complete and Healthwatch is represented through their Chair, Chris Graves until final arrangements are determined.

026/17 MATTERS ARISING

Rhona Macdonald, Non-Executive Director: – The Chair said that Rhona Macdonald had stepped in at short notice in the autumn of 2016 to help our Trust as an Interim Non-Executive Director. Her appointment had been extended for three months from February 2017. Rhona has enquired whether her appointment was required for the third and final month, being April 2017. The Chair had discussed this with Rhona and given the Non-Executive Director requirements in that month and her existing commitments Rhona has resigned as an Interim Non-Executive Director from 31 March 2017. The Chair was very pleased to be able to place on record her valuable contribution to our Trust which he would convey to her.

RESOLVED – This action is now complete.

NED “6” recruitment: – This is discussed further in the agenda under item 040/17.

RESOLVED – This action is now complete.

029/17 GOVERNORS VISITS & TRAINING UPDATE

Dates were set out for Governors to visit both Cheltenham and Gloucestershire Royal Hospital on two occasions during the year. The visits had been arranged by the Nursing Director and Governors were invited to contact her with areas which they would like to see. Each of the four visits would accommodate a maximum of eight Governors, in two groups of four. The Lead Governor said that priority would be given to the newer Governors. The Lead Governor was invited to liaise with the Nursing Director before the visits took place to determine their purpose.

RESOLVED – This action is now complete.

The Trust Secretary was invited to ensure that all Governors had access to the e-learning modules by mid-April 2017.

RESOLVED – This action is now complete.

030/17 GOVERNORS LOG / CONTACT YOUR GOVERNOR

Mrs Davies said that the meeting referred to in her question on trolley waits had been cancelled three times. The Chief Executive undertook to ascertain the reasons for the cancellation.

RESOLVED – This action is now complete. Thanks to Ms D Lee as this was very interesting and helpful.

Mr Marstrand asked that the second "Governor" column be deleted as it was superfluous. This was agreed.

ACTION: Unsure if this has been actioned. To be checked by the administrator and amended accordingly. **LC**

The Lead Governor said that he had made some suggested changes to the Standard Operating procedure and the Trust Secretary was invited to update and circulate by mid-April 2017.

RESOLVED – This action is now complete.

040/17 RATIFICATION OF NED APPOINTMENT 6

The Chair asked the Council for ratification of the new Non-Executive appointment (Alison Moon). The Council approved the appointment. The Chair confirmed the likely start date to be September.

The Lead Governor welcomed this appointment.

041/18 CHAIRS UPDATE

- The Chair reported that much of his time is spent preparing for Board meetings and sub-committees. He feels this is important to help gain insight into committees and monitor their effectiveness.
- The Chair also reported that he has recently spent a lot of time on recruitment of executives, non-executives and consultants.
- The governor groups are bedding in and impacting positively on how the Council works; he felt the training sessions are really showing a benefit.
- The Chair continues to attend Health & Wellbeing, HCOSC and STP meetings. He is also developing links with charities that support the Trust.
- The Chair has reported that he has been enjoying the visits around the hospital and one of the highlights has been a talk on radiotherapy equipment. It's clear that the team put patients experiences at the heart of what they do. In addition to this looking at staff and what they are doing to develop and progress.
- The Lead Governor has highlighted the Chairs Twitter page as

discussed in their pre-meeting. This contains information on fundraising.

042/17 REPORT OF THE CHIEF EXECUTIVE

The Chief Executive presented the report to the Committee to explain that the operational context reflects more typical seasonal patterns which has been a welcome progression however, periods of peak activity continue to be experienced – particularly in the early part of each week and during these times patient experience is adversely impacted with A&E waits and cancelled operations still being a feature of some patients care. The Executive team and staff across the Trust remain very focussed on this priority both in respect of immediate steps and the more strategic solutions to the issues that create these conditions. Since the last report, there have been signs of improvement, notably in the days following the May Bank Holiday period – a typically challenging period – the Trust achieved in excess of 90% performance against the 4 hour A&E standard at both sites.

During the course of the discussion, the following were the points raised:-

- It has been a challenging weekend operationally and is still volatile. This is due to service demand and gaps in staffing rotas.
- We are still being monitored closely by the regulator which is not an ideal place to be. At the next Governors Quality & Performance Committee will be focusing on performance to address some of these issues.
- Since the A&E Improvement Director left us last year there has been a slip in performance suggesting the changes she instigated were not fully embedded. On the positive there is a new team in place and will be working hard to turn this around.
- There will be a ballot for the Staff Governor place for Allied Professionals / Healthcare Scientist. We are awaiting the outcome.
- A date has been decided for publication of the CQC feedback. This will be in early July.
- Discussions on when a publication of the Financial Governance Review Report are ongoing but likely to be mid to late July.
- Director of Quality & Chief Nurse interviews take place on 20th June and the Director of People and OD will take place on 6th July
- The One You Pledge campaign is progressing positively. We are been seen by others as leading the way and drawing attention to the work we are doing on staff health and wellbeing.
- Congratulation has been given to Mr Foster on his current fundraising in giving up cheese. He has so far raised an impressive £1500 for the oncology centre.
- In response to a question, the CEO advised that she believes we have a good relationship with the regulator and are currently working more closely with them so they can provide us with support. We are however at risk of further regulatory intervention if A&E does not improve significantly.
- The Chief Executive has advised the Committee that we are now on the right pathway for recovery in relation to TrakCare but we are not yet at the right scale or pace. There has however been a drastic change of loss in M1 (£2m) to M2 where we

have seen a much smaller loss of £200,000. At present there is no time scale for improvement as a timed recovery plan is not yet completed pending Cymbios arrival. This should help to show turnaround into recovery and then business as usual. Looking forward to the next phase (1.5) lessons have been learnt.

- Mrs Powell reported a good experience when attending A & E recently and feels there has been a vast improvement. Staff were able to keep patients safe during an altercation with an aggressive patient.

RESOLVED: That the report be noted.

043/17 BUSINESS CONTINUITY (CYBERSECURITY & IT IN THE TRUST

The Chief Information Officer provided Governors with a presentation on information regarding Cybersecurity and Business Continuity in light of recent events of cyber-attacks.

During the course of the presentation the following were the points raised:-

- We in the county were very fortunate not to have been affected by the recent cyber-attack as we had already downloaded software which protected us. The Governors were pleased that we have such professional systems in place.
- The Chief Information Officer advised that are systems are routinely monitored and that they ask an outside team to test the systems by trying to hack our computers.
- It was raised that we could be heavily fined for breaking the data protection act as per a recent occurrence involving the County Council. The Chief Information Officer has advised this does still happen within the Trust however we have good policies and procedures in place that ensure this is kept to a minimum with no significant impact. CQC always monitor this during their visits.

RESOLVED: That the presentation be noted.

044/17 GOVERNORS LOG / CONTACT YOUR GOVERNOR

The Chief Executive provided Governors with a brief update. The following points were discussed:

- A copy of the log was missing from the papers. This will need to be included at the next meeting. **LC**
- Emails, including the questions and answers, when the log is updated are a real improvement.
- Unfortunately there are still formatting issues however this will not be addressed fully until the new web page is up and running.
- The Committee feel that the process could still be slicker however improvements have been made.

045/16 UPDATE FROM GOVERNORS ON MEMBER ENGAGEMENT

The Chair of the Committee reported an interesting and positive

session last week. No further comment from Governors was made.

046/17 GOVERNORS TRAINING & DEVELOPMENT FEEDBACK

The Chair has reported that these sessions have been well attended. The Committee members have reported that these have been fantastic. They could see all the effort that the directors have put in and described it as inspiring.

Overall the Governors have been really impressed with these sessions. The Chief Executive has advised there will be further sessions arranged post October 2017 for new Governors and feedback will be collected to see if any improvements can be made.

047/17 COUNCIL OF GOVERNORS VACANCIES / ELECTIONS

The Chief Executive has presented the report to the Committee to advise that the Council has ten governor vacancies looming which need to be filled as soon as possible in order to limit the workload impact on other governors associated with prolonged vacancies and the effectiveness of the governing body more generally, including the visibility and responsiveness to members in the vacant constituencies.

Progress has been made in respect of the three staff governor vacancies with recent appointments into the two non-clinical constituents and elections underway for the Allied Health Professional vacancy.

There are currently two vacancies in public governor constituencies, a further four vacancies later this year and one public constituency (out of area) vacancy.

The aim is to run the election process over the coming months with a view to being able to confirm governors in post at the October Annual Members Meeting (AMM). Due to financial constraints, the election will be run by the Trust Secretariat supported by a Returning Officer from outside the Trust, in keeping with the required approach.

During the course of the discussion the following were the points raised:-

- The Committee were unsure if Mr Llewelyn is due for renewal. This will need to be confirmed. Post meeting note – renewal is due. **DL**
- We are currently well in on staff appointments and we will need to decide when to do this.
- Dr Jackson will be resigning as of today. This is discussed further under item 050/17 Any other business.
- Natashia Judge has had conversations with the external officer to discuss the details. The Chief Executive is due to meet with Natashia to discuss. Post meeting note – non-staff governor elections will need to be undertaken by an external party and discussion are now in hand with a third party previously used. **DL**

RESOLVED: That the report be noted.

048/17 AUDITOR APPOINTMENT

Procurement process now in hand to mirror previous approach.

Mr Thomas would like to be Lead Governor for this and will be creating a working group soon and said he would call for volunteers from the Council to support him.

049/17 REPORTS FROM BOARD COMMITTEES

The Chief Executive has asked that the main points are highlighted to allow time for questions to get reassurance from the Board.

Finance Committee – 26th April 2017 and 24th May 2017 – The key points noted where as follows:

- Year end delivered to plan and a smooth process for accounts production was noted.
- Income for Month 1 is significantly reduced due to reporting difficulties post TrakCare but negotiations to offset the impact of this are in hand.
- The Cost Improvement Programme total was £34.7m (7%) which is a huge task and is the major risk to the 2017/18 plan.

The following points were raised:

- The Theatre Management proposal was explained in summary but the CEO offered to provide a dedicated briefing at a future meeting if helpful.
- In response to a question about establish a subsidiary company which would employ staff, the Chief Executive has advised this is not a significant transaction although will be treated as such in respect of governor involvement.

Quality and Performance Committee – 27th April 2017 and 25th May 2017 - The key points noted where as follows:

- Dr Feehily has expressed an enjoyment of the Divisional Attendance Report and presentation received at Quality & Performance Committee. This provides a good opportunity to meet colleagues and have conversations around any risks within the organisation.
- Ramifications of TrakCare and the impact on the Trust have been routinely discussed.
- Serious Untoward Incidents have been discussed and it has been highlighted what these are and what is being imbedded across the Trust to ensure these are not reoccurring.

The following points were raised:

- Performance targets are not being met and this is a huge concern and thus focus for Q&P.
- The Lead Governor has highlighted that there was missing information in relation to morality within the report. This will be updated for next time.
- Due to TrakCare issues the latest mortality data is inaccurate and this cannot be validated until work has been done around TrakCare.

Workforce Committee – 6th April 2017 and 9th June 2017 – The key points noted were:

- IR35 Risk – This was being managed with minimal impact of safe staffing. The CEO said they had paid some locum staff more to ensure retention in a few key specialities but staff were being paid within the caps set by NHS Improvement.
- Brexit impact is an issue to be monitored. Administrator to update the Governors Log with recent question in relation to this and EU staff. **LC**

Audit and Assurance Committee – 23rd May 2017 – The key points noted were:

- The Governors have been very impressed with the work being done by the Finance Team and have allowed a solid financial base for the new year.
- There has been an increase in numbers of items on the Audit Recommendations Tracker not being followed up. This will now be reviewed regularly and the Chair of Audit is expecting to see a significant reduction at the next Committee.

050/17 ANY OTHER BUSINESS

-**Farewell Dr Jackson & Ms Harley** – The Committee members have thanked both members for all their hard work. As valued members of the Committee they will be missed.

Dr Jackson has advised he has truly enjoyed his time here and is sad to leave but his personal circumstances mean that he must.

051/17 DATE OF NEXT MEETING

The next meeting of the Council of Governors will be now held in the Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital **on Wednesday 2nd August 2017** commencing at 5.30pm.

052/17 PUBLIC BODIES (ADMISSION TO MEETINGS ACT) 1960

RESOLVED:- That under the provisions of Section 1(2) of the Public Bodes (Admission to Meetings Act) 1960, the public be excluded from the remainder of the meeting on the grounds that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted.
The meeting ended at 6.50 pm.

Chair