Gloucestershire Hospitals NHS Foundation Trust

PUBLIC BOARD AGENDA

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

Date/Time: Thursday 12 March 2020 at 12:30

Location: Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital

	Agenda Item	Lead	Purpose	Time	Paper
	Welcome and Apologies	Chair		12:30	
1.	Declarations of Interest	Chair		12:31	
2.	Patient Story	Katie Parker-Roberts	Information	12:32	
3.	Minutes of the Previous Meeting	Chair	Approval	13:00	YES
4.	Matters Arising	Chair	Approval	13:05	YES
5.	Chief Executive Officer's Report	Deborah Lee	Information	13:10	YES
6.	Trust Risk Register	Emma Wood	Assurance	13:20	YES
	QUALITY AND PERFORMANCE				
7.	Quality and Performance Report	Steve Hams Mark Pietroni	Assurance	13:30	YES
8.	Assurance Report of the Chair of the Quality and Performance Committee	Alison Moon	Assurance	13:40	YES
	FINANCE AND DIGITAL				
9.	Finance Report	Karen Johnson	Assurance	13:45	YES
10.	Digital Report	Mark Hutchinson	Assurance	13:55	YES
11.	Assurance Report of the Chair of the Finance and Digital Committee	Rob Graves	Assurance	14:05	YES
	BREAK			14:10	
	PEOPLE AND ORGANISATIONAL DEVELOPMENT				
12.	People and OD Report	Emma Wood	Assurance	14:20	YES
13.	Assurance Report of the Chair of the People and Organisational Development (OD) Committee	Balvinder Heran	Assurance	14:30	YES

	ADDITIONAL PAPERS				
14.	Gloucestershire Cancer Institute – One year on	Felicity Taylor-Drewe / James Curtis	**Information**	14:40	YES
	QUESTIONS				
15.	A period of ten minutes will be available for Governors to ask questions.			14:55	
16.	A period of ten minutes will be available for members of staff to ask questions.			15:05	
17.	A period of ten minutes will be available for members of the public to ask questions submitted in accordance with the Board's procedure.			15:15	
	STANDING ITEMS				
18.	New Risks Identified	Chair		15:25	
19.	Items for the Next Meeting	Chair			
20.	Any Other Business	Chair			
	CLOSE			15:30	

Date of the next meeting: Thursday 9 April 2020 in the Lecture Hall, Sandford Education Centre, Cheltenham General Hospital

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

Board Members

Peter Lachecki, Chair

Non-Executive Directors

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

Associate Non-Executive Director

Marie-Annick Gournet

Executive Directors

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

Gloucestershire Hospitals NHS
NHS Foundation Trust

MINUTES OF THE MEETING OF THE TRUST BOARD HELD IN THE LECTURE HALL, REDWOOD EDUCATION CENTRE, GLOUCESTERSHIRE ROYAL HOSPITAL ON THURSDAY 13 FEBRUARY 2010 AT 12:30

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

PRESENT:

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

IN ATTENDANCE:

Suzie Cro	SC	Deputy Director of Quality (Item 20/20)
Andy Foo	AF	Trust Lead for the ReSPECT process and Consultant in Intensive Care Medicine and Anaesthetics (Item 20/20)
Sim Foreman	SF	Trust Secretary
Marie-Annick Gournet	MAG	Associate Non-Executive Director
Emma Husbands	EH	Gloucestershire Clinical Commissioning Group (CCG) Lead for ReSPECT and Community Palliative Care Consultant (Item 20/20)
Simon Pirie	SP	Guardian for Safe Working (Item 3420)

MEMBERS OF THE PUBLIC/PRESS/STAFF/GOVERNORS:

Hilary Bowen	HB	Public Governor, Forest of Dean
Anne Davies	AD	Public Governor, Cotswolds
Craig MacFarlane	CM	Head of Communications

One member of staff and four members of the public attended.

APOLOGIES:

Deborah Lee	DL	Chief Executive Officer
Bilal Lala	BL	Associate Non-Executive Director

The Chair welcomed all to the meeting and reported that Bilal Lala had decided to step down from his role as an Associate Non-Executive Director (ANED) due to lack of time to fulfil the role and this would be his last day. The Board wished him success in his future endeavours.

ACTION

19/20 DECLARATIONS OF INTEREST

There were none.

20/20 PATIENT STORY

MP introduced AF as the Trust's ReSPECT lead and EH, CCG lead for ReSPECT and Community Palliative Care Consultant.

AF explained that ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) was a national campaign highlighting the importance of patient choice. The campaign (and form) was more than just whether to attempt CPR on a patient, it allowed patients to state how they wished to live and how they wished to die. The completed form followed the patient and facilitated communication between the acute hospital and community care settings. The Board NOTED that there had been good take-up and positive enthusiasm for ReSPECT within the Trust and the next step was to move to public engagement. Healthcare workers had been engaged first so they were prepared when the community got involved.

EW questioned who held the ultimate decision making responsibility and cautioned that circumstances could arise where medical advice might conflict with the patient's preferences. AF explained that the ultimate decision rested with clinical teams but the change resulting from ReSPECT was a shift to explaining and sharing information on treatments. EH added that ReSPECT aimed to empower patients and not all the conversations on care and treatment were negative.

RG asked if the form would be digitalised and included within the Electronic Patient Record (EPR) and AF advised there were plans for this, being led by Coventry, but until all Trusts had the same system a paper form was needed (and had allowed the launch of the campaign). EH added that while ReSPECT was included in a system wide project "Joining Up Your Information" (JUYI) expected to complete within 12 months. However to avoid the patients losing ownership over the document there would always be a physical form which they could keep.

CF asked how conversations about care and treatment through the patient experience were captured and recorded. EH advised that training to raise awareness was taking place to ensure that appropriate follow-up happened.

The Board recognised the huge benefits for staff due to the removal of ambiguity. It was confirmed that the form did not cover organ donation but it continued to evolve (current version v75).

In response to a question on the appropriateness of engagement with BME (Black and Minority Ethnic) groups, AF explained that the national work had been led by the Resuscitation Council UK and had included minority groups within their panel of 30.

RESOLVED: The Board NOTED the update on ReSPECT and commended the positive uptake and benefits for patients and staff from this national campaign.

SC, SF and EH left the meeting at 13:05.

21/20 MINUTES OF THE PREVIOUS MEETING

RESOLVED: The minutes of the meeting held on Thursday 9 January 2020 were APPROVED as a true and accurate record for signature by the Chair.

22/20 MATTERS ARISING

In relation to Matter 254/19 it was reported that the Governors' Quality Group has discussed the Governors' Quality Indicator on 10 February 2020 with formal approval of the selected indicator to lie with the Council of Governors meeting on 18 February. The Board agreed the matter could be CLOSED.

RESOLVED: The Board APPROVED all matters arising as CLOSED.

23/20 CHIEF EXECUTIVE OFFICER'S REPORT

EW presented the report and updated on planning and preparedness related activities with NHS England to provide assurance on the Trust's ability to respond to Coronavirus.

The Electronic Patient Record (EPR) had been launched at Cheltenham General Hospital (CGH) the previous day with a great deal of positivity and excitement amongst staff who had really embraced the technology. The Board expressed thanks to MH and the team for their work on this.

The 2020 Staff Hub had been launched in May 2019 and had been welcomed by staff. Following its success, work was underway to start a peer support network and staff had been invited to become peer supports to other staff members. 65 applicants from a range of different posts across the Trust had applied, with 43 expected to be trained in skills such as mental health first aid. Feedback would also be provided to unsuccessful applicants to acknowledge their interest and suggest some self-development opportunities if they wished to reapply in future. It was confirmed that the Hub was managed internally and that not many providers had similar provision although RG suggested there would be benefit in doing some comparison or benchmarking if possible.

Fit For the Future (FFtF) developments included the Citizens' Jury and Solutions' Appraisal workshop which were both noted to be well attended.

It was confirmed that SL had tendered his resignation and would leave in six months and the Board NOTED his contribution over the past two years, especially with regards to FFtF.

It was confirmed that a balanced system plan had been submitted and approved for the next year.

Additional funding had been secured to support an increase in compliance with Continuity of Care standards for pregnant women. This would enable to the Trust to achieve 51% compliance by 2021 as opposed to 2024.

Linked to the report, aware that there was a pilot underway involving a new system of working for porters, the Chair asked when this was to be reviewed. The response from RdC was that this would be at the Estates and Facilities Committee (EFC) as part of the Gloucestershire Managed Services (GMS) business plan.

CF asked whether there had been any formal opportunities to revisit the Winter Plan to identify any learning opportunities or reassess the patient experience for the current or future periods. RdC confirmed the plan was still being used to deal with winter pressures/coronavirus but that a formal system debrief and review was planned for 18 March 2020.

RESOLVED: The Board NOTED the report.

24/20 TRUST RISK REGISTER

EW presented the risk register and confirmed no risks had been closed and no risks had been changed, but seven risks had been added:

MN queried why some of these risks were being added to the register now, as they were not new, had undergone divisional review and all possible mitigations were in place. It was explained that some risks had a consequence score of five for safety which according to the Risk Management Policy would result in inclusion onto the Trust register. More detail for addition would be provided if possible, mindful of the reporting limitations of the current Datix system as described in risk C3084P&OD. It was not clear whether these risks should have been brought to Board and although there was some discussion relating to them, it was agreed that Execs would review whether the full process had been followed in bringing these risks to Board.

AM welcomed that “forming risks” from the Quality and Performance Committee (QPC) were on the register and challenged whether a replacement for Datix should be a system solution. EW advised the cloud based version being considered was commonly used and work was underway with MH’s team to assess whether there were other alternatives. In the meantime work continued to improve ways to extract data.

RdC updated on the ambient temperature risks and advised that she was keeping close to the discussions within the Division. RdC also advised that the most expensive option had been proposed and the team had been asked to look at this again.

AM queried the risk related to adolescents’ safety (C1850NSafe) and if it was due to a lack of tier four beds. SH confirmed that it was and that this was regional issue. SH agreed to review the narrative for this risk to clarify the position. SH

AM queried the process for decision making related to funding for intolerable risks. It was confirmed that the Executive applied a risk based approach with SL acting as an “independent facilitator” which was discussed at the Directors’ Operational Group and Trust Leadership Team.

There were more requests for funding than funds available and the Board would see the output of discussion reflected in the TLT minutes and as part of the budget setting process at the Finance and Digital Committee (FDC). In response to a question from AM, RdC advised parallel conversations were taking place as part of the executive review process. The Board would also look to refresh its risk appetite.

RESOLVED: The Board NOTED the report and APPROVED the addition of the seven risks.

25/20 ASSURANCE REPORT OF THE CHAIR OF THE QUALITY AND PERORMANCE COMMITTEE

AM updated that the December 2019 meeting had considered a "deep dive" into ophthalmology (with a follow-up due in February 2020, a systematic approach to clinical harm reviews (follow up due in in April 2020) and the Learning from Deaths and LeDeR report.

The Committee had also requested the patient experience report consider the question "so what does that mean for us" to provide greater assurance on actions and follow-up. The Committee were reviewing data in the Quality and Performance report and how the Medical Division were coping with demand. SH updated that meetings with DL, divisional leaders and the unscheduled care team colleagues had taken place to discuss the serious concerns, learning and actions from Debbie's patient story in November 2019.

The January Committee had considered safeguarding, in particular the learning from case reviews, and commended the improvement in leadership in this area. There was also an update on Getting It Right First Time (GIRFT) and discussion on what happens next where performance is "best in class". The Continuity of Carer action plan was agreed on behalf on the Board. The ICS update covered different ways of working.

RTT performance was noted to be stable although there were challenges in emergency care.

The Chair also updated on a great presentation on cancer services at the governors' quality meeting.

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

26/20 QUALITY AND PERFORMANCE REPORT

RdC presented the report and recognised the performance of cancer services with all specialities meeting the Two Week Wait for the first time in seven years. There had also been progress against the 62 day target.
A new 28 day faster diagnostic target would come into force from April 2020 and present some logistical challenges and although the Trust was expected to achieve above 70% performance with shadow reporting tracking at 81%. There is no guidance on the National target that will be set for 28 days.

SH highlighted the SPC charts had shown some gradual improvement to dementia screening and a continued focus on C. Difficile (with December's performance better).

RdC summarised that, notwithstanding emergency department challenges, the report showed many areas had made what appeared to be sustainable improvements and that Specialities were using the report and the SPC charts to undertake reflective reviews. It was confirmed the SPC charts would become integrated into the report and both types of reports would continue to be presented for another month.

RESOLVED: The Board RECEIVED the report as assurance that the Executive team and divisions fully understood the current levels of non-delivery against performance standards and had action plans to improve this position.

27/20 ASSURANCE REPORT OF THE CHAIR OF THE FINANCE AND DIGITAL COMMITTEE

RG updated from the January 2020 Finance and Digital Committee (FDC) meeting and confirmed the revised pattern of the meeting was working well. The prime focus of the digital agenda had been the launch of EPR, the plans to extend roll out in CGH and for electronic observations (e-obs). All four of MH's deputies had presented and provided assurance to the Committee, which had been impressed by the calibre and responses.

With regard to Finance, RG reported that the end of Month 9 (M9) showed a slight positive variation from the control total, although this was diminishing as year-end approached and it looked likely that the Quarter 4 (Q4) control total would also be delivered, although there was still a lot of work to do.

Cost Improvement Programme (CIP) continued to be challenging and the Trust was approximately £7m away from the target position although stringent efforts were being made to address this.

The cash balance was currently high with funds received for imminent investments to unfold.

RG advised that the previous questions from the Committee on the reports had been addressed by the Finance Team through the provision of analysis for assurance.

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

28/20 FINANCE REPORT

KJ presented the report and highlighted that the £7.7m variation from the CIP target was in addition to a £5.5m variation on non-recurrent CIP, giving a £13.2m variation for the start of 2020/21. KJ confirmed the starting positon would be restated at the next FDC.

KJ continued that £4.7m of Q3 FRF (Financial Recovery Fund) had been received as cash into the system and that regulators were

monitoring the Trust to deliver its control total. KJ flagged that next year would be a huge challenge for the Trust.

It was reported that M10 performance appeared to be on track and the forecast outturn stated the control total would be likely be achieved.

The Trust had been asked to submit capital bids for the current financial year and KJ had been working with RdC and the Executive team on these. A decision on the outcome was expected in the next week. KJ reported that the Trust was £2m behind plan on capital spending and there was a risk of losing this if not spent so work was underway within divisions to identify projects and schemes that could be brought forward. KJ was as confident as possible that the money would be spent.

RESOLVED: The Board NOTED the report.

29/20 DIGITAL REPORT

MH presented the Digital Report which outlined the progress and status of a number of enabling projects. There was a need for some challenging conversations to ensure all of these could be funded but they were all currently on track to be delivered.

The QPC had discussed the opportunities to better identify patients whose condition was deteriorating through e-obs capturing metrics digitally. MH advised that subject to the roll-out of EPR in CGH, the plan for e-obs launch had been brought forward to March 2020 (from July 2020). The implementation would be a “switch on” rather than a phased launch and MH flagged this might identify unmet need that would require clinical prioritisation. AM welcomed this, as it would minimise the risk of things going wrong when recording metrics and SH advised that evidence suggested an improvement in the level of accuracy of reporting from 56% (paper) to 96% (electronic).

The Chair challenged whether this was allowing the Trust to do something really well which it should be doing anyway or was enabling an improvement in the level of care. MP replied that the latter was correct to an extent at ward level, and that the new system would allow information to be accessed from any computer with clinicians able to intervene appropriately, which would bring a step change in improvements for the acute care response team in particular. SH added that, in time, better capturing blood results would enable acute team to be much more proactive in linking with other teams i.e. renal to prevent patients deteriorating.

MH reinforced that using e-obs to link documents and results in one place would not deskill staff but empower them to interject. Additional efficiencies would be gained from removing the need for telephone calls in the patient’s care pathway.

CF queried the RED flagged scheme in the report related to transfers of care and the likely impact of this. MH explained this related to a project called “Docman” that ensured important information i.e. discharge summaries were produced and shared electronically. This was not currently joined up and flagged as red because it was being

done alongside the other projects and was therefore likely to take slightly longer than planned.

RESOLVED: The Board NOTED the report.

30/20 DIGITAL STRATEGY

MH advised the Digital Strategy had been reviewed by the FDC in October and was presented for formal Board approval. The Strategy focused on digitally enabled best care for all and by continuing to invest and develop digital capabilities over the next five years, the Trust would become a HIMSS (Healthcare Information and Management Systems Society) level six hospital that consistently delivered and was able to demonstrate it had consistently safe, reliable and effective care.

KJ advised the strategy was ambitious and whilst it would deliver efficiencies and improvements in care, this must be done in an affordable way. EW explained that the Financial Strategy would be presented for approval after all the other enabling strategies to enable robust costing and reflection of priorities.

AM commended the document and felt it was easy to read, but challenged the ambitions stated in years three to five as some of the items outlined were needed now. MH accepted the challenge and advised there had been and would continue to be considerable acceleration of the work over the next year to progress the strategy.

EWa asked where the Trust would be positioned if HIMSS level six could be achieved in five years. MH stated he would be interested to see current levels of other Trusts but would expect the Trust to be in the upper quartile if level six was attained.

EW advised the Board that subject to approval, further work would take place to identify the strategic and operational measures of success for the strategy and build these into the executive review process and work plans.

RESOLVED: The Board APPROVED the Digital Strategy.

31/20 ASSURANCE REPORT OF THE CHAIR OF THE ESTATES AND FACILITIES COMMITTEE

MN updated from the January 2020 meeting and highlighted the quality of agenda items, presentations and discussion focused on the key issues.

The Committee discussed cleaning issues with the GMS Chair and Managing Director and as a Trust risk in its own right. SH, in his capacity as Director for Infection Prevention and Control, thanked MN, RdC and the Committee for their scrutiny of cleaning and advised this had helped progress improvements at a faster pace.

The Committee had been updated on and were monitoring the possibility of industrial action by GMS staff and RDC confirmed that GMS had shared their business continuity plans with the Trust

The Committee also received an update on the Estates Strategy and undertook a detailed review of the Strategic Site Development (SSD) Outline Business case (OBC). As part of this review the Committee were assured that the OBC was completely independent of the FFtF programme and did not impact upon consultation process.

Following on from the Board declaring a climate emergency, the Committee received an update on steps being taken by the Trust and approved terms of reference for a new sustainability group (overseen by the EFC).

RdC added that work on tracking medical equipment had been undertaken with SH's teams. This had been reported to FDC and Audit and Assurance Committee (AAC) and provided a better understanding of where equipment was going. It was suggested that this be linked to EPR.

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

32/20 ASSURANCE REPORT OF THE CHAIR OF THE AUDIT AND ASSURANCE COMMITTEE

CF presented the report. The Committee had discussed the relationship between GMS and "Group" audit activities and felt that, with one year of data available, there was an opportunity to review and strengthen the oversight from a Group perspective. Work was ongoing to agree the final approach.

Cleaning issues had again been considered by the Committee and more work was taking place to look at how GMS was addressing these. This would be reviewed at the next meeting.

The Board heard that productive discussions with the external auditors had provided assurance on the progress of the year-end audit and the interaction of the Trust and auditors within this. Following the Committee, the external auditors had delivered a development session for governors on their role and the role of the Council of Governors in the audit signoff process. KJ added that she was actively meeting with the audit partner and confirmed additional resource was in place to support the audit process and mitigate against "bottlenecks" through provision of support and escalation of issues.

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

33/20 MODERN SLAVERY STATEMENT

SF presented the report and updated on the work within in the Trust to prevent, identify and combat modern slavery. The Board NOTED that the People and Organisational Development Committee had reviewed the statement in December 2019 and heard that the Trust Secretary would continue to liaise with colleagues in the Trust to seek assurance on the work and controls in place across the organisation to support and promote compliance with the Act. Future reviews on the Modern

Slavery statement would take place closer to the year end of the reporting period.

RESOLVED: The Board NOTED the ongoing work taking place across the Trust to ensure that slavery and human trafficking was not taking place in any of its supply chains, and in any part of its own business and APPROVED the updated statement.

34/20 QUARTERLY GUARDIAN REPORT ON SAFER WORKING HOURS FOR DOCTORS AND DENTISTS IN TRAINING

SP joined for this item.

SP presented the Guardian Report for the period from August to October 2019. There had been an increase in the number of exception reports logged during the quarter (183 up from 104) but no fines had been levied. The number of vacancies had improved and SP felt this likely related to the workload for exceptions. There had also been NO correlation with Datix clinical incident or safety reports for this period.

SP reminded the Board of his last update in December 2019 which outlined work to provide facilities for those "too tired to drive" and was pleased to report staff were using these and providing positive feedback. More rooms were needed and discussions were underway with Sovereign Housing to try and increase availability. SH and EW's teams were also working to provide access to rest facilities for other professional groups.

SP had also met with parking colleagues to optimise access for shift workers at night. RdC confirmed that this was being considered as part of a wider parking review over the next two months.

MP thanked SP for his work in his role as the Guardian and commended that the agenda had been progressed at pace.

RESOLVED: The Board NOTED the Guardian report on safer working hours for doctors and dentists in training for the period from August to October 2019.

35/20 GOVERNOR QUESTIONS

AD asked that the Trust be more proactive in advertising the hearing loop system in the Lecture Hall to increase visibility for potential users.

AD welcomed that the signage changes to state "Children and Young People" were being costed and requested feedback when the work might be completed. **SH**

AD commented that on a recent patient safety walkabout, it was nice to see recognition of the work taking place to improve support for mental health patients requiring a place of safety at night. AD added that MIND had apps available that may support this work and had offered to speak with Trust colleagues.

AD thanked MH for the Digital Report as easy to follow and

understand and commented on how far the Trust had come from the historic issues with Trak Care.

36/20 STAFF QUESTIONS

There were none.

37/20 PUBLIC QUESTIONS

There were none.

38/20 NEW RISKS IDENTIFIED

There were none.

39/20 ITEMS FOR THE NEXT MEETING

There were none.

40/20 ANY OTHER BUSINESS

Approval of Operational Plan – Due to the timing of meetings, KJ requested delegated authority for the Finance and Digital Committee (FDC) to approve the latest draft of the Operational Plan for submission on 5 March 2020 and this was APPROVED. The Board also heard that that final version of the plan would be available in mid-April 2020.

RESOLVED: The Board DELEGATED authority for the Finance and Digital Committee to APPROVE the draft operational plan submission due on 5 March 2020.

[Meeting closed at 15:08]

Date of the next meeting: Thursday 12 March 2020, Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital at 12:30.

Signed as a true and accurate record:

Chair
12 March 2020

Gloucestershire Hospitals NHS Foundation Trust

MAIN BOARD (PUBLIC) – MATTERS ARISING

Minute	Action	Owner	Target Date	Update	Status
13 FEBRUARY 2020					
24/20	**Trust Risk Register** Risk related to adolescents' safety (C1850NSafe) - SH agreed to review the narrative for this risk to clarify the position	SH	March 2020	Risk Register updated.	**CLOSED**
35/20	**Governor Questions:** Signage changes to "Children and Young People" – provide feedback when the work might be completed.	SC	March 2020	Target completion date for a change in signage is Autumn 2020 in order to allow for further engagement with children and young people during spring and summer.	**CLOSED**
19 DECEMBER 2019					
254/19	**Quality Strategy:** Attention to be given to selection process for Governors' Quality Indicators.	SH	February 2020	On 18 February 2020, governors selected an indicator looking at Caesarean Section (CS) rates to show the percentage CS rate (planned and emergency).	**CLOSED**

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD - MARCH 2020

REPORT OF THE CHIEF EXECUTIVE

1. The Trust

1.1 Despite relatively mild weather, operational pressures remain considerable characterised by the relatively high acuity of those presenting. Unfortunately, the numbers of patients in our care, who are ready to be discharged, has increased and a combination of these issues means that we continue to deliver a waiting experience for our patients and their families that is short of what we aspire to. Work with partners, including social care, has been escalated to with the aim of reducing the numbers of patients whose discharge is delayed. However, although waiting time performance is considerably poorer than last year, the Trust and wider system's position remains strong relative to regional and national performance; at the end of quarter 3, the Trust was the top performing Type 1 A&E in the South West and *One Gloucestershire* performed in the upper third of systems nationally. To date, the current pathway for patients with symptoms and travel history consistent with the risk of COVID-19 (novel coronavirus) means that the impact on our A&E department is currently contained. More on COVID-19 preparedness below.

1.2 On a positive note, operational performance in respect of cancer, 52 week elective care and outpatient follow up remains strong. The Trust has achieved the 2 week cancer wait for six consecutive months which is the first time ever; given 90% of patients will have cancer excluded following this initial assessment this is a huge boost to cancer patient experience. December also saw the first month that we achieved the standard in all specialties, not just at an aggregate Trust level since May 2013. From a high of 120 patients in August 2018, who had waited more than 52 weeks for their treatment, the Trust is on track to achieve single figures for March 2020 – a reduction of 73.1% from January 2019 to January 2020 - with the expectation of 52 week waits, being eliminated in quarter one this year. A whole organisational effort with fantastic leadership from our operational and clinical teams. Finally, the seemingly intractable issue of backlogs in follow up outpatient care is at long last moving forward considerably. Our longest waiting patients overdue follow up, without a booked appointment, has reduced from a staggering 57,213 in January 2019 to 5,071. The total number of patients now on an active follow up has also reduced significantly (30,271) reflecting the focus on discharging those patients who can be safely cared for outside a specialist setting or for whom follow up is no longer necessary.

1.3 Along with all NHS organisations, the Trust is working very closely with system partners and Public Health England to ensure that we are prepared for the potential implications arising from the COVID-19 virus and the subsequent confirmation of two cases in Gloucestershire. The Trust has tried and tested emergency preparedness plans for a wide range of scenarios and has established a local response team to oversee COVID-19 operational planning and more recently a Task & Finish Group to consider the implications specific to workforce. Guidance abounds and is changing as the situation unfolds; the Trust is compliant with all requirements having established coronavirus assessment areas called *Coronavirus Priority Assessment Pods*, remote from our A&E departments. To date, patients presenting with symptoms that fit the criteria, is low and whilst a serious issue, the risk to our local population also remains low with travel to infected areas such as Northern Italy, being the greatest risk factor.

1.4 Importantly, in England we remain in the *containment phase* and, as such, I cannot underestimate the importance of following the advice from Public Health England

regarding hand hygiene and other basic infection prevention and control measures. The local situation is being led by Gloucestershire's Director of Public Health, Sarah Scott and I have nothing but praise for her leadership and approach.

1.5 Following on from the very successful first phase roll-out of our Electronic Patient Record (EPR), we are now poised to go-live on the 17 March with the next phase described as electronic observations or *e-obs* to most of us. I can't recollect a single intervention, in recent times that had the potential to change the safety profile of patient care to the extent that this development will. At a glance, clinicians will be able to see who the sickest patients in our hospitals are and, even better, our Acute Care Response Team will receive an alert when a patient's acuity reaches the threshold trigger requiring their involvement. The next phase will be the development of the system to enable tests (laboratory and imaging) to be requested, receipted and reviewed. This next phase requires considerable configuration of the system's architecture and build of the TrakCare laboratory platform; deployment is currently scheduled for October 2020.

1.6 Results from last autumn's national staff survey have been published and overall the picture for our Trust is an improving one, albeit more slowly than my impatient self would like! Of particular note is the 3.4% point increase in the proportion of staff recommending the Trust as a place to work which is underpinned by some equally positive themes about the quality of line management and the Trust's focus on staff health and wellbeing. We continue to score well in respect of our approach to diversity and inclusion (9.1/10) but the trend is a very slow decline and staff who identify as LGBTQ+ have reported a 3.3% increase in discrimination arising from their sexual orientation; understanding the reasons for this, not least given the tremendous work of our *Diversity Network,* is a priority for the leadership team. For me, the most disappointing insight is the static measure relating to the proportion of staff who would recommend the Trust as a place to receive care. Whilst we remain in the top half of Trusts for this indicator, if we are to realise our ambition of being an "outstanding" Trust, we need to better understand what it is that prompts a third of our staff to respond negatively to this question and, more importantly, what would need to change in their view, for them to respond positively. We are currently evaluating the narrative comments provided by staff through the survey and also looking at the responses by Division and staff group with the aim of better understanding this finding and the actions we need to take. Without doubt, the intensity of workload for our staff, is a key influencing factor alongside staff perception of acute and emergency care.

1.7 Nurse recruitment and retention has been a huge focus for the Trust since I arrived, with our level of vacancies for trained nurses fairly static at about 180. I am delighted, therefore, that a number of our recent initiatives appear to be paying dividends with a vacancy rate at c100 for the first time in many years. On the 7 March, we will be hosting a Nursing Careers Fair, with a twist; the event will not only try to appeal to our usual target audiences of soon to qualify nurses and those working in our neighbouring Trusts but it will also be providing information to those considering returning to practice and staff already working in our Trust (or outside) who are considering nursing as career change. With the aim of full recruitment, I am also delighted that the Trust is just one of 14 NHS Trusts nationally who are participating in Chief Nursing Officer for England, Ruth May's *Pathway To Excellence* programme; a real "feather in our cap" given the interest and criteria for involvement. The Trust's 100 Leaders, Extended Leaders Network and Quality Committee all heard last month from Chief Nurse Steve Hams and Pathway Lead, Eve Olivant about what this programme means for us, our colleagues and our patients. At its heart is in the concept of "shared governance" where those with an interest in care quality, work together for the benefit of each other and participate in truly shared decision making about the things that matter most. Finally, I am equally delighted that the Trust has been accepted into an exciting research collaborative *Magnet4Europe,* which builds upon the success of the American Nursing Credentialing Centre (ANCC) model in the USA. This interventional study is aimed at redesigning and improving the work environment of clinicians to improve mental health and wellbeing including impacting positively on job satisfaction,

absenteeism, retention and "burnout" whilst also redesigning for improved patient safety, patient experience and health outcomes. The overarching purpose of the study is to determine if redesign of hospital environments, in a European setting, guided by the *Magnet* principles (and in collaboration with an experienced and successful *Magnet* accredited US hospital) delivers the scale of benefits evidenced in the USA. The study will take place in five European countries with 12 hospitals from each country participating. A fantastic addition to our research portfolio and journey to becoming a *university hospital.* Congratulations to Steve Hams, Chief Nurse for securing this opportunity. We await confirmation of which phase of the trial we will participate in.

1.8 Another huge milestone in the Trust's journey was the Board's recent approval of our £39.5m Outline Business Case (OBC) for the development of estate and infrastructure which will bring much needed benefits to patients and staff on both our sites. The next step is approval of the OBC by our regulator NHS Improvement (NHSI), before we commence of the final planning stage to produce the Full Business Case. The timeline for commencement of building works remains early summer 2021 with completion autumn 2022.

1.9 As part of the NHS's response to addressing yet another year of increasing attendances at A&E departments throughout the country, NHS England and NHSI have commissioned Ipsos Mori to undertake a series of structured interviews in A&E departments, with aim of capturing patients' motivations for attending A&E. With year on year increases in activity, outstripping any demographic explanations, it is certainly a topic where theories abound and so any attempt to better understand the drivers is welcome. Surveys will take part on 11 and 23 March at GRH site and be conducted by independent interviewers.

1.10 There have been numerous things to celebrate since I last reported to the Board including three patient experience initiatives being nominated for a national award and our very own Patient Experience Improvement Manager, Jean Tucker has also been shortlisted for PALS Manager of the Year. Developments in outpatients and ophthalmic imaging have also been recognised nationally and nominated for national awards.

1.11 Finally, recruitment for a new Director of Strategy and Transformation is now underway with a very healthy interest and notably from candidates outside the NHS. Interviews will take place on the first of April. We are fortunate to retain Simon until mid-summer.

2. The System

2.1 Following the very successful engagement events, and the more recent *Solutions' Appraisal*, we are now in the phase of assimilating all that we have heard and learnt from these activities into the pre-consultation business case (PCBC). From a 1000+ possible permutations of service configuration, we have now reached a short list of eight and it is these eight that are now being developed more fully. The next major milestones are consideration of the PCBC by Boards, our regulator and the South West Clinical Senate, ahead of finalising the timeline for public consultation, later this year.

2.2 In January, I reported that the system intended to submit a deficit financial plan for the coming year 2020/21. Following further work between partners and NHSI, the system has now been able to develop a balanced plan which was submitted to NHSI on the 5 March ahead of final submissions on the 29 April 2020. Delivery of the plan is predicated on a number of significant variables and associated planning assumptions coming to fruition, including delivery of 2.6% reduction in the Trust's cost base, identification of a further £7m of system wide cost savings and a 100% achievement of the £12m Financial Restructuring Fund (FRF). Differently to last year, 50% of FRF funding is now reliant upon delivery of the system financial plan and the balance linked to delivery of the Trust plan – a huge incentive to work together as a system. A key focus for the coming year, for all organisations, will be a move away from delivery of non-recurrent savings to the transformation of services in such a way the costs of delivery are reduced on a recurring basis. Easier said than done, it would seem!

Deborah Lee
Chief Executive Officer

3 March 2020

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

Report Title
Trust Risk Register

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

Executive Summary

Purpose

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

Key issues to note

- The Trust Risk Register (appendix 1) enables the Board to have oversight, and be assured of the active management, of the key risks within the organisation which have the potential to affect patient safety, care quality, workforce, finance, business, reputation or statutory matters.
- Divisions are required on a monthly basis to submit reports indicating any changes to existing high risks and any new 12+ for safety and 15+ other domains to the Trust Leadership Team (TLT) for consideration of inclusion on the Trust Risk Register.
- New risks are required to be reviewed and reassessed by the appropriate Executive Director prior to submission to TLT to ensure that the risk does not change when considered in a corporate context.
- Future reports will add extra context and rationale as to the change in risk rating.
- A new risk C3169MD (below) is being assessed on the impact of the Covid-19 virus. As the national and local position is dynamic and frequently changing the risk has been agreed at TLT with final scoring to be assessed at Board, based on the up to date information presented in the Covid-19 briefing paper.

  C3169MD - The risk to business continuity and ability to provide safe care, as a consequence of Covid-19 developing into a pandemic affecting availability of workforce, equipment, consumables and hospital capacity – Proposed scoring of 4x4=16 - Business

Changes in the reporting period

The Trust Leadership Team (TLT) met on 4 March 2020.

Risks reviewed by TLT:

There were no changes to the Trust Risk Register to report with the exception of the new potential risk C3169MD noted above.

No risk on TRR has been upgraded in this period.

No risks have been downgraded in this period

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

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

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

Recommendations
To agree changes to the Trust Risk Register proposed in the report.

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

Equality & Patient Impact
Potential impact on patient care, as described under individual risks on the register.

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

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

Date the paper was presented to previous Committees and/or Trust Leadership Team (TLT)							
Audit & Assurance Committee	**Finance & Digital Committee**	**Estates & Facilities Committee**	**People & OD Committee**	**Quality & Performance Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
						4 March 2020	Directors Operational Group 12 Feb 2020

Outcome of discussion when presented to previous Committees/TLT
TLT recommended to the Board endorsing the above comments on the TRR

Ref	Inherent Risk	Controls in place	Action / Mitigation	Division	Highest Scoring Domain	Score	Executive Lead title	Title of Strategic Group	Title of Operational Group	If other, please specify name of Operational Group	Title of Assurance Committee / Board	Date Risk to be reviewed by	Operational Lead for Risk	Approval status
F2927	Risk that the Trust does not achieve the required cost improvement resulting in failure to deliver the Financial Recovery Plan for FY20	1. PMO in place to record and monitor the FY20 programme 2. Finance Business Partners to assist budget holders 3. Fortnightly CIP Deep Dives 4. Monthly monitoring and reporting of performance against target 5. Monthly Financial Sustainability Delivery Group 6. Monthly Finance and Digital Committee scrutiny 7. Monthly and Quarterly executive reviews 8. NHSI monitoring through monthly Finance reporting		Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Finance	C5xL4=20	Director of Finance	Finance and Digital Committee, Turnaround Implementation Board	Other	Finance and Digital Committee	Finance and Digital Committee, Trust Leadership Team	27/03/2020	Johnson, Karen	Trust Risk Register
M2473Emer	The risk of poor quality patient experience during periods of overcrowding in the Emergency Department	Identified corridor nurse at GRH for all shifts; ED escalation policy in place to ensure timely escalation internally; Cubicle kept empty to allow patients to have ECG / investigations (GRH);	CQC action plan for ED Development of and compliance with 90% recovery plan Winter summit business case	Medical	Quality	C4xL5=20	Director of Quality / Chief Nurse	Divisional Board - Medical, Emergency Care Delivery Group	Emergency Care Operational Group		Emergency Care Board, Trust Leadership Team	01/06/2020	Blake, Anna	Trust Risk Register
C2667NIC	The risk to patient safety and quality of care and/or outcomes as a result of hospital acquired C .difficile infection.	1. Annual programme of infection control in place 2. Annual programme of antimicrobial stewardship in place 3. Action plan to improve cleaning together with GMS	1. Delivery of the detailed action plan, developed and reviewed by the Infection Control Committee. The plan focusses on reducing potential contamination, improving management of patients with C.Diff, staff education and awareness, buildings and the envi	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	C4xL4=16	Director of Quality and Chief Nurse	Divisional Board - Corporate / DOG, Infection Control Committee	Decontamination Group		Quality and Performance Committee, Trust Leadership Team	31/03/2020	Bradley, Craig	Trust Risk Register
D&S3103Path	The risk of total shutdown of the Chem Path laboratory service on the GRH site due to ambient temperatures exceeding the operating temperature window of the instrumentation.	Air conditioning installed in some laboratory areas but not adequate. Cooler units installed to mitigate the increase in temperature during the summer period (now removed). Quality control procedures for lab analysis Temperature monitoring systems Contingency would be to transfer work to another laboratory in the event of total loss of service (however, ventilation and cooling in both labs in GHT is compromised, so there is a risk that if the ambient temperature in one lab is high enough to result in loss of service, the other lab would almost certainly be affected). Thus work may need to be transferred to N Bristol (compromising their capacity and compromising turnaround times).		Diagnostics and Specialties	Quality	C4xL4=16	Chief Operating Officer	Divisional Board - D & S	Pathology Management Board			19/03/2020	Rees, Linford	Trust Risk Register
F2335	The risk of agency spend in clinical and non-clinical areas exceeding planned levels due to ongoing high vacancy levels, with resulting impact of delivery of FY20 CIP programme	1. Challenge to agency requests via VCP 2. Agency Programme Board receiving detailed plans from nursing medical workforce and operations working groups 3. Finance agency report review on a 6 monthly basis 4. Financial Sustainability Delivery Group 5. Quarterly Executive Reviews	Establish Workforce Committee Complete PIDs for each programme Reconfiguring Structures Agency Programme Board recieving detailed plans from nursing medical workforce and operational working groups 1. Convert locum/agency posts to substantive 2. Promote higher utilisation of internal nurse and medical bank 3. Implementation of healthRoster for roster and Bank management 4. implementation of Master Vendor Agreement for Nursing Agency - improving the control of medical agency spend and authorisation 5. Finalise job planning 6. Ongoing recruitment processes including international recruitment 7. Creation of new medical roles such as Associate specialists 8. Creation of a health and wellbeing hub aimed at reducing absence and reliance on costly temporary solutions	Corporate, Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Finance	C4 xL4=16	Director of Quality and Chief Nurse	Finance and Digital Committee, People and OD Delivery Group, Workforce Review Group	Agency Programme Board		Finance and Digital Committee, People and OD Committee, Trust Leadership Team, Workforce Committee	27/03/2020	Murrell, Mel	Trust Risk Register

C2628COO	The risk of regulatory intervention (including fines) and poor patient experience resulting from the non-delivery of appointments within 18 weeks within the NHS Constitutional standards.	The RTT standard is not being met and re-reporting took place in March 2019 (February data). RTT trajectory and Waiting list size (NHS I agreed) is being met by the Trust. The long waiting patients (52s)are on a continued downward trajectory and this is the area of main concern Controls in place from an operational perspective are: 1.The daily review of existing patient tracking list 2. Additional resource to support central and divisional validation of the patient tracking list. 3.Review of all patients at 45 weeks for action e.g. removal from list (DNA / Duplicates) or 1st OPA, investigations or TCI. 4. A delivery plan for the delivery to standard across specialities is in place 5. Additional non-recurrent funding (between cancer/ diagnostics and follow ups) to support the reduction in long waiting 6. Picking practice report developed by BI and theatres operations, reviewed with 2 specialities (Jan 2020) and issued to all service lines (Jan 2020) to	1.RTT and TrakCare plans monitored through the delivery and assurance structures	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Statutory	C4xL4=16	Chief Operating Officer	Divisional Board - Corporate / DOG, Planned Care Delivery Group	Clinical Systems Safety Group		Quality and Performance Committee, Trust Leadership Team	31/03/2020	Taylor-Drewe, Felicity	Trust Risk Register
C2997RadSafety	The risk of statutory prosecution due to failure to comply with the Ionising Radiation (Medical Exposure) Regulations 2017. Failure to comply the CQC Improvement Notice, specifically the requirement for sufficient written procedures as defined in schedule 2 of IR(ME)R (a)-(n)and a suitable governance structure by 24 October 2019.	1.Radiation Protection Advisors in place to advise specialties 2. Some procedures in place i.e. Radiology (although outdated) 3. Practices in place in specialties 4. Radiation Safety Committee reports to H&S Committee 5. Radiation Safety Policy 6. Radiation Risk Assessments 7. Training packages available for practitioner or operator engaged by the employer to carry out exposures 8. Reviews are undertaken at a local level, to evaluate the reasons why diagnostic reference levels (DRLs)have been consistently exceeded 9. Local practices to protect those of child bearing age	Weekly update calls with Emma Wood Set up task and finish group Review governance for radiation safety Increase the frequency of the Radiation Safety Committee. Chair to pass to Mark Pietroni Run briefing session for Risk Managers and Workshops for Radiation Leads To produce a suitable quality set of IRMER Procedures and SOPs To produce a suitable set of IRMER procedures and SOPs	Corporate, Diagnostics and Specialties, Medical, Surgical	Statutory	C4xL4=16	Medical director	Divisional Board - Corporate / DOG, People and OD Delivery Group, Quality Delivery Group, Trust Health and Safety Committee	Radiation Safety Committee		People and OD Committee, Quality and Performance Committee, Trust Leadership Team	11/03/2020	Dix, Tony	Trust Risk Register
D&S2517Path	The risk of non-compliance with statutory requirements to the control the ambient air temperature in the Pathology Laboratories. Failure to comply could lead to equipment and sample failure, the suspension of pathology laboratory services at GHT and the loss of UKAS accreditation.	Air conditioning installed in some laboratory (although not adequate) Desktop and floor-standing fans used in some areas Quality control procedures for lab analysis Temperature monitoring systems Temperature alarm for body store Contingency plan is to transfer work to another laboratory in the event of total loss of service, such as to North Bristol	Review performance and advise on improvement Review service schedule A full risk assessment should be completed in terms of the future potential risk to the service if the temperature control within the laboratories is not addressed A business case should be put forward with the risk assessment and should be put forward as a key priority for the service and division as part of the planning rounds for 2019/20.	Diagnostics and Specialties	Statutory	C4xL4=16	Chief Operating Officer	Divisional Board - D & S	Pathology Management Board			19/03/2020	Lewis, Jonathan	Trust Risk Register
S2275	A risk of sub-optimal surgical staffing caused by a combination of insufficient trainees, senior staff and increased demand resulting in compromised trainee supervision, excessive work patterns and use of agency staff impacting on the ability to run a safe and high quality surgical rotas. Impact of any changes to non-contractual clinical support to services. Impact of any risk through workload leading to deanery withdrawal of trainees.	1. Guardian of Safe working Hours. 2. Junior doctors support 3. Staff support services available to staff 4. Mental health first aid services available to trainees in ED 5. Guardian of Safe working Hours.	Escalation Attempts to recruit 1. Agency/locum cover for on call rotas 2. Nursing staff clerking patients 3. Prioritisation of workload 4. exisiting junior doctors covering gaps where possible 5. consultants acting down 6. Ongoing recruitment for substantive and locum surgeons for rota including international opportunities 7. Health and well being hub will offer greater emotional well being services Launch of Locum's Nest software for advertising and allocating locum shifts	Surgical	Workforce	C4xL4=16	Medical Director	Divisional Board - Surgery, People and OD Delivery Group			People and OD Committee, Trust Leadership Team	30/12/2019	Turner, Bernie	Trust Risk Register
C2895COO	Risk that patients and staff are exposed to poor quality care or service interruptions arising from failure to make required progress on estate maintenance, repair and refurbishment of core equipment and/or buildings, as	1. Board approved, risk assessed capital plan including backlog maintenance items; 2. Prioritisation and allocation of cyclical capital (and contingency capital) via	1. Prioritisation of capital managed through the intolerable risks process for 2019/20 Ongoing escalation to NHSI and system	Corporate, Gloucestershire Managed Services	Environmental	C4xL4=16	Chief Operating officer	Divisional Board - Corporate / DOG	GMS Health and Safety Committee		GMS Board, Trust Leadership Team	03/04/2020	Makinde, Akin	Trust Risk Register
S3038	A risk of sub-optimal care for emergency surgery patients requiring surgical treatment caused by limited day time access to emergency theatres resulting in increased length of stay and poor patient experience.	2 slots are allocated in GRH to the gynaecology emergencies first thing Regularly negotiate with other specialities to prioritise cases according to clinical need The vascular service in CGH reutilises	Task and Finish group in situ to review all possible mitigations, meeting weekly Fit for the Future engagement process re emergency general surgery	Surgical	Quality	C4 xL4=16	Medical Director	Divisional Board - Surgery, Theatre Transformation and Collaboration Board	Theatres Utilisation Group		Trust Leadership Team	30/12/2019	Turner, Bernie	Trust Risk Register

C3089COOEFD	Risk of failure to achieve the Trust's performance standard for domestic cleaning services due to performance standards not being met by service partner.	1. Domestic Cleaning Services are currently provided by the Service Partner with defined performance standards/KPIs for functional areas in the clinical & non-clinical environment. (NB. Performance Standards/KPIs are agreed Trust standards that marginally deviate from guideline document 'The National Specifications for Cleanliness in the NHS – April 2007'); 2. Cleaning Services are periodically measured via self-audit process and performance is reported against the agreed Performance Standards/KPIs to the Contract Management Group (bi-monthly, every two months); 3. Scope of Cleaning Service currently agreed with the Service Partner includes – Scheduled & Reactive Cleaning, Planned Cleaning, Barrier Cleaning, Deep Cleaning and other Domestic Duties; 4. Provision of an Ad-hoc cleaning service is provided by the Service Partner with defined rectification times for the functional areas; 5. Cleaning activities and schedules are noted as being agreed at local levels (e.g. departmental/ward level) between	Review, Assess and enact agreed future actions/controls	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Quality	C4xL4=16	Chief Operating Officer	Estates and Facilities Contract Management Group, Infection Control Committee	Other	Opened by Strategic Group	Quality and Performance Committee, Trust Leadership Team	03/04/2020	Makinde, Akin	Trust Risk Register
S3035	A risk to safe service provision caused by an inability to provide an appropriate training environment leading to poor trainee feedback which could result in a reduction in trainee allocation impacting further on workforce and	Current service configuration does not lend itself to creating an environment for improved training and therefore the risk of poor feedback and the associated implications are not mitigated.	Fit for the Future engagement process re emergency general surgery Task and Finish group in situ to review all possible mitigations, meeting weekly	Surgical	Workforce	C5 x L3=15	Medical Director	Divisional Board - Corporate / DOG, Divisional Board - Surgery, Education and Learning Development Strategy Group (ELD)	Medical Education Board		Trust Leadership Team	30/12/2019	Turner, Bernie	Trust Risk Register
S3036	A risk of sub-optimal care for patients with specialist care and other sub-specialty conditions caused by a lack of ability to create sub-specialty rotas resulting in inequitable care and different clinical outcomes	An upper GI surgeon is the on call surgeon approximately 50% of the time so patients admitted with gallbladder disease when this is the case do get this optimal treatment. In the event of UGI elective theatre cases being cancelled or DNA emergency gallbladder disease cases may be operated on due to unexpected surgeon availability.	Lap Chole Pathway Mapping workshop	Surgical	Quality	C3xL5=15	Medical Director	Divisional Board - Corporate / DOG, Divisional Board - Surgery			Trust Leadership Team	30/12/2019	Turner, Bernie	Trust Risk Register
C1798COO	The risk of delayed follow up care due outpatient capacity constraints all specialities. (ENT; Rheumatology & Ophthalmology) Risk to both quality of care through patient experience impact(15)and safety risk associated with delays to treatment(4).	1. Speciality specific review administratively of patients (i.e. clearance of duplicates) (administrative validation) 2. Speciality specific clinical review of patients (clinical validation) 3. Utilisation of existing capacity to support long waiting follow up patients 4.Weekly review at Check and Challenge meeting with each service line, with specific focus on the three specialties 5.Do Not Breach DNB (or	1. Revise systems for reviewing patients waiting over time 2. Assurance from specialities through the delivery and assurance structures to complete the follow-up plan 3. Additional provision for capacity in key specialiities to support f/u clearance of backlog	Medical, Surgical	Quality	C3xL5=15	Chief Operating Officer	Divisional Board - Corporate / DOG, Planned Care Delivery Group, Quality Delivery Group	Trak Operational Group		Planned Care Board, Trust Leadership Team	31/03/2020	Taylor-Drewe, Felicity	Trust Risk Register
C3084P&OD	The risk of inadequate quality and safety management owing to frequent reliance on outdated electronic systems currently used for data and information recording, reporting, analysis and	Risk Managers monitoring the system daily Risk Managers manually following up overdue risks, partially completed risks, uncontrolled risks and overdue actions	Prepare a business case for upgrade / replacement of DATIX Arrange demonstration of DATIX and Ulysis	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Quality	C3xL5=15	Director of People and OD	Divisional Board - Corporate / DOG, Finance and Digital Committee, Risk Management Group	Quality and Safety Systems Group		Finance and Digital Committee, People and OD Committee, Trust Leadership Team	30/03/2020	Troake, Lee	Trust Risk Register
S2930	A risk to patient safety caused by insufficient senior surgical cover resulting in delayed senior assessment and delays to urgent treatment for patients.	Criteria of patients suitable for transfer to SAU is in place (e.g. NEWS < 2 and specific conditions described in SOP that are suitable for SAU) Limited (one wte) ANP cover for SAU with a plan in place for training of additional ANPs. Current cover (1) Medical: team cover admissions and operating theatre (reducing availability	Transformation Delivery Group Risk to be discussed at Surgical Board Fit for the Future engagement process re emergency general surgery Task and Finish group in situ to review all possible mitigations, meeting weekly	Surgical	Quality	C3xL5=15	Director of Safety and Medical Director	Divisional Board - Surgery, People and OD Delivery Group	Clinical Safety Effectiveness and Improvement Group		People and OD Committee, Trust Leadership Team	30/12/2019	Turner, Bernie	Trust Risk Register
C2669N	The risk of harm to patients as a result of falls	1. Patient Falls Policy 2. Falls Care Plan 3. Post falls protocol 4. Equipment to support falls prevention and post falls management 5. Acute Specialist Falls Nurse in post 6.Falls link persons on wards 7. Falls monitored and reported at the	4. Discussion with Matrons on 2 ward to trial process 1. Falls training 2. HCA specialist training 3. #Litle things matter campaign 4. Discussion with matrons on 2 wards to trial process	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	C4xL3=1212	Chief Nurse/ Quality Lead	Divisional Board - Corporate / DOG, Infection Control Committee, Quality Delivery Group	Other	Falls and Pressure Ulcers Group	Quality and Performance Committee, Trust Leadership Team	31/01/2020	Bradley, Craig	Trust Risk Register
C1850NSafe	The risk of safety to adolescents 12-18 presenting with significant mental health issues and self harming behaviour who require assessment and	1. The paediatric environment has been risk assessed and adjusted to make the area safer for self harming patients with agreed protocols.	Develop Intensive Intervention programme Escalation of risk to Mental Health County Partnership	Medical, Surgical, Women's and Children's	Safety	C3xL4=12	Director of Quality and Chief Nurse	Safeguarding Adults Strategy Board, Safeguarding Adults and Children Committee, Safeguarding Children Strategic	Safeguarding Adults Operational Group, Safeguarding Children Operational Group / Board, Safeguarding Operation Group			01/04/2020	Mortimore, Vivien	Trust Risk Register
C1945NTVN	The risk of moderate to severe harm due to insufficient pressure ulcer prevention controls	1. Evidence based working practices including, but not limited to; Nursing pathway, documentation and training including assessment of MUST score, Waterlow (risk) score, Anderson score (in ED), SSKIN bundle (assessment of at risk patients and prevention management), care rounding and first hour priorities. 2. Tissue Viability Nurse team cover both sites in Mon-Fri providing advice and training. 3. Nutritional assistants on several wards where patients are at higher risk (COTE and T&O) and dietician review	1. To create a rolling action plan to reduce pressure ulcers 2. Amend RCSA for presure ulcers to obtain learning and facilitate sharing across divisions 3. Sharing of learning from incidents via matrons meetings, governance and quality meetings, Trust wide pressure ulcer group, ward dashboards and metric reporting. 4. NHS collabborative work in 2018 to support evidence based care provision and idea sharing	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	C3xL4=12	Director of Quality and Chief Nurse	Divisional Board - Corporate / DOG, Quality Delivery Group	Clinical Safety Effectiveness and Improvement Group		Trust Leadership Team	31/01/2020	Bradley, Craig	Trust Risk Register

		available for all at risk of poor nutrition. 4. Pressure relieving equipment in place Trust wide throughout the patients journey - from ED to DWA once assessment suggests patient's skin may be at risk. 5. Trustwide rapid learning from the most serious pressure ulcers, RCAs completed within 72 hours and reviewed at the weekly Preventing Harm Improvement Hub.	Discuss DoC letter with Head of patient investigations Advise purchase of mirrors within Division to aid visibility of pressure ulcers update TVN link nurse list and clarify roles and responsibilities implement rolling programme of lunchtime teaching sessions on core topics TVN team to audit and validate waterlow scores on Prescott ward	Children's										
C2819N	The risk of serious harm to the deteriorating patient as a consequence of inconsistent use of NEWS2 which may result in the risk of failure to recognise, plan and deliver appropriate urgent care needs	Ongoing education on NEWS2 to nursing, medical staff, AHPs etc o E-learning package o Mandatory training o Induction training o Targeted training to specific staff groups, Band 2, Preceptorship and	Monthly Audits of NEWS2. Assessing completeness, accuracy and evidence of escalation. Feeding back to ward teams Development of an Improvement Programme	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	C4xL3=12	Director of Quality and Chief Nurse	Divisional Board - Corporate / DOG, Quality Delivery Group, Digital Care Board	Clinical Systems Safety Group, Resuscitation and Deteriorating Patient Group		Quality and Performance Committee, Trust Leadership Team	31/07/2020	King, Ben	Trust Risk Register
M2268Emer	The risk of patient deterioration (Safety) due to lack of capacity leading to ED overcrowding with patients in the corridor	RN identified for ambulance assessment corridor 24/7 Identified band 3 24 hours a day for third radiology corridor with identified accountable RN on every shift Additional band 3 staffing in ambulance assessment corridor 24 hours a day - improvement in NEWS compliance and safety checklist	Complete CQC action plan Compliance with 90% recovery plan Monies identified to increase staffing in escalation areas in E, increase numbers in Transfer Teams, increase throughput in AMIA.	Medical	Safety	C3xL4=12	Director of Quality and Chief Nurse	Divisional Board - Medical, Trust Health and Safety Committee	Resuscitation and Deteriorating Patient Group		Trust Leadership Team	31/03/2020	Cairns, Tiffany	Trust Risk Register
C3034N	The risk of patient deterioration, poor patient experience, poor compliance with standard operating procedures (high reliability)and reduce patient flow as a result of high registered nurse vacancies within adult inpatient areas at Gloucestershire Royal Hospital and Cheltenham General Hospital.	1. Temporary Staffing Service on site 7 days per week. 2. Twice daily staffing calls to identify shortfalls at 9am and 3pm between Divisional Matron and Temporary Staffing team. 3. Out of hours senior nurse covers Director of Nursing on call for support to all wards and departments and approval of agency staffing shifts. 4. Band 7 cover across both sites on Saturday and Sunday to manage staffing and escalate concerns. 5. Safe care live completed across wards 3 times daily shift by shift of ward acuity and dependency, reviewed shift by shift by divisional senior nurses. 6. Master Vendor Agreement for Agency Nurses with agreed KPI's relating to	To review and update relevant retention policies Set up career guidance clinics for nursing staff Review and update GHT job opportunities website Support staff wellbing and staff engagment Assist with implementing RePAIR priorities for GHFT and the wider ICS Devise an action plan for NHSi Retention programme - cohort 5 Trustwide support and Implementation of BAME agenda Devise a strategy for international recruitment	Medical, Surgical	Safety	C3xL4=12	Director of Quality and Chief Nurse	Divisional Board - Corporate / DOG, People and OD Delivery Group, Quality Delivery Group, Recruitment Strategy Group	Recruitment Strategy Group, Vacancy Control Panel		People and OD Committee, Quality and Performance Committee, Trust Leadership Team	31/03/2020	Webster, Carole	Trust Risk Register
C2989COOEFD	The risk of patient, staff, public safety due to fragility of single glazed windows. Risk of person falling from window and sustaining serious injury or life threatening injuries. Serious injury from contact with broken glass / shattered windows. Glass shards may be used as a weapon against staff, other patients or visitors. Risk of distress to other patients / visitors and staff if person falls	1. All faults are logged on Backtraq via the Estates Helpdesk either on-line or via the 6800 number and reports are available as necessary; 2. Many windows have a protective film to prevent shards of glass fragmenting and causing harm; 3. Patient Risk Assessments are in place by the Trust for vulnerable patients to ensure that controls are in place locally to minimise and/or mitigating patient contact with windows/glass; 4. Window Restrictors are fitted to all windows which require them and are maintained on an annual PPM schedule by Gloucestershire Managed Services; 5. Window Restrictor Policy in place which is reviewed and updated on a three yearly basis or as required; 6. If a window is broken or damaged it is replaced with a window which has toughened glass and complies with all current legislative requirements (e.g. 6.4mm laminate safety glass tested to	Replacement, or upgrade of windows. 100 windows need replacing throughout the Tower Block. Decision to be made as to whether each window needs to be replaced, or whether each window is replaced on a ward first at a cost of £30, 000 per ward	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Environmental	C2xL5=10 for Environmental but C5xL1=5 for Safety	Chief Operating Officer	Divisional Board - Corporate / DOG, Estates and Facilities Committee, Trust Health and Safety Committee	GMS Health and Safety Committee		GMS Board, Trust Leadership Team	03/04/2020	Makinde, Akin	Trust Risk Register
C2817COO	Risk of fire in Tower Block ward ducts/vents due to build up of dust over many years. Wards needs to be empty for 24 hrs to clean ducts	Funding for cleaning to be secured (some already secured) Schedule for cleaning drawn up to be undertaken in the summer months where wards can be decanted to day surgery areas to allow cleaning to take place at the weekends.	Duct cleaning only possible when ward is fully decanted. Implement ward closure programe to provide access to undertake the works. Ward 3B being assessed for ability to undertake works this Summer	Corporate, Gloucestershire Managed Services	Safety	C5xL1=5	Chief Operating officer	Divisional Board - Corporate / DOG, Estates and Facilities Committee, Trust Health and Safety Committee	GMS Health and Safety Committee		Executive Management Team, GMS Board, Trust Board, Trust Leadership Team	30/09/2020	Minett, Rachel	Trust Risk Register
C2970COOEFD	Risk of harm or injury to staff and public due to dilapidation and/or structural failure of external elevations of Centre Block and Hazelton Ward Ceiling – resulting in loose, blown or spalled render/masonry to external & internal areas.	1) Snapshot' visual survey undertaken from ground level to establish the scope of the loose, blown or spalled render and masonry to the external elevations of the building & any loose material removed (frequency TBC); 2) Heras fencing has been put up to isolate persons from the areas of immediate concern; 3) Areas of concern being monitored (frequency TBC). (All Controls to be reviewed and	Refurbish the roof outside and make safe To undertake a comprehensive structural survey of the external elevations of Centre Block to identify all areas requiring repair or replacement and to undertake those works Planning permission for investigatory works	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical	Safety	C5xL1=5	Chief Operating Officer	Divisional Board - Corporate / DOG, Estates and Facilities Committee, Trust Health and Safety Committee			GMS Board, Trust Board, Trust Leadership Team	03/04/2020	Makinde, Akin	Trust Risk Register

C2719COO	The risk of compromised safety of our patients and staff within the Tower building in the event of a fire if training and equipment is not in place.	All divisions now taking accountability to ensure fire training and evacuation is being undertaken and evidence to support this is kept at local level as per fire safety standards. This includes fire warden training, e-learning, fire drills and location of fire safety equipment. - Firesafety committee reinstated Training needs and equipment needs identified Training programme now launched to include drills , education standardising documentation for all areas walkabouts arranged with fire officer - Site team prioritised Consistent messaging cascaded at the site meeting for training and compliance.	Monitoring and ensure all areas received the approrpaite training and drills to evaucate patients safely	Corporate, Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	C5xL1=5	Chief Operating O fficer	Divisional Board - Corporate / DOG, Estates and Facilities Committee, Trust Health and Safety Committee	GMS Health and Safety Committee		GMS Board, Trust Board, Trust Leadership Team	31/05/2020	McGirr, Alison	Trust Risk Register
S2917CC	The risk of patient and staff harm and loss of life as a result of an inability to horizontally evacuate patients from critical care	Presence of fire escape staircase Hover-jack to aid evacuation of level 3 patient Fire extinguisher training for staff	Fire extinguisher training Simulation training to evaluate hoverjack and slide sheets Discuss estates option for creating adequate fire escape facilities Purchase of twenty sliding sheets order oxygen cylinder holders Evacuation practice	Gloucestershire Managed Services, Surgical	Safety	C5xL1=5	Chief Operating Officer	Divisional Board - Surgery				15/06/2020	Offord, Rebecca	Trust Risk Register

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – MARCH 2020
LECTURE HALL, REDWOOD EDUCATION CENTRE, GRH

Report Title
QUALITY AND PERFORMANCE REPORT

Sponsor and Author(s)	
Author:	Felicity Taylor-Drewe, Director Planned Care / Deputy COO
Sponsor:	Rachael De Caux, Chief Operating Officer

Executive Summary

Purpose

This report summarises the key highlights and exceptions in Trust performance for the January 2020 reporting period.

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

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

Quality Summits -Preventing Harm
Hospital Acquired Pressure Ulcers (HAPU) and Falls (with injurious harm)

- The Electronic Patient Record (EPR) digital system has now been launched at CGH as well as GRH. This gives us the ability to review HAPU and falls risk assessments in real time and on every ward.
- The Harm Hub continues to review all pressure ulcer and falls data with ward managers confirming their 3 improvement actions.
- The Specialist Tissue Viability Team have been reviewing every grade 2 pressure ulcer with ward staff and this has seen a reduction in our numbers as ward staff have been incorrectly categorising them as a grade 2 instead of grade 1. This has been a really good learning opportunity for ward staff to work with the specialist team and will improve categorisation in the future.
- The QI plan is for a launch event for the Falls improvement programme in March once the data has been reviewed for each ward.
- We are about to submit our Q3 falls data but initial audits are not showing an improvement and the data continues to demonstrate that more focused work is required in this area.
- Education has continued around the reasons and the importance of recording a lying/standing BP and there is beginning to be a slight increase in recording or a rationale if not being recorded.

Red indicators
Never event
The never events will undergo their usual investigation process and the learning will come to the Q&P Committee for assurance.

Friends and family Test results ED
This indicator is stable as there has been no real change over the year. The national question is not really suitable for ED patients (would you recommend your friends or family to come to ED?). We are developing our new platform for FFT and will be moving to the new national question in April 2020 when more useful data will be collated. Our new data system is being rolled out to staff and people are

being trained in its use. The new system does sentiment analysis and word clouds so colleagues can see positive and negative areas.

Delayed Discharge Summaries

The discharge summary is primarily for the communication of specific patient activity that has occurred in the Trust. These relate to inpatient activity or day case activity. The agreement with the CCG is a target of 88% of discharge summaries complete within 24 hours. The Quality Delivery Group members discussed the potential reasons for poor compliance. The overall performance remains poor; however the SPC chart showed there had been some improvement during the latter part of 2019. The electronic patient record (EPR) will make recording easier. Following discussion the Group agreed that Divisions would discuss further with their Tris and review through Executive Reviews to provide a level of scrutiny.

Performance

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

In January 2020, the trust performance against the 4hr A&E standard was 72.4% including system performance was 81.02%.

In respect of RTT, we are reporting 81.04% for January 2020, whilst this is below the national standard, this is above the trajectory set with NHS I. Operational teams continue to monitor and manage the long waiting patients on the Referral to Treatment pathways. As reported previously to the Board we will continue to see 52 week breaches, the teams are working to meet the trajectory of 0 breaches by the end of the financial year. Further information is provided within the exception report for specific speciality actions. The Trust is currently achieving the trajectory agreed with NHS Improvement to reduce our long waiting patient breaches.

Our performance against the cancer standard saw delivery in delivery for the 2 week standard at 94.6% (un-validated) for January. Indications are that performance for February will continue to be met for this standard.

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

Cancer 62 day Referral to Treatment (GP referral) performance for January was 65.9% (un-validated). December performance is 74.9%.

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

Key issues to note

The focus of operational teams is on delivery against the constitutional targets with particular regard to our longest waiting patients in RTT & Cancer pathways. The focus is also to deliver sustainably against the 62 day trajectory and A&E performance.

RTT performance has been sustained above the agreed trajectory and additionally has remained stable since re-reporting in March; likewise the number of 52 week waiting patients, albeit unacceptable has maintained a downward trajectory and is within the locally agreed trajectory. In addition the waiting list size is in line with agreed trajectory and less than the start of the year.
Diagnostic 6 week wait continues to deliver to the national performance standards.
For Cancer Delivery we have engaged the support of NHS I to facilitate our timed pathways and

prepare for the 28 day standards. As noted last month, the key intervention will be our diagnostic support to change the Prostate Pathway which has commenced in December as planned and so will track through to Q4 performance.

Quality delivery (with the exception of those areas discussed) remains stable, with exception reporting from divisions through QDG for monitoring and assurance.

Recommendations

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

Impact Upon Strategic Objectives

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

Impact Upon Corporate Risks

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

Regulatory and/or Legal Implications

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

Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required

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

Date the paper was presented to previous Committees						
Quality & Performance Committee	**Finance & Digital Committee**	**Audit & Assurance Committee**	**People & OD Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
26 Feb 20						
Outcome of discussion when presented to previous Committees						
Recommended for Board assurance.						

Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report

Reporting period January 2020

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

Contents

Gloucestershire Hospitals NHS Foundation Trust

Executive Summary

Gloucestershire Hospitals NHS Foundation Trust

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

The Trust performance (type 1) for the 4 hour standard in January was 72.45% against the STP trajectory at 86.19% against a backdrop of significant attendances. The system did not meet the delivery of 90% for the system in January, at 81.02%.

The Trust did not meet the diagnostics standard for January at 1.50%.

The Trust has met the standard for 2 week wait cancer at 94.90% in January, this is as yet un-validated performance at the time of the report.

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

For elective care, the RTT performance (81.06% in January) is above trajectory agreed with NHS I, work continues to ensure that the performance is stabilised. Significant work is underway to reduce our longest waiting patients of over 52 weeks, to date we have met the trajectory agreed with NHS I to reduce our breaches (28 in January).

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

Performance Against STP Trajectories

Gloucestershire Hospitals NHS Foundation Trust

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

Indicator		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Count of handover delays 30-60 minutes	Trajectory	52	50	48	46	43	40	40	40	40	40	40	40
	Actual	57	53	42	50	77	96	145	159	127	161		
Count of handover delays 60+ minutes	Trajectory	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	0	0	0	0	0	1	3	3	11	10		
ED: % total time in department – under 4 hours (types 1 & 3)	Trajectory	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
	Actual	90.39%	91.70%	91.05%	92.20%	92.01%	89.13%	86.36%	83.41%	81.18%	81.02%		
ED: % total time in department – under 4 hours (type 1)	Trajectory	85.32%	85.37%	85.17%	85.90%	85.22%	85.61%	85.89%	86.04%	85.99%	86.19%	85.36%	85.79%
	Actual	86.01%	87.99%	86.80%	88.53%	88.16%	84.03%	80.58%	76.24%	72.91%	72.45%		
Referral to treatment ongoing pathways under 18 weeks (%)	Trajectory	78.00%	78.00%	78.00%	78.30%	78.60%	79.00%	79.30%	79.60%	80.00%	80.30%	80.60%	81.00%
	Actual	79.46%	80.63%	81.11%	81.80%	81.41%	81.38%	81.33%	80.29%	80.57%	81.06%		
Referral to treatment ongoing pathways over 52 weeks (number)	Trajectory	95	93	90	86	83	80	74	67	60	40	20	0
	Actual	93	91	90	78	77	78	62	45	39	28		
% waiting for diagnostics 6 week wait and over (15 key tests)	Trajectory	0.98%	0.98%	0.99%	0.99%	0.98%	0.99%	0.98%	0.99%	0.98%	0.98%	0.98%	0.98%
	Actual	0.54%	0.67%	1.08%	0.76%	0.84%	0.72%	0.66%	1.06%	0.94%	1.50%		
Cancer – urgent referrals seen in under 2 weeks from GP	Trajectory	93.00%	93.00%	93.00%	93.00%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%
	Actual	87.50%	86.70%	89.50%	92.70%	86.00%	96.50%	94.60%	94.60%	97.00%	94.90%		
2 week wait breast symptomatic referrals	Trajectory	93.10%	93.20%	93.20%	93.30%	93.3%	93.0%	93.0%	93.1%	93.2%	93.2%	93.2%	93.2%
	Actual	96.90%	97.30%	99.00%	96.30%	98.40%	99.30%	98.10%	96.00%	97.20%	96.80%		
Cancer – 31 day diagnosis to treatment (first treatments)	Trajectory	96.10%	96.20%	96.20%	96.20%	96.2%	96.1%	96.1%	96.1%	96.2%	96.2%	96.2%	96.2%
	Actual	92.10%	92.00%	93.80%	92.60%	92.30%	91.00%	98.00%	92.20%	92.20%	94.70%		
Cancer – 31 day diagnosis to treatment (subsequent – drug)	Trajectory	98.10%	98.30%	98.20%	98.90%	98.1%	98.00%	99.0%	98.0%	98.9%	98.0%	98.0%	98.0%
	Actual	100.00%	97.50%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	98.40%		
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	Trajectory	94.90%	94.40%	94.80%	94.30%	94.0%	95.10%	95.1%	95.1%	95.1%	95.1%	95.1%	95.1%
	Actual	96.40%	97.90%	98.80%	100.00%	84.80%	80.80%	98.80%	93.80%	96.20%	94.00%		
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	Trajectory	94.00%	95.50%	95.30%	94.80%	94.4%	95.10%	95.5%	95.4%	95.6%	94.8%	94.8%	94.8%
	Actual	91.10%	89.10%	96.20%	89.60%	89.80%	97.60%	100.00%	100.00%	92.10%	94.40%		
Cancer 62 day referral to treatment (screenings)	Trajectory	90.30%	90.90%	91.70%	90.90%	91.4%	91.70%	91.4%	91.4%	92.3%	90.6%	90.6%	90.6%
	Actual	100.00%	96.60%	85.20%	85.20%	100.00%	100.00%	96.30%	96.70%	95.10%	97.70%		
Cancer 62 day referral to treatment (upgrades)	Trajectory	100.00%	100.00%	100.00%	100.00%	100%	100.00%	100%	100%	100%	100%	100%	100%
	Actual	36.40%	44.40%	63.20%	91.70%	75.00%	66.70%	61.50%	83.30%	86.70%	66.70%		
Cancer 62 day referral to treatment (urgent GP referral)	Trajectory	81.80%	82.30%	82.40%	82.60%	84.3%	85.00%	85.2%	85.0%	85.0%	85.1%	85.0%	85.0%
	Actual	80.10%	71.80%	68.20%	72.70%	75.40%	71.00%	78.00%	63.80%	73.90%	67.50%		

Summary Scorecard

Gloucestershire Hospitals NHS Foundation Trust

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

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

Safe

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

Effective

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

Caring

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

Responsive

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

Well Led

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

Demand and Activity

Gloucestershire Hospitals NHS Foundation Trust

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

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

Measure	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	% change from previous year Monthly (Jan)	YTD
GP referrals	14,521	13,202	14,044	13,094	13,415	12,709	12,061	10,302	10,429	11,836	13,356	11,169	10,191	-29.82%	-14.42%
OP attendances	14,083	12,474	13,525	12,663	13,025	13,063	13,856	11,850	13,534	14,545	13,661	10,823	13,634	-3.19%	-1.85%
Day cases	6,167	5,995	6,318	5,815	6,520	6,198	6,955	6,348	6,276	7,142	6,578	6,228	7,067	14.59%	7.41%
All electives	7,124	6,955	7,465	7,255	7,556	7,213	8,096	7,378	7,238	8,275	7,690	7,155	8,039	12.84%	6.42%
ED attendances	12,962	11,701	13,245	12,949	13,618	13,072	14,066	13,267	13,240	13,329	13,066	13,287	12,624	-2.61%	5.39%
Non electives	5,132	3,085	4,900	4,696	4,861	4,586	4,802	4,698	4,833	5,083	4,837	5,052	4,664	-9.12%	-0.56%

Trust Scorecard – Safe (1)

OVERALL SCORE

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

	18/19	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	19/20 Q3	19/20	Standard	Threshold
Infection Control																		
Number of trust apportioned MRSA bacteraemia	1	0	0	1	0	1	0	0	0	1	0	0	0	0	0	2	Zero	
MRSA bacteraemia – infection rate per 100,000 bed days						3.5				3.6						0.7	Zero	
Number of trust apportioned Clostridium difficile cases per month	56	6	5	4	7	6	7	10	9	9	11	12	7	8	30	87	2019/20: 114	
Number of hospital-onset healthcare-associated Clostridioides difficile cases per month								7	6	1	10	3	5	4	18	45	<=5	
Number of community-onset healthcare-associated Clostridioides difficile cases per month								3	4	8	1	9	2	4	12	42	<=5	
Clostridium difficile – infection rate per 100,000 bed days					24.7	20.8	25.5	35.7	32.5	32.8	37.9	42.4	24.4	29.7	34.9	30.6	<30.2	
Number of MSSA bacteraemia cases		1	0	1	0	1	1	4	1	2	2	1	2	1	5	14	<=8	
MSSA – infection rate per 100,000 bed days						3.5	3.6	14.3	3.6	7.3	6.9	3.5	7	3.3	5.8	5.3	<=12.7	
Number of ecoli cases		3	2	3	5	4	5	1	4	3	2	5	9	3	16	41	No target	
Number of pseudomona cases		0	1	0	1	0	0	2	1	0	1	0	0	3	1	7	No target	
Number of klebsiella cases		2	3	3	1	3	1	1	3	4	1	1	1	1	3	15	No target	
Number of bed days lost due to infection control outbreaks					40	66	83	70	136	0	0	240	276	100	516	1,151	<10	>30
Patient Safety Incidents																		
Number of patient safety alerts outstanding	5				5	1	0	0	0	0	0	0	0	0	0	5	Zero	
Number of falls per 1,000 bed days		6.8	7.1	6	6.6	6	5.3	6.6	5.5	6.2	6.6	6.4	6.7	7.1			<=6	
Number of falls resulting in harm (moderate/severe)	8	8	2	7	3	4	2	7	1	5	7	1	4	5			<=3	
Number of patient safety incidents – severe harm (major/death)	1	0	3	7	13	7	9	4	12	4	7	3	3	6			No target	
Medication error resulting in severe harm				0	0	0	0	0	0	0	0	0	0	0			No target	
Medication error resulting in moderate harm				1	1	3	0	2	3	1	2	1	1	5			No target	
Medication error resulting in low harm				12	10	15	10	11	11	10	21	23	7	10			No target	
Number of category 2 pressure ulcers acquired as in-patient					43	36	28	38	36	30	24	31	29	27			<=30	
Number of category 3 pressure ulcers acquired as in-patient					10	7	7	6	6	4	4	4	2	2			<=5	

Trust Scorecard – Safe (2)

OVERALL SCORE

	18/19	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	19/20 Q3	19/20	Standard	Threshold
Patient Safety Incidents																		
Number of category 4 pressure ulcers acquired as in-patient					0	0	0	0	0	0	0	0	0	0			Zero	
Number of unstagable pressure ulcers acquired as in-patient					3		3	14	12	5	6	5	2	4			<=3	
Number of deep tissue injury pressure ulcers acquired as in-patient				6	10	14	2	8	7	2	3	8	3	5			<=5	
RIDDOR																		
Number of RIDDOR		1	3	3	2	2	1	3	2	1	2	1	2	4	8	39	SPC	
Safeguarding																		
Level 2 safeguarding adult training - e-learning package									93.00%	93.00%	94.00%	95.00%					TBC	
Number of DoLs applied for											45	36	50				TBC	
Total number of maternity social concerns forms completed											55	44	53				TBC	
Safety Thermometer																		
Safety thermometer – % of new harms		97.30%	97.70%	97.20%	96.20%	97.20%	98.10%	97.40%	97.90%	96.30%	97.30%	95.80%	97.90%	96.50%			>96%	<93%
Sepsis Identification and Treatment																		
Proportion of emergency patients with severe sepsis who were given IV antibiotics within 1 hour of diagnosis		88.00%	81.00%	82.00%			64.00%			64.70%			71.00%				>=90%	<50%
Serious Incidents																		
Number of never events reported	1	0	0	1	1	0	0	1	0	0	1	0	1	1			Zero	
Number of serious incidents reported		3	0	3	2	3	4	2	1	5	4	3	1	2			No target	
Serious incidents – 72 hour report completed within contract timescale		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	99%	100%			>90%	
Percentage of serious incident investigations completed within contract timescale		100%	100%	100%	100%	100%	100%	100%	100%	100%		100%	100%	100%			>80%	
VTE Prevention																		
% of adult inpatients who have received a VTE risk assessment	93.20%	96.60%	94.20%	94.80%	95.40%	88.60%	95.80%	96.70%	92.90%	91.60%	95.90%	91.80%	92.60%	90.10%	93.50%	93.10%	>95%	

Trust Scorecard – Effective (1)

OVERALL SCORE

	18/19	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	19/20 Q3	19/20	Standard	Threshold
Dementia Screening																		
% of patients who have been screened for dementia (within 72 hours)	1.90%	1.90%	0.80%	0.60%	0.40%	0.30%	67.00%	66.00%	85.00%	63.00%	62.00%	50.00%	37.00%				>=90%	<70%
% of patients who have scored positively on dementia screening tool that then received a dementia diagnostic assessment (within 72 hours)	27.90%	40.00%	0.00%	33.30%	100%	50.00%	0.00%	0.00%	N/A	50.00%	0.00%	0.00%	18.00%				>=90%	<70%
% of patients who have received a dementia diagnostic assessment with positive or inconclusive results that were then referred for further diagnostic advice/FU (within 72 hours)	2.80%	0.00%	0.00%	0.00%	0.00%	0.00%	N/A	N/A	N/A	50.00%	N/A	N/A	0.00%				>=90%	<70%
Maternity																		
% of women on a Continuity of Carer pathway														4.30%			No target	
% C-section rate (planned and emergency)	26.78%			29.71%	28.93%	30.20%	29.19%	32.49%	25.61%	27.99%	25.97%	26.57%	31.30%	28.66%	27.82%	28.39%	<=27%	>=30%
% emergency C-section rate	14.13%			16.11%	16.31%	16.73%	15.78%	17.42%	14.02%	16.04%	13.70%	15.77%	13.48%	13.60%	14.27%	15.74%	No target	
% of women booked by 12 weeks gestation	89.80%	89.80%	90.50%	91.50%	89.70%	88.00%	87.90%	89.00%	85.30%	89.60%	91.80%	92.20%	91.90%	90.30%	92.00%	88.70%	>90%	
% of women that have an induced labour	29.19%			31.17%	29.13%	27.96%	28.99%	28.38%	26.83%	29.66%	29.04%	29.59%	30.00%	27.20%	29.45%	28.65%	<=30%	>33%
% of women smoking at delivery	11.21%	7.79%	13.05%	10.46%	12.06%	11.22%	11.83%	9.78%	10.16%	9.14%	10.22%	13.63%	11.52%	13.18%	11.72%	10.95%	<=14.5%	
% stillbirths as percentage of all pregnancies > 24 weeks	0.26%			0.21%	0.39%	0.00%	0.00%	0.38%	0.20%	0.19%	0.20%	0.43%	0.43%	0.21%	0.35%	0.22%	<0.52%	
Mortality																		
Summary hospital mortality indicator (SHMI) – national data	1	1	1	1	1.1	1.1	1.1	1.1	1.1							1.1	NHS Digital	
Hospital standardised mortality ratio (HSMR)	94.5	97.2	95.2	94.5	96.5	96.8	100.1	98.6	98	97.6	99.7					99.7	Dr Foster	
Hospital standardised mortality ratio (HSMR) – weekend	96.8	101.3	97.2	96.8	96.9	96.4	97.6	97.9	100.5	101.6	102.7					102.7	Dr Foster	
Number of inpatient deaths				168	165	159	166	125	124	143	144	152	211	214	507	1,603	No target	
Number of deaths of patients with a learning disability				2	4	1	1	2	2	0	0	0	1	4	1	15	No target	
Readmissions																		
Emergency re-admissions within 30 days following an elective or emergency spell	6.70%	6.50%	6.60%	6.40%	7.30%	7.10%	6.50%	6.40%	7.50%	7.20%	6.70%	7.10%	6.40%		6.70%	6.90%	<8.25%	>8.75%
Research																		
Research accruals	1,621	71	81	91	115	119	134	123	103	76	121	101	73	110	288		No target	

Trust Scorecard – Effective (2)

OVERALL SCORE

	18/19	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	19/20 Q3	19/20	Standard	Threshold
Stroke Care																		
Stroke care: percentage of patients receiving brain imaging within 1 hour	36.90%	37.10%	32.70%	22.40%	52.10%	55.30%	43.80%	53.50%	50.60%	48.60%	52.50%	39.40%	48.70%	45.20%	47.10%	49.10%	>=50%	<45%
Stroke care: percentage of patients spending 90%+ time on stroke unit	90.80%	88.70%	84.10%	87.70%	85.70%	96.30%	87.10%	80.90%	98.80%	87.90%	84.50%	81.10%	87.30%		84.40%	87.70%	>=80%	<70%
% of patients admitted directly to the stroke unit in 4 hours				51.70%	68.10%	62.70%	62.00%	67.90%	68.40%	62.00%	64.90%	41.40%	40.00%	38.40%	49.10%	57.80%	>=80%	<72%
% patients receiving a swallow screen within 4 hours of arrival				70.70%	52.10%	59.20%	63.80%	66.30%	64.90%	69.40%	70.00%	66.20%	56.60%	61.60%	64.30%	63.10%	>=90%	<80%
Trauma & Orthopaedics																		
% of fracture neck of femur patients treated within 36 hours	76.00%	83.90%	85.60%	77.80%	77.00%	81.80%	82.20%	67.10%	46.60%	66.70%	39.60%	56.10%	58.30%	73.10%	52.00%	63.90%	>=90%	<80%
% fractured neck of femur patients meeting best practice criteria				77.78%	77.78%	81.82%	80.49%	65.70%	45.21%	66.70%	37.90%	56.06%	58.30%	73.10%	51.50%	63.00%	>=65%	<55%

Trust Scorecard – Caring (1)

OVERALL SCORE

	18/19	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	19/20 Q3	19/20	Standard	Threshold
Friends & Family Test																		
Inpatients % positive	91.20%	91.90%	89.20%	91.50%	89.10%	90.80%	91.60%	90.70%	91.10%	91.50%	90.60%	91.80%	90.20%	90.20%	90.80%	90.80%	>=96%	<93%
ED % positive	83.10%	82.70%	82.80%	82.70%	82.70%	81.90%	85.30%	79.80%	83.30%	82.30%	82.90%	87.90%	78.90%	79.90%	82.50%	82.30%	>=84%	<81%
Maternity % positive	96.70%	100%	93.50%	97.50%	96.60%	97.00%	87.10%	96.20%	100%	96.90%	100%	0.00%	100%	100%	100%	97.20%	>=97%	<94%
Outpatients % positive	92.60%	93.40%	92.50%	93.10%	92.80%	93.20%	92.50%	92.80%	93.20%	92.70%	92.80%	93.80%	93.20%	93.10%	93.20%	93.00%	>=94%	<91%
Total % positive	91.20%	91.90%	90.70%	91.40%	90.60%	91.10%	91.40%	90.70%	91.30%	91.00%	91.10%	92.80%	91.30%	91.40%	91.50%	91.20%	>=93%	<90%
Inpatient Questions (Real time)																		
How much information about your condition or treatment or care has been given to you?					71.57%	77.35%	79.55%	79.67%	83.69%	77.40%	83.00%	83.00%	74.00%	81.00%	80.00%	79.00%	>=90%	
Are you involved as much as you want to be in decisions about your care and				89.66%	94.06%	89.44%	89.65%	90.61%	95.03%	89.66%	93.00%	91.00%	88.00%	93.00%	91.00%	92.00%	>=90%	
Do you feel that you are treated with respect and dignity?				99.32%	93.07%	97.16%	94.26%	96.09%	98.58%	99.32%	98.00%	100%	97.00%	99.00%	99.00%	98.00%	>=90%	
Do you feel well looked after by staff treating or caring for you?					96.97%	97.71%	95.37%	98.33%	97.16%	99.31%	99.00%	98.00%	98.00%	100%	98.00%	99.00%	>=90%	
Do you get enough help from staff to eat your meals?					95.96%	98.86%	95.93%	97.20%	97.17%	100%	100%	90.00%	63.00%	80.00%	81.00%	89.00%	>=90%	
In your opinion, how clean is your room or the area that you receive treatment in?					96.88%	95.93%	95.81%	96.45%	96.40%	90.97%	100%	98.00%	99.00%	98.00%	99.00%	99.00%	>=90%	
Do you get enough help from staff to wash or keep yourself clean?					96.97%	98.29%	94.74%	98.87%	97.86%	99.32%	100%	85.00%	96.00%	97.00%	90.00%	96.00%	>=90%	
MSA																		
Number of breaches of mixed sex accommodation	68	2	1	3	4	11	18	16	11	9	0	0	2	2	2	73	<=10	>=20

Trust Scorecard – Responsive (1)

OVERALL SCORE

	18/19	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	19/20 Q3	19/20	Standard	Threshold
Cancer																		
Cancer – urgent referrals seen in under 2 weeks from GP	90.00%	92.00%	93.90%	95.20%	87.50%	86.70%	89.50%	92.70%	86.00%	96.50%	94.60%	94.60%	97.00%	94.90%	95.40%	91.90%	>=93%	<90%
2 week wait breast symptomatic referrals	95.80%	95.50%	97.00%	95.60%	96.90%	97.30%	99.00%	96.30%	98.40%	99.30%	98.10%	96.00%	97.20%	96.80%	97.10%	97.40%	>=93%	<90%
Cancer – 31 day diagnosis to treatment (first treatments)	94.60%	92.90%	91.60%	92.10%	92.10%	92.00%	93.80%	92.60%	92.30%	91.00%	98.00%	92.20%	92.20%	94.70%	94.50%	93.00%	>=96%	<94%
Cancer – 31 day diagnosis to treatment (subsequent – drug)	99.90%	100%	100%	100%	100%	97.50%	100%	100%	100%	100%	100%	100%	100%	98.40%	100%	99.60%	>=98%	<96%
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	95.30%	93.20%	96.60%	96.60%	91.10%	89.10%	96.20%	89.60%	89.80%	97.60%	100%	100%	92.10%	94.40%	97.40%	94.00%	>=94%	<92%
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	99.30%	100%	98.90%	98.70%	96.40%	97.90%	98.80%	100%	84.80%	80.80%	98.80%	93.80%	96.20%	94.00%	97.40%	94.40%	>=94%	<92%
Cancer 62 day referral to treatment (urgent GP referral)	74.80%	76.80%	66.20%	77.40%	80.10%	71.80%	68.20%	72.70%	75.40%	71.00%	78.00%	63.80%	73.90%	67.50%	72.60%	72.50%	>=85%	<80%
Cancer 62 day referral to treatment (screenings)	96.50%	94.10%	96.40%	100%	100%	96.60%	85.20%	85.20%	100%	100%	96.30%	96.70%	95.10%	97.70%	96.10%	94.70%	>=90%	<85%
Cancer 62 day referral to treatment (upgrades)	68.90%	71.40%	60.00%	77.30%	36.40%	44.40%	63.20%	91.70%	75.00%	66.70%	61.50%	83.30%	86.70%	66.70%	77.50%	69.60%	>=90%	<85%
Number of patients waiting over 104 days with a TCI date	141	8	8	14	20	15	20	18	13	9	15	12	6	5	33	163	Zero	
Number of patients waiting over 104 days without a TCI date	347	42	37	25	19	30	21	37	32	28	36	22	25	19	83	373	<=24	
Diagnostics																		
% waiting for diagnostics 6 week wait and over (15 key tests)	0.45%	0.67%	0.21%	0.45%	0.54%	0.67%	1.08%	0.76%	0.84%	0.72%	0.66%	1.06%	0.94%	1.50%	0.94%	1.50%	<=1%	>2%
The number of planned / surveillance endoscopy patients waiting at month end	726	639	600	726	835	872	966	770	714	756	756	763	835	853	835	853	<=600	
Discharge																		
Number of patients delayed at the end of each month	37	29	24	43	45	39	18	43	41	35	44	32	22	55	22	55	<=38	
Patient discharge summaries sent to GP within 24 hours	50.60%	51.80%	49.60%	51.00%	56.60%	54.60%	53.20%	57.90%	55.70%	56.50%	58.00%	56.40%	56.30%		56.90%	56.20%	>=88%	<75%

Trust Scorecard – Responsive (2)

OVERALL SCORE

	18/19	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	19/20 Q3	19/20	Standard	Threshold
Emergency Department																		
ED: % total time in department – under 4 hours (type 1)	89.60%	84.46%	86.08%	87.13%	86.01%	87.99%	86.80%	88.53%	88.16%	84.03%	80.58%	76.24%	72.91%	72.45%	76.58%	82.46%	>=95%	<90%
ED: % total time in department – under 4 hours (types 1 & 3)	92.78%	89.02%	90.21%	91.00%	90.39%	91.70%	91.05%	92.20%	92.01%	89.13%	86.36%	83.41%	81.18%	81.02%	83.65%	87.85%	>=95%	<90%
ED: % total time in department – under 4 hours CGH	96.40%	93.70%	95.50%	96.10%	94.66%	96.04%	96.40%	95.44%	96.20%	92.68%	95.54%	90.92%	88.74%	91.50%	91.73%	93.70%	>=95%	<90%
ED: % total time in department – under 4 hours GRH	86.20%	80.10%	81.60%	82.80%	81.89%	84.16%	82.77%	85.09%	84.25%	79.90%	73.72%	69.25%	65.20%	63.30%	69.39%	77.10%	>=95%	<90%
ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission)	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	Zero	
ED: % of time to initial assessment – under 15 minutes	87.40%	85.20%	83.60%	78.40%	75.80%	78.30%	77.30%	71.30%	75.70%	71.40%	68.40%	66.50%	64.30%	68.00%	66.40%	71.70%	>=95%	<92%
ED: % of time to start of treatment – under 60 minutes	33.50%	34.90%	32.40%	32.60%	32.00%	35.90%	37.20%	30.30%	31.20%	29.90%	28.30%	26.60%	26.00%	31.90%	27.00%	30.80%	>=90%	<87%
% of ambulance handovers that are over 30 minutes				7.90%	1.66%	1.28%	1.01%	1.25%	1.93%	2.48%	3.48%	3.71%	2.81%	3.76%	3.33%	2.32%	<=2.96%	
% of ambulance handovers that are over 60 minutes				0.10%	0.00%	0.00%	0.00%	0.00%	0.00%	0.02%	0.07%	0.07%	0.24%	0.23%	0.13%	0.06%	<=1%	>2%
Operational Efficiency																		
Cancelled operations re-admitted within 28 days					72.09%	64.29%	41.67%	96.30%	90.48%	95.12%	91.18%	64.71%	80.00%	88.89%	80.99%	81.33%	>=95%	
Urgent cancelled operations					0	0	0	0	0	2	3	0	1	1	4	7	No target	
Number of patients stable for discharge	73	74	72	77	86	77	63	79	88	88	90	87	81	112	86	85	<=70	
% of bed days lost due to delays					4.74%	3.78%	2.24%	3.42%	4.26%	4.51%	3.71%	3.28%	2.77%	4.49%	2.77%	4.49%	<=3.5%	>4%
Number of stranded patients with a length of stay of greater than 7 days	384	399	412	397	389	391	370	371	360	371	380	406	403	431	396	387	<=380	
Average length of stay (spell)	5.03	5.16	5.36	4.97	5.03	5.31	4.82	4.85	4.75	4.85	4.82	4.92	5.22	5.66	4.98	5.02	<=5.06	
Length of stay for general and acute non-elective (occupied bed days) spells	5.66	5.68	6.04	5.62	5.53	5.94	5.38	5.45	5.25	5.38	5.35	5.56	5.78	6.45	5.56	5.6	<=5.65	
Length of stay for general and acute elective spells (occupied bed days)	2.71	2.8	2.8	2.64	2.77	2.68	2.55	2.58	2.69	2.53	2.74	2.57	2.77	2.34	2.69	2.65	<=3.4	>4.5
% day cases of all electives				84.60%	80.00%	86.28%	85.92%	85.91%	86.04%	86.71%	86.31%	85.54%	87.04%	87.91%	86.30%	85.79%	>80%	<70%
Intra-session theatre utilisation rate				84.70%	87.80%	88.49%	85.50%	87.40%	87.60%	87.70%	88.20%	88.00%	87.40%	86.40%	87.90%	87.80%	>85%	<70%

Trust Scorecard – Responsive (3)

OVERALL SCORE

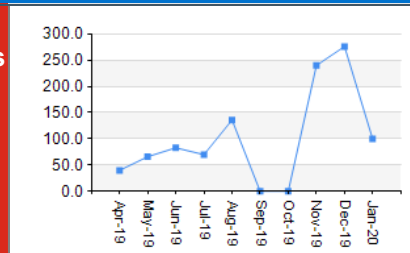
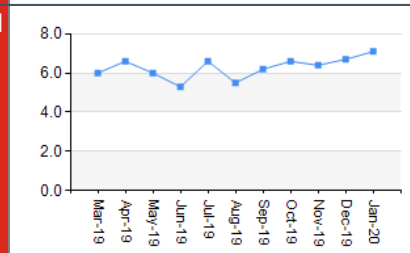
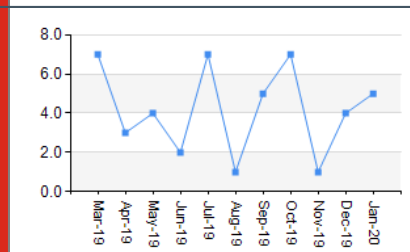
	18/19	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	19/20 Q3	19/20	Standard	Threshold
Outpatient																		
Outpatient new to follow up ratio's				1.93	1.92	1.91	1.91	1.88	1.92	1.8	1.75	1.81	1.88	1.83	1.81	1.86	<=1.9	
Did not attend (DNA) rates				6.40%	6.80%	6.80%	6.80%	7.00%	6.90%	7.20%	6.70%	6.80%	7.00%	6.90%	6.80%	6.90%	<=7.6%	>10%
RTT																		
Referral to treatment ongoing pathways under 18 weeks (%)				79.75%	79.46%	80.63%	81.11%	81.80%	81.41%	81.38%	81.33%	80.29%	80.57%	81.06%	80.57%	81.06%	>=92%	
Referral to treatment ongoing pathways 35+ Weeks (number)				2,352	2,163	2,149	1,953	1,772	1,703	1,699	1,650	1,792	1,790	1,658	1,790	1,658	No target	
Referral to treatment ongoing pathways 40+ Weeks (number)				1,860	1,699	1,748	1,626	1,437	1,378	1,390	1,312	824	1,263	1,298	1,263	1,298	No target	
Referral to treatment ongoing pathways over 52 weeks (number)	95	89	97	95	93	91	90	78	77	78	62	45	39	28	39	28	Zero	
SUS																		
Percentage of records submitted nationally with valid GP code	100%	100%	100%	100%	100%	99.90%	100%	100%	100%	99.80%	99.80%	99.80%	99.90%			99.90%	>=99%	
Percentage of records submitted nationally with valid NHS number	99.80%	99.80%	99.80%	99.80%	99.90%	99.40%	99.80%	99.80%	99.80%	99.80%	99.80%	99.90%	99.80%			99.80%	>=99%	

Trust Scorecard – Well Led (1)

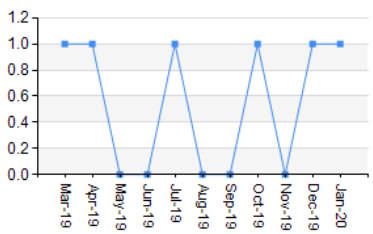
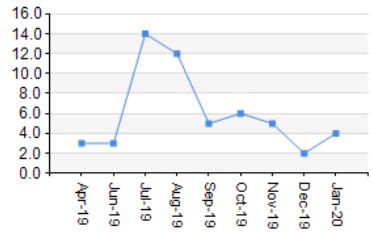
OVERALL SCORE

	18/19	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	19/20 Q3	19/20	Standard	Threshold
Appraisal and Mandatory Training																		
Trust total % overall appraisal completion	79.00%	79.00%	79.00%	81.00%	80.00%	81.00%	82.00%	83.00%	81.00%	79.00%	80.00%	82.00%	82.00%	83.00%	82.00%	82.00%	>=90%	<70%
Trust total % mandatory training	89%	89%	89%	91%	91%	91%	92%	92%	92%	91%	91%	92%	92%	90%	92%	92%	>=90%	<70%
Finance																		
Total PayBill Spend		29.4	29.9	33.3	31.8	30.8	30.9	30.7	31.7	30.9	31.5	31.3	31.4	30.1				
YTD Performance against Financial Recovery Plan		-3	-6.6	-14.1	0.2	0.3	0.6	0.5	0.5	0.6	0.7	0.6	0.4	0.3				
Cost Improvement Year to Date Variance		0	-1,784	-3,378	0	1	1	2	2	2	1	1	-2	-2				
NHSI Financial Risk Rating		3	4	4	4	3	3	3	3	3	3	3	3	3				
Capital service		4	4	4	4	4	4	4	4	4	4	4	4	4				
Liquidity		4	4	4	4	4	4	4	4	4	4	4	4	4				
Agency – Performance Against NHSI Set Agency Ceiling		3	3	3	3	3	4	3	3	3	3	3	3	3				
Safe Nurse Staffing																		
Overall % of nursing shifts filled with substantive staff					96.55%	96.40%	95.10%	97.40%	95.40%	96.40%	98.40%	99.40%	98.30%	99.30%	98.69%	97.30%	>=75%	<70%
% registered nurse day					97.90%	97.90%	96.60%	98.70%	96.50%	97.40%	99.40%	100.7%	98.70%	98.50%	99.58%	98.20%	>=90%	<80%
% unregistered care staff day					97.00%	99.20%	99.40%	101%	99.40%	98.60%	101.4%	104.2%	98.60%	102.1%	101.3%	100.1%	>=90%	<80%
% registered nurse night					94.10%	93.50%	92.40%	94.80%	93.30%	94.50%	96.40%	97.10%	97.50%	100.8%	97.03%	95.50%	>=90%	<80%
% unregistered care staff night					100.3%	99.40%	104.8%	105.7%	105.3%	106.7%	108.6%	115.5%	105.4%	107.8%	109.6%	105.9%	>=90%	<80%
Care hours per patient day RN				6.2	4.61	4.6	4.7	4.8	4.7	4.7	4.7	4.8	4.9	4.6	4.8	4.7	>=5	
Care hours per patient day HCA				3.2	2.8	2.9	3	3	3	2.9	3	3	3	2.9	3	3	>=3	
Care hours per patient day total	7.1	7.3	7.2	8.1	7.4	7.5	7.7	7.8	7.6	7.6	7.7	7.8	7.9	7.6	7.8	7.7	>=8	
Vacancy and WTE																		
% total vacancy rate					9.03%	10.02%	9.54%	8.65%	8.60%	7.20%	7.00%	6.95%	7.00%				<=11.5%	>13%
% vacancy rate for doctors					8.07%	8.86%	8.53%	8.20%	0.53%	2.70%	2.25%	2.80%	2.80%				<=5%	>5.5%
% vacancy rate for registered nurses					12.09%	9.52%	9.42%	8.65%	8.65%	8.07%	8.22%	8.30%	8.30%				<=5%	>5.5%
Staff in post FTE					6181.16	6150.11	6148.56	6171.97	6226.64	6350.1	6358.09	6354.32	6355	6351.41			No target	
Vacancy FTE					610	683	650	652.42	500	492.55	478.95	474.24	475				No target	
Starters FTE					65.5	52.8	45.2	66.66	60.55	147.7	72.72	51.61	69.42				No target	
Leavers FTE					55.14	37.5	57.4	44.69	46.75	84.63	40.81	47.02	49.37				No target	
Workforce Expenditure and Efficiency																		
% turnover	11.80%	11.70%	11.90%	12.20%	11.80%	11.60%	11.60%	11.80%	11.10%	11.90%	11.60%	11.70%	11.80%				<=11%	>15%
% turnover rate for nursing	10.99%				1.09%	10.93%	10.87%	10.99%	10.77%	11.40%	11.09%	10.75%	10.75%				<=11%	>15%
% sickness rate	3.90%	3.90%	3.90%	3.90%	3.90%	3.40%	3.80%	3.80%	3.90%	3.90%	3.90%	3.90%	4.00%	3.80%			<=3.5%	>4%

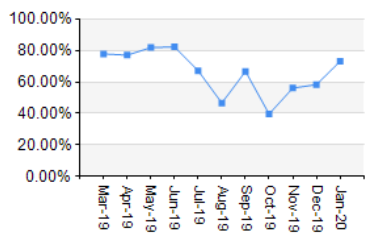
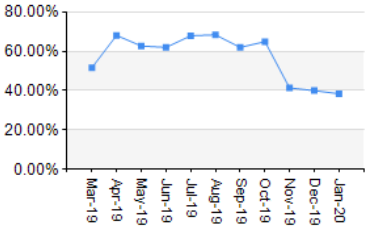
Exception Reports – Safe (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of bed days lost due to infection control outbreaks **Standard: <10**		During January there were a number of wards affected by outbreaks of either Influenza or Norovirus. Bays and wards were closed as part of outbreak management to control transmission of infection to other patients. Outbreak affected ward areas were reviewed daily by the Infection Prevention and Control Team and management plans discussed with the site team. Beds were re-opened in affected areas when the outbreak was deemed to be over and safe to do so.	**Associate Chief Nurse and Deputy Director of Infection Prevention and Control**
Number of falls per 1,000 bed days **Standard: <=6**		The number of falls during January 2020 was 214. The rate is the highest since the winter of 2019. Restricted visiting during January may have had an impact on increasing the number of falls.	**Director of Safety**
Number of falls resulting in harm (moderate/severe) **Standard: <=3**		The number of moderate harm falls and above remains lower than the same period last year and despite an increase in the total number of falls.	**Director of Safety**

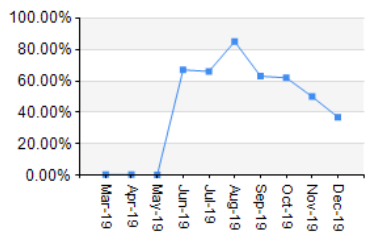
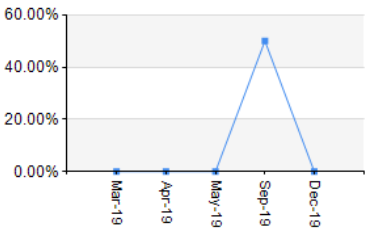
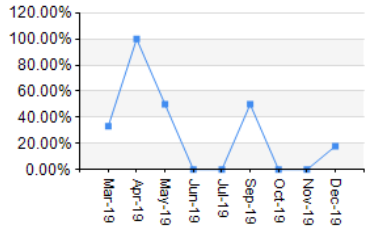
Exception Reports – Safe (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of never events reported **Standard: Zero**		The Never Event (wrong implant) will be investigated following the normal process. In addition the packaging from the equipment has been reported to the MHRA and company as a significant contributory factor.	**Director of Safety**
Number of unstagable pressure ulcers acquired as in-patient **Standard: <=3**		There were 4 unstageable pressure ulcers during January 2020. Two of these were on Gallery Ward, one on 8b and one on 9b. All of these cases are investigated at ward level with support from the Tissue Viability Team.	**Deputy Nursing Director & Divisional Nursing Director - Surgery**

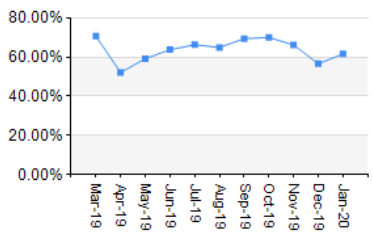
Exception Reports – Effective (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of fracture neck of femur patients treated within 36 hours **Standard: >=90%**		Action plan in place but increase in trauma have resulted in cancellations of elective list provision. Escalation policy from T&O service line in place. Trauma Task and Finish group now chaired by Deputy COO. Plan, Do, Study, Act (PDSA) cycles. For example extended theatre lists for 2 weeks. Issues with radiology capacity remain and the team are looking to review lists to support this. In addition we are supporting through site management the ring-fencing of a #NOF bed daily. The team are reviewing the placement of patients with the site management team to see if any further cohorting or pull back to the trauma wards can be undertaken.	**Director of Operations - Surgery**
% of patients admitted directly to the stroke unit in 4 hours **Standard: >=80%**		Deterioration of 24% on December performance (62.40%). 17 patients breached the target in the month of December. Of these 17: 3 patients were an inpatient already when the stroke presented and experienced a delayed transfer. 9 patients were delayed due to lack of beds - non-Strokes on the Stroke ward due to increased demand for medical beds at GRH during this period. 4 patients were delayed due to an unclear diagnosis which led to them initially being admitted to AMU for further tests. 1 patient was too unwell to move from ED and subsequently died as a result of their condition.	**Director of Unscheduled Care and Deputy Chief Operating Officer**

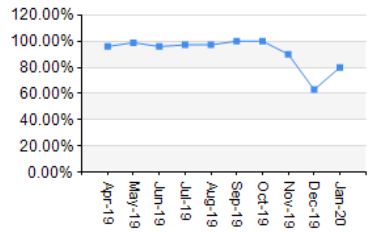
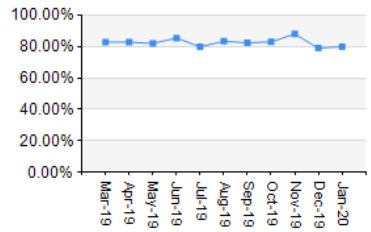
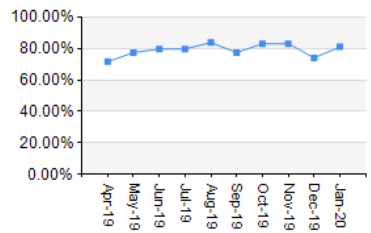
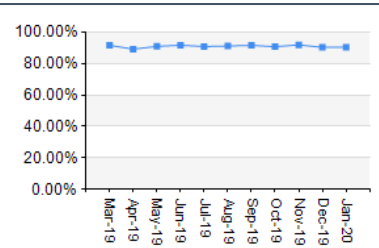
Exception Reports – Effective (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of patients who have been screened for dementia (within 72 hours) **Standard: >=90%**		Actions continuing through divisions	**Deputy Chief Nurse**
% of patients who have received a dementia diagnostic assessment with positive or inconclusive results that were then referred for further diagnostic advice/FU (within 72 hours)		Manual audit continuing, we are currently reviewing how EPR can support further through looking at TRusts who have a good compliance	**Deputy Chief Nurse**
% of patients who have scored positively on dementia screening tool that then received a dementia diagnostic assessment (within 72 hours) **Standard: >=90%**		Manual audit continuing, we are currently reviewing how EPR can support further through looking at TRusts who have a good compliance	**Deputy Chief Nurse**

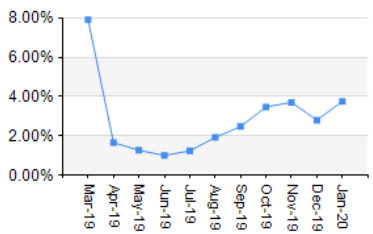
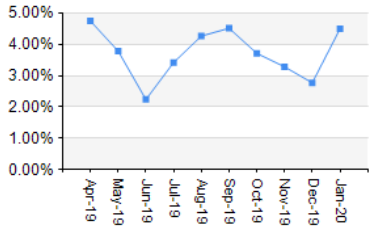
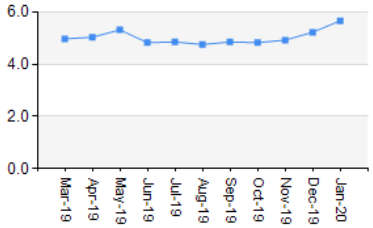
Exception Reports – Effective (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% patients receiving a swallow screen within 4 hours of arrival **Standard: >=90%**		Deterioration of 2.5% on December performance (64.10%). 28 patients breached the target in the month of December. Of those 28: 3 patients were an inpatient when stroke presented and were delayed in transfer to stroke unit due to lack of bed capacity. 9 patients were delayed in receiving a bed on the Stroke Unit and therefore had a delayed swallow screening. 4 patients had an unclear diagnosis on initial presentation and therefore were a late diagnosis. Knock on impact were delays to each of the onward pathway elements as a result. 8 patients were too unwell to receive a swallow screen within the four hour target. 4 patients had an unknown breach reason.	**Director of Unscheduled Care and Deputy Chief Operating Officer**

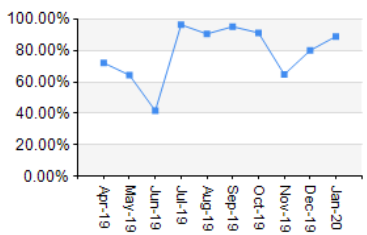
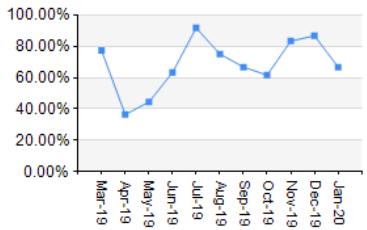
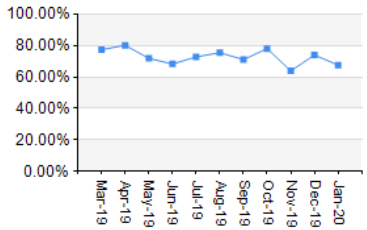
Exception Reports – Caring (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Do you get enough help from staff to eat your meals? **Standard: >=90%**		This information has reported through to DDQNs for improvement plans to be identified.	**Head of Patient Experience Improvement**
ED % positive **Standard: >=84%**		This has been shared with DDQN for ongoing monitoring and to support improvement. Patient Experience team are working with divisions to identify new methodologies and approaches as part of new FFT roll out from April that could improve response rates and quality of data returned.	**Deputy Director of Quality**
How much information about your condition or treatment or care has been given to you? **Standard: >=90%**		Work is happening in divisions looking to address this, with communication tools being piloted in some surgical teams, and medicine division delivering work looking at improving discharge and the need for better conversations throughout someone's stay.	**Head of Patient Experience Improvement**
Inpatients % positive **Standard: >=96%**		This has been shared with DDQN for ongoing monitoring and to support improvement. Patient Experience team are working with divisions to identify new methodologies and approaches as part of new FFT roll out from April that could improve response rates and quality of data returned.	**Deputy Director of Quality**

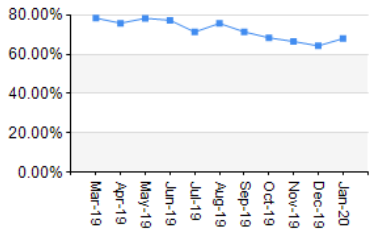
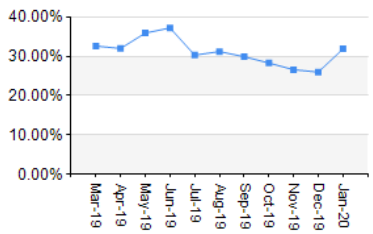
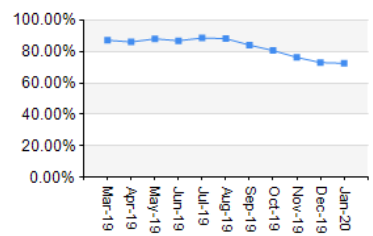
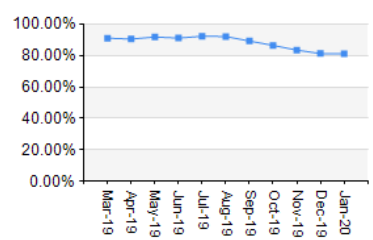
Exception Reports – Responsive (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of ambulance handovers that are over 30 minutes **Standard: <=2.96%**		There has been a decrease in the total number of handover delays over 1 hour. The longest delay was 1 hour 24 minutes with an average handover delay of 1 hour and 12 minutes. Factors behind the delays are lack of physical space in which to offload and lack of trolleys and chairs due to the increase in pre-empting patients up to the ward.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
% of bed days lost due to delays **Standard: <=3.5%**		End of January showed total bed days lost due to delays as 4.49%. The increase in our figures are attributable to infection control ward closures, lack of capacity in the community and delays in having patients assessed	**Director of Unscheduled Care and Deputy Chief Operating Officer**
Average length of stay (spell) **Standard: <=5.06**		Capacity and Flow meeting attended by all Divisions with actions/outcomes including Criteria Led discharge and Ward tool kit which provides information on LOS Led by Matt Little and Sandra Attwood EDD and ADD, SORT criteria and Red to Green reinforced. All wards review 21 day LOS and now 14 days ERAS programme - underway	**Deputy Chief Operating Officer**

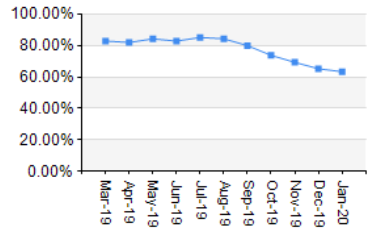
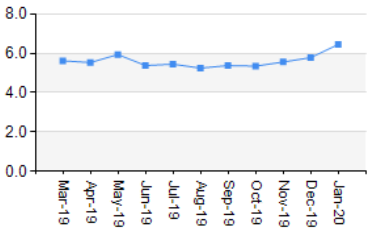
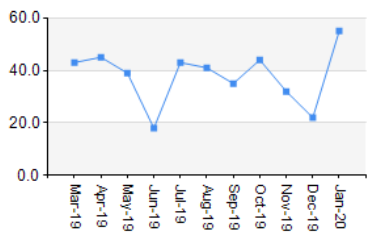
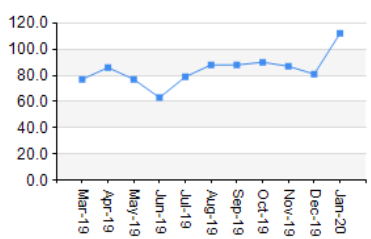
Exception Reports – Responsive (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Cancelled operations re-admitted within 28 days **Standard: >=95%**		Cancellated operations have a workstream within the Theatre Collaborative meeting, they are reviewed at speciality level. Work to support communication with patients to re-confirm TCI dates (i.e. calling patients 2 days before / text messages) are being investigated.	**Deputy Chief Operating Officer**
Cancer 62 day referral to treatment (upgrades) **Standard: >=90%**		Performance - 66.7% No target 6 treatments 2 breaches Lung = 1 Uro = 1	**Director of Planned Care and Deputy Chief Operating Officer**
Cancer 62 day referral to treatment (urgent GP referral) **Standard: >=85%**		62 day GP performance (unvalidated) = 65.6% target = 85% National performance = 77.4% 163 treatments 56 breaches Uro - 26 LGI - 10 Skin - 5 Lung 2.5 Delay to imaging - 11 Tertiary breaches - 5 Patient initiated delay - 2	**Director of Planned Care and Deputy Chief Operating Officer**

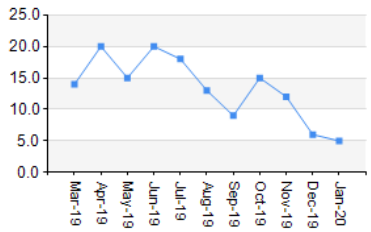
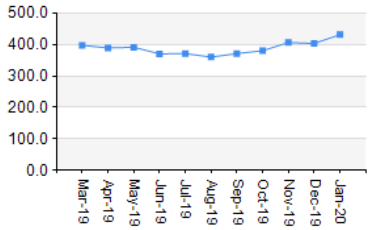
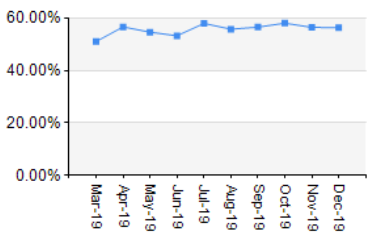
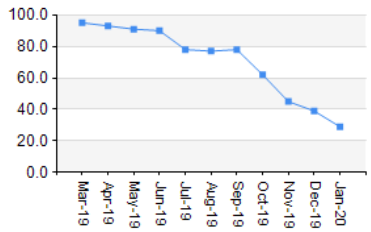
Exception Reports – Responsive (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % of time to initial assessment – under 15 minutes **Standard: >=95%**		Additional triage resource has impacted the improvement in performance in this metric at GRH. The change in referral pathway for GP expected patients will have impacted this metric at GRH.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % of time to start of treatment – under 60 minutes **Standard: >=90%**		Average time to see a Doctor has decreased despite the challenges seen in both departments throughout the month	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % total time in department – under 4 hours (type 1) **Standard: >=95%**		The number of trolley waits has increased at GRH but decreased at CGH. This metric reflects the pressures in flow through the Hospital	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % total time in department – under 4 hours (types 1 & 3) **Standard: >=95%**		The number of trolley waits has increased at GRH but decreased at CGH. This metric reflects the pressures in flow through the Hospital	**Director of Unscheduled Care and Deputy Chief Operating Officer**

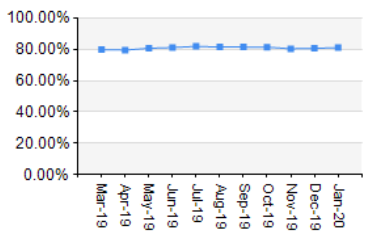
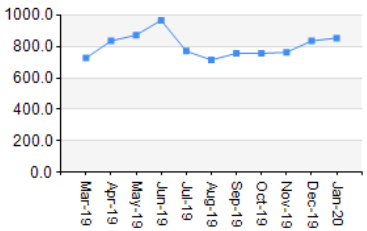
Exception Reports – Responsive (4)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % total time in department – under 4 hours GRH **Standard: >=95%**		The number of trolley waits has increased at GRH but decreased at CGH. This metric reflects the pressures in flow through the Hospital	**Director of Unscheduled Care and Deputy Chief Operating Officer**
Length of stay for general and acute non-elective (occupied bed days) spells **Standard: <=5.65**		Capacity and Flow meeting attended by all Divisions with actions/outcomes including Criteria Led discharge and Ward tool kit which provides information on LOS Led by Matt Little and Sandra Attwood EDD and ADD, SORT criteria and Red to Green reinforced. All wards review 21 day LOS and now 14 days ERAS programme - underway	**Deputy Chief Operating Officer**
Number of patients delayed at the end of each month **Standard: <=38**		There were 55 DTOC's at the end of January- 30 of these DTOC's were coded as 'Waiting for Assessment' with 20/30 being attributable to ASC. 4/55 patients were waiting for further non-acute care, 3/55 patients were waiting for nursing home placement or availability, 9/55 awaiting package of care in their own home with 6/9 being attributable to ASC.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
Number of patients stable for discharge **Standard: <=70**		The number of our patients MSFD has increased this month and this is attributable to length of time waiting for assessment either by ASC or therapies. There have also been ward closures due to infection control issues which has also been a problem in the community thus hindering OCT's ability to get some of the complex discharges actioned. OCT continue to support the wards and encourage a decision on discharge pathways as a priority.	**Director of Unscheduled Care and Deputy Chief Operating Officer**

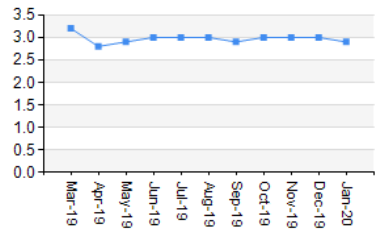
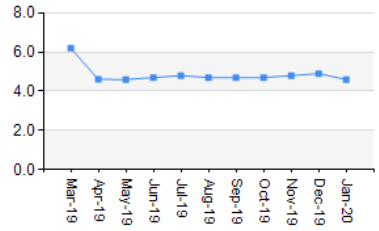
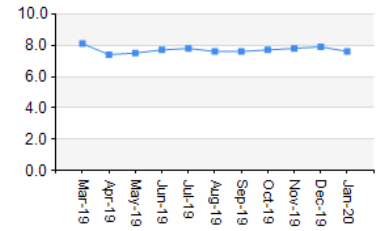
Exception Reports – Responsive (5)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of patients waiting over 104 days with a TCI date **Standard: Zero**		Specialties Breast 1 Urological 3 Lower GI 1 Grand Total 5	**Director of Planned Care and Deputy Chief Operating Officer**
Number of stranded patients with a length of stay of greater than 7 days **Standard: <=380**		System partners review underway as numbers worsening.	**Deputy Chief Operating Officer**
Patient discharge summaries sent to GP within 24 hours **Standard: >=88%**		Report presented to QDG this month, divisions to plans to improve performance, to be monitored at executive reviews.	**Medical Director**
Referral to treatment ongoing pathways over 52 weeks (number) **Standard: Zero**		The Trust continues to see a reduction in the longest waiting patients, whilst not acceptable January was within the trajectory agreed with NHS I.	**Deputy Chief Operating Officer**

Exception Reports – Responsive (6)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Referral to treatment ongoing pathways under 18 weeks (%) **Standard: >=92%**		Performance is in line with agreed trajectory. As is the reduction in the waiting list since April 2019 to January 2020, from 58,374 o 55,623	**Deputy Chief Operating Officer**
The number of planned / surveillance endoscopy patients waiting at month end **Standard: <=600**		There has been a slight increase in the number of patients waiting past recall due to increased pressures in month on the 2ww colorectal straight to test pathway and 6ww diagnostic pathway. Patients are being prioritised in order of clinical urgency and then longest waiting. The specialty are still in the process of clinically validating the waiting list and it is anticipated this will further reduce the backlog through discharging back to GP. Further capacity has been organised January - March 2020 to clear the longest waiting patients (278) via GLANSO and 18 Weeks Support insourcing.	**Medical Director**

Exception Reports – Well Led (1)

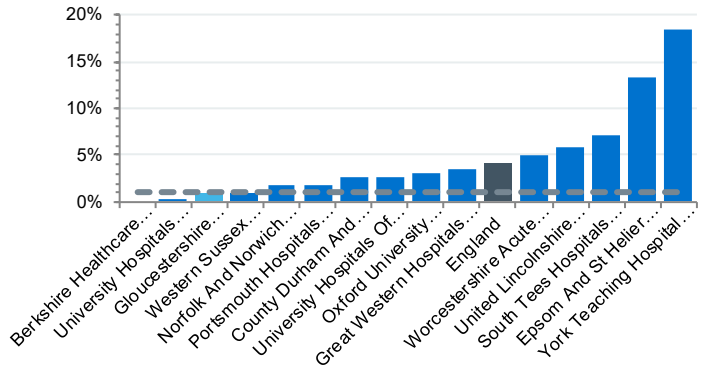
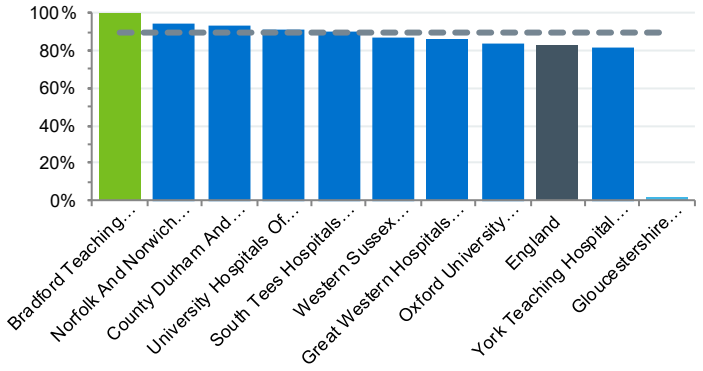
Metric Name & Standard	Trend Chart	Exception Notes	Owner
Care hours per patient day HCA **Standard: >=3**		Increased activity and demand has impacted on this months figures. Also escalation areas open which required additional staffing. Monthly substantive and bank HCA recruitment continues. Workshop has taken place with key stake holders to review and enhance the unregistered nurse career pathway.	**Director of Nursing and Midwifery**
Care hours per patient day RN **Standard: >=5**		Increase in activity and demand with escalation areas open has impacted on this months figures. 9 new OSN have joined the Trust from India. Retention work continues with a workshop held to review and enhance the RN career pathway.	**Director of Nursing and Midwifery**
Care hours per patient day total **Standard: >=8**		Increased activity and demand has impacted on this months figures with more beds and escalation areas open. The first meeting of the Recruitment and retention subgroup for nursing has taken place with key stakeholders from all clinical divisions in attendance. Monthly HCA recruitment continues and 9 overseas nurses have joined the Trust. Work continues with the actions of the retention action plan and the overarching Person Centred Careers framework	**Director of Nursing and Midwifery**

Benchmarking (1)

Gloucestershire Hospitals NHS Foundation Trust

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

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

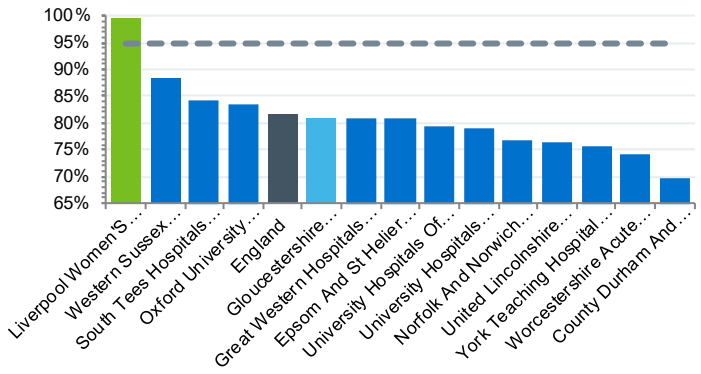
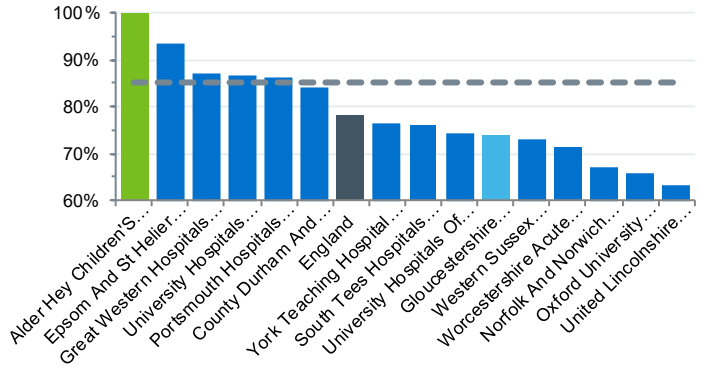
Metric	Period	Peer Group	Rank	Quartile
Diagnostics	December-19		61 / 166	2nd
Dementia	November-19		84 / 84	4th

Benchmarking (2)

Gloucestershire Hospitals NHS Foundation Trust

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

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

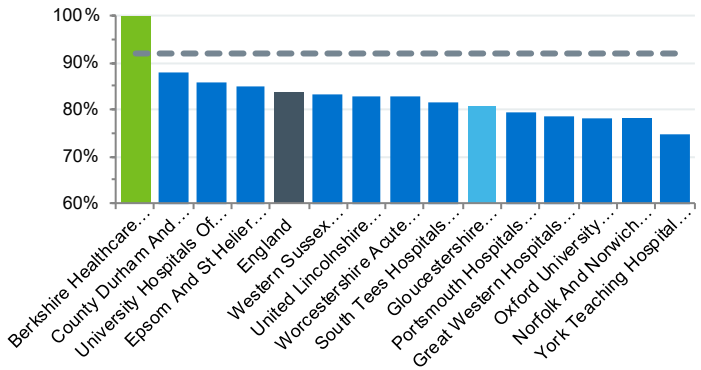
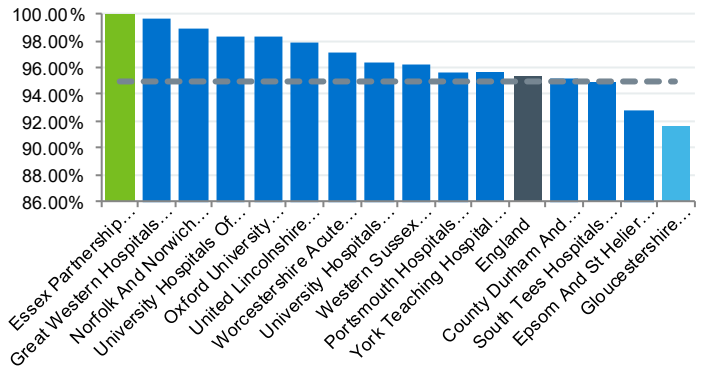
Metric	Period	Peer Group	Rank	Quartile
ED 4 Hour (Type 1 & Type 3)	January-20		62 / 119	3rd
Cancer 62 Days GP Referrals	December-19		104 / 142	3rd

Benchmarking (3)

Gloucestershire Hospitals NHS Foundation Trust

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

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

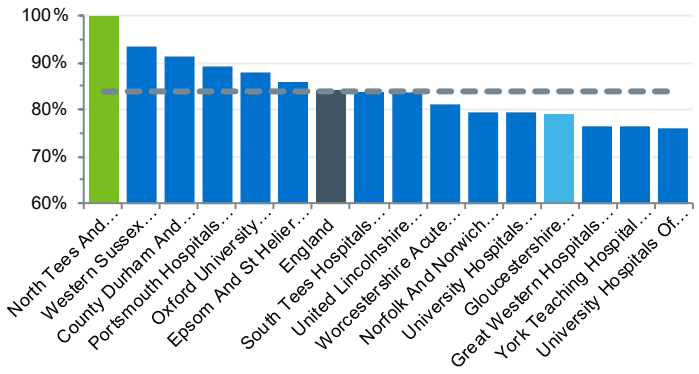
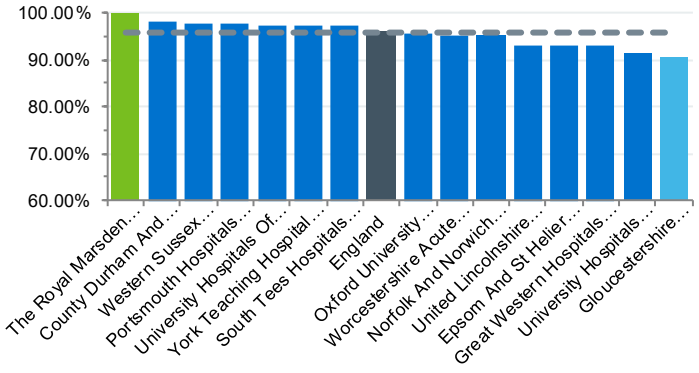
Metric	Period	Peer Group	Rank	Quartile
RTT	December-19		121 / 163	3rd
VTE (published quarterly)	September-19		131 / 149	4th

Benchmarking (4)

Gloucestershire Hospitals NHS Foundation Trust

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

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

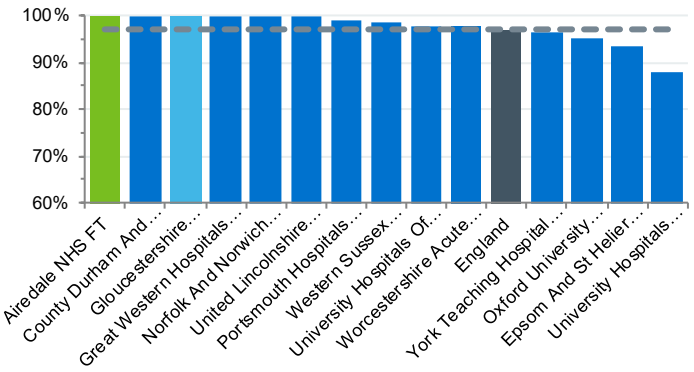
Metric	Period	Peer Group	Rank	Quartile
FFT - ED	December-19		104 / 131	4th
FFT - Inpatient	December-19		135 / 145	4th

Benchmarking (5)

Gloucestershire Hospitals NHS Foundation Trust

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

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

Metric	Period	Peer Group	Rank	Quartile
FFT - Maternity	December-19		13 / 117	1st

Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report Statistical Process Control Reporting

Reporting period January 2020

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

Contents

Gloucestershire Hospitals NHS Foundation Trust

Guidance

Gloucestershire Hospitals NHS Foundation Trust

Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

How to interpret variation results:

- Variation results show the trends in performance over time
- Trends either show **special cause variation** or **common cause variation**
- **Special cause variation: Orange icons** indicate **concerning** special cause variation requiring action
- **Special cause variation: Blue icons** indicate where there appears to be **improvements**
- **Common cause variation: Grey icons** indicate **no significant change**

How to interpret assurance results:

- Assurance results show whether a target is likely to be achieved, and is based on trends in achieving the target over time
- **Blue icons** indicate that you would expect to **consistently achieve a target**
- **Orange icons** indicate that you would expect to **consistently miss a target**
- **Grey icons** indicate that **sometimes the target will be achieved and sometimes it will be missed**

Source: NHSI Making Data Count

Executive Summary

Gloucestershire Hospitals NHS Foundation Trust

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

The Trust performance (type 1) for the 4 hour standard in January was 72.45% against the STP trajectory at 86.19% against a backdrop of significant attendances. The system did not meet the delivery of 90% for the system in January, at 81.02%.

The Trust did not meet the diagnostics standard for January at 1.50%.

The Trust has met the standard for 2 week wait cancer at 94.90% in January, this is as yet un-validated performance at the time of the report.

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

For elective care, the RTT performance (81.06% in January) is above trajectory agreed with NHS I, work continues to ensure that the performance is stabilised. Significant work is underway to reduce our longest waiting patients of over 52 weeks, to date we have met the trajectory agreed with NHS I to reduce our breaches (28 in January).

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

Access Dashboard

Gloucestershire Hospitals NHS Foundation Trust

This dashboard shows the most recent performance of metrics in the Access category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.

Key

Assurance

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

Variation

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

MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
Cancer	Cancer – urgent referrals seen in under 2 weeks from GP	>=93%	?	Jan-20	94.9%	
Cancer	2 week wait breast symptomatic referrals	>=93%	?	Jan-20	96.8%	
Cancer	Cancer – 31 day diagnosis to treatment (first treatments)	>=96%	?	Jan-20	94.7%	
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – drug)	>=98%	P	Jan-20	96.6%	L
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – surgery)	>=94%	?	Jan-20	94.4%	
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	>=94%	?	Jan-20	94.0%	
Cancer	Cancer 62 day referral to treatment (urgent GP referral)	>=85%	?	Jan-20	67.5%	
Cancer	Cancer 62 day referral to treatment (screenings)	>=90%	?	Jan-20	97.7%	
Cancer	Cancer 62 day referral to treatment (upgrades)	>=90%	?	Jan-20	66.7%	
Cancer	Number of patients waiting over 104 days with a TCI date	Zero	?	Jan-20	5	
Cancer	Number of patients waiting over 104 days without a TCI date	<=24	?	Jan-20	19	
Diagnostics	% waiting for diagnostics 6 week wait and over (15 key tests)	<=1%	?	Jan-20	1.50%	H
Diagnostics	The number of planned / surveillance endoscopy patients waiting at month end	<=600	?	Jan-20	853	H
Discharge	Number of patients delayed at the end of each month	<=38	?	Jan-20	55	
Discharge	Patient discharge summaries sent to GP within 24 hours	>=88%	F	Dec-19	56.3%	H
Emergency Department	ED: % total time in department – under 4 hours (type 1)	>=95%	F	Jan-20	72.45%	L
Emergency Department	ED: % total time in department – under 4 hours (types 1 & 3)	>=95%	F	Jan-20	81.02%	L
Emergency Department	ED: % total time in department – under 4 hours CGH	>=95%	?	Jan-20	91.50%	L
Emergency Department	ED: % total time in department – under 4 hours GRH	>=95%	F	Jan-20	63.30%	L
Emergency Department	ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission)	Zero		Jan-20	0	
Emergency Department	ED: % of time to initial assessment – under 15 minutes	>=95%	F	Jan-20	68.0%	L
Emergency Department	ED: % of time to start of treatment – under 60 minutes	>=90%	F	Jan-20	31.9%	L

MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
Emergency Department	% of ambulance handovers that are over 60 minutes	<=2.96%		Jan-20	3.76%	
Emergency Department	% of ambulance handovers that are over 60 minutes	<=1%		Jan-20	0.23%	
Maternity	% of women booked by 12 weeks gestation	>90%	?	Jan-20	90.3%	
Operational Efficiency	Number of patients stable for discharge	<=70	?	Jan-20	112	H
Operational Efficiency	% of bed days lost due to delays	<=3.5%		Jan-20	4.49%	
Operational Efficiency	Number of stranded patients with a length of stay of greater than 7 days	<=380	?	Jan-20	431	H
Operational Efficiency	Average length of stay (spell)	<=5.06	?	Jan-20	5.66	H
Operational Efficiency	Length of stay for general and acute non-elective (occupied bed days) spells	<=5.65	?	Jan-20	6.45	H
Operational Efficiency	Length of stay for general and acute elective spells (occupied bed days)	<=3.4	P	Jan-20	2.34	
Operational Efficiency	% day cases of all electives	>80%		Jan-20	87.91%	
Operational Efficiency	Intra-session theatre utilisation rate	>85%		Jan-20	86.4%	
Operational Efficiency	Cancelled operations re-admitted within 28 days	>=95%		Jan-20	88.89%	
Operational Efficiency	Urgent cancelled operations	No target		Jan-20	1	
Outpatient	Outpatient new to follow up ratio's	<=1.9		Jan-20	1.83	
Outpatient	Did not attend (DNA) rates	<=7.6%		Jan-20	6.90%	
Readmissions	Emergency re-admissions within 30 days following an elective or emergency spell	<8.25%	P	Dec-19	6.4%	
Research	Research accruals	No target		Jan-20	110	L
RTT	Referral to treatment ongoing pathways under 18 weeks (%)	>=92%		Jan-20	81.06%	
RTT	Referral to treatment ongoing pathways 35+ Weeks (number)	No target		Jan-20	1658	
RTT	Referral to treatment ongoing pathways 40+ Weeks (number)	No target		Jan-20	1298	
RTT	Referral to treatment ongoing pathways over 52 weeks (number)	Zero	F	Jan-20	28	L

99% of data should ... Average performance ... 99% of ... uld

Access Dashboard

Gloucestershire Hospitals NHS Foundation Trust

This dashboard shows the most recent performance of metrics in the Access category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.

MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
Stroke Care	Stroke care: percentage of patients receiving brain imaging within 1 hour	>=50%		Jan-20	45.2%	
Stroke Care	Stroke care: percentage of patients spending 90%+ time on stroke unit	>=80%		Dec-19	87.3%	
Stroke Care	% of patients admitted directly to the stroke unit in 4 hours	>=80%		Jan-20	38.4%	
Stroke Care	% patients receiving a swallow screen within 4 hours of arrival	>=90%		Jan-20	61.6%	
SUS	Percentage of records submitted nationally with valid GP code	>=99%		Dec-19	99.9%	
SUS	Percentage of records submitted nationally with valid NHS number	>=99%		Dec-19	99.8%	
Trauma & Orthopaedics	% of fracture neck of femur patients treated within 36 hours	>=90%		Jan-20	73.1%	
Trauma & Orthopaedics	% fractured neck of femur patients meeting best practice criteria	>=65%		Jan-20	73.1%	

Key

Assurance

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

Variation

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

Process Limits

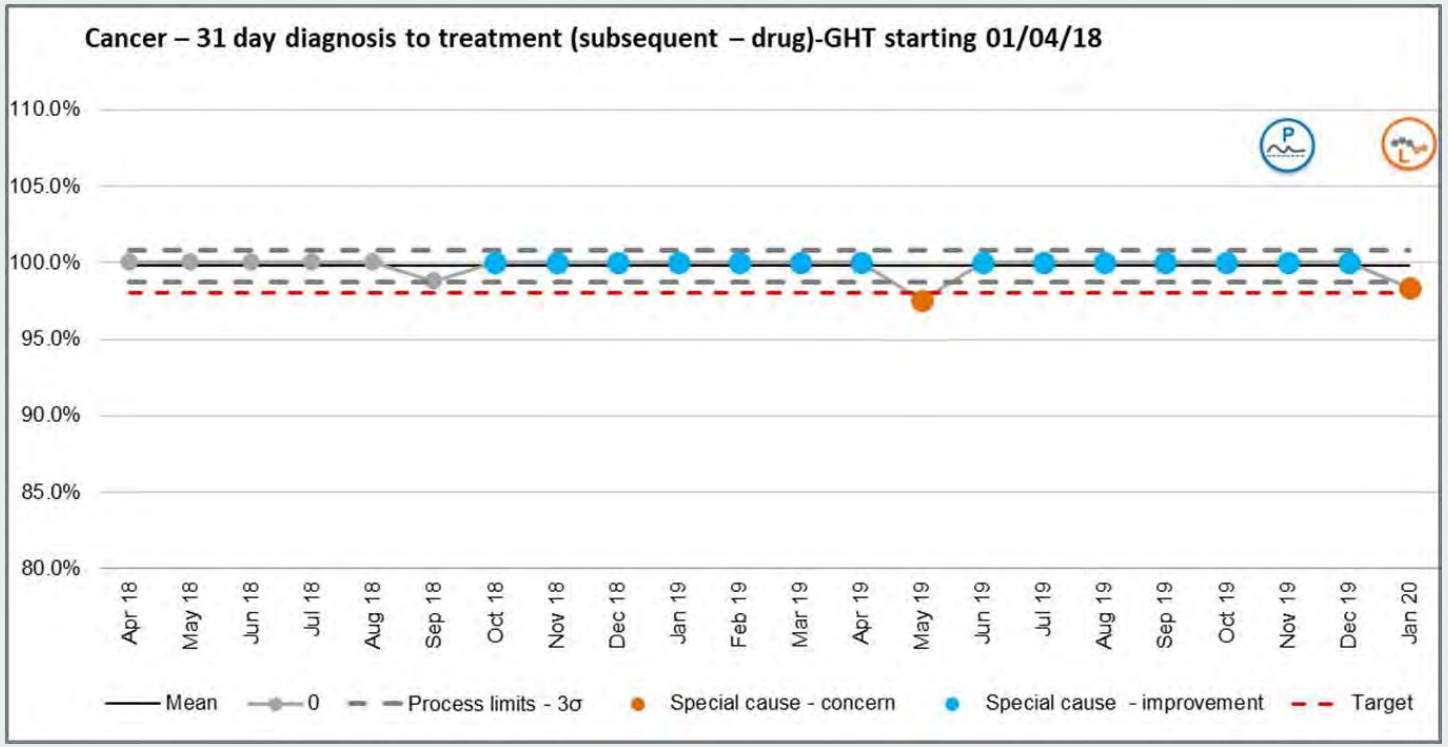
Lower Limit
99% of data should fall between the lower and upper limit

Mean
Average performance over the baseline period

Upper Limit
99% of data should fall between the lower and upper limit

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

62 treatments and 1 breach
Average number of treatments is 82 so would suggest that we are yet to load up some treatments and therefore this will not be considered special cause variation following our submission for January on 4th March.

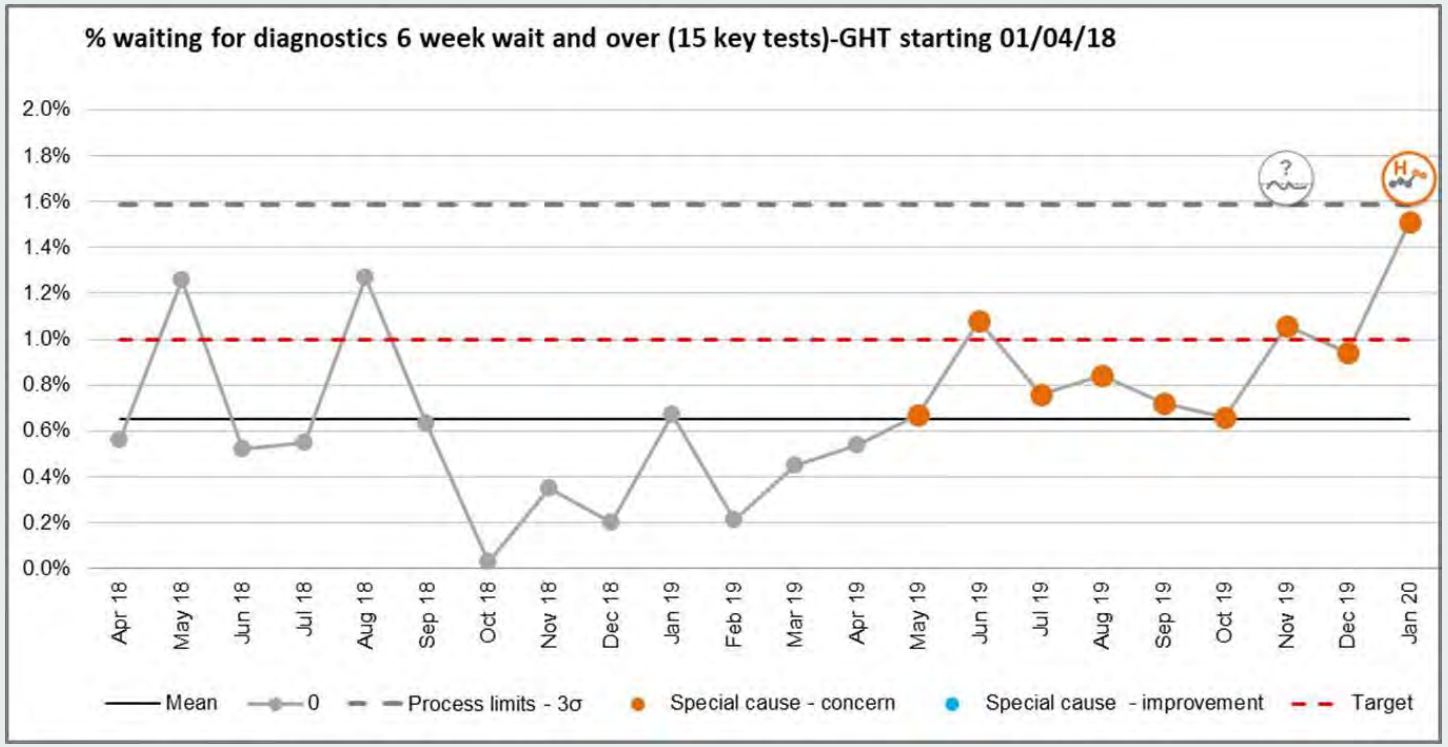
- Director of Planned Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 2 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above the mean.

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The diagnostic standard comprises 14 different modalities. In the month of January there was excessive demand in cardiac CT, which was above the capacity of the service. Previous months have had breakdowns in CT and MR which have impacted performance. A replacement programme with capital investment is underway through 2020.

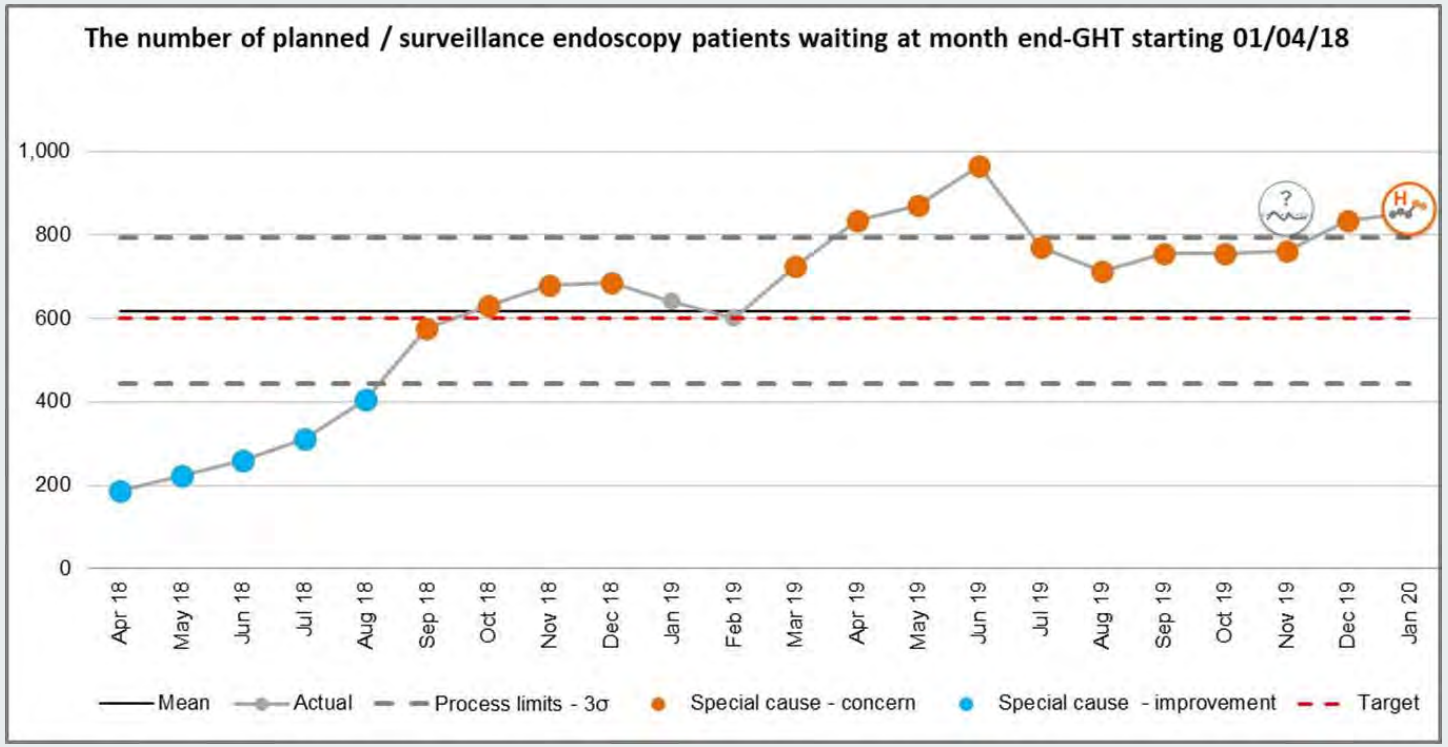
- Deputy Chief Operating Officer

Data Observations

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

There has been a slight increase in the number of patients waiting past recall due to increased pressures in month on the 2ww colorectal straight to test pathway and 6ww diagnostic pathway.
Patients are being prioritised in order of clinical urgency and then longest waiting. The specialty are still in the process of clinically validating the waiting list and it is anticipated this will further reduce the backlog through discharging back to GP.
Further capacity has been organised January - March 2020 to clear the longest waiting patients (278) via GLANSO and 18 Weeks Support insourcing.

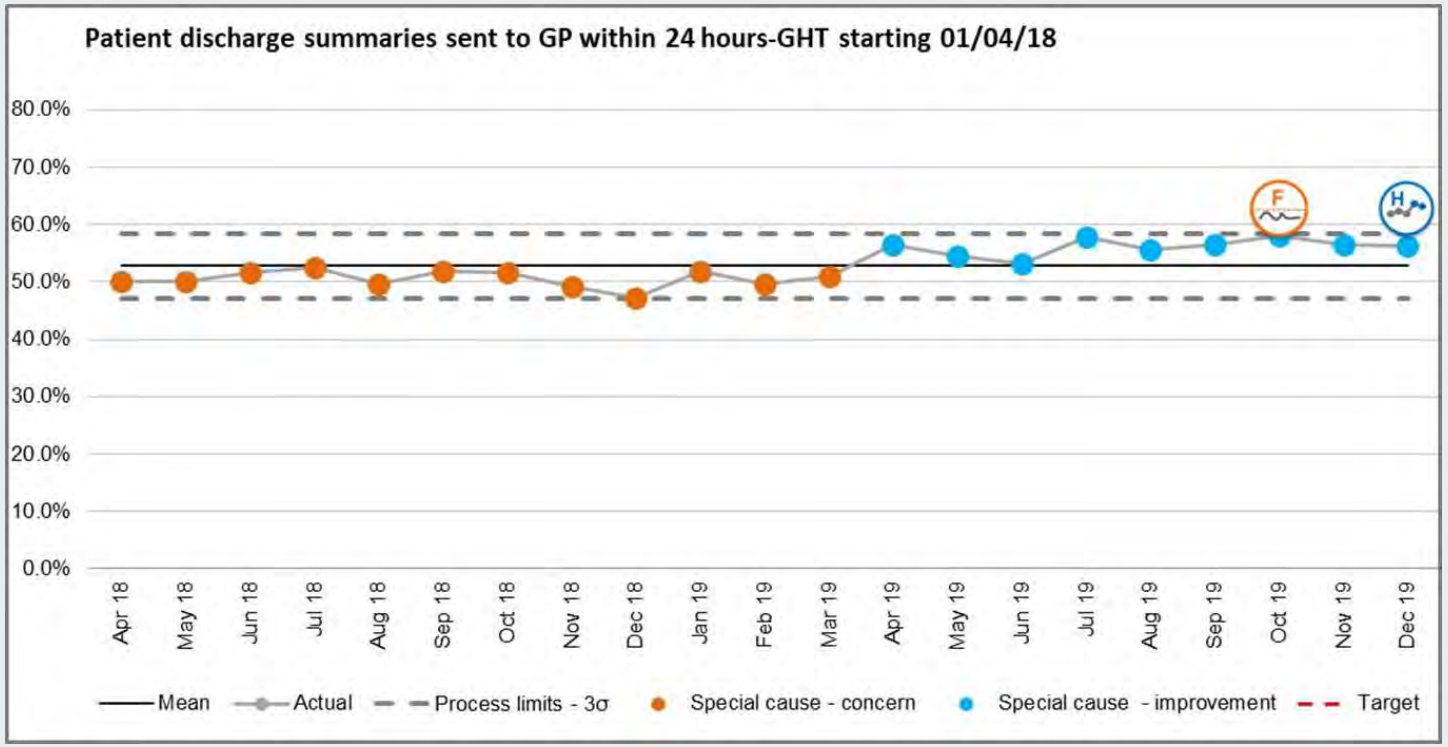
- Medical Director

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 5 data points which are above the line. There are 5 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing
2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Report presented to QDG this month, divisions to plans to improve performance, to be monitored at executive reviews.

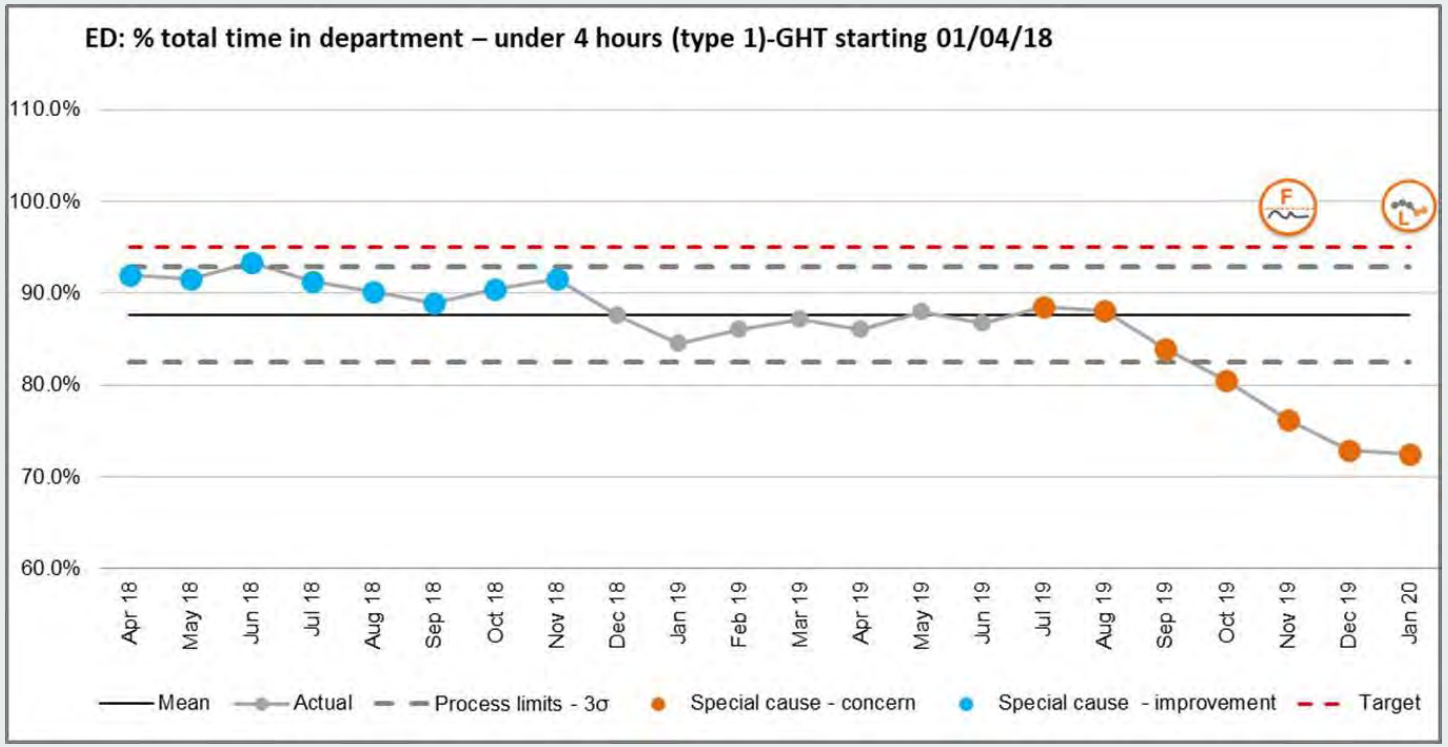
- Medical Director

Data Observations

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The number of trolley waits has increased at GRH but decreased at CGH. This metric reflects the pressures in flow through the Hospital

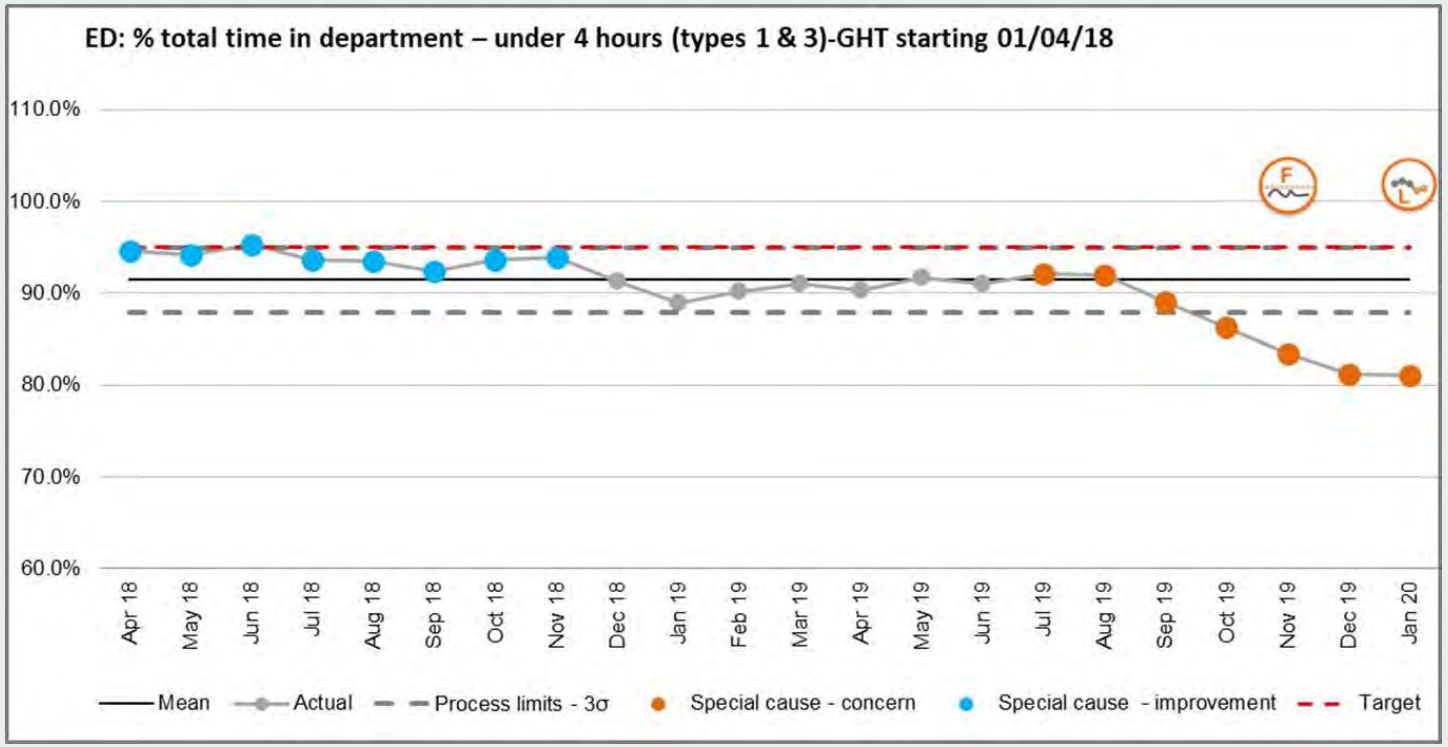
- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 1 data point which is above the line. There are 4 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of falling points
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing
2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The number of trolley waits has increased at GRH but decreased at CGH. This metric reflects the pressures in flow through the Hospital

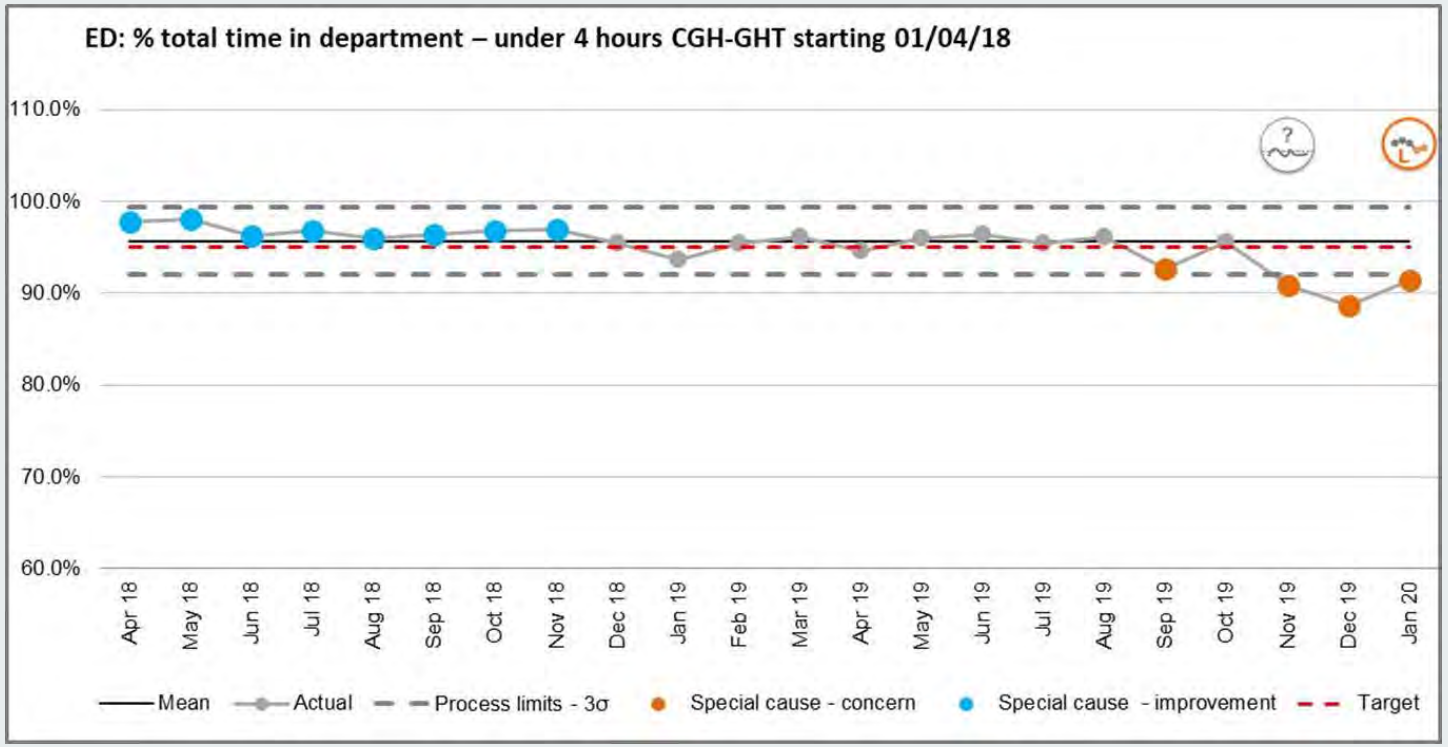
- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 1 data point which is above the line. There are 4 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of falling points
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing
2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Performance has declined marginally at CGH. This represents the pressures we often see at CGH. In a system with flow, these patients would all be admitted direct rather than wait in a corridor. Infection control issues have also resulted in bed closures.

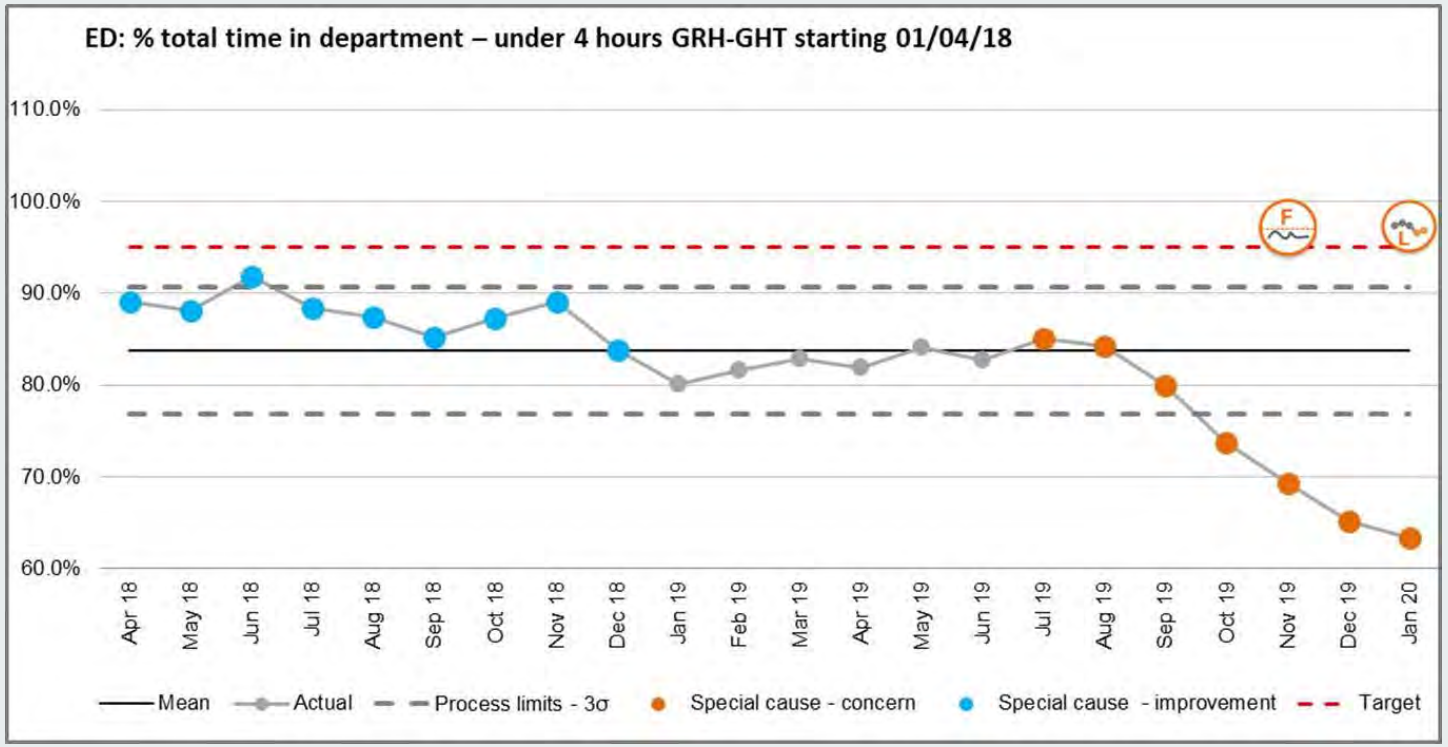
- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 3 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above the mean.
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The number of trolley waits has increased at GRH but decreased at CGH. This metric reflects the pressures in flow through the Hospital

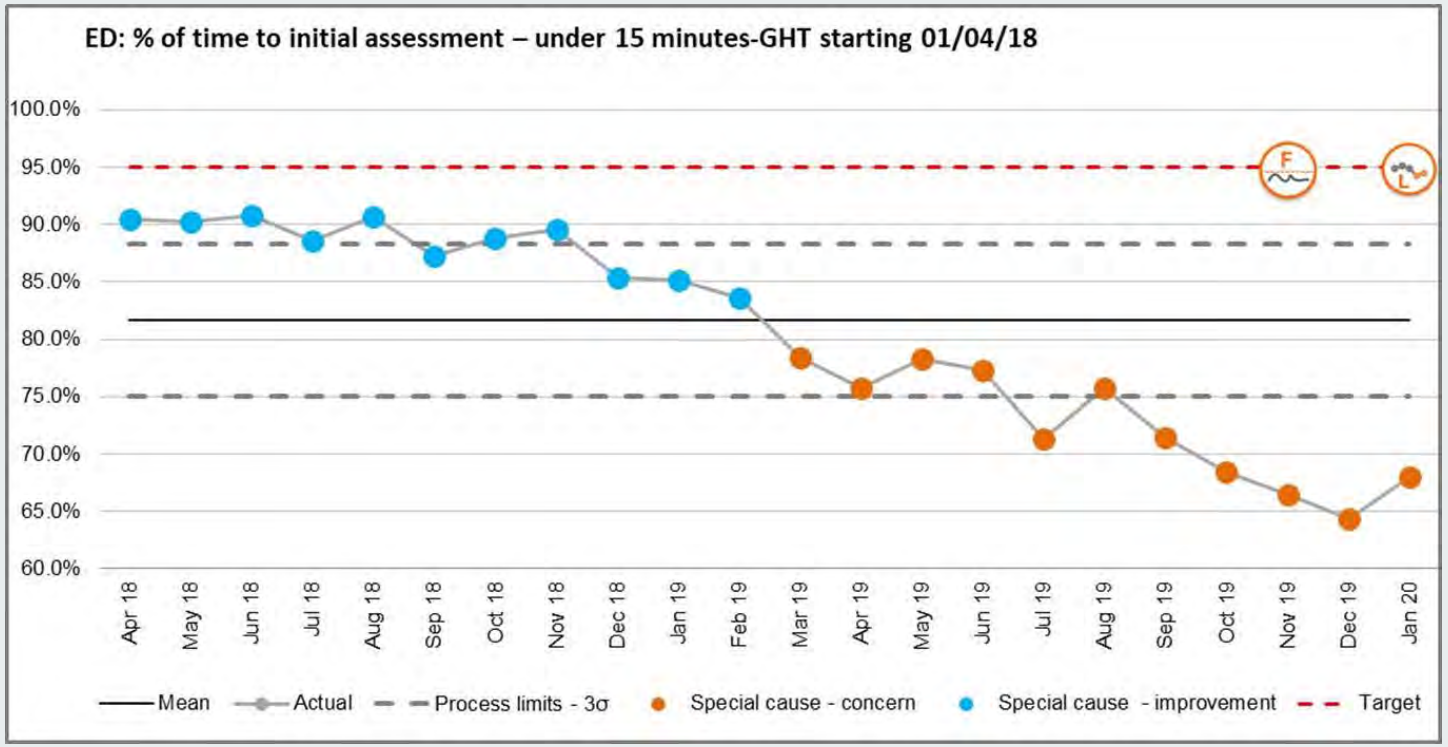
- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 1 data point which is above the line. There are 4 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of falling points
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing
2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Additional triage resource has impacted the improvement in performance in this metric at GRH. The change in referral pathway for GP expected patients will have impacted this metric at GRH.

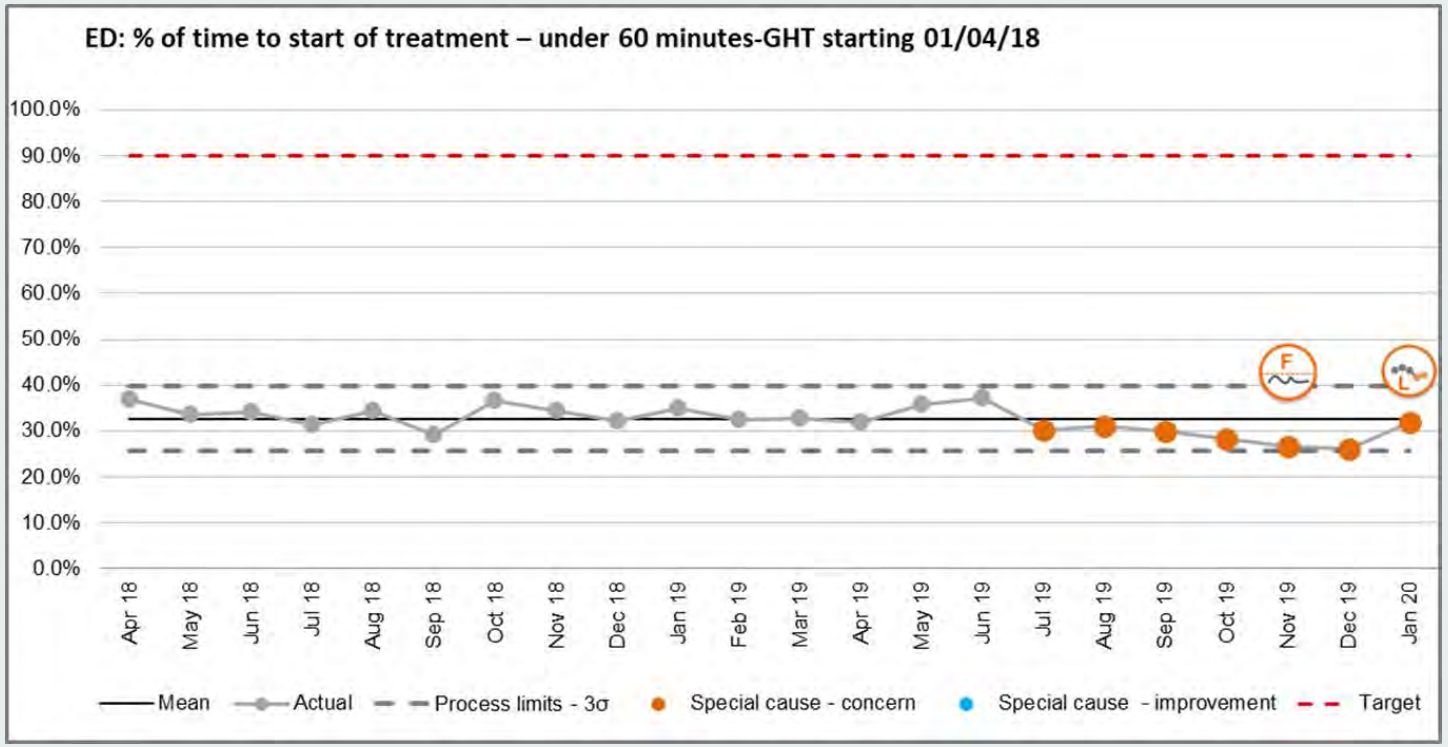
- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 7 data points which are above the line. There are 6 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing
2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Average time to see a Doctor has decreased despite the challenges seen in both departments throughout the month.

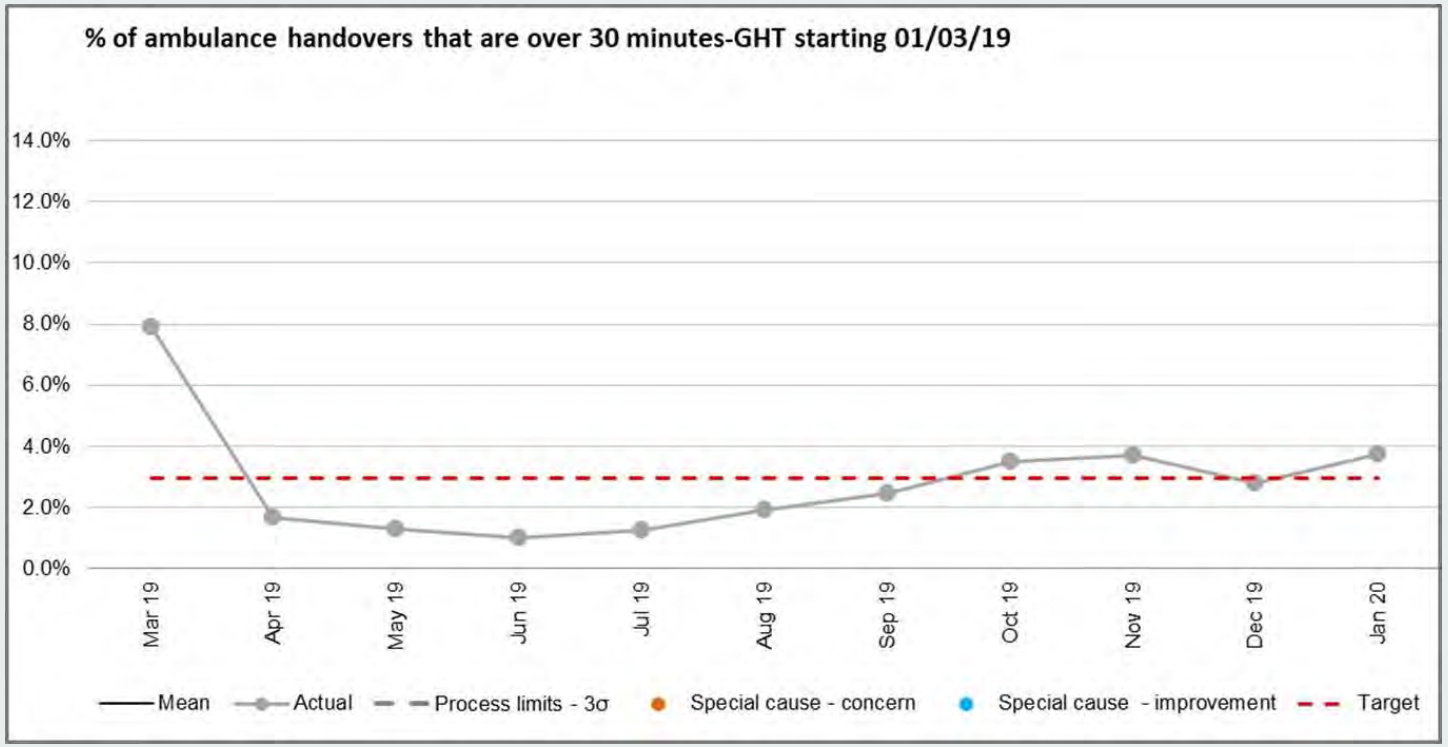
- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing

Access:
Run Chart – Target Not Achieved

Gloucestershire Hospitals NHS Foundation Trust



Commentary

There has been a decrease in the total number of handover delays over 1 hour. The longest delay was 1 hour 24 minutes with an average handover delay of 1 hour and 12 minutes. Factors behind the delays are lack of physical space in which to offload and lack of trolleys and chairs due to the increase in pre-empting patients up to the ward.

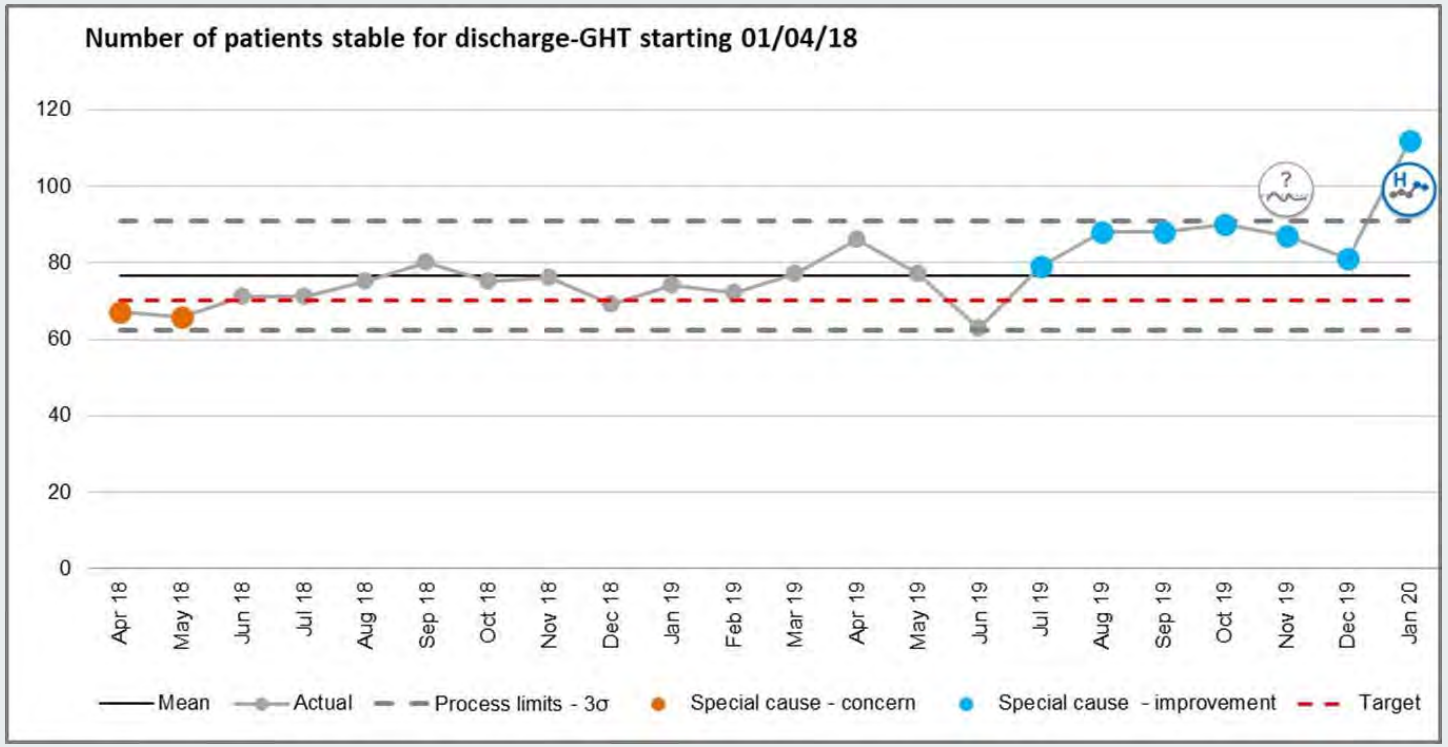
- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

An exception report has been generated for this metric because it has not achieved its target this month.
There are not enough consecutive data points to create an accurate SPC chart, therefore a run chart will be presented until an SPC chart can be created in the future.

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The number of our patients MSFD has increased this month and this is attributable to length of time waiting for assessment either by ASC or therapies. There have also been ward closures due to infection control issues which has also been a problem in the community thus hindering OCT's ability to get some of the complex discharges actioned. OCT continue to support the wards and encourage a decision on discharge pathways as a priority.

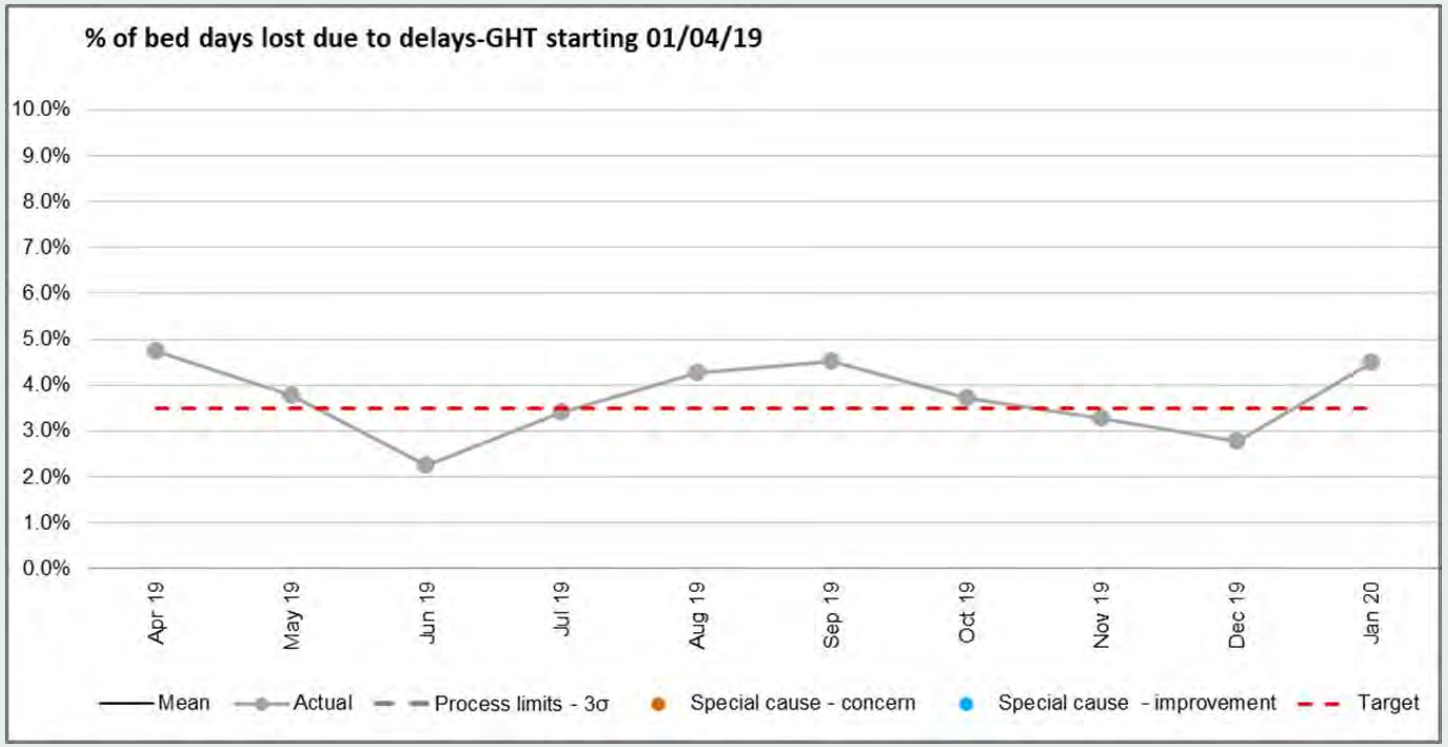
- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 1 data point which is above the line.
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points below the mean.
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing
2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing

Access:
Run Chart – Target Not Achieved

Gloucestershire Hospitals NHS Foundation Trust



Commentary

End of January showed total bed days lost due to delays as 4.49%. The increase in our figures are attributable to infection control ward closures, lack of capacity in the community and delays in having patients assessed

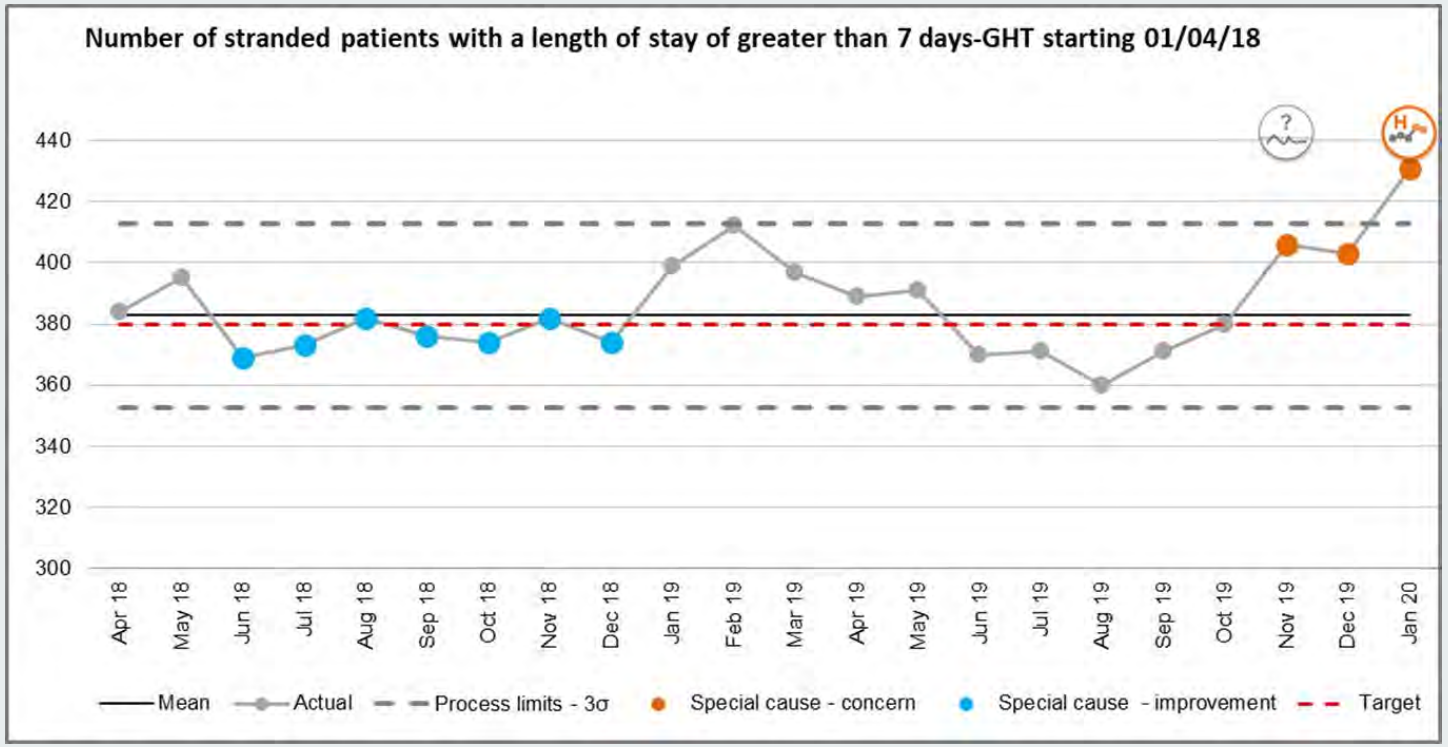
- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

An exception report has been generated for this metric because it has not achieved its target this month.
There are not enough consecutive data points to create an accurate SPC chart, therefore a run chart will be presented until an SPC chart can be created in the future.

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

System partners review underway as numbers worsening.

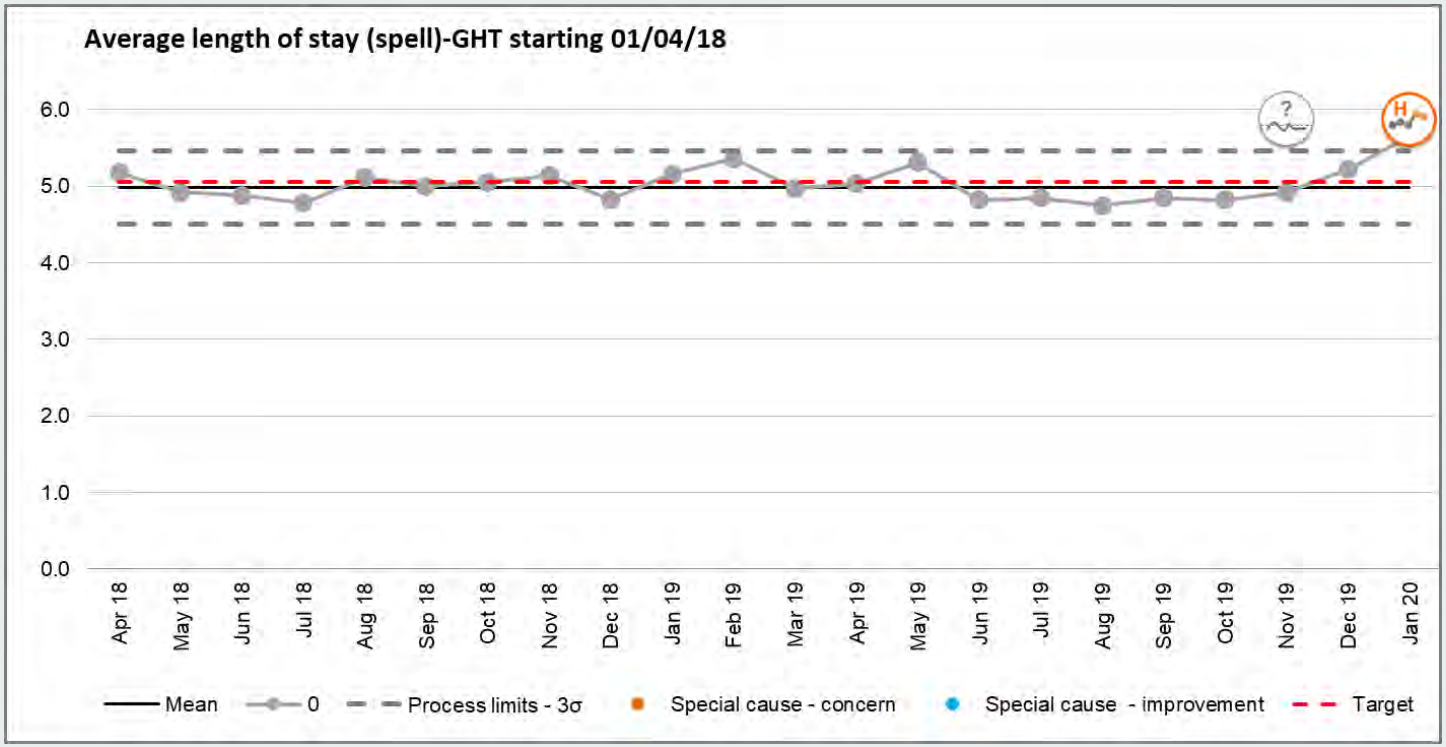
- Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 1 data point which is above the line.
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points below the mean.
2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Capacity and Flow meeting attended by all Divisions with actions/outcomes including Criteria Led discharge and Ward tool kit which provides information on LOS Led by Matt Little and Sandra Attwood
EDD and ADD, SORT criteria and Red to Green reinforced.
All wards review 21 day LOS and now 14 days
ERAS programme - underway

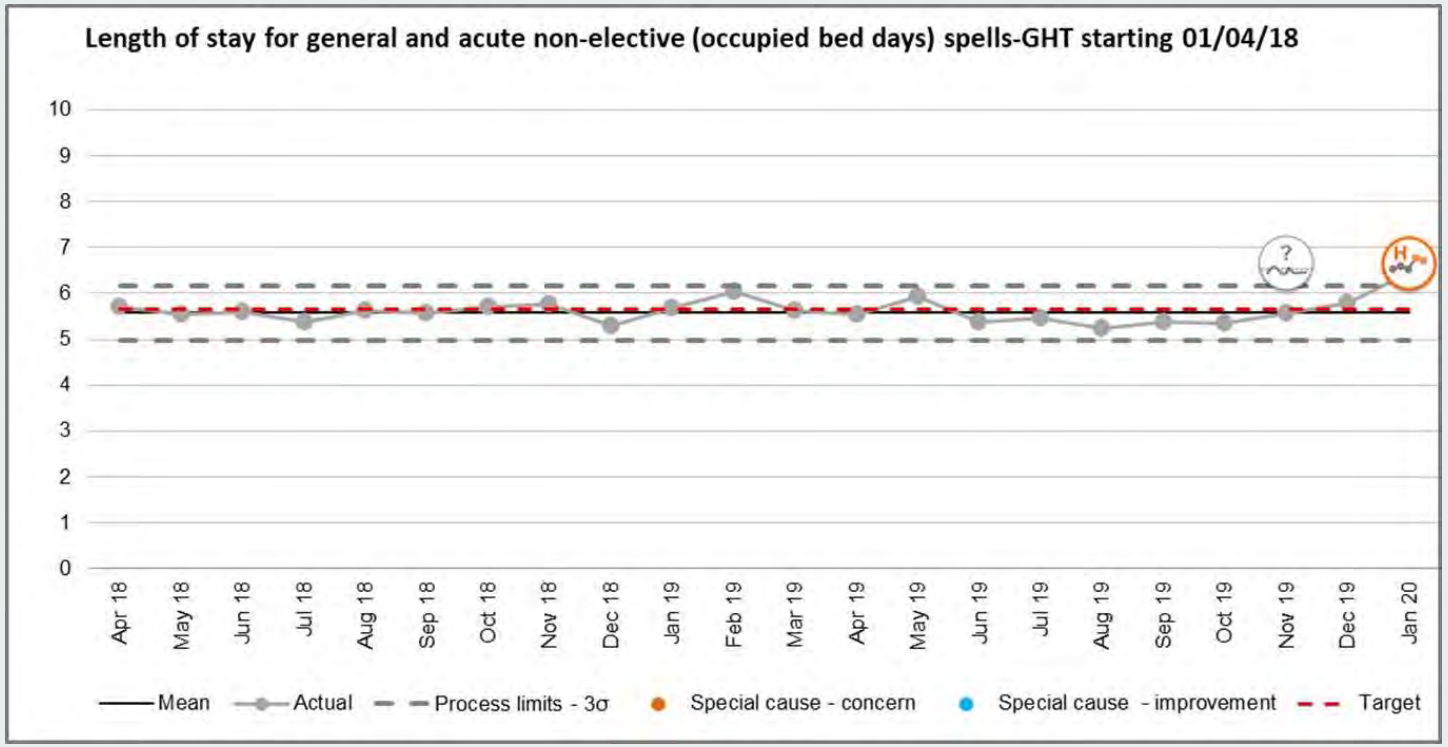
- **Deputy Chief Operating Officer**

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 1 data point which is above the line.

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Capacity and Flow meeting attended by all Divisions with actions/outcomes including Criteria Led discharge and Ward tool kit which provides information on LOS Led by Matt Little and Sandra Attwood
EDD and ADD, SORT criteria and Red to Green reinforced.
All wards review 21 day LOS and now 14 days
ERAS programme - underway

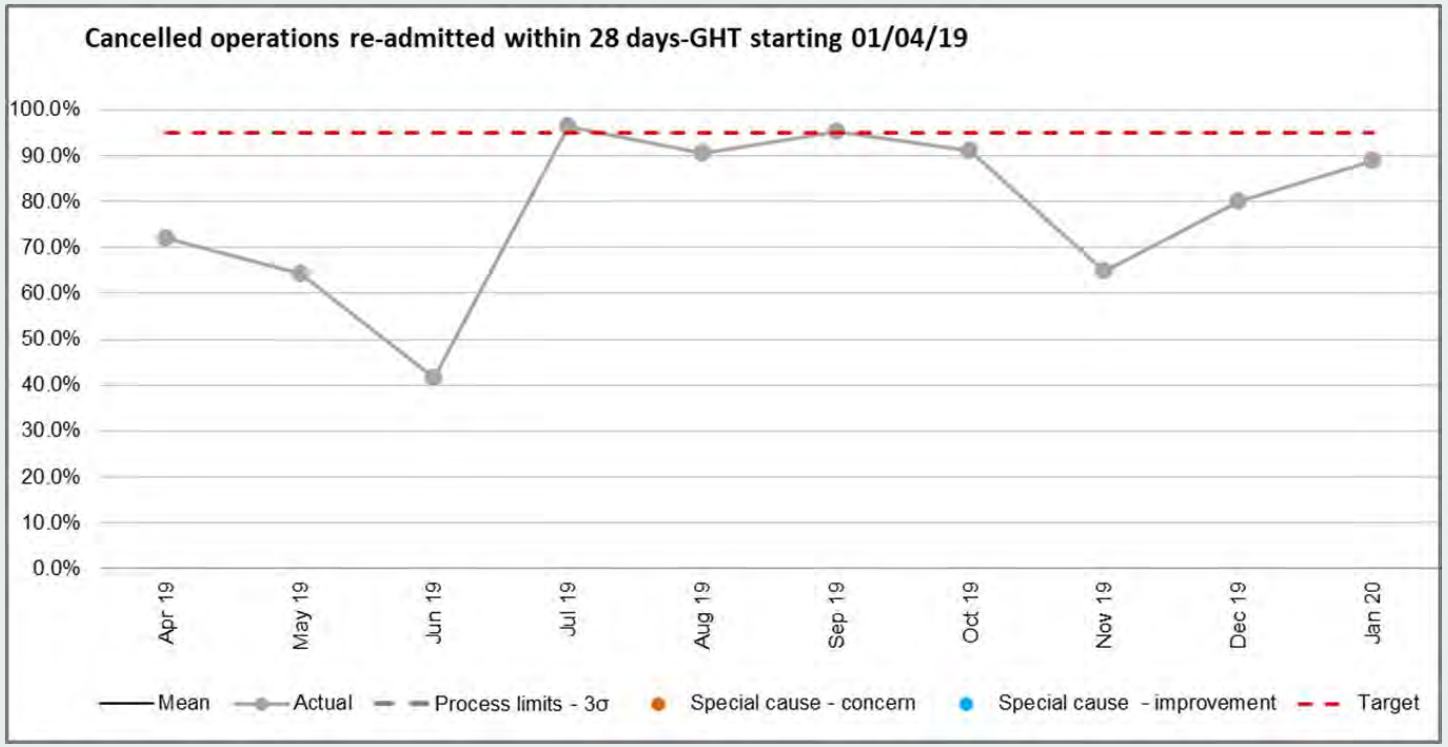
- Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 1 data point which is above the line.

Access:
Run Chart – Target Not Achieved

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Cancelled operations have a workstream within the Theatre Collaborative meeting, they are reviewed at speciality level. Work to support communication with patients to re-confirm TCI dates (i.e. calling patients 2 days before / text messages) are being investigated.

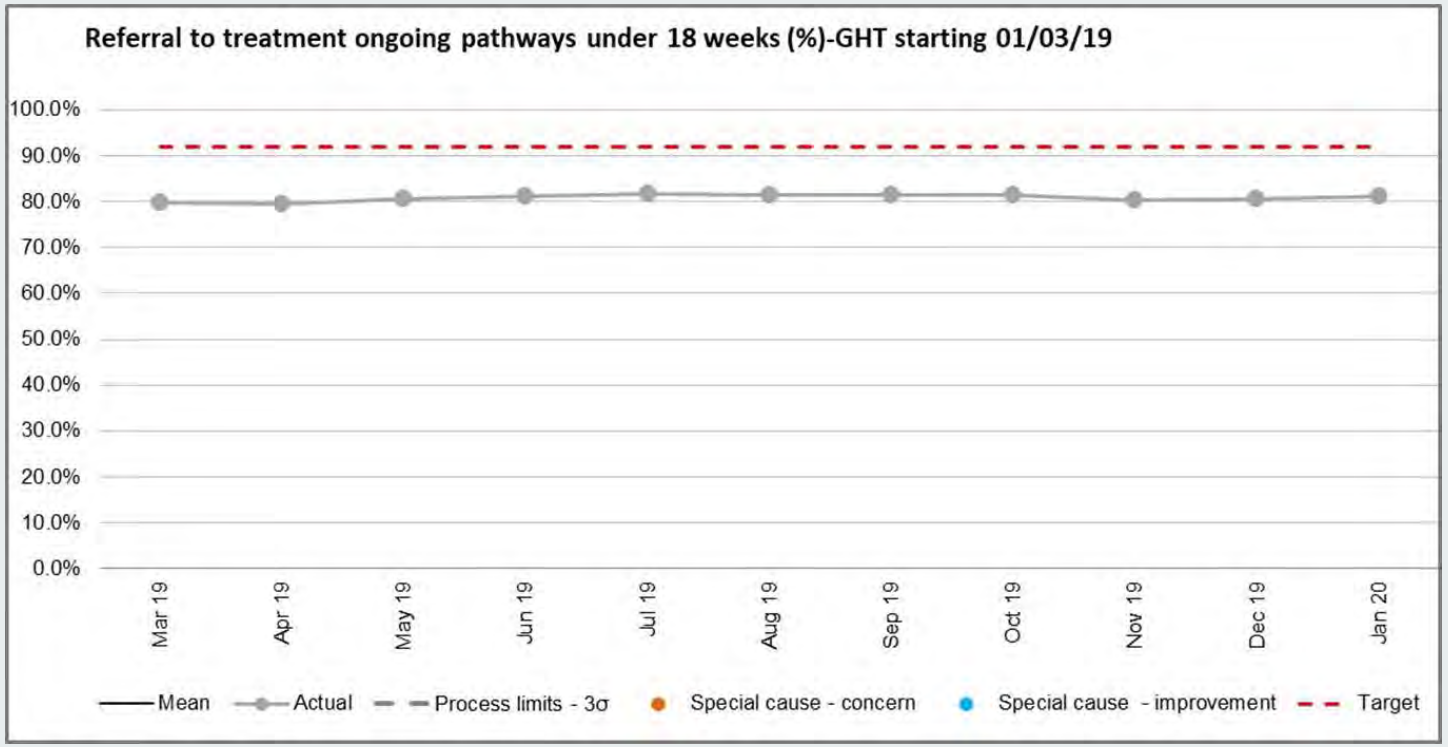
- Deputy Chief Operating Officer

Data Observations

An exception report has been generated for this metric because it has not achieved its target this month.
There are not enough consecutive data points to create an accurate SPC chart, therefore a run chart will be presented until an SPC chart can be created in the future.

Access:
Run Chart – Target Not Achieved

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Performance is in line with agreed trajectory. As is the reduction in the waiting list since April 2019 to January 2020, from 58,374 o 55,623

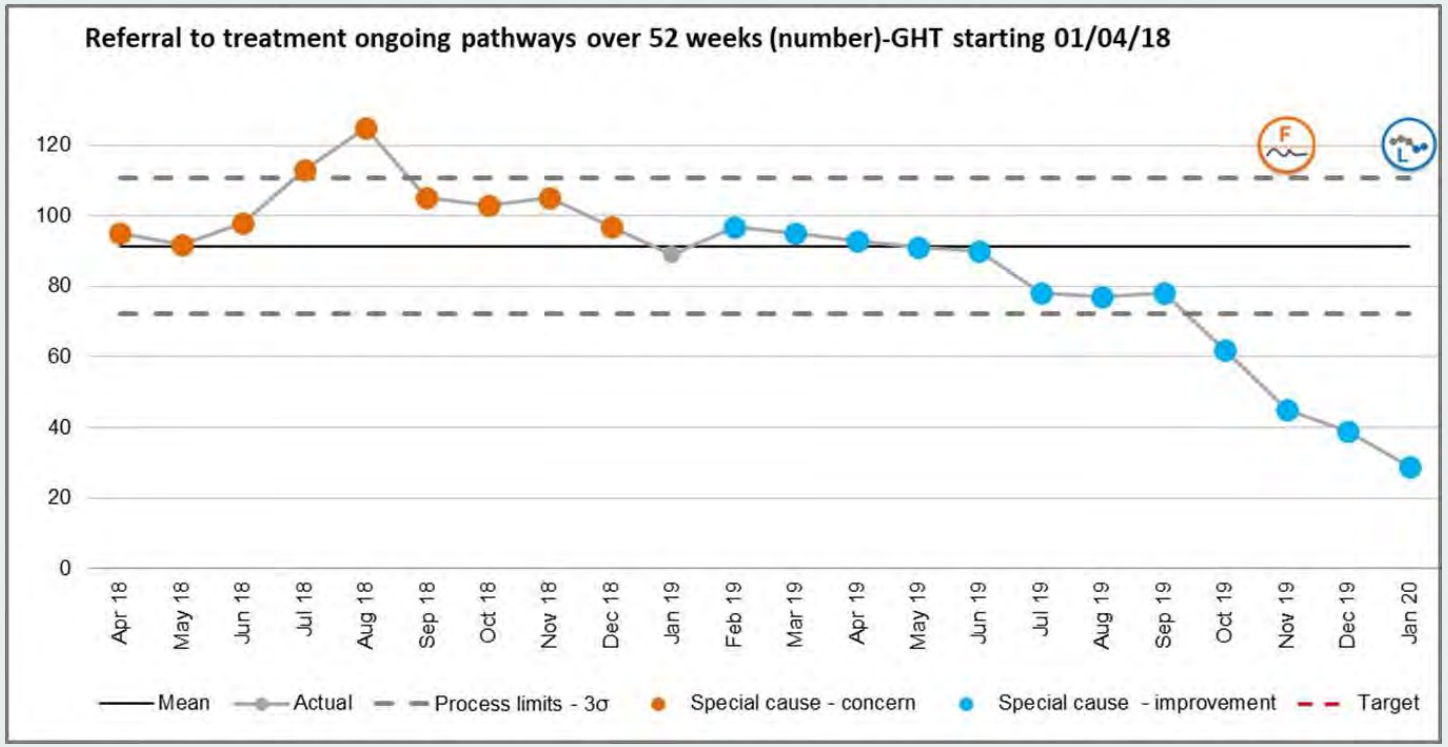
- Deputy Chief Operating Officer

Data Observations

An exception report has been generated for this metric because it has not achieved its target this month.
There are not enough consecutive data points to create an accurate SPC chart, therefore a run chart will be presented until an SPC chart can be created in the future.

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The Trust continues to see a reduction in the longest waiting patients, whilst not acceptable January was within the trajectory agreed with NHS I.

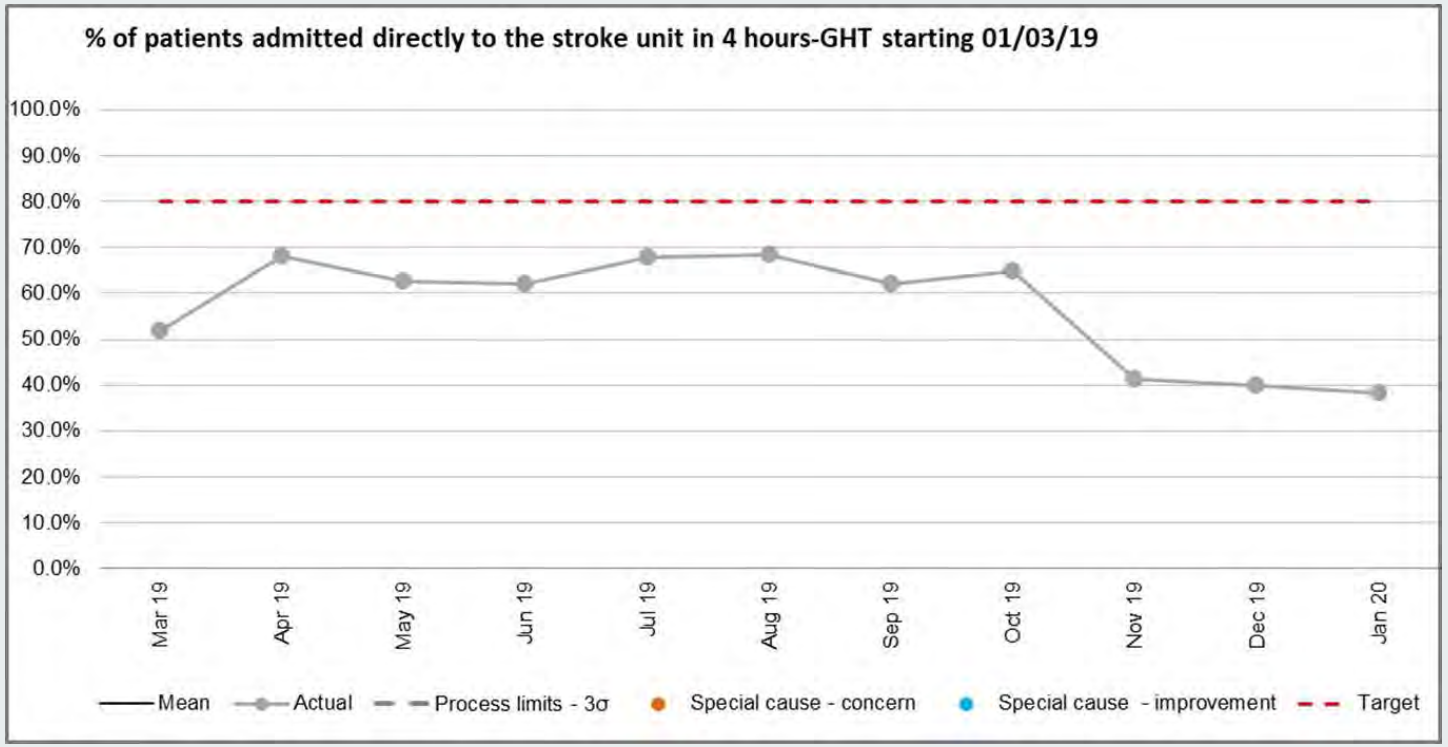
- Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 2 data points which are above the line. There are 4 data point(s) below the line.
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data there is a run of falling points.
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing
2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing

Access:
Run Chart – Target Not Achieved

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Deterioration of 24% on December performance (62.40%). 17 patients breached the target in the month of December. Of these 17:
- 3 patients were an inpatient already when the stroke presented and experienced a delayed transfer.
- 9 patients were delayed due to lack of beds - non-Strokes on the Stroke ward due to increased demand for medical beds at GRH during this period.
- 4 patients were delayed due to an unclear diagnosis which led to them initially being admitted to AMU for further tests.
- 1 patient was too unwell to move from ED and subsequently died as a result of their condition.

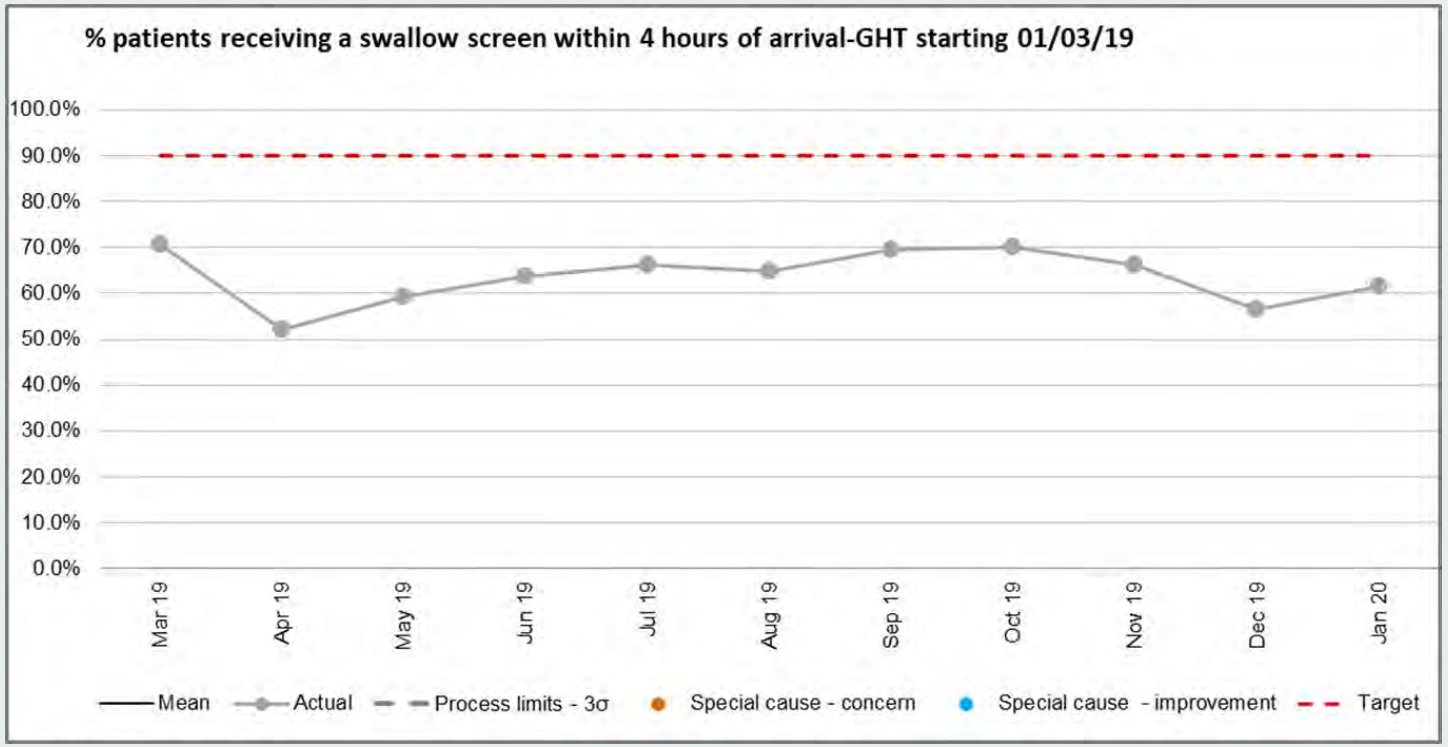
- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

An exception report has been generated for this metric because it has not achieved its target this month.
There are not enough consecutive data points to create an accurate SPC chart, therefore a run chart will be presented until an SPC chart can be created in the future.

Access:
Run Chart – Target Not Achieved

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Deterioration of 2.5% on December performance (64.10%). 28 patients breached the target in the month of December. Of those 28:
- 3 patients were an inpatient when stroke presented and were delayed in transfer to stroke unit due to lack of bed capacity.
- 9 patients were delayed in receiving a bed on the Stroke Unit and therefore had a delayed swallow screening.
- 4 patients had an unclear diagnosis on initial presentation and therefore were a late diagnosis. Knock on impact were delays to each of the onward pathway elements as a result.
- 8 patients were too unwell to receive a swallow screen within the four hour target.
- 4 patients had an unknown breach reason.

- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

An exception report has been generated for this metric because it has not achieved its target this month.
There are not enough consecutive data points to create an accurate SPC chart, therefore a run chart will be presented until an SPC chart can be created in the future.

Quality Dashboard

Gloucestershire Hospitals NHS Foundation Trust

This dashboard shows the most recent performance of metrics in the Quality category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.

Key

Assurance

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

Variation

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

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance
Dementia Screening	% of patients who have been screened for dementia (within 72 hours)	>=90%	Dec-19 37%
Dementia Screening	% of patients who have scored positively on dementia screening tool that then received a dementia diagnostic	>=90%	Dec-19 18%
Dementia Screening	% of patients who have received a dementia diagnostic assessment with positive or inconclusive results that were	>=90%	Dec-19 0%
Friends & Family Test	Inpatients % positive	>=96%	Jan-20 90.2%
Friends & Family Test	ED % positive	>=84%	Jan-20 79.9%
Friends & Family Test	Maternity % positive	>=97%	Jan-20 100.0%
Friends & Family Test	Outpatients % positive	>=94%	Jan-20 93.1%
Friends & Family Test	Total % positive	>=93%	Jan-20 91.4%
Infection Control	Number of trust apportioned MRSA bacteraemia	Zero	Jan-20 0
Infection Control	MRSA bacteraemia – infection rate per 100,000 bed days	Zero	Jan-20 0
Infection Control	Number of trust apportioned Clostridium difficile cases per month	2019/20: 114	Jan-20 8
Infection Control	Number of community-onset healthcare-associated Clostridioides difficile cases per month	<=5	Jan-20 4
Infection Control	Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	<=5	Jan-20 4
Infection Control	Clostridium difficile – infection rate per 100,000 bed days	<30.2	Jan-20 29.7
Infection Control	Number of MSSA bacteraemia cases	<=8	Jan-20 1
Infection Control	MSSA – infection rate per 100,000 bed days	<=12.7	Jan-20 3.3
Infection Control	Number of ecoli cases	No target	Jan-20 3
Infection Control	Number of pseudomona cases	No target	Jan-20 3
Infection Control	Number of klebsiella cases	No target	Jan-20 1
Infection Control	Number of bed days lost due to infection control outbreaks	<10	Jan-20 100

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance
Inpatient Questions	How much information about your condition or treatment or care has been given to you?	>=90%	Jan-20 81%
Inpatient Questions	Are you involved as much as you want to be in decisions about your care and treatment?	>=90%	Jan-20 93%
Inpatient Questions	Do you feel that you are treated with respect and dignity?	>=90%	Jan-20 99%
Inpatient Questions	Do you feel well looked after by staff treating or caring for you?	>=90%	Jan-20 100%
Inpatient Questions	Do you get enough help from staff to eat your meals?	>=90%	Jan-20 80%
Inpatient Questions	In your opinion, how clean is your room or the area that you receive treatment in?	>=90%	Jan-20 98%
Inpatient Questions	Do you get enough help from staff to wash or keep yourself clean?	>=90%	Jan-20 97%
Maternity	% C-section rate (planned and emergency)	<=27%	Jan-20 28.66%
Maternity	% emergency C-section rate	No target	Jan-20 13.6%
Maternity	% of women smoking at delivery	<=14.5%	Jan-20 13.18%
Maternity	% of women that have an induced labour	<=30%	Jan-20 27.2%
Maternity	% stillbirths as percentage of all pregnancies > 24 weeks	<0.52%	Jan-20 0.21%
Maternity	% of women on a Continuity of Carer pathway	No target	Jan-20 4.3%
Mortality	Summary hospital mortality indicator (SHMI) – national data	NHS Digital	Aug-19 1.1
Mortality	Hospital standardised mortality ratio (HSMR)	Dr Foster	Oct-19 99.7
Mortality	Hospital standardised mortality ratio (HSMR) – weekend	Dr Foster	Oct-19 102.7
Mortality	Number of inpatient deaths	No target	Jan-20 214
Mortality	Number of deaths of patients with a learning disability	No target	Jan-20 4
MSA	Number of breaches of mixed sex accommodation	<=10	Jan-20 2
Patient Safety Incidents	Number of patient safety alerts outstanding	Zero	Jan-20 0
Patient Safety Incidents	Number of falls per 1,000 bed days	<=6	Jan-20 7.1

99% of data should Average performance

Quality Dashboard

Gloucestershire Hospitals NHS Foundation Trust

This dashboard shows the most recent performance of metrics in the Quality category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.

Key

Assurance

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

Variation

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

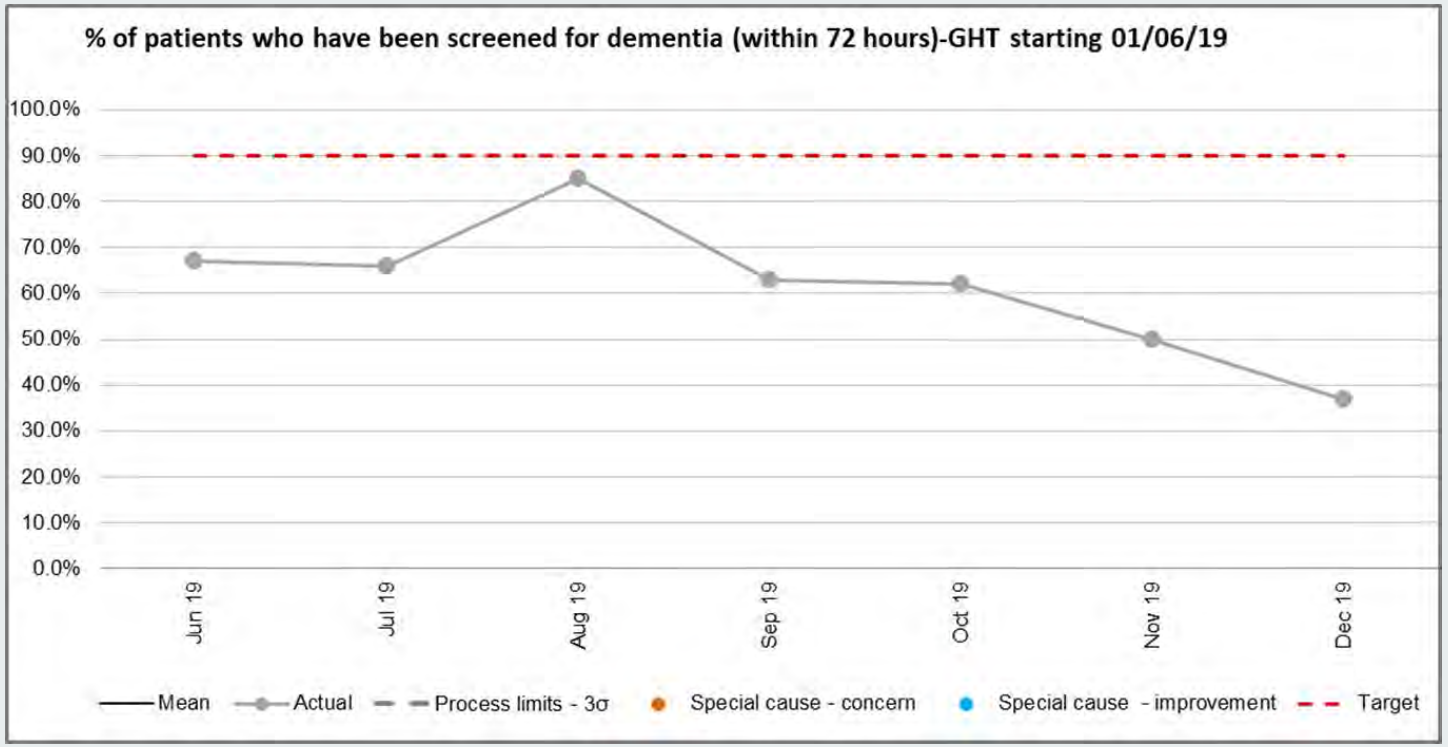
Process Limits

- **Lower Limit**: 99% of data should fall between the lower and upper limit
- **Mean**: Average performance over the baseline period
- **Upper Limit**: 99% of data should fall between the lower and upper limit

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance		
Patient Safety Incidents	Number of falls resulting in harm (moderate/severe)	<=3	Jan-20	5	
Patient Safety Incidents	Number of patient safety incidents – severe harm (major/death)	No target	Jan-20	6	
Patient Safety Incidents	Medication error resulting in severe harm	No target	Jan-20	0	
Patient Safety Incidents	Medication error resulting in moderate harm	No target	Jan-20	5	
Patient Safety Incidents	Medication error resulting in low harm	No target	Jan-20	10	
Patient Safety Incidents	Number of category 2 pressure ulcers acquired as in-patient	<=30	Jan-20	27	
Patient Safety Incidents	Number of category 3 pressure ulcers acquired as in-patient	<=5	Jan-20	2	
Patient Safety Incidents	Number of category 4 pressure ulcers acquired as in-patient	Zero	Jan-20	0	
Patient Safety Incidents	Number of unstagable pressure ulcers acquired as in-patient	<=3	Jan-20	4	
Patient Safety Incidents	Number of deep tissue injury pressure ulcers acquired as in-patient	<=5	Jan-20	5	
RIDDOR	Number of RIDDOR		Jan-20	4	
Safety Thermometer	Safety thermometer – % of new harms	>96%	Jan-20	96.5%	
Serious Incidents	Number of never events reported	Zero	Jan-20	1	
Serious Incidents	Number of serious incidents reported	No target	Jan-20	2	
Serious Incidents	Serious incidents – 72 hour report completed within contract timescale	>90%	Jan-20	100.0%	
Serious Incidents	Percentage of serious incident investigations completed within contract timescale	>80%	Jan-20	100%	
VTE Prevention	% of adult inpatients who have received a VTE risk assessment	>95%	Jan-20	90.1%	

Quality:
Run Chart – Target Not Achieved

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Actions continuing through divisions

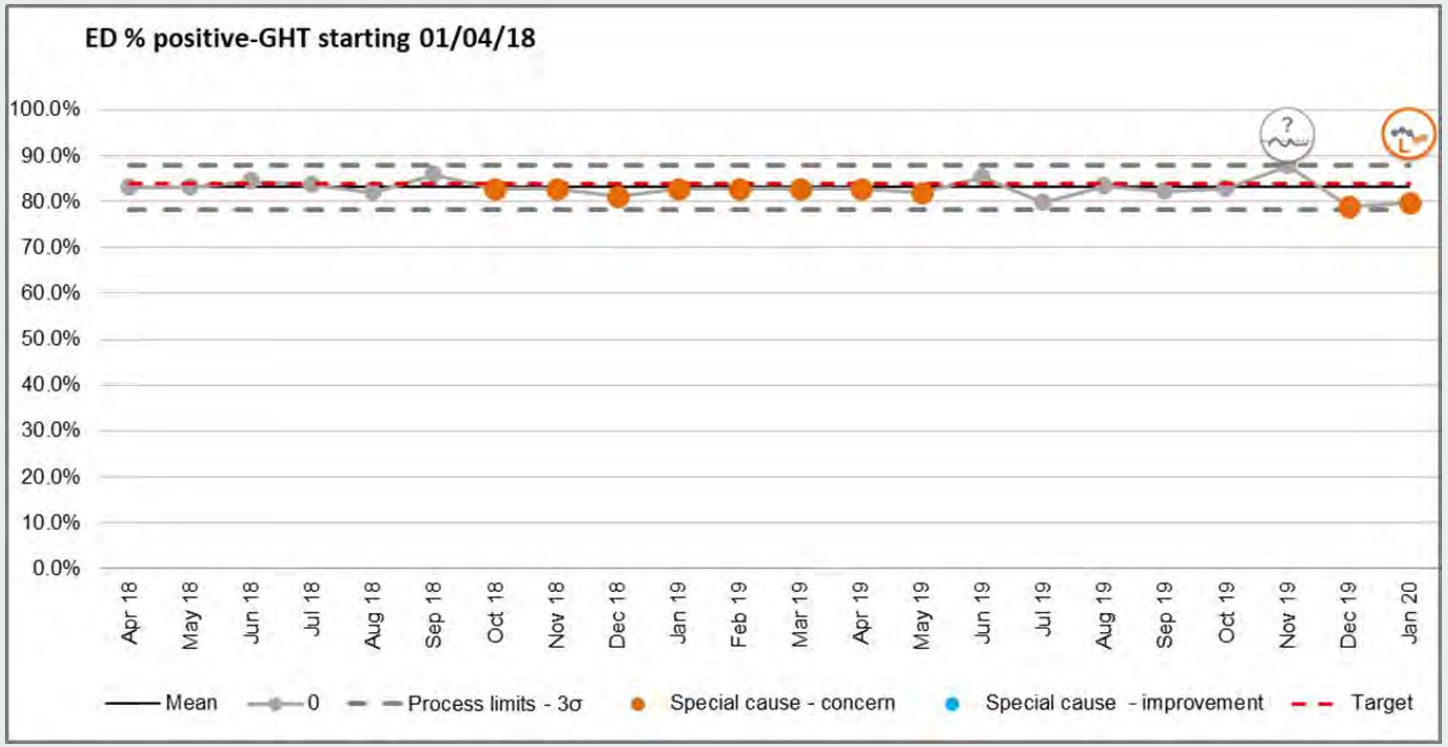
- Deputy Chief Nurse

Data Observations

An exception report has been generated for this metric because it has not achieved its target this month.
There are not enough consecutive data points to create an accurate SPC chart, therefore a run chart will be presented until an SPC chart can be created in the future.

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

This has been shared with DDQN for ongoing monitoring and to support improvement. Patient Experience team are working with divisions to identify new methodologies and approaches as part of new FFT roll out from April that could improve response rates and quality of data returned.

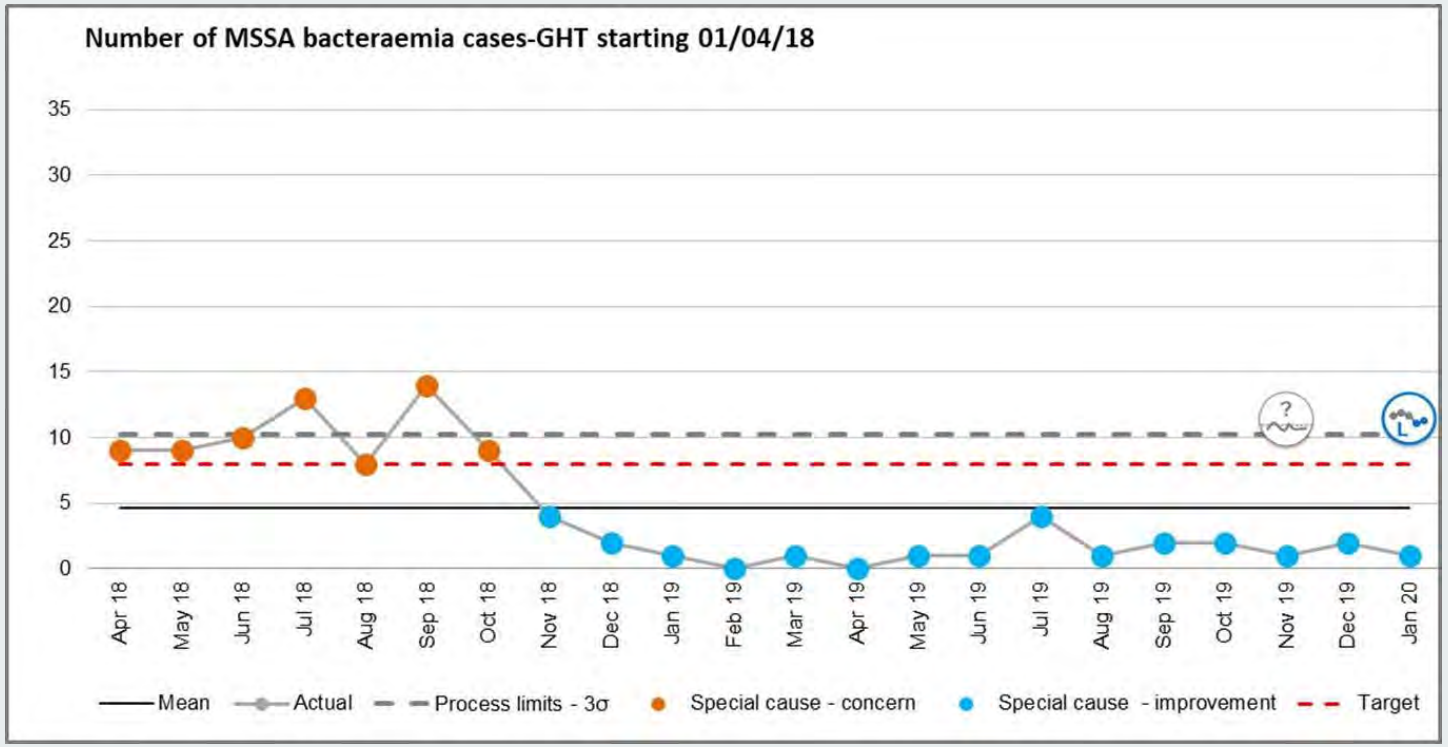
- Deputy Director of Quality

Data Observations

Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points below the mean.
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

During January 2020 there were 3 hospital onset cases of MSSA blood stream infections. The trust's IPC strategy aim to reduce MSSA blood stream infections with a focus on improving vascular access device insertion and care. Also all MSSA BSI cases associated with total parenteral nutrition go through the root cause analysis process to establish practice changes if required.

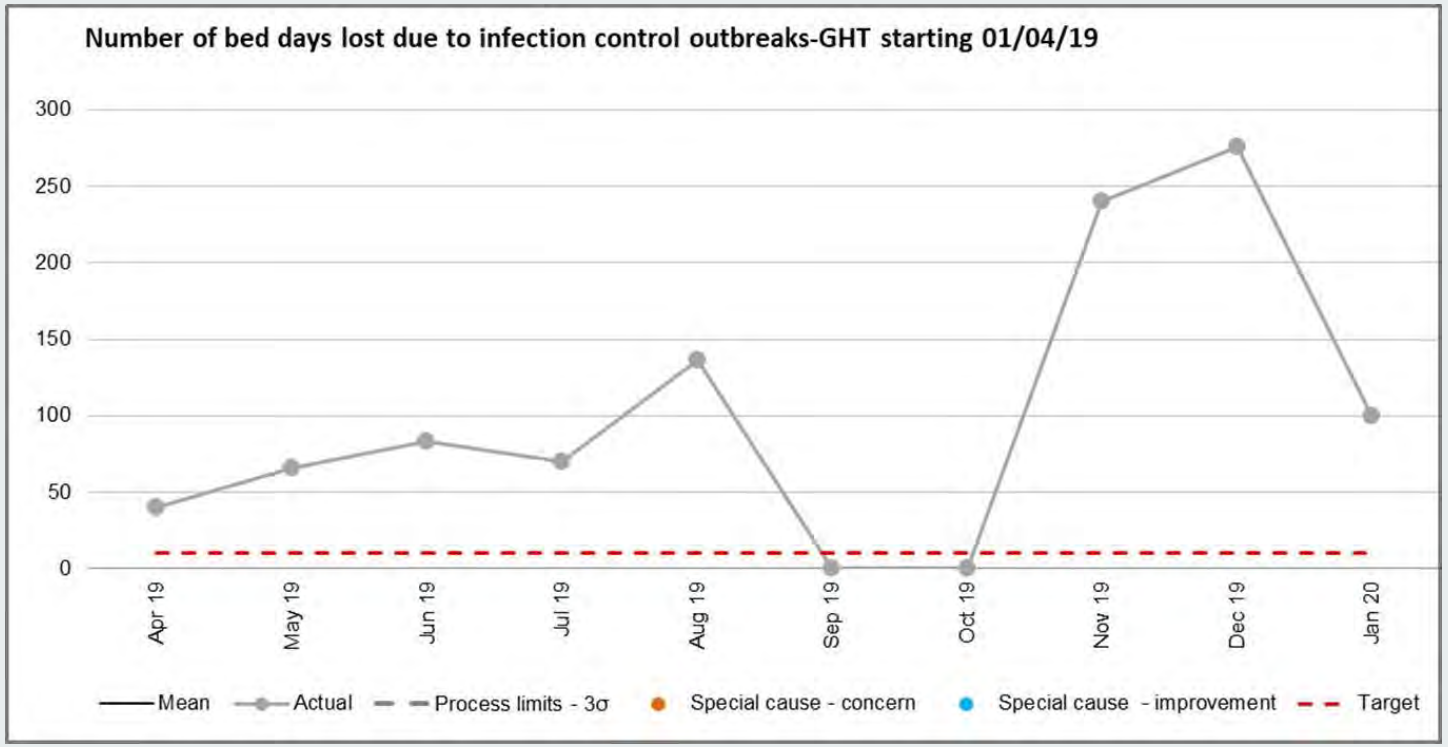
- Associate Chief Nurse and Deputy Director of Infection Prevention and Control

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 2 data points which is above the line.
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points below the mean.
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing
2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing

Quality:
Run Chart – Target Not Achieved

Gloucestershire Hospitals NHS Foundation Trust



Commentary

During January there were a number of wards affected by outbreaks of either Influenza or Norovirus. Bays and wards were closed as part of outbreak management to control transmission of infection to other patients. Outbreak affected ward areas were reviewed daily by the Infection Prevention and Control Team and management plans discussed with the site team. Beds were re-opened in affected areas when the outbreak was deemed to be over and safe to do so

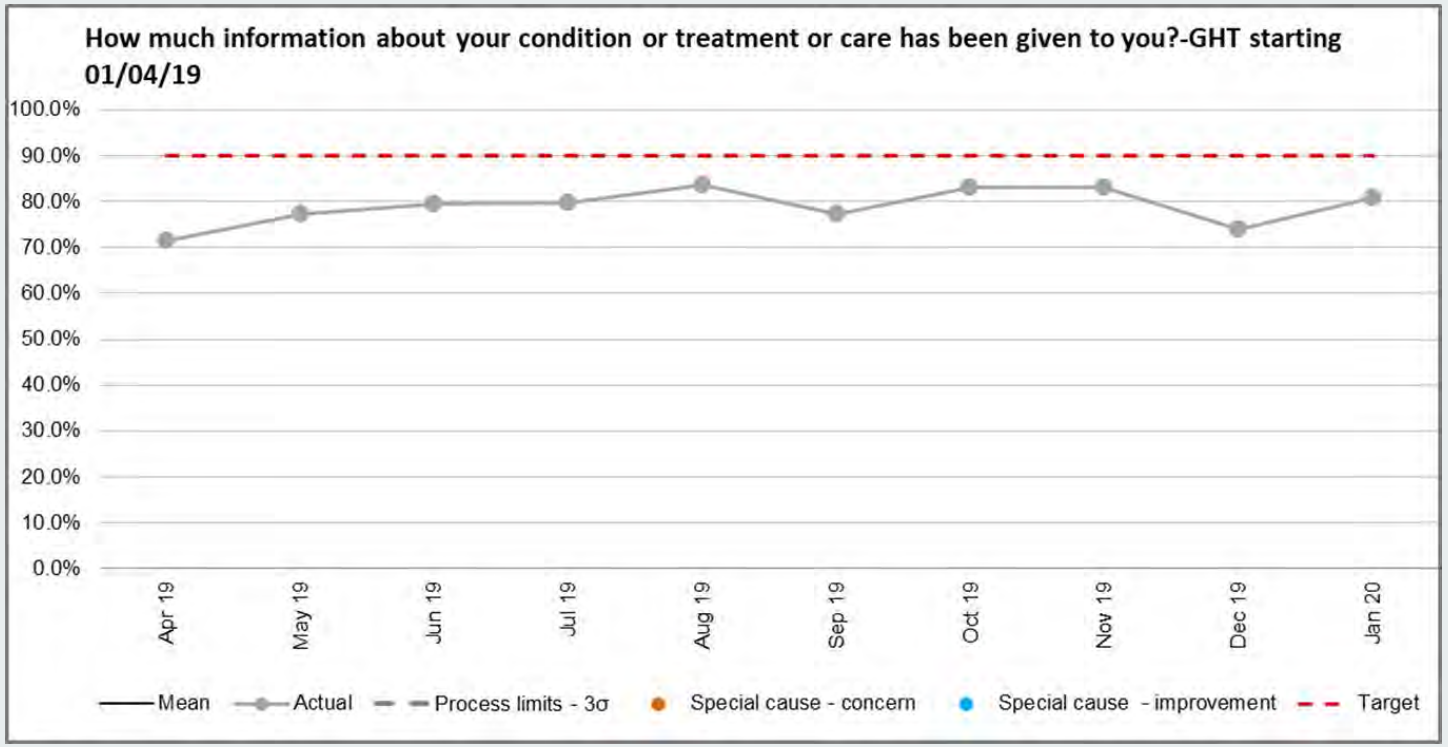
- Associate Chief Nurse and Deputy Director of Infection Prevention and Control

Data Observations

An exception report has been generated for this metric because it has not achieved its target this month.
There are not enough consecutive data points to create an accurate SPC chart, therefore a run chart will be presented until an SPC chart can be created in the future.

Quality:
Run Chart – Target Not Achieved

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Work is happening in divisions looking to address this, with communication tools being piloted in some surgical teams, and medicine division delivering work looking at improving discharge and the need for better conversations throughout someone's stay.

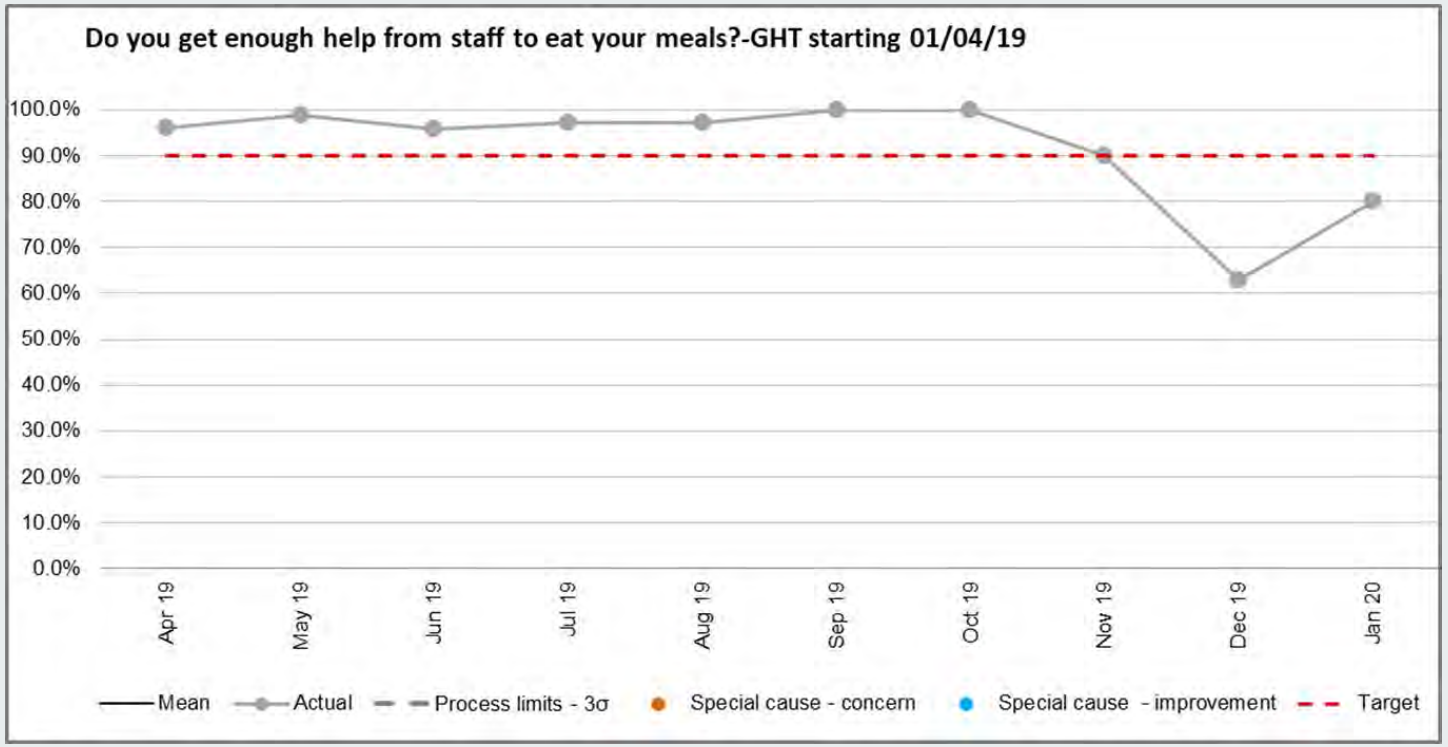
- Head of Patient Experience Improvement

Data Observations

An exception report has been generated for this metric because it has not achieved its target this month.
There are not enough consecutive data points to create an accurate SPC chart, therefore a run chart will be presented until an SPC chart can be created in the future.

Quality:
Run Chart – Target Not Achieved

Gloucestershire Hospitals NHS Foundation Trust



Commentary

This information has reported through to DDQNs for improvement plans to be identified.

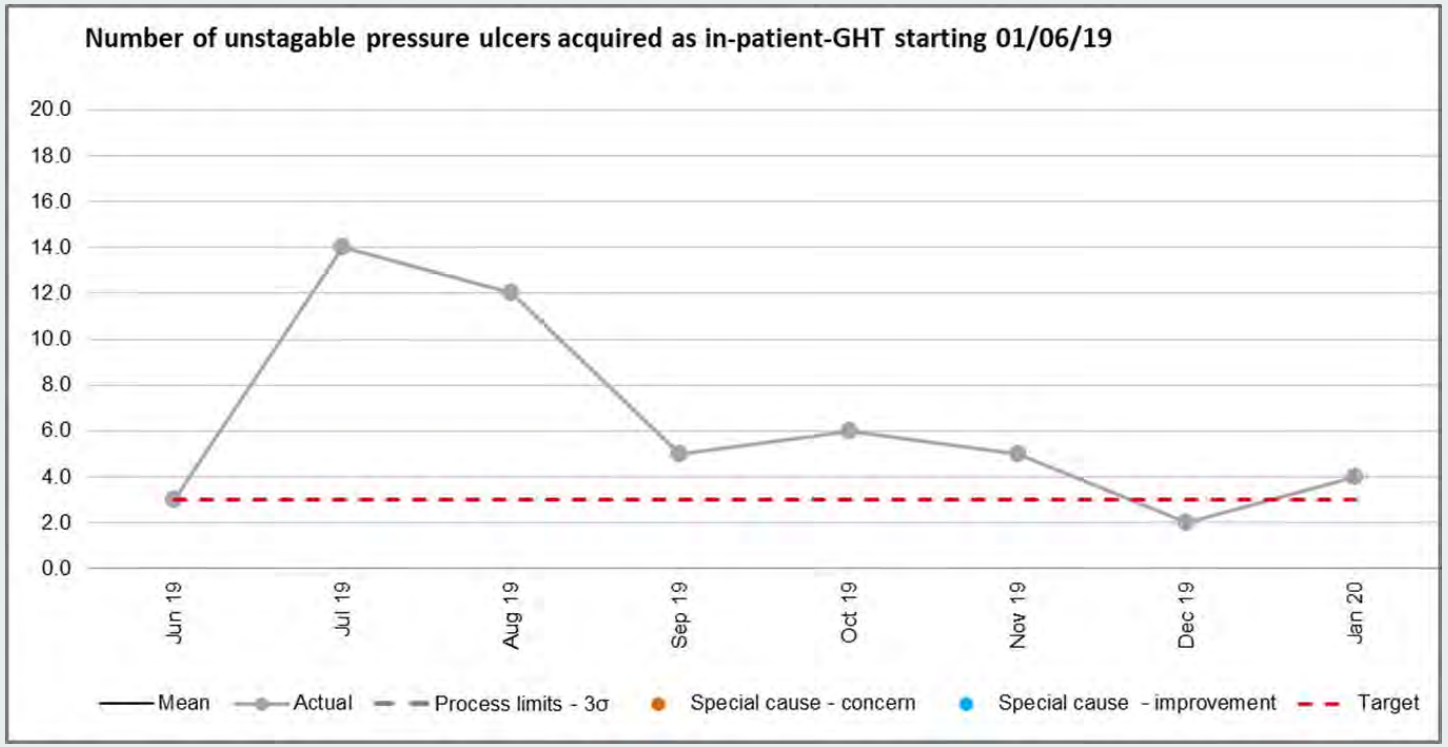
- Head of Patient Experience Improvement

Data Observations

An exception report has been generated for this metric because it has not achieved its target this month.
There are not enough consecutive data points to create an accurate SPC chart, therefore a run chart will be presented until an SPC chart can be created in the future.

Quality:
Run Chart – Target Not Achieved

Gloucestershire Hospitals NHS Foundation Trust



Commentary

There were 4 unstageable pressure ulcers during January 2020. Two of these were on Gallery Ward, one on 8b and one on 9b. All of these cases are investigated at ward level with support from the Tissue Viability Team.

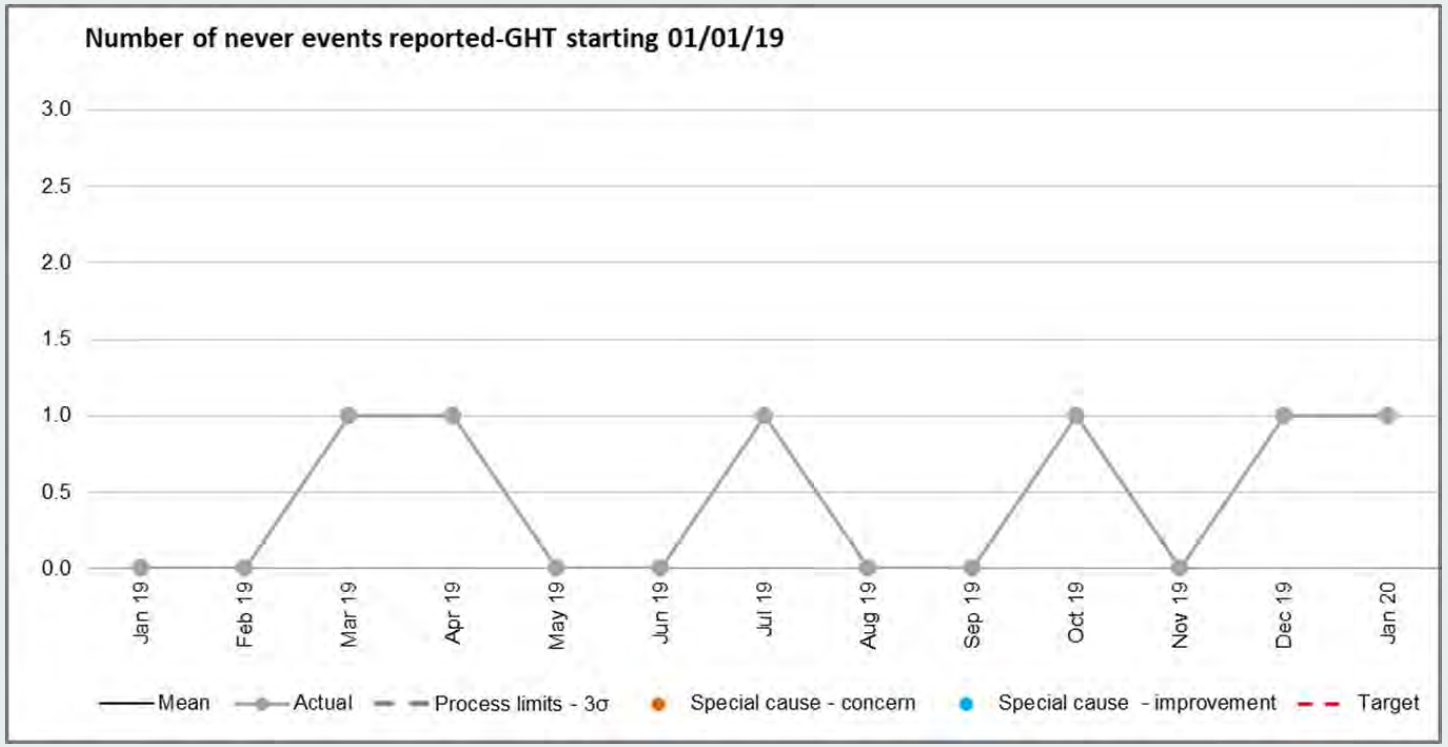
- Deputy Nursing Director & Divisional Nursing Director - Surgery

Data Observations

An exception report has been generated for this metric because it has not achieved its target this month.
There are not enough consecutive data points to create an accurate SPC chart, therefore a run chart will be presented until an SPC chart can be created in the future.

Quality:
Run Chart – Target Not Achieved

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The Never Event (wrong implant) will be investigated following the normal process. In addition the packaging from the equipment has been reported to the MHRA and company as a significant contributory factor

- Director of Safety

Data Observations

An exception report has been generated for this metric because it has not achieved its target this month.
There are not enough consecutive data points to create an accurate SPC chart, therefore a run chart will be presented until an SPC chart can be created in the future.

Financial Dashboard

Gloucestershire Hospitals NHS Foundation Trust

This dashboard shows the most recent performance of metrics in the Financial category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Finance	Total PayBill Spend		Jan-20	30.1
Finance	YTD Performance against Financial Recovery Plan		Jan-20	0.3
Finance	Cost Improvement Year to Date Variance		Jan-20	-2.4
Finance	NHSI Financial Risk Rating		Jan-20	3
Finance	Capital service		Jan-20	4
Finance	Liquidity		Jan-20	4
Finance	Agency – Performance Against NHSI Set Agency Ceiling		Jan-20	3

Key

Assurance

Consistently hit target

Hit and miss target subject to random

Consistently fail target

Variation

Special Cause Concerning variation

Common Cause

Special Cause Improving variation

Process Limits

Lower Limit
99% of data should fall between the lower and upper limit

Mean
Average performance over the baseline period

Upper Limit
99% of data should fall between the lower and upper limit

People & OD Dashboard

Gloucestershire Hospitals NHS Foundation Trust

This dashboard shows the most recent performance of metrics in the People & Organisational Development category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.

MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
Appraisal and Mandatory	Trust total % overall appraisal completion	>=90%	F	Jan-20	83.0%	H
Appraisal and Mandatory	Trust total % mandatory training compliance	>=90%	?	Jan-20	90%	
Safe Nurse Staffing	Overall % of nursing shifts filled with substantive staff	>=75%		Jan-20	99.3%	
Safe Nurse Staffing	% registered nurse day	>=90%		Jan-20	98.5%	
Safe Nurse Staffing	% unregistered care staff day	>=90%		Jan-20	102.1%	
Safe Nurse Staffing	% registered nurse night	>=90%		Jan-20	100.8%	
Safe Nurse Staffing	% unregistered care staff night	>=90%		Jan-20	107.8%	
Safe Nurse Staffing	Care hours per patient day RN	>=5		Jan-20	4.6	
Safe Nurse Staffing	Care hours per patient day HCA	>=3		Jan-20	2.9	
Safe nurse staffing	Care hours per patient day total	>=8	?	Jan-20	7.6	H
Vacancy and WTE	Staff in post FTE	No target		Jan-20	6351.41	
Workforce Expenditure	% turnover	<=11%	F	Dec-19	11.8%	
Workforce Expenditure	% sickness rate	<=3.5%	?	Jan-20	3.8%	L

Key

Assurance

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

Variation

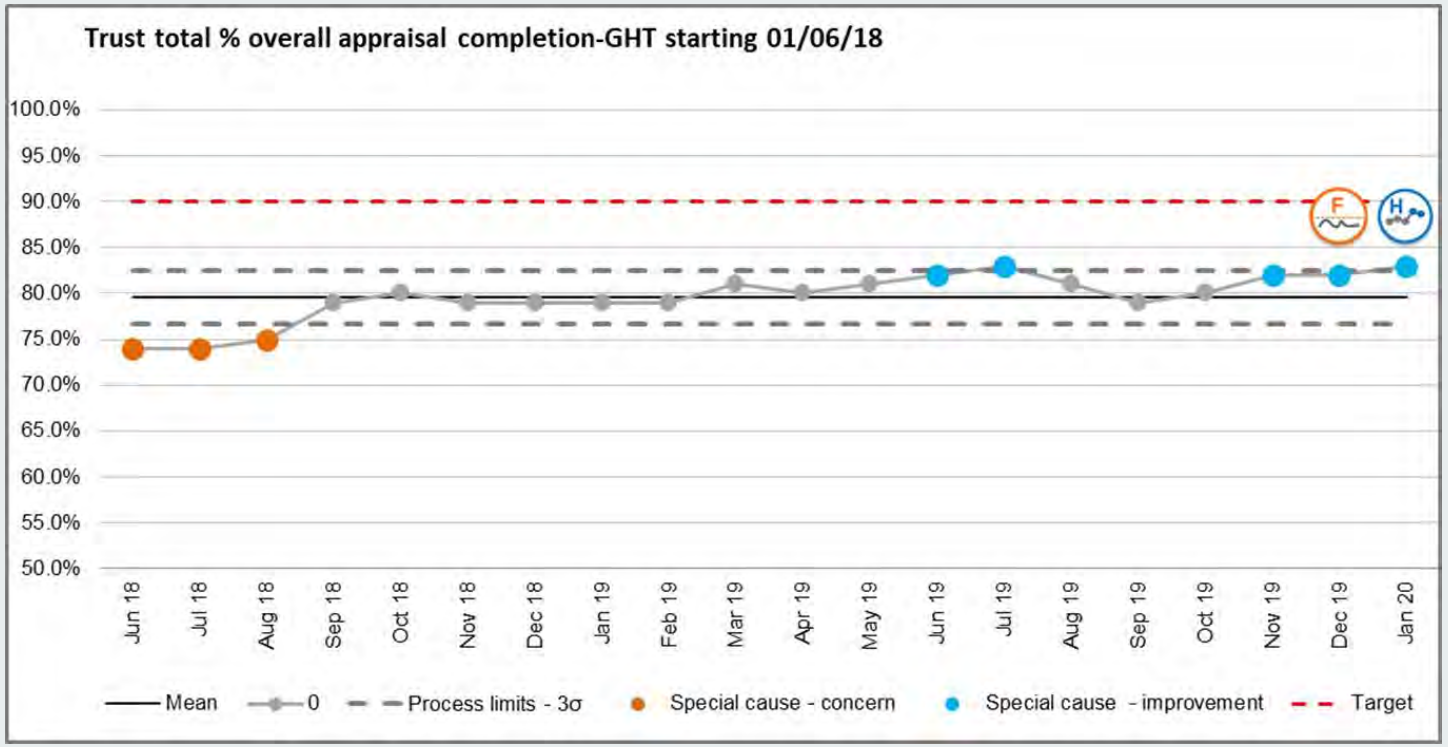
- H / L — Special Cause Concerning variation
- Common Cause
- H / L — Special Cause Improving variation

Process Limits

- **Lower Limit**: 99% of data should fall between the lower and upper limit
- **Mean**: Average performance over the baseline period
- **Upper Limit**: 99% of data should fall between the lower and upper limit

People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Whilst still below the 90 target for appraisal completion, the data shows for the past 3 months compliance has been consistently above mean levels. This is an encouraging picture, especially against the context of winter pressures.

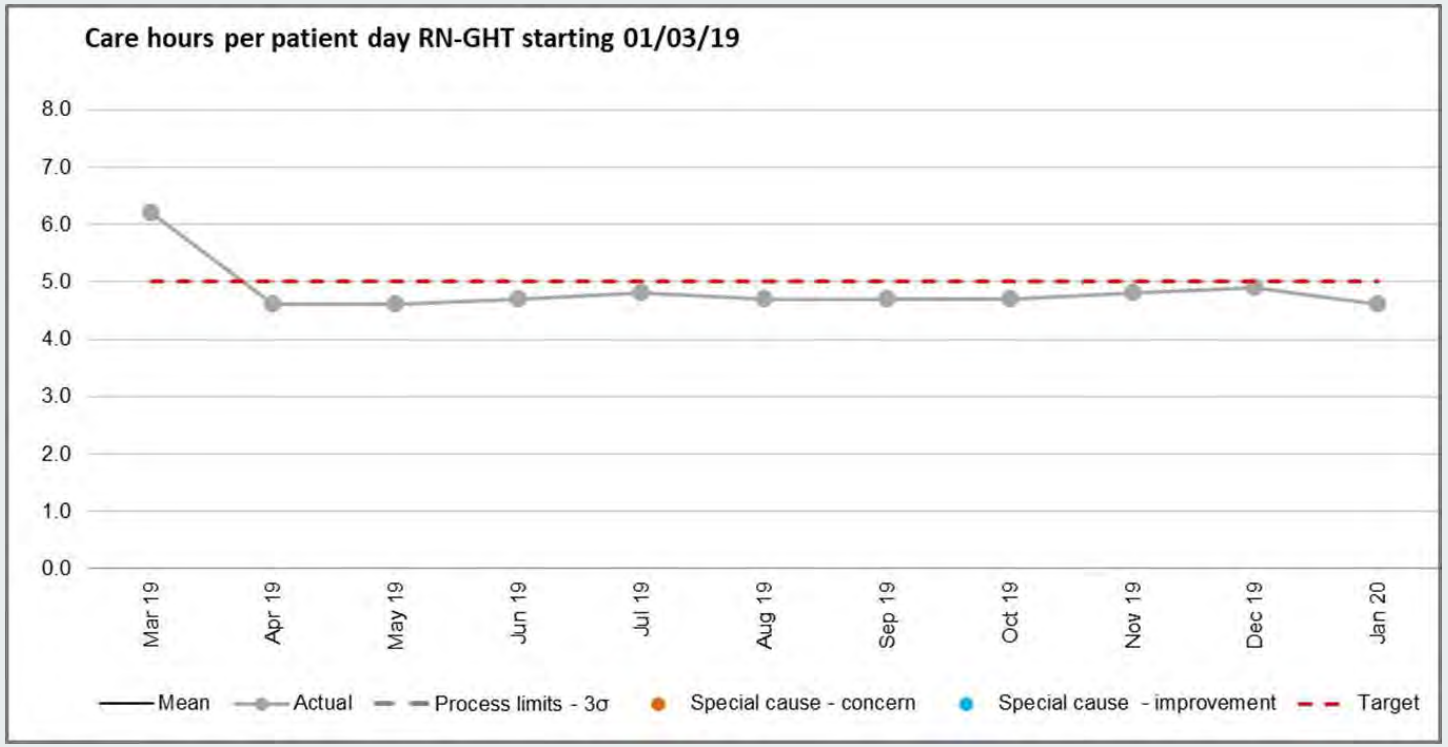
- **Deputy Director of People and Organisational Development**

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 2 data points which are above the line. There are 3 data point(s) below the line
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing
2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing

People & OD:
Run Chart – Target Not Achieved

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Increase in activity and demand with escalation areas open has impacted on this months figures.

9 new OSN have joined the Trust from India. Retention work continues with a workshop held to review and enhance the RN career pathway.

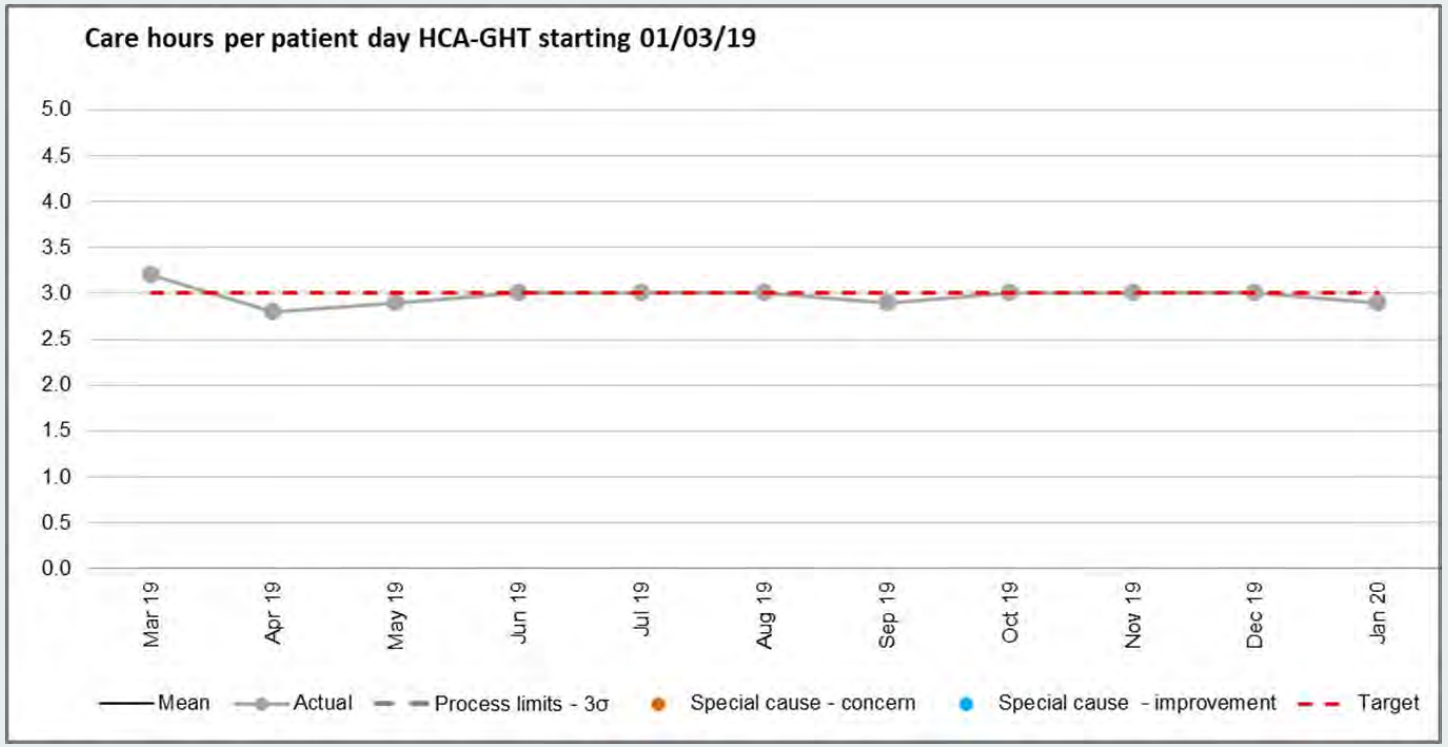
- Director of Nursing and Midwifery

Data Observations

An exception report has been generated for this metric because it has not achieved its target this month.
There are not enough consecutive data points to create an accurate SPC chart, therefore a run chart will be presented until an SPC chart can be created in the future.

People & OD:
Run Chart – Target Not Achieved

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Increased activity and demand has impacted on this months figures. Also escalation areas open which required additional staffing.

Monthly substantive and bank HCA recruitment continues. Workshop has taken place with key stake holders to review and enhance the unregistered nurse career pathway.

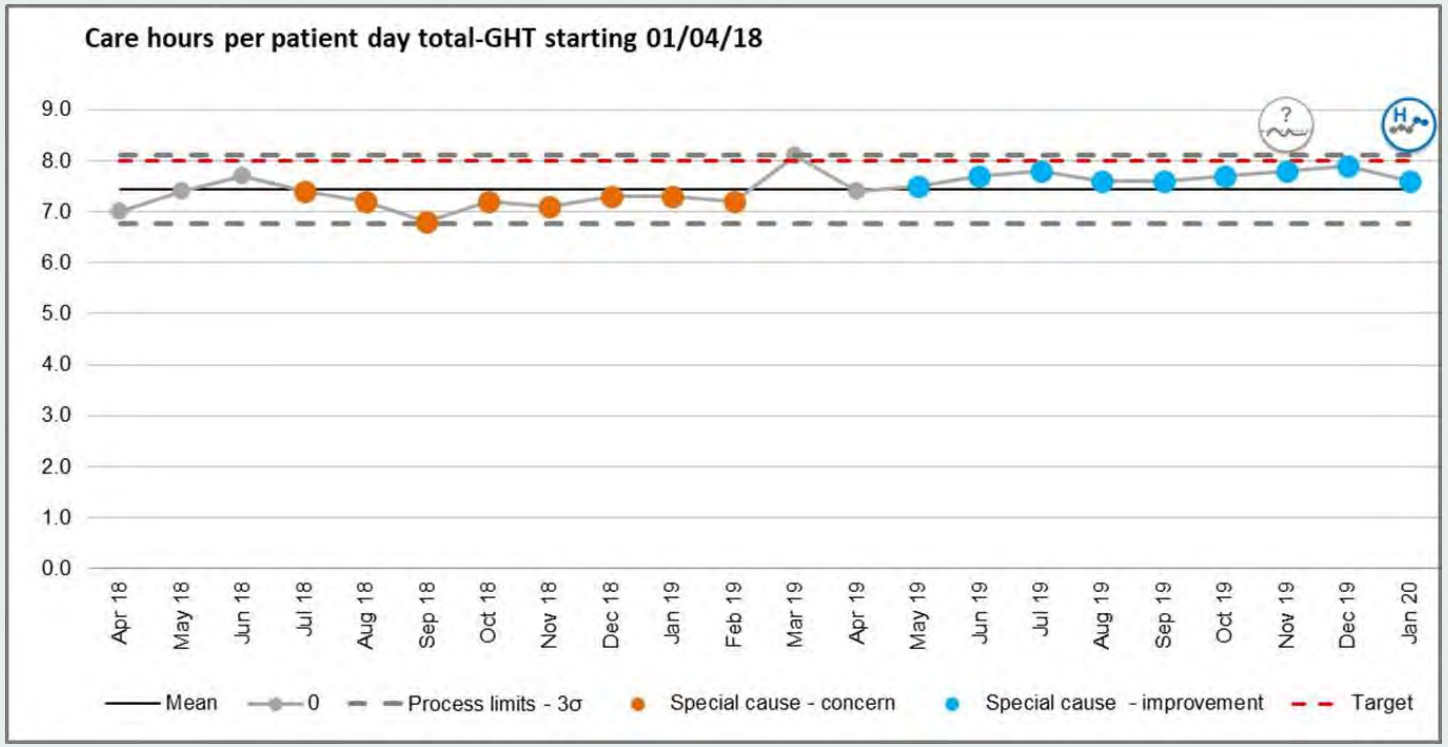
- Director of Nursing and Midwifery

Data Observations

An exception report has been generated for this metric because it has not achieved its target this month.
There are not enough consecutive data points to create an accurate SPC chart, therefore a run chart will be presented until an SPC chart can be created in the future.

People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Increased activity and demand has impacted on this months figures with more beds and escalation areas open. The first meeting of the Recruitment and retention subgroup for nursing has taken place with key stakeholders from all clinical divisions in attendance. Monthly HCA recruitment continues and 9 overseas nurses have joined the Trust. Work continues with the actions of the retention action plan and the overarching Person Centred Careers framework

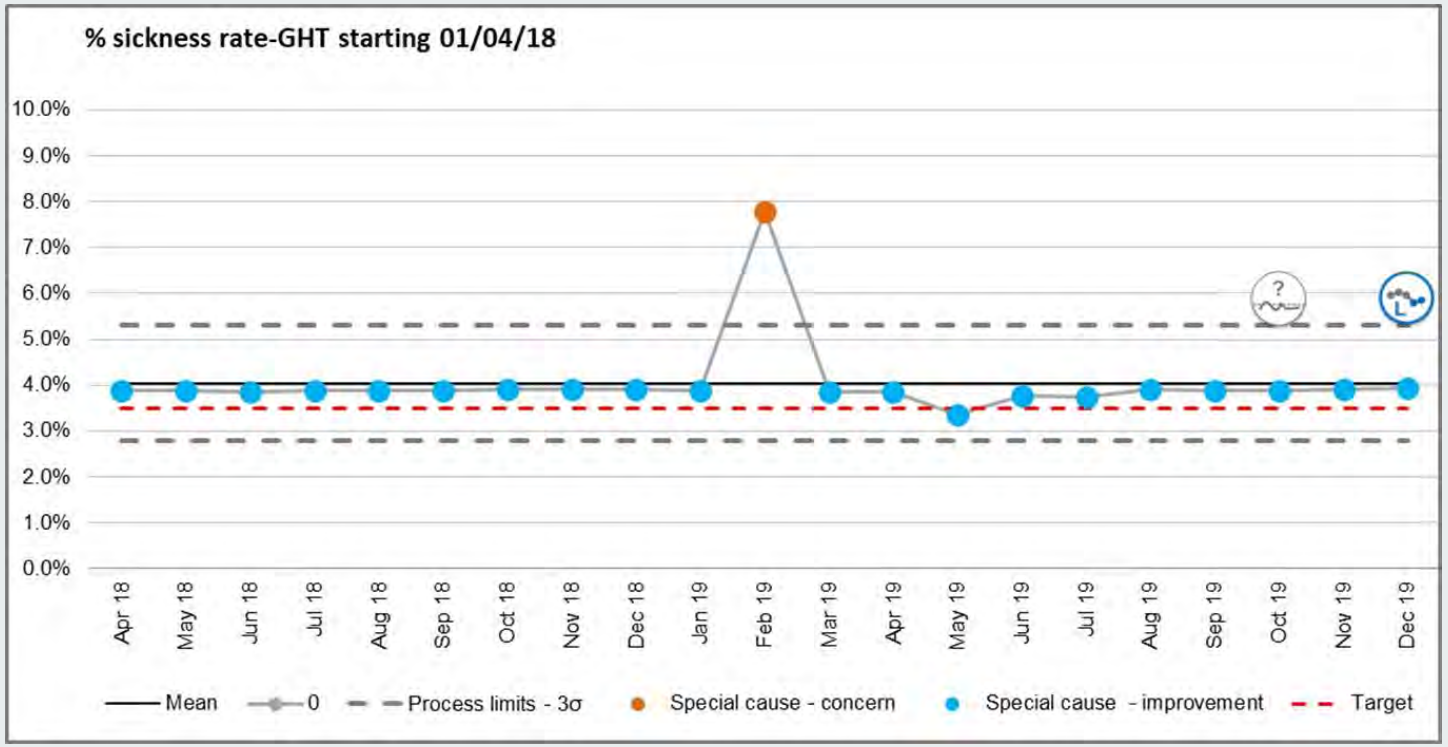
- Director of Nursing and Midwifery

Data Observations

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

People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Sickness trends are consistently below the mean, triggering special cause variation rules. The SPC chart has highlighted an irregularity in reporting for Feb 2019, which will now be further investigated.

- **Director of Human Resources and Operational Development**

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 1 data point which is above the line.
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points below the mean.

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD – February 2020

From Alison Moon – Non-Executive Director

This report describes the business conducted at the Quality and Performance Committee held 27th February 2020, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Quality and Performance report	**Quality Delivery group** Use of quality summits for organisational improvement, open summit focussing on harm through hospital acquired pressure ulcers and falls.		Quality summits provide an opportunity to focus organisational efforts in delivering improvements and a focus on actions.	
	Enhanced surveillance in place for deteriorating patients	Recognition that calculating of NEWS2 scores can have a high error rate, resolved by electronic observations.	Detailed discussion on benefits of electronic observations being introduced in March 2020 which supports better identification and early treatment of patients who deteriorate.	
	Backlog with some histopathology services remains	What impact on patients is there and when will this be resolved?	All patients reviewed at weekly check and challenge meetings. New Consultant histopathology appointment starts early March 2020 and focus is on backlog.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	Fractured neck of femur data indicates a deterioration in performance although still within the national benchmark	Raised at last Quality and Performance Committee and level of actions being taken to address more detailed at this committee.	Train of actions described and in place to review and improve, positive and proactive not waiting until an outlier in benchmark terms.	
	Continuity of Carer (maternity) current position deteriorated at 4.3%.	Stroud pilot has been paused to allow for a workforce revision.	Noted system wide plans to support additional midwives, plans tested through the Local Maternity System (LMS)	Future reporting of continuity of carer performance to be included in the report
	Care Quality Commission (CQC) re inspection of governance and procedures associated with Ionising Radiation		Plan agreed at last Quality and Performance Committee to deliver improvements Successful visit, written confirmation from CQC no further action needed against the Trust	
	Planned Care Delivery Group Referral to Treatment stable at 81.22%, within trajectory set by NHSI/E		Good level of detail and validated data which shows an improving picture and senior level focus	
	Diagnostic 6 week wait achieving national standards. Overall waiting lists size less than previous year	Where are we with patient initiated follow ups across the Trust?		Speciality specific position to be included in future reports

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	Number of over 52 week waiting patients now at 28, continued, continued improvements seen. Number of patients waiting over 40 week's also reducing and clear data at speciality level. Detailed paper on ophthalmology follow up position and actions in place, (GIRFT report shows a third of Units do not know the extent of delayed follow ups.) **Cancer Delivery Group** 2 week wait performance achieving national standards. Shadow 28 day reporting (new standard from April) included in data pack. 62 day standard not achieved, speciality specific data included with detailed action plans	Range of breach days included, what has been the impact of the longest wait on the patients involved? Will the task and finish group provide a list of enablers to achieve the 62 day standard?	Service line data shared showing an improving position. Additional capacity planned for April and May and short term plans being enacted. All patients reviewed at weekly meeting, assurance given that no indication of any harm as a result of the breach. Patients have regular touchpoints during their pathway to keep them	Further presentation by Speciality lead at April Quality and Performance Committee meeting to monitor improvements

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
			informed. Assurance received on details within work stream	
	Living Well and Beyond Cancer achievements and plans included and noted 5th best in the country. .			
	Urgent and Emergency care Delivery Group Continued pressures on the system, not achieving national standard or locally agreed trajectory.	How does it feel for staff?	Two listening events held for ED staff and regular input from leaders.	
	Additional winter monies used, some improvement in triage times and waiting time to see a doctor. Better data quality with patient's safety checklist undertaken and a focus on experience. Acute Medical Investigation and Assessment Unit seeing high numbers of patients, reducing need for admission	A letter of concern received by the CEO and Director of Quality and Chief Nurse in relation to workload pressures and staffing within the Acute Medical Unit at Gloucestershire Royal Hospital.	Executive currently testing the surveillance systems, to test if issues highlighted in the letter could have been predicted. Key immediate steps taken in response to the letter outlined, alongside key assurances set out with additional staffing in place, an unannounced Nursing	Further detailed report on Acute Medical Unit to Quality and Performance Committee in March 2020, including rating review of generic nursing risk currently on risk register. Overall nursing staffing review also due back in April 2020

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	Delayed transfers of care and medically stable patient numbers both increased.		Assessment and Accreditation System (NAAS) visit which did not highlight any immediate safety concerns but was red rated. Staff describing feeling more supported alongside a series of engagement meetings planned with divisional senior leadership team.	
Quarterly Executive Divisional Review briefing	Assurance report on the divisional leadership performance and accountability, including progress against strategic objectives		Assurance received on the approach of the review process. Risks identified will be followed up and come through the assurance route through existing mechanism	
Clinical Improvement and Audit Report	Oversight of the Gloucestershire Safety and Quality Improvement Academy and clinical audit functions. 2700 staff trained, three collaboratives in place (children, cancer and deteriorating patient). Health Foundation Grant to		Quality improvement approach and progress noted, and increasingly recognised as a national example of good practice.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	focus on quality 'wicked issues' across the ICS system. Active Trust participation in national audits, two identified as partial or non-compliance.	What are the implications of not taking part in national audits? Where was decision made to be non or partially complaint? Are there any plans for interface audits across the ICS?	National audit participation will become part of executive divisional reviews. Plans for safeguarding, infection control and integrated services audits.	
CQUIN report on medicines optimisation	Report outlining 100% achievement of Medicines Optimisation CQUIN for 19/20, value of £468,500 for specialised commissioning CQUINs.		Achievement noted and commended	Report of wider CQUIN position to future Quality and Performance Committee
7 day services report	Follow up paper from October 2019. Two of four standards not achieved, Consultant Review within 14 hours of emergency admission and ongoing daily review. Action plan in progress, all specialities asked to consider what is needed to become compliant	Recruitment of Consultants is green rated, what does this mean? Are there any bottlenecks in daily reviews?	Process of recruitment in place, positive outcomes in progress All new and acutely unwell patients seen on a daily basis	Risk rating of non-compliance being reviewed. Further paper due to Quality and Performance Committee in November

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		Are there any services where you do not see a solution? How are other parts of the system monitoring their 7 day service achievements?	None identified CCG noted this and describe a work in progress.	
Patient Experience quarterly report	Friends and Family test responses and ratings, overall satisfaction is 91.54%, areas with lower scores noted in specific areas, e.g. Acute Medical Unit. Real time data being produced which indicate higher experience ratings, although noted capacity issues to implement robust real time feedback currently. PALs reporting 60 % of issues relate to outpatients either delays waiting for appointments or loss or delay in referrals.	Is there a differential experience in relation to equality strands as looks a broad approach taken? There continues to be a differential Friends and Family Test rating between Cheltenham General Hospital and Gloucestershire Royal Hospital, what does the data tell us and why is there a differential? Is there a correlation with this data and complaints data? Are the concerns re outpatients new?	Work ongoing with equalities lead and ability to use existing data. Patient experience improvement project planned for AMU working with carer who presented to Board recently. Not new information and an improving picture over time. All feedback goes into the outpatient's transformation programme team. Fully engaged, use of data reviewed through divisional review process. Linked to the work on leadership and staffing levels.	Review of accessible information standards position, what data is collected and how review of Datix/PALs and EPR can work together. To be included in future reports.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		How do you assess the engagement of divisions in the process of patient experience? What is your confidence of improving real time feedback process?	New patient engagement lead just appointed and focus of work will be on improving use of real time feedback across the Trust .	
Infection Control quarterly report	2 cases of MRSA year to date, C difficile figures below limit set nationally, although still an area of significant focus. Surgical site infection data included, two areas where an outlier. Spinal surgery and hip surgery. Significant norovirus outbreaks which have affected patients and operational flow. Extensive review of cleaning provision undertaken and joint working with GMS. Funding agreed to support meeting contractual	Following review of C difficile cases, some lapses in care noted, have these results and learning been fed into the established C difficile action plan?	Confirmed that all learning taken into the revised action plan which is then updated. Executive confidence of the joint working on cleaning schedules and improvements being made, noted focus from Contract Management Board and Estates and Facilities Committee.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	standards.			
Review of corporate risk register and never events.	Review of relevant corporate risks and mitigations. Review of status and actions in progress relating to never events.	What are the mitigations for the risk of ambient temperature in pathology labs? Is there an easier way for us to see how dynamic the risk register is?	External survey underway, results due very soon, funding has been approved as part of the capital planning round for 2020/21	
Serious Incidents report	Report on new, open and closed serious incidents action plans.	Questions raised included availability of timely and consistent phlebotomy through 7 days, links to the IT system and actions to protect the deteriorating patient.		Further updates on these areas due as part of action plan closure evidence presented to Quality and Performance Committee
ICS update for information	System challenges, including social care discussed as part of AE delivery board. GIRFT visit to ED, benchmark well, need to focus on over 70's frailty model and length of stay issues in CGH. New clinical standards due soon. First Gloucestershire Nursing and Midwifery Professional Council has		Assurance of examples of Trust role and leadership in system working across ICS	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	taken place, in line with AHP and Medical councils, will feed into the ICS through clinical council Coronavirus update provided, noted guidance being updated on a regular basis			
CCG update	No new issues or concerns raised by CCG. Currently monitoring cleaning progress and fractured neck of femur actions			

Alison Moon
Chair of Quality and Performance Committee
01 March 2020

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – MARCH 2020
Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital

Report Title
Financial Performance Report - Month Ended 31 January 2020
Sponsor and Author(s)
Author: Tony Brown, Senior Finance Advisor Sponsor: Karen Johnson, Director of Finance
Executive Summary
Purpose This report provides the Board with details of the financial performance for the period ended 31 January 2020. Key issues to note • At Month 10 the Trust is reporting a cumulative deficit of £5.6m, which is £0.3m favourable to plan. • Commissioner income is £6.3m favourable against plan. • Other NHS patient related income is £1m favourable against plan. • Private and paying patients' income is £0.9m favourable to plan. • Other operating income (including Hosted Services) is £2.9m favourable to plan. • Pay expenditure is showing an adverse variance of £4.3m. • Non-pay expenditure is showing an adverse variance of £6.9m. • Non-operating costs are £4.5m adverse to plan (reflecting the impairment of TrakCare) – this is reversed out from a control total point of view leaving a favourable variance to the planned position. Conclusions The Board is asked to note the contents of the report. Implications and Future Action Required The Board is asked to note the contents of the report.
Recommendations
The Board is asked to NOTE the report.
Impact Upon Strategic Objectives
Supports Trust to deliver Strategic Objectives around financial position and sustainability.
Impact Upon Corporate Risks
Risks around CIP delivery and budget management.
Regulatory and/or Legal Implications
Potential for regulatory action if the financial position is not delivered as planned.
Equality & Patient Impact
None.
Resource Implications

Finance	**X**	Information Management & Technology	

Human Resources		Buildings	

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

Date the paper was presented to previous Committees and/or Trust Leadership Team (TLT)							
Audit & Assurance Committee	**Finance & Digital Committee**	**Estates & Facilities Committee**	**People & OD Committee**	**Quality & Performance Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
	27 Feb 2020						
Outcome of discussion when presented to previous Committees/TLT							
Recommended to Board.							

Gloucestershire Hospitals NHS
NHS Foundation Trust

Report to the Trust Board

Financial Performance Report
Month Ended 31st January 2020

Director of Finance Summary

Gloucestershire Hospitals NHS
NHS Foundation Trust

Financial Performance Month 10

In January Divisional performance after adjusting for passthrough variances was generally in line with or better than forecast, evidence that Divisional actions to hold run rates are having a positive effect. Pay was better than forecast across **all** Divisons notably in Medicine where the actual Pay spend was £0.25m below forecast. Surgery showed similar performance with a favourable variance to forecast of £0.22m. Against the backdrop of operational pressures highlighted below it is encouraging that Pay spend in particular is being held. These positive performances have favourably impacted on Divisional forecasts (see below).

Forecast Outturn

The position at month 9 and a continued stabilisation in month 10 has provided a level of confidence around the ability to achieve the control total by the end of the financial year.

The non-delivery of CIP in the last quarter has been partially mitigated by improvements in Divisional forecasts and continued re-prioritisation of the contingency. The likely scenario has now moved to achievement of the control total although there are still some risks to this, mainly the assumption around penalties on 52 week waits however, no charge has been raised to date so this risk is considered to be low.

Capital

As at month 10 the capital programme has spent £18.2m which is 69% of the total original budget. There is a requirement this year that all capital money should be spent otherwise it will be lost. The capital control group met on 18th Feb and agreed a plan to ensure all the capital budget is spent this financial year. The Trust is still waiting for the outcome of the emergency capital bids NHSI/E asked us to submit during the end of Jan. It is likely that Trusts will be notified at the end of Feb which puts at risk the ability to spend the money by the end of the financial year.

Balance Sheet

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

Introduction and Overview

Gloucestershire Hospitals NHS
NHS Foundation Trust

The Trust submitted a revised budget for the 2019/20 financial year to NHSI on 15th May 2019 reflecting a deficit of £1.5m on a control total basis (after removing the impact of donated asset income and depreciation). This plan forms the basis for reporting in month 10.

The financial position as at the end of January 2020 reflects the Group position including Gloucestershire Hospitals NHS Foundation Trust and Gloucestershire Managed Services Limited, the Trust's wholly-owned subsidiary company. The Group position in this report excludes the Hospital Charity.

In January the Group's consolidated position shows a year to date deficit of £5.6m. This is £0.3m favourable against plan. The position includes an impairment of £4.9m for the writing down of TrakCare expenditure incurred in previous financial years, which has no impact on the control total position. This favourable position continues to reduce and will need to be monitored closely over the next 2 months to ensure delivery of the Control Total, this in line with forecast.

Statement of Comprehensive Income (Trust and GMS)

	TRUST POSITION			GMS POSITION			GROUP POSITION *		
Month 10 Cumulative Financial Position	Budget £000s	Actuals £000s	Variance £000s	Budget £000s	Actuals £000s	Variance £000s	Budget £000s	Actuals £000s	Variance £000s
SLA & Commissioning Income	402,072	408,373	6,302	0	0	0	402,072	408,373	6,302
PP, Overseas and RTA Income	4,002	4,923	921	0	0	0	4,002	4,923	921
Other Income from Patient Activities	748	1,712	964	0	0	0	748	1,712	964
Operating Income	67,175	69,584	2,408	38,333	38,580	247	70,420	73,298	2,878
Total Income	**473,997**	**484,591**	**10,594**	**38,333**	**38,580**	**247**	**477,242**	**488,306**	**11,064**
Pay	293,086	296,814	(3,728)	15,225	15,935	(710)	308,031	312,360	(4,329)
Non-Pay	167,935	174,974	(7,039)	21,092	20,599	494	154,218	161,097	(6,879)
Total Expenditure	**461,020**	**471,787**	**(10,767)**	**36,317**	**36,534**	**(217)**	**462,249**	**473,456**	**(11,207)**
EBITDA	**12,976**	**12,804**	**(173)**	**2,016**	**2,046**	**30**	**14,992**	**14,849**	**(143)**
EBITDA %age	**2.7%**	**2.6%**	**(0.1%)**	**5.3%**	**5.3%**	**0.0%**	**3.1%**	**3.0%**	**(0.1%)**
Non-Operating Costs	19,255	23,709	(4,455)	2,016	2,046	(30)	21,270	25,755	(4,485)
Surplus/(Deficit) with Impairments	(6,278)	(10,906)	(4,627)	0	0	0	(6,278)	(10,906)	(4,627)
Less Fixed Asset Impairments	0	4,918	4,918	0	0	0	0	4,918	4,918
Surplus/(Deficit) excluding Impairments	(6,278)	(5,988)	290	0	0	0	(6,278)	(5,988)	290
Excluding Donated Assets	368	365	(3)	0	0	0	368	365	(3)
Control Total Surplus/(Deficit)	(5,910)	(5,623)	287	0	0	0	(5,910)	(5,623)	287

Group Statement of Comprehensive Income

Gloucestershire Hospitals NHS
NHS Foundation Trust

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

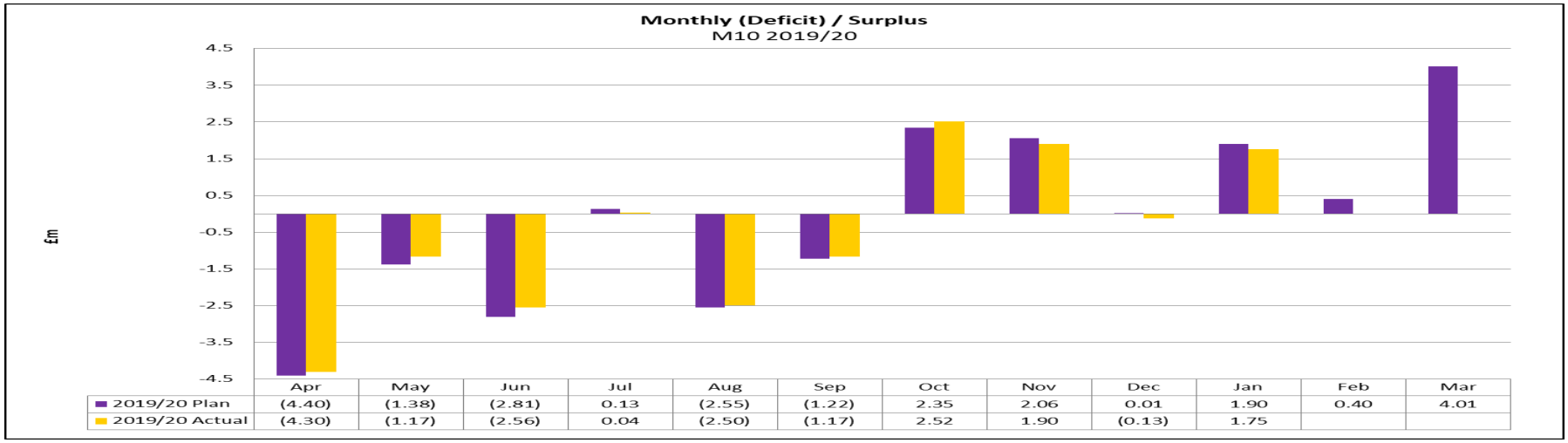
In January the Group's consolidated position shows an in month surplus of £1.753m on a control total basis, an adverse variance to plan of £0.14m.

Month 10 Financial Position	Annual Budget £000s	M10 Budget £000s	M10 Actuals £000s	M10 Variance £000s	M10 Cumulative Budget £000s	M10 Cumulative Actuals £000s	M10 Cumulative Variance £000s
SLA & Commissioning Income	482,404	41,402	41,726	324	402,072	408,373	6,302
PP, Overseas and RTA Income	4,802	400	630	230	4,002	4,923	921
Other Income from Patient Activities	898	75	198	124	748	1,712	964
Operating Income	86,896	7,738	8,116	378	70,420	73,298	2,878
Total Income	**574,999**	**49,615**	**50,670**	**1,055**	**477,242**	**488,306**	**11,064**
Pay	367,900	29,940	31,629	(1,689)	308,031	312,360	(4,329)
Non-Pay	182,515	15,689	15,201	488	154,218	161,097	(6,879)
Total Expenditure	**550,415**	**45,629**	**46,830**	**(1,201)**	**462,249**	**473,456**	**(11,207)**
EBITDA	**24,584**	**3,986**	**3,840**	**(146)**	**14,992**	**14,849**	**(143)**
EBITDA %age	**4.3%**	**8.0%**	**7.6%**	**(0.5%)**	**3.1%**	**3.0%**	**(0.1%)**
Non-Operating Costs	25,526	2,128	2,124	4	21,270	25,755	(4,485)
Surplus/(Deficit) with Impairments	**(942)**	**1,858**	**1,716**	**(142)**	**(6,278)**	**(10,906)**	**(4,627)**
Less Fixed Asset Impairments	0	0	0	0	0	4,918	4,918
Surplus/(Deficit) excluding Impairments	**(942)**	**1,858**	**1,716**	**(142)**	**(6,278)**	**(5,988)**	**290**
Excluding Donated Assets	(558)	37	37	(0)	368	365	(3)
Control Total Surplus/(Deficit)	**(1,500)**	**1,895**	**1,753**	**(143)**	**(5,910)**	**(5,623)**	**287**

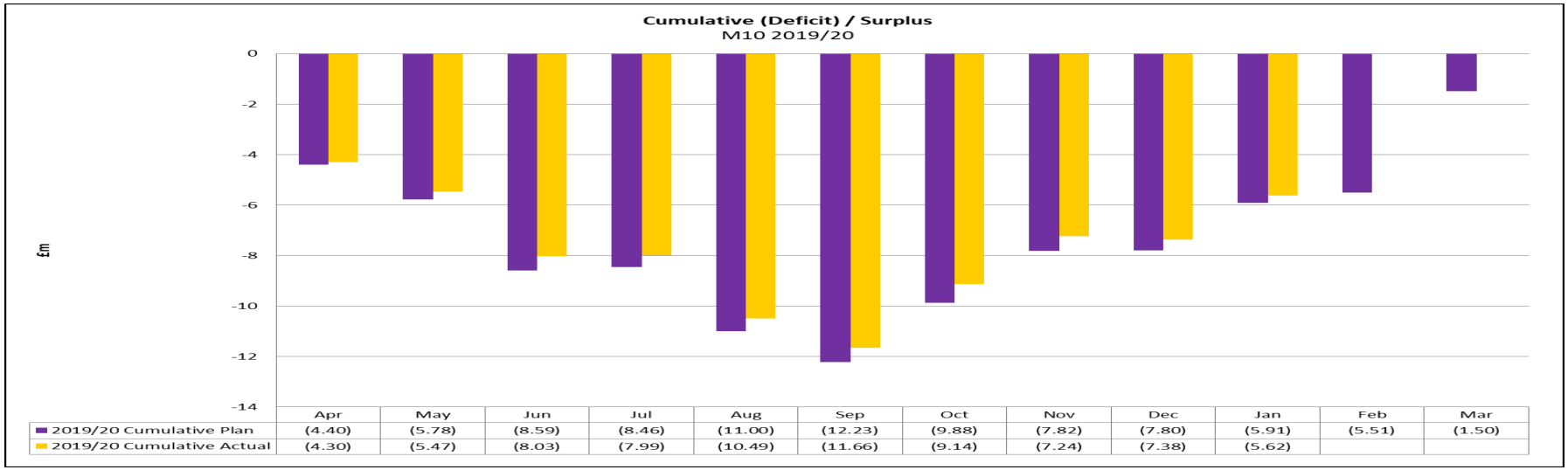
2019/20 Position Trend

Gloucestershire Hospitals NHS
NHS Foundation Trust

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019/20 Plan	(4.40)	(1.38)	(2.81)	0.13	(2.55)	(1.22)	2.35	2.06	0.01	1.90	0.40	4.01
2019/20 Actual	(4.30)	(1.17)	(2.56)	0.04	(2.50)	(1.17)	2.52	1.90	(0.13)	1.75		



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019/20 Cumulative Plan	(4.40)	(5.78)	(8.59)	(8.46)	(11.00)	(12.23)	(9.88)	(7.82)	(7.80)	(5.91)	(5.51)	(1.50)
2019/20 Cumulative Actual	(4.30)	(5.47)	(8.03)	(7.99)	(10.49)	(11.66)	(9.14)	(7.24)	(7.38)	(5.62)		

Detailed Income & Expenditure

Gloucestershire Hospitals NHS
NHS Foundation Trust

Month 10 Financial Position	M10 Budget £000s	M10 Actuals £000s	M10 Variance £000s	M10 Cumulative Budget £000s	M10 Cumulative Actuals £000s	M10 Cumulative Variance £000s	Passthrough Variance £000s	Net Variance £000s
SLA & Commissioning Income	41,402	41,726	324	402,072	408,373	6,302	(4,775)	1,527
PP, Overseas and RTA Income	400	630	230	4,002	4,923	921		921
Other Income from Patient Activities	75	198	124	748	1,712	964		964
Operating Income	7,738	8,116	378	70,420	73,298	2,878		2,878
Total Income	**49,615**	**50,670**	**1,055**	**477,242**	**488,306**	**11,064**	**(4,775)**	**6,290**
Pay								
Substantive	27,885	28,830	(944)	287,650	286,110	1,540		1,540
Bank	976	1,320	(344)	9,763	12,709	(2,946)		(2,946)
Agency	1,079	1,479	(400)	10,618	13,541	(2,923)		(2,923)
Total Pay	**29,940**	**31,629**	**(1,689)**	**308,031**	**312,360**	**(4,329)**	**0**	**(4,329)**
Non Pay								
Drugs	6,023	6,842	(819)	56,619	61,642	(5,023)	5,127	105
Clinical Supplies	3,221	3,985	(764)	32,391	34,136	(1,745)	(221)	(1,965)
Other Non-Pay	6,444	4,374	2,070	65,207	65,319	(111)		(111)
Total Non Pay	**15,689**	**15,201**	**488**	**154,218**	**161,097**	**(6,879)**	**4,907**	**(1,972)**
Total Expenditure	**45,629**	**46,830**	**(1,201)**	**462,249**	**473,456**	**(11,207)**	**4,907**	**(6,300)**
EBITDA	**3,986**	**3,840**	**(146)**	**14,992**	**14,849**	**(143)**	**132**	**(11)**
EBITDA %age	**8.0%**	**7.6%**	**(0.5%)**	**3.1%**	**3.0%**	**(0.1%)**	**(2.8%)**	**(0.2%)**
Non-Operating Costs	2,128	2,124	4	21,270	25,755	(4,485)		
Surplus/(Deficit)	1,858	1,716	(142)	(6,278)	(10,906)	(4,627)	132	(4,495)
Fixed Asset Impairments	0	0	0	0	4,918	4,918		4,918
Surplus/(Deficit) after Impairments	1,858	1,716	(142)	(6,278)	(5,988)	290	132	422
Excluding Donated Assets	37	37	(0)	368	365	(3)		(3)
Surplus/(Deficit)	1,895	1,753	(143)	(5,910)	(5,623)	287	132	419

Non-Pay – expenditure is showing a year to date £6.9m overspend, reflecting overspends on pass through drugs and clinical supplies which are offset within income (£4.9m). The clinical supplies overspend of £1.7m includes the hire from Cobalt of MRI and CT Scanners (£0.3m), and tube repairs (£0.1m). Theatres clinical supplies (£0.3m).

SLA & Commissioning Income – is reporting an over performance of £6.3m year to date, reflecting over performance on Gloucestershire CCG and Specialised Commissioning, offset by under performance on other commissioners.

PP / Overseas / RTA Income – is reporting a year to date over performance of £0.9m, reflecting private Oncology patients activity in D&S £0.5m, overseas and private patients in Medicine £0.2m and Surgery and W&C PP income £0.1m each.

Other Operating income – Includes additional non-commissioned income in Cytology, Microbiology and Histology £0.4m, training income of £0.7m, car parking £0.2m, and hosted services of £0.4m and R&D £0.3m; the final two being offset by expenditure.

Pay – Cumulatively there is an overspend of £4.3m, reflecting an underspend on substantive budgets (£1.5m), offset by overspends on bank (£2.9m) and agency budgets (£2.9m). The in month overspend reflects the increased CIP requirement in pay budgets.

Cost Improvement Programme

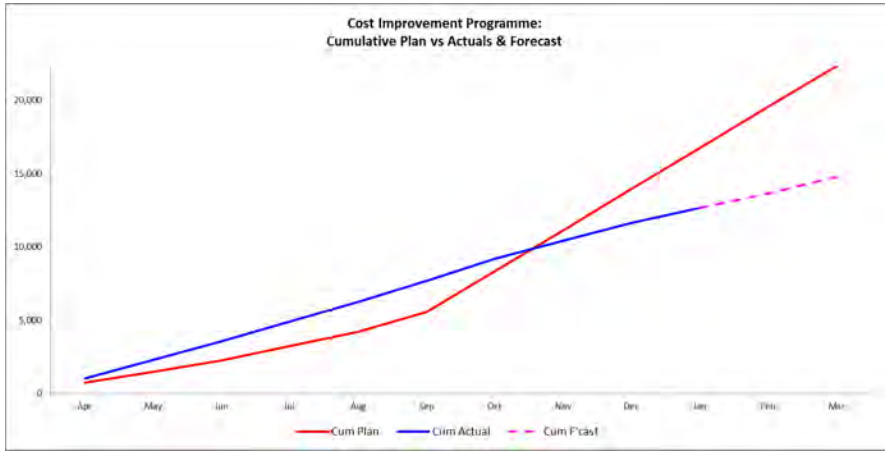
Gloucestershire Hospitals NHS
NHS Foundation Trust

1. At Month 10 the trust has delivered £12.68m of CIP against the Year to date NHS Improvement target of £16.76m, this is an under performance of £4.08m. Within the month, the Trust has delivered £1.04m of CIP against an in-month NHSI target of £2.8m. Within the month, this is a negative variance of £1.76m which is largely due to the profiling of 'unidentified' schemes from M7.

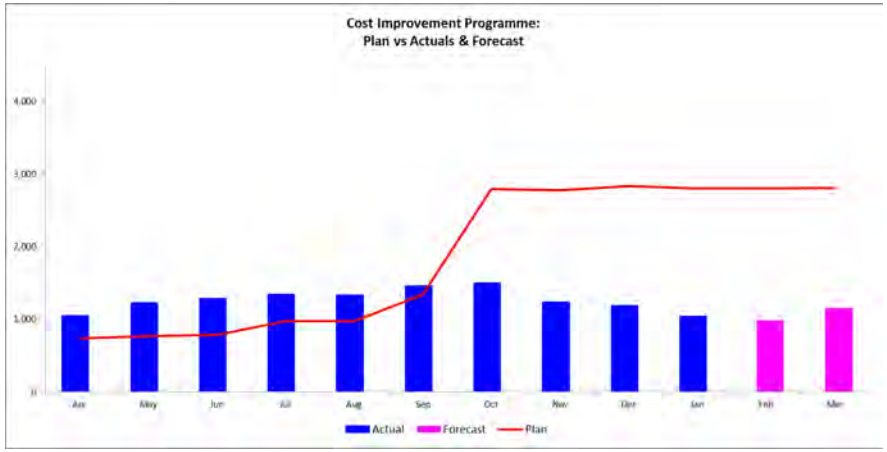
2. At Month 10, the divisional year end forecast figures indicate delivery of £14.8m against the Trust's target of £22.4m. This has improved by £106k from M09 due to additional vacancies which leaves a negative variance against target of £7.55m. The FOT splits into £9.5m (64%) of recurrent schemes and £5.3m (36%) of non-recurrent schemes not including the gap against target which is counted as non-recurrent.

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

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



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



Balance Sheet (1)

Gloucestershire Hospitals NHS
NHS Foundation Trust

Trust Financial Position	Opening Balance 31st March 2019 £000	GROUP Balance as at M10 £000	B/S movements from 31st March 2019 £000
Non-Current Assests			
Intangible Assets	10,412	5,897	(4,515)
Property, Plant and Equipment	231,216	236,197	4,981
Trade and Other Receivables	5,185	4,675	(510)
Investment in GMS		0	
Total Non-Current Assets	**246,813**	**246,769**	**(44)**
Current Assets			
Inventories	7,571	8,560	989
Trade and Other Receivables	25,419	36,980	11,561
Cash and Cash Equivalents	7,317	25,845	18,528
Total Current Assets	**40,307**	**71,385**	**31,078**
Current Liabilities			
Trade and Other Payables	(54,315)	(72,317)	(18,002)
Other Liabilities	(5,837)	(3,027)	2,810
Borrowings	(12,527)	(34,756)	(22,229)
Provisions	(160)	(160)	0
Total Current Liabilities	**(72,839)**	**(110,260)**	**(37,421)**
Net Current Assets	**(32,532)**	**(38,875)**	**(6,343)**
Non-Current Liabilities			
Other Liabilities	(6,860)	(6,547)	313
Borrowings	(135,294)	(137,950)	(2,656)
Provisions	(1,434)	(1,434)	0
Total Non-Current Liabilities	**(143,588)**	**(145,931)**	**(2,343)**
Total Assets Employed	**70,693**	**61,963**	**(8,730)**
Financed by Taxpayers Equity			
Public Dividend Capital	172,676	174,852	2,176
Equity		0	
Reserves	23,915	23,915	0
Retained Earnings	(125,898)	(136,804)	(10,906)
Total Taxpayers' Equity	**70,693**	**61,963**	**(8,730)**

The table shows the M10 balance sheet and movements from the 2018/19 closing balance sheet, supporting narrative is on the following page.

Balance Sheet (2)

Gloucestershire Hospitals NHS
NHS Foundation Trust

The commentary below reflects the Month 10 balance sheet position against the 2018/19 outturn

Current Assets

- Inventories have increased in year by £989k reflecting an increase in pharmacy stock.
- Cash has increased by £18.5m since the year-end, reflecting the deficit income and expenditure position, offset by borrowing, the movement in working balances and the timing of capital expenditure.

Current Liabilities

- Trade and other payables is the largest item in this area, and is summarised in the table below. The other liabilities relate to payments received on account.

Retained Earnings

- The retained earnings reduction of £12.6m reflects the impact of the in year deficit.

Better Payment Practice Code (BPPC)

Gloucestershire Hospitals NHS
NHS Foundation Trust

	Cumulative for Financial Year		Current Month January	
	Number	£'000	Number	£'000
Total Bills Paid Within period	88,250	194,163	11,004	22,204
Total Bill paid within Target	76,131	166,687	7,977	17,557
Percentage of Bills paid within target	86%	86%	72%	79%

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

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

The percentage paid within target this month has dropped as we did not have creditor payment runs during the Christmas period.

Liabilities – Borrowings

Analysis of Borrowing	As at 31st January 2020 £000
<12 months	
Loans from ITFF	2,999
Capital Loan	1,184
Distress Funding	28,407
Obligations under finance leases	1,598
Obligations under PFI contracts	568
Balance Outstanding	**34,756**
>12 months	
Loans from ITFF	19,955
Capital Loan	18,233
Distress Funding	78,752
Obligations under finance leases	3,519
Obligations under PFI contracts	17,491
Balance Outstanding	**137,950**
Total Balance Outstanding	**172,706**

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

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

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

The position reflects £27.4m of additional in-year borrowing from the DoH, £12.5m deficit support and £14.9m of capital loans.

Cash flow: January

Gloucestershire Hospitals NHS
NHS Foundation Trust

Cashflow Analysis	Apr-19 £000s	May-19 £000s	Jun-19 £000s	Jul-19 £000s	Aug-19 £000s	Sep-19 £000s	Oct-19 £000s	Nov-19 £000s	Dec-19 £000s	Jan-20 £000s	Forecast Movement Feb-20 to March-20 £000s	Forecast Outturn £000s
Surplus (Deficit) from Operations	(3,464)	(5,470)	(1,626)	835	(1,700)	(305)	3,037	2,668	5,496	(2,364)	(1,448)	(4,341)
Adjust for non-cash items:												
Depreciation	1,229	1,229	1,229	1,229	1,229	1,229	1,229	1,229	1,229	1,229	2,458	14,745
Other operating non-cash	0	4,918	0	0	0	0	0	0	0	0	(1,000)	3,918
Operating Cash flows before working capital	(2,235)	677	(397)	2,063	(471)	924	4,266	3,897	6,725	(1,135)	10	14,322
Working capital movements:												
(Inc.)/dec. in inventories	113	0	298	(202)	(28)	0	(825)	0	(726)	381	345	(644)
(Inc.)/dec. in trade and other receivables	1,430	2,796	78	(4,472)	(2,526)	(1,033)	(1,296)	(1,182)	(999)	4,637	(3,863)	(6,430)
Inc./(dec.) in current provisions	0	0	0	0	0	0	0	0	0	0	0	0
Inc./(dec.) in trade and other payables	(2,349)	916	154	16,467	(6,712)	(161)	7,732	(1,528)	(3,664)	(2,216)	(2,092)	6,547
Inc./(dec.) in other financial liabilities	0	(1,055)	0	0	0	0	(1,761)	(131)	(698)	44	4,133	532
Net cash in/(out) from working capital	(806)	2,657	530	11,793	(9,266)	(1,194)	3,850	(2,841)	(6,087)	2,846	(1,477)	5
Capital investment:												
Capital expenditure	(1,129)	(1,629)	(1,729)	(3,125)	(1,129)	(500)	(1,807)	(4,208)	(807)	(360)	(13,389)	(29,812)
Capital receipts	0	0	0	0	0	0	0	0	0	0		0
Net cash in/(out) from investment	(1,129)	(1,629)	(1,729)	(3,125)	(1,129)	(500)	(1,807)	(4,208)	(807)	(360)	(13,389)	(29,812)
Funding and debt:												
PDC Received	0	0	0	0	0	0	0	0	0	2,177	4,206	6,383
Interest Received	17	17	17	17	17	17	16	16	16	16	32	198
Interest Paid	(124)	(294)	(114)	(259)	(196)	(1,327)	0	(291)	(114)	(181)	(1,480)	(4,380)
DH loans - received	2,442	3,368	2,887	0	10,049	3,842	0	0	0	4,950	0	27,538
DH loans - repaid	0	0	0	0	(167)	(1,317)	0	0	0	0	(1,486)	(2,970)
Finance lease capital	(488)	(488)	(488)	(488)	(488)	(488)	(488)	(488)	(488)	(488)	(976)	(5,856)
Interest element of Finance Leases	(12)	(12)	(12)	(12)	(12)	(12)	(13)	(13)	(13)	(13)	(26)	(150)
PFI capital element	(68)	(68)	(68)	(68)	(68)	(68)	(68)	(68)	(68)	(68)	(145)	(825)
Interest element of PFI	(38)	(38)	(38)	(38)	(38)	(38)	(38)	(38)	(38)	(38)	(76)	(456)
PDC Dividend paid						(277)					(764)	(1,041)
Net cash in/(out) from financing	1,729	2,485	2,184	(848)	9,097	332	(591)	(882)	(705)	6,355	(715)	18,441
Net cash in/(out)	(2,441)	4,190	588	9,883	(1,769)	(438)	5,718	(4,034)	(874)	7,706	(15,571)	2,956
Cash at Bank - Opening	7,317	4,876	9,065	9,653	19,537	17,768	17,330	23,047	19,013	18,139	25,845	7,317
Closing	4,876	9,065	9,653	19,537	17,768	17,330	23,047	19,013	18,139	25,845	10,273	10,273

The cash flow for January 2020 is shown in the table opposite

Cashflow Key movements:

The Cash Position – reflects the Group position. The Trust has drawn down loan support of £12.5m and a capital loan of £14.9m in 2019/20, and the position also reflects the receipt of Incentive PSF funds from 2018/19 of £3.3m.

The closing cash position includes £9.8m of committed cash:

Committed cash from 2018/19 £2.9m

The remaining cash balance of £16m represents Group working capital.

The year end forecast cash position reflects the income and expenditure forecast, and assumes full commitment of the capital programme.

Year End Income and Expenditure Forecast

Gloucestershire Hospitals NHS
NHS Foundation Trust

M10 Forecast Outturn	FY PLAN £000s	M10 FoT £000s	FoT VARIANCE £000s
Total Income	574,658	592,230	17,572
Pay	(367,559)	(375,666)	(8,107)
Non Pay	(182,515)	(192,090)	(9,576)
EBITDA	24,584	24,473	(111)
Non Operating Costs	(25,526)	(30,329)	(4,803)
Surplus/(Deficit)	(942)	(5,856)	(4,914)
Fixed Asset Impairments	0	4,918	4,918
Surplus/(Deficit) after Impairments	(942)	(938)	4
Excluding Donated Assets	(558)	(562)	(4)
Surplus/(Deficit)	(1,500)	(1,500)	0

The table opposite summarises the forecast year end income and expenditure position for the Trust.

Following completion of the month 10 forecast review the Trust is now forecasting a deficit of £1.5m, this is in line with the Control Total.

Forecast Movement M09 to M10	£m
Reported Forecast M09	(8,492)
Divisional Forecast Improvements	1,461
Initial M10 Forecast	(7,031)
Q4 PSF/FRF	5,531
M10 Forecast Outturn	(1,500)

In Month 10 Divisions have held run rates in line with or better than forecast. When these outturns have been factored into the detailed forecasts along with the expected outcomes of grip and control and other measures being undertaken the Divisional forecasts show an improvement of £1.4m when compared to Month 9, this improvement means that the FOT **before** Q4 PSF/FRF would be £7.0m. PSF/FRF counts towards the reported outturn for control total purposes and so with the £5.5m Q4 PSF/FRF assumed to be received the Trust is able to forecast delivery of the £1.5m deficit control total. The month on month movement is shown opposite.

It must be noted that this forecast includes the following key assumptions:

- No 52 week wait fines are levied by NHSE&I (current estimated value is c£1.8m)
- Winter capacity measures are delivered within the Month 10 revised Divisional forecast expenditure
- The revised forecast run rates are achieved by Divisions

Introduction and Overview

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

Capital Programme Expenditure Summary position at 31st January 2020

Capital Summary	19/20 Full Year Plan £k	Internal YTD Plan £k	YTD Spend £k	YTD Var £k	Feb 20 £k	Mar 20 £k	FOT 19/20 Spend £k	Forecast Variance £k
Health & Safety Projects	4,033	2,787	3,259	472	388	387	4,034	2
Environmental Works	350	278	274	(4)	61	61	396	46
Non Health & Safety Projects	827	120	536	415	200	480	1,216	389
Committed Schemes	460	369	368	(1)	47	47	461	1
Service Reconfiguration	37	7	6	(1)	19	19	44	7
Major Equipment Replacement	20	16	19	3	3	3	25	5
IM&T	9,883	7,837	8,105	268	500	1,082	9,687	(196)
MEF	2,490	2,241	1,737	(504)	45	45	1,827	(663)
Other Schemes	9,902	4,235	3,422	(812)	1,500	4,737	9,660	(242)
Contingency/Leases Capitalisation	3,182	712	500	(212)	100	176	776	(2,406)
Overspend/(Underspend)	**31,183**	**18,602**	**18,225**	**(377)**	**2,863**	**7,038**	**28,126**	**(3,057)**
Brought Forward Schemes								
Cath Lab equipment								1,600
Pharmacy roof								70
Tower entrance								35
Medical records roof								130
Tower Toilets								150
Operating tables								100
PCs								800
CT enabling works								200
Total								**3,085**

Points to note:

- Following a successful bid, the Trust has been awarded £677k to install energy efficient LED lighting across the two hospital sites. The funding will need to be spent by March 2021 and will produce electricity and carbon savings as well as reducing maintenance costs.
- The significant spend in March under 'Other Schemes' reflects the purchase of the centrally funded diagnostic equipment.
- The Executive Team and the Capital Control Group have agreed the list of brought forward schemes for this year to utilise the underspend. Scheme leads recognise the importance of delivering the capital programme in its entirety and have confirmed that they will deliver against the forecast against their schemes.

Recommendations

Gloucestershire Hospitals NHS
NHS Foundation Trust

The Board is asked to note:

- Note the Trust is reporting a year to date actual income and expenditure deficit on a control total basis of £5.6m at January 2020. This is £0.3m favourable to plan.
- Note the revised forecast outturn in line with control total, risks to delivery, and endorse the submission of control total delivery to NHSE&I in the month 10 provider return.

Author: **Tony Brown, Senior Finance Advisor**

Presenting Director: **Karen Johnson, Director of Finance**

Date: **March 2020**

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – MARCH 2020

Report Title									
DIGITAL UPDATE									
Sponsor and Author(s)									
Author: Leah Parry, Digital Transformation Lead Sponsoring Director: Mark Hutchinson, Exec. CIO									
Audience(s)									
Board members	✓	Regulators		Governors		Staff		Public	
Executive Summary									
This paper details the overarching digital update for GHFT. <u>Key issues to note</u> There are no new areas of concern to note									
Recommendations									
The Board is asked to NOTE the report.									
Impact Upon Strategic Objectives									
The position presented identifies how the relevant strategic objectives will be achieved									
Impact Upon Corporate Risks									
Progression of the digital agenda will allow us to significantly reduce a number of corporate risks									
Regulatory and/or Legal Implications									
Progression of the digital agenda will allow the trust to provide more robust and reliable data and information to provide assurance of our care and operational delivery									
Equality & Patient Impact									
Progression of the Digital agenda will improve the safety and reliability of care in the most efficient and effective manner.									
Resource Implications									
Finance				Information Management & Technology				✓	
Human Resources				Buildings					
Action/Decision Required									
For Decision		For Assurance	✓	For Approval		For Information			

Date the paper was presented to previous Committees					
Quality & Performance Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**
	In iteration Feb 2020				In Iteration DCB Feb 2020

1.0 Digital Care Board Update

Total Number of Projects:	Total Change since last report:	Number of Red Projects:	Number of Amber Projects:	Number of Green Projects:	Number of Projects Closed since last Board:
3	+/-0	0	0	3	0

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

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

Green – Project is on track

Implementation	**TrakCare Optimisation**	RTT performance data continues to be submitted on schedule. The Validation Team continue to undertake additional validation of these issues with the risk to reporting maintained at less than 0.5%, and currently showing a negligible impact on reporting at less than 0.1%.A further audit of RTT across the whole process is being planned with external auditors and is scheduled for February 2020. The number of new issues per week has reduced from 2,500 at the beginning of June to 1,645 per week. TrakCare upgrade - A further set of updates will be required early in 2020 to support the deployment of the TrakCare Lab Enterprise (TCLE) module as a replacement for the current laboratory information management system. Scheduling of the upgrade work has proven to be challenging when attempting to avoid clashes with TCLE build work and EPR testing.	**Mar 2020**
Implementation	**ICNet**	Go live took place 25 February, no issues have been reported; early feedback is that the system is working well.	**March 2020**
Scoping	**Pharmacy Stock Control System**	Order for core functionality placed and processed. Awaiting quote from Allscripts to enable interface to Sunrise. Project governance and timescales being worked through.	**TBC**

2.0 Sunrise EPR Update

1. Roll Out 1b: Cheltenham Go Live

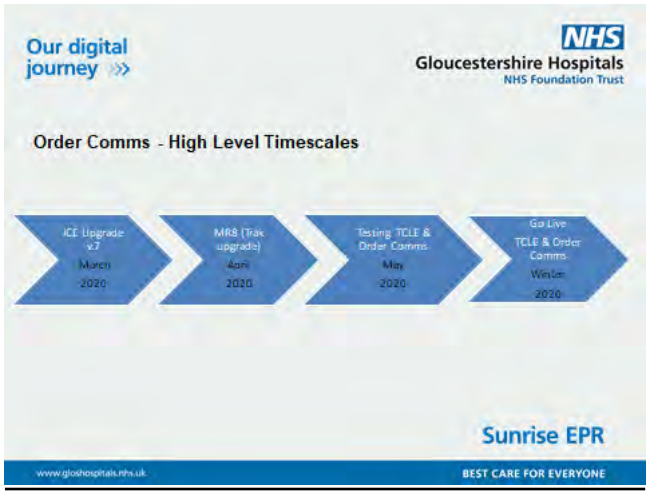
- Successful go live across 18 adult inpatient wards at CGH at 08:00 on Wednesday 12 February 2020.
- Almost 50 staff provided 24 hour command centre and ward based support to ensure a smooth go live.
- We were able to stand down our support after five days due to well engaged, calm and supported staff teams.
- No major issues were reported during go live – issues mainly centred around optimisation of the system, user queries and understanding of tracking boards.

2. Roll Out 2: E- Observations

Failure to recognise the deteriorating patient is a common cause of serious adverse events. Sepsis kills over 40,000 people a year and by taking observations, patients can be identified as at risk or their care escalated in a timely and prompt fashion. The use of NEWS2 to standardise the review, communication and escalation of patients was mandated in 2018. Nursing staff are familiar with Sunrise now and we're confident that this change will cause minimum disruption and provide significant benefits that truly drive improved safety and reliability of care. The programme of work progresses at pace now with a confirmed 17 March go live. Ward 2b and 7a will again act as Early adopter wards to test drive the new flowsheet in the days before main go live.

3. Roll Out 3: Order Communications- "Requests and Resulting"

The EPR Programme Delivery Group (PDG) is ensuring that the interdependent ICE upgrade, Trakcare upgrades and TCLE projects are managed together, to ensure a successful go live of Order Communications in winter 2020. Individual project updates are below.



Order comms (requests and results)

One of our biggest (and most complex) additions to Sunrise EPR later this year will be electronic order communications - or requests and results as it's more commonly known. Using Sunrise EPR to order, receive and review tests and results will give us a much safer, more accurate approach to the way we manage patient care.

It will provide electronic ordering and results viewing of Pathology and Radiology investigations and tests, available through Sunrise EPR. One log in, one place for clinicians to access all of the patient information they need.
In the background, this means the new Pathology Lab system called TCLE (replacing IPS) will talk directly to Sunrise EPR – so that users can make requests and review results in one system.

- Clinical working group membership established and dates now set & communicated

- Registrars and EPR team members visited Liverpool Heart & Chest Hospital to see order comms systems in action

TCLE Pathology System Replacement)

The IPS LIMS has been in place for over 25 years and whilst stable has received little recent development. InterSystems *TrakCare Labs Enterprise* (TCLE) is being implemented in its place.

- The Pathology implementation team resumed work on the implementation project in January 2019, with the build recommencing in March 2019.

ICE

The Trust uses Clinisys ICE (formerly Anglia/Sunquest ICE), to provide an order communications platform for Pathology and Radiology requesting and resulting. The solution is used across the One Gloucestershire partnership. The application, whilst stable has not been upgraded since 2017.

TCLE also requires enhancements to ICE in order to support order communications and results reporting. The project is on target to go live by the end of March 2020.

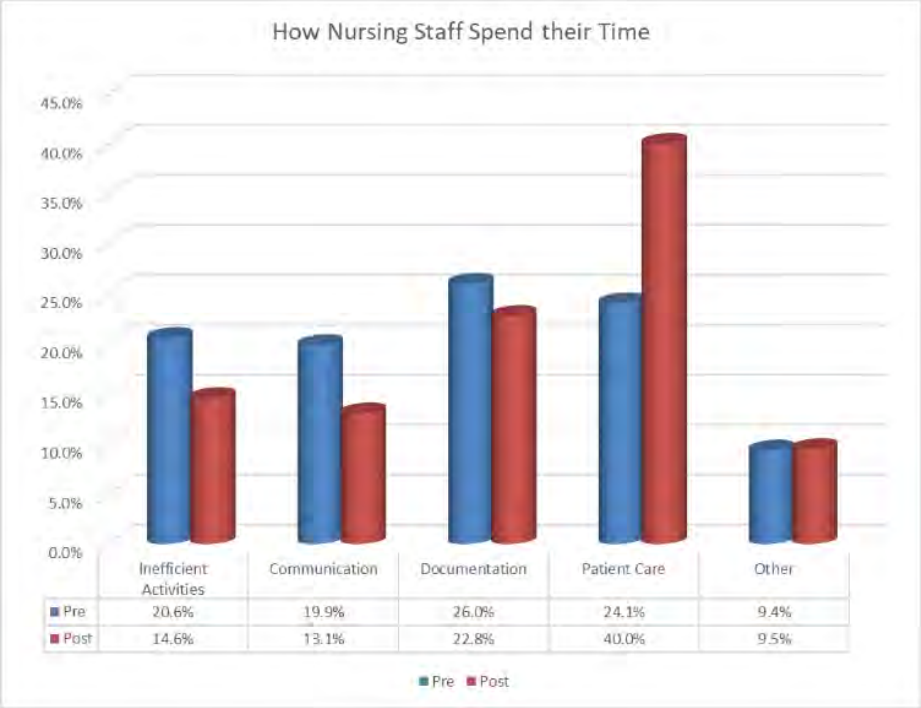
1.8 Early Review of Benefits

Our team have started the initial review of how nursing staff are spending their time and the impact that Sunrise EPR has on our colleagues' time.

Prior to our go live of Sunrise EPR the team spent a number of weeks carrying out audits on various different staff groups, across various different areas. The audit focused on collecting information in four main categories:

a) To Identify where there was inefficient time spent on activities due to reliance on paper (e.g. looking for notes, duplicating writing, putting stickers on pieces of paper etc.)
b) How much time was spent communicating with either colleagues, patients of families
c) To identify how much time was spent carrying out documentation
d) To identify how much time was spent on direct patient care

Having carried out our repeat audit on a number of nursing colleagues on our early adopter wards and the acute medical unit the below graph details how our colleagues time has started to transition. The team are continuing their data collection and will have a picture across all specialties at Gloucestershire Royal Hospital prior to E-Obs go live. This data will then be reviewed and presented back in its totality to Digital Care Board.



	Inefficient Activities	Communication	Documentation	Patient Care	Other
Pre	20.6%	19.9%	26.0%	24.1%	9.4%
Post	14.6%	13.1%	22.8%	40.0%	9.5%

3.0 IM & T Programme Board Update

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

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

Total Number of Projects: **29**	**Total Change since last report:** **+/- 0**	**Number of Red Projects:** **1**	**Number of Amber Projects:** **3**	**Number of Green Projects:** **25**	**Number of Projects Closed since last Board:** **0**

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

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

Green — Project is on track

	New key risks / escalation to Board: • One project to note is the Docman project, this project is currently being reviewed and re-scoped		
	2018/19 Capital Programme		**Status**
Implementation	**Desktop Imaging – Windows 10**	Over half of Trust devices have now been migrated to Windows 10 with just over 2000 devices remaining. Around 500 of those remaining devices are used to access applications not compliant with Windows 10, therefore will not be able to be upgraded at this time. This is the reason for this project to be reporting as Amber. The project has been upgrading ED over the last reporting period. As this is a high impact area, all the computers here have been upgraded by hand. This slows the process a little but prevents any issues in such a critical area.	**March 2020**
	2019/20 Capital/Improvements Programme		
Implementation	**Imprivata**	Project ahead of schedule with over 6700 users now enrolled compared with 5164 users as reported last month. Around 1500 users have also been enrolled onto the single sign on functionality of Imprivata. The next phase of this product to be reviewed will be Tap & Go as this may be a	**March 2020**

		dependency for EPR Order Comms. No issues expected to complete	
Implementation	**Next Generation Telephony**	Procurement and legal teams are looking into contractual elements of this project and whether Daisy are in breach of the tender exercise. A letter has been sent to Daisy requesting a meeting to discuss further, no response has been received as yet. The Datix risk relating to telephony has been reviewed and rescored based on the findings from the independent review. In the meantime deployment of handsets is almost complete with a last few remaining outstanding. Decommissioning of old handsets and lines is in the final stages also. Four new Mitel servers have now been installed by CITS in readiness for number porting to take place.	**June 2020**
Implementation	**Windows 2003 Upgrade**	This project has been downgraded this month to Amber. This is due to mitigating action being in place for all remaining servers, which will maintain a safe protected environment even though the servers have not been migrated over. The project will continue on the micro-segmenting of the remaining servers and working with suppliers to either decommission or move to other environments when able.	**March 2020**
Implementation	**Fax Replacement**	Progress this period continues as: • Archival Tape storage procured • Software environment prepped for installation and configuration • Network changes made to accommodate the new environment. Over the coming weeks, the new environment will be switched on and configured before bringing services into live. The project still aims to complete by the end of March 2020	**Mar 2020**
Scoping	**Firewall Replacement/ HSCN Migration – Fibre replacement.**	Order for Sophos upgrade has now been placed. HSCN network design is being finalised. Meeting to take place week commencing 17 February to sign this off, project continues to plan an April completion.	**April 2019**
Implementation	**Back Up Solution**	Progress this period continues as: • Archival Tape storage procured • Software environment prepped for installation and configuration • Network changes made to accommodate the new environment. Over the coming weeks, the new environment will be switched on and configured before bringing services into live. The project still aims to complete by the end of March 2020	**April 2019**

DIGITAL UPDATE – FEBRUARY 2020

Implementation	**Email Archiving**	Remote install of Software being planned for 19 February. There is a meeting planned with Trust comms to talk through a communications strategy before rolling out any further. In essence the project is good for completion, user buy in is what is required now.	**Mar 2020**
Implementation	**NEW - Network Remediation – Phase 3**	Project in flight, plan in place and progressing as expected. Some milestones require dates	**Sept 2020**
Scoping	**Wi-Fi Review**	A design workshop has taken place to agree the low level design and placement of APs. 2 virtual servers for the PRIME controllers have been built; this will enable monitoring and reporting across the Wi-Fi estate. Next steps are to select a pilot area and plan the AP replacement which is due to start 1 March.	**May 2020**
Implementation	**DOCMAN10 Transfers of Care**	This project continues reporting as red despite acceptance that the solution will continue to be rolled out there is ongoing discussions in relation to how Docman will link into GP systems. A solutions approach paper is being developed by Andy Atherton, completion is due by 21 February. Once this is complete resource estimates and schedules will be developed. In the meantime ongoing discussions are taking place with TPP to look at community options for Rio and arrangements are being put in place for the management of rejections.	**March 2020**
Scoping	**Multi-Functional Devices (printer replacement)**	A print policy has been developed and a PID and Business Case is being drafted.	**TBC**

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO MAIN BOARD – MARCH 2020

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

This report describes the business conducted at the Finance and Digital Committee held on 27 February 2020, indicating the NED challenges, the assurances received, and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Digital Care Board Project Report	Update provided on; - Trakcare optimization - ICNet PAS & Laboratory - Pharmacy Stock Control System All on track except for a week's delay on ICNet due to infection control issues.		Progress noted These items to be consolidated in IM & T Programme Board Report	
Sunrise EPR Highlight Report	Project overview covering: - Roll out and Go live on Cheltenham site - Workstream planning for E-Observations including plan for initial roll out in March - Order Communications	How will agency staff access/be trained in system use? How would locum doctor test requests be managed in the system? What is plan to cover all areas?	A clear process in in place for agency staff to sign in at the site office and receive access passes and user guidance These will be flagged for referral to other team members as appropriate Process mapping underway to optimize the method to achieve this Implementation currently restricted to adult inpatient wards.	Complexities associated with paediatrics, surgery and A & E require

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
		Is the Committee receiving appropriate assurance from the Digital Care Board?		specific configurations that are under discussion Directors to review assurance method to avoid F & D Committee being too operational
Pathology Deep Dive Update	A comprehensive presentation by operational leads covering: - Proposed system architecture - Building blocks of the new clinical ordering system - Project engagement and vision - Timeline - Current and future process mapping work - Resilience planning to minimise system downtime Ongoing review will be incorporated as part of the overall EPR reports to Committee	Will connectivity permit communication outside the Trust? Once fully deployed will paper request be eliminated? Will the software have predictive features to signpost different pathways Is there a risk that the system will lead to a proliferation of test requests? Is there a risk of de-personalising care? What are issues face the	Standards exist to ensure this can be achieved. ICS agreement will be needed to ensure technical solutions are in place to ensure capability system wide Yes Risk is understood but work is underway to optimize standard request protocols and experience in other trusts indicates a reduction in unnecessary tests Current experience with EPR shows positive trends with greater time of nursing staff at patients' bedside Significant integration	Paperless commitment to be reinforced Ongoing monitoring of key supplier

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
		design and implementation of this system? How would the key risks be summarised?	between software packages is a prerequisite. While the challenge is understood it must not be underestimated As follows: 1. Obtaining the correct resource and people to maintain pace 2. Understanding and correctly configuring the system 3. Communicating processes well across the system 4. The management and performance of key suppliers	relationships and delivery are critical to success
IM & T Programme Board update	Update of active projects: - Desktop Imaging – Windows 10 - Imprivata implementation - Next generation telephony - Windows 2003 upgrade - Fax replacement - MDT Video conferencing - PC Refresh Phase 2 - Firewall replacement - Back up solution - Email archiving - Network remediation -		Overall assurance received that project management is appropriate and on track	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	Phase 3 - Wi-Fi Review - DOCMAN 10 - Multi-Functional Devices			
Integrated Care System (Digital)	Update on the "Joining Up Your Information" project and review of current ICS plans to establish oversight of digital direction		The issue of divergence between GHFT and Gloucestershire Health and Care is known and will be addressed at ICS level	
Finance Performance Report	10 months' cumulative deficit at £5.6 million (on a Control total basis) is a £0.2 million favourable variance against plan. Key favourable variances: - Commissioner income £6.3m - Other income £2.8m - Other patient related income £1.8m Partially offset by adverse variance on pay (£4.3 m) and non-pay (£6.9m) non-pay Detailed variance analysis presented Cash balance (£25.8 million) continues to be relatively high	Have the favourable expenditure positions in some divisions arisen through un-recorded Cost Improvement Programmes (CIP)? Is there a continuing risk of 52 week wait fines being levied? With a shortfall in CIP accomplishment of c. £8 million how is the overall result at plan level rationalised	No – these improvements are the result of grip and control No – this risk has now been eliminated Explanation of the variance provided	Communication challenge to be addressed ahead of year end

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	representing cash held following loan receipts for committed capital expenditure Balance sheet commentary and supplementary analysis reviewed Challenges and opportunities for balance of year described in detail with dialogue on plans to meet the year's control total.			
Capital Programme Update	Update on capital project spending and key project status including information on three additional bids Current projected year's spend is £30.3 million reflecting a c.£5m increase from the original plan	Detailed questions about project scope including - strategic site development, backlog maintenance, and spending flexibility in the light of timing in the financial year	Assurance provided around the approach to programme implementation	
Cost Improvement Programme Update	At month 9 savings are £12.7 million a £4.1 million shortfall form plan. Current year's projection is a shortfall of £7.6 million from plan - a delivery of £14.8million A review of the contents and status of the 20/21 plans – currently programmes with documented plans amount to £1.6 million with a further £12 m under	Are transformational plans included notably any ICS level programmes? Are outpatient transformation plans adequately addressed?		ICS level discussion required to progress Current infrastructure to address this has gaps and requires review

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	development leaving a gap of £2.6 million from the amount included in the overall 20/21 plan.			
Operational Plan and Budget Setting	Overview of plan provided highlighting the following: - The plan was noted to be break even and included a revised Financial Recovery Funding (FRF) value of c£12.0m. - Increased patient care income was noted to be c£40.4m. - Net increase in operational budget (post efficiency) was noted to be of c£19.1m. - Efficiency requirement of £15.8m were needed. - The plan includes a Capital plan of c£21.7m - Cash balance was forecast to be c£11m at 31/03/2021. - Minimal reserves would be available. There were risks in relation to successful delivery, particularly CIP.		A well-presented plan with clear explanations of its basis and appropriate highlighting of those elements in national guidance that are not funded in the plan as currently prepared.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Clinical Productivity Update	Update on the progress of this analysis. Of the specialties analysed it was identified that 97% of outpatient clinics have been delivered as expected with an identification of 200+ clinics missed in a year. This work highlights a cost avoidance opportunity. The next steps will be to look at the productivity of theatres and digitisation of the data (currently this analysis in very manual and labour intensive).			Future opportunities covering job planning and annual leave system to be kept under review. Decision required on where oversight of this project best resides.

Rob Graves
Finance & Digital Committee

Gloucestershire Hospitals
NHS Foundation Trust

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

Report Title
People and Organisational Development Performance Dashboard

Sponsor and Author(s)	
Author:	Alison Koeltgen, Deputy Director of People and Organisational Development
Sponsor:	Emma Wood, Director of People and Organisational Development and Deputy CEO

Executive Summary

Purpose

This performance dashboard aligns to key metrics identified within the People and Organisational Development Strategy. Key performance indicators detailed within are benchmarked (where appropriate) to Model Hospital Peer rates and University Hospital/ Teaching Peer rate. The indicators include:

- Retention
- Vacancy levels (Establishment /Ledger)
- Turnover
- Sickness
- Appraisal and Mandatory Training

The People and Organisational Development Committee are advised that there are a variety of other strategic and operational measures contained within the strategy for which performance is more appropriately measured in narrative/ more detailed report form (i.e. Bullying and Harassment, Equality, Diversity and Inclusion measures, Staff Engagement, ICS) . These have been mapped accordingly in People and Organisational Development Committee Assurance Mapping profile (presented at October 2019 meeting) and feature, as part of the overarching People and Organisational Development Committee work plan.

Annexed to the dashboard for information:

1. **Executive Review exception reports,** containing scorecards and SPC charts for: Medicine, Surgery, Diagnostics and Specialities, Women and Children Division. This detail provides a divisional overview of compliance against the operational and strategic objectives and measures linked to the People and Organisational Development strategy and includes progress against these. The reports provide assurance to the committee of the detail explored on a monthly basis through the Executive review process.
2. **Actual Nurse and HCA vacancy information** (Annex 2)
3. **Safer Staffing report** (Annex 1)

Key issues to note

Turnover and Retention
Medicine Division has the highest Turnover rate for non-registered nursing staff at 23.56%. The next highest Division is Surgery at 13.17%.
When we benchmark our Registered Nurse retention rate against Model Hospital Peers (rate **86.8%) and** University/Teaching Peer (rate **87%**). The Trust outperforms with a current retention rate of **88.38%.** An SPC chart for turnover is enclosed which demonstrates the

activity within this mean rate and a reduction in Turnover since April 2019.

Sickness Absence
Trust annual sickness absence rates are **stable (3.91%)** and sit below both Model Hospital Peers (rate 4.01%) and University/Teaching Peer (rate 4.05%). An SPC chart is enclosed which demonstrates the activity within this mean rate.

Vacancy levels

1. Vacancy levels are identified from the Ledger/ Establishment figures. **Actual Nurse and HCA vacancy information is attached to the report in response to the** known challenges with this level of reporting; which unfortunately fail to track alternative application of vacancy money to solutions such as alternative skill mixes, an actual vacancy report for Registered Nurses and HCA's has been appended to this report.

Appraisal
Appraisal compliance remains an area of concern with compliance at 80% as of November 2019 and anticipated reduction in appraisal completion across clinical areas during the winter pressure period. Divisions are challenged via the executive review process to report on specific action plans to improve compliance and their progress.

Mandatory Training
Compliance is achieved at **91% against a target of 90%.** Only Medicine Division is below target at 89%. By Staff Group, Additional Clinical Services and SAS Doctors are at 87%, Training Grade Medical staff are at 81%. All other groups are over target. Further breakdown of training compliance is provided in the Education report to People and OD Committee, February 2020.

Conclusions

The Trust continues to progress delivery of operational and strategic measures as set out in the People and OD Strategy. The Trust outperforms against Peers and University Hospital Trusts in areas such as turnover, stability, vacancy levels and sickness absence. The dip in appraisal performance is an area of challenge and impacted upon by operational pressures.

Implications and Future Action Required

The People and OD function will continue to monitor of areas of concern and support divisions.
Updating the Purchase Ledger is a key programme of work for 20/21 to ensure accurate vacancy reports and positions can be provided.

Recommendations

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

Impact Upon Strategic Objectives

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

Impact Upon Corporate Risks

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

Regulatory and/or Legal Implications
The appended reports are designed in such a way to provide assurance that the Trust is operating in accordance with: National reporting requirements associated with Equality, Diversity and Inclusion Freedom to Speak Up best practice NHSI/E requirements Best practice and employment legislation, including the Equality Act.
Equality & Patient Impact
There is a known researched link between employee experience, stability, retention and patient experience. The People and OD Strategy promotes a culture of 'caring for those who care', who in turn will enhance the experience of our patients.

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

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

Date the paper was presented to previous Committees and/or TLT							
Audit & Assurance Committee	**Finance & Digital Committee**	**Estates & Facilities Committee**	**People & OD Committee**	**Quality & Performance Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
			17 Feb 2020				

Outcome of discussion when presented to previous Committees/TLT
Vacancy detail was provided on actuals vs purchase ledger numbers and it was noted that actual vacancies are significantly less than purchase ledger for nurses and Health Care Assistants resulting in a lower vacancy rate for nurses of c5%. The improved position on vacancy and turnover was noted. The improved reporting with SPC charts was noted. Fill rates and safer staffing information was provided to meet Quality and Performance Committee requests for People and OD to oversee, however further discussion is required to ensure the data presented meets the committee's needs. Divisional exception reports (post executive reviews) were presented for the first time to show challenge. These were welcomed however summarising issues of concern and how they are being managed was requested as an addition.

PEOPLE AND OD COMMITTEE
17 February 2020
F7, Redwood Education Centre, Gloucestershire Royal Hospital

Report Title
Nursing and Midwifery Safe Staffing January 2020
Sponsor and Author(s)
Author: Mel Murrell, Associate Director of Resourcing Sponsor: Steve Hams, Director of Quality and Chief Nurse
Executive Summary

Purpose

The purpose of this report is to provide monthly assurance to the People and Organisational Development Committee in respect of nurse staffing levels for January 2020, against the compliance framework *'Hard Truths' – Safer Staffing Commitments'*.

Key issues to note

A summary is provided in the presentation, however the key things to note are:

- Staffing fill rate data is extracted from Healthroster
- Overall fill rate is 87%
- 27 clinical areas failed to meet the 75% substantive fill standard.
- There were 31 Red Flags were recorded in January with 18 recorded as shortfalls in Registered Nurse time.
- 2.58% of patients have experienced a new harm (as measured by safety thermometer), 0.49% higher than the national percentage of 2.1%.
- SafeCare Live if now fully operational and being used to record the three times daily patient acuity and dependency census. Further support to validate the data continues to be provided to wards and departments as required.

Conclusions

The presentation provides an overall summary of nursing and midwifery fill rates for January 2020.

Implications and Future Action Required

Further triangulation of staffing data with harm and overall performance will be developed so that the safety, outcome and regulatory compliance impact of staffing is better understood. This will include benchmarking the Trust position on Care hours per patient day (CHPPD) and the use of red flags within SafeCare Live relating to patient acuity and dependency.

Recommendations
The People and Organisational Development Committee are asked to note the report and consider the information within in conjunction with the Workforce dashboard.
Impact Upon Strategic Objectives
Correct staffing will enable us to meet the aspirations of 'outstanding' in the caring domain and 'outstanding' overall in relation to CQC fundamental standards.

Impact Upon Corporate Risks							
Improving our ability to substantively fill our shifts will reduce the risk of poor continuity of care arising from high use of agency staff in some service areas. Linked to risk C1609N							
Regulatory and/or Legal Implications							
NHS Improvement ask that all NHS organisations undertake a monthly review of nursing and midwifery staffing, which is discussed by the Board and available for the public to see.							
Resource Implications							
Finance		X	Information Management & Technology				
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 & Assurance Committee**	**Workforce Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
Outcome of discussion when presented to previous Committees						

Gloucestershire Hospitals NHS Foundation Trust

Appendix Two

Nursing Vacancy Update Band 5 and Band 2 February 2020

During February a process of reconciliation has been completed to understand what our actual vacancy position is when looking at Band 5 Registered Nurses (including Operating Department Practitioners) and Band 2 Healthcare Assistants. Previously, reported vacancy position has been based solely on the finance ledger and has not accounted for the repurposing of positions or movement of money which can then present a higher vacancy position than is actually the case.

The information presented in table 1 and 2 is a reconciliation between the ledger, information provided by the Division, candidates current in the recruitment pipeline and in the case of the Band 5 International Recruitment and expected Newly Qualified Nurses (NQN) expected in March. The additional information relating to the NQN's expected in September has not been included within the remaining vacancy position calculation at this time.

Band 5 Registered Nurse and Operating Department Practitioners

Division	Ledger (Jan 20)	Division (Feb 20)	In Pipeline (Feb 20)	International Recruits (Feb arrival)	NQN March 2020	Remaining Vacancy (Feb 20)		NQN Sept 2020
Medicine	81.18 WTE	60.92 WTE	7 WTE	5 WTE	2.7 WTE	**46.22 WTE**		9 WTE
Surgery	50.59 WTE	30 WTE	3.8 WTE	3 WTE	8 WTE	**15.2 WTE**		17 WTE
W&C (Paeds only)	7.54 WTE	12 WTE	0	0	3 WTE	**9 WTE**		3 WTE
D&S	0.33 WTE	5 WTE	4.4 WTE	0	3 WTE	**2.4 - WTE**		2 WTE
Totals	**139.64 WTE**	**107.92 WTE**	**15.2 WTE**	**8 WTE**	**16.7 WTE**	**68.02 WTE**		**31 WTE**

Table 1: Band 5 Registered Nurse and Operating Department Practitioner Vacancy position, February 2020

The structured recruitment calendar of events for Registered Nurses continues to be refined. The new contract for International Recruitment has been awarded to ID Medical with the first cohort of 8 nurses from India having arrived on 3rd February, with the next cohort of 10 nurses scheduled for arrival during April and anticipated cohorts of between 10 and 15 monthly thereafter.

Appendix Two

Band 2 Healthcare Assistants

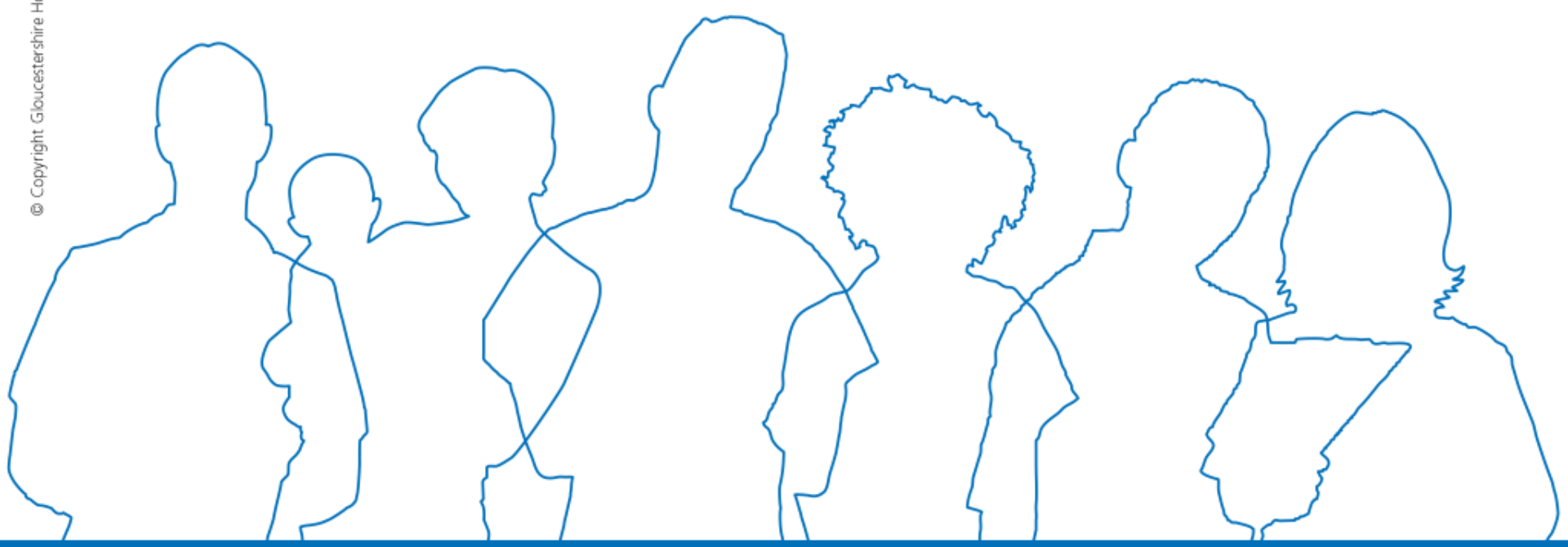
Division	Ledger (Jan 20)	Division (Jan 20)	Pipeline (Jan 20)	Remaining vacancy (Feb 20)
Medicine	53.48 WTE	36.4 WTE	24.2 WTE	12.2 WTE
Surgery	23.91 WTE	30.5 WTE	7.2 WTE	23.3 WTE
W&C (Paeds)	1.57 WTE	0.3 WTE	3 WTE	2.7 + WTE
D&S	4.87 + WTE	0	0.8 WTE	0.8 WTE
To be allocated			2 WTE	
Totals	**95.05 WTE**	**74.7 WTE**	**37.2 WTE**	**33.5 WTE**

Table 2: Band 2 Healthcare Assistant vacancy position, February 2020

A full calendar of recruitment activities has been developed with Matron led events scheduled monthly and across both Cheltenham General and Gloucestershire Royal.

Gloucestershire Hospitals
NHS Foundation Trust

Divisional Executive Review
P&OD Exception Reports



P&OD Exception Report – Medicine

Enabling Pillar: Workforce Sustainability	Divisional Narrative	Actions in Place and Progress to Note
Workforce Supply/ Vacancies / Retention	Vacancy rate across the Division - 8.09%(as at Nov 19) Nursing and Midwifery vacancy rate 13.01% , Additional Clinical Services vacancy rate at 6.79% Turnover rate 14.22% - highest areas Additional Clinical Services at 22.94% and Nursing and Midwifery Turnover 13.06% Winter summit staffing progressing and regularly reviewed	Recruitment and Retention continues to be reviewed and addressed across the Division, with recruitment and retention plans being developed as part of the retention strategy 3 month trend shows a decrease in turnover rate from 14.70% to 14.22%; 'Grow your own' embedded in the Division within Cardiac Physiology. AMU R&R premia and golden handshake approved in Sept 2019
Embedding new roles/Alternative Role Development	Developing the service line workforce plans , identifying scope and opportunities for developing new roles and embedding ACPs and Physicians Associates.	In progress
Advanced Development Pool Membership	Division currently have 4 ADP members	Discussions with L&OD team and Divisional representatives at Staff Patient Experience Group to promote the ADP pool and promotion at Divisional meetings and appraisals.
Apprenticeships	Currently 53 Apprenticeships , majority in Higher Apprenticeship Nursing Associate Roles (HANA). Previous year figure (2018) was 24.	Continuing to support embedding apprenticeships and reviewing opportunities through the VCP process
Enabling Pillar: Colleague Experience	**Divisional Narrative**	**Actions in Place and Progress to Note**
Improved reporting of bullying and harassment resolution and ensure faster resolution of cases.	Currently no active cases of reported bullying and harassment within the division	Triangulate with FTSU data and review with the 2019 staff survey results when released . This will be followed by action planning in conjunction with the L& OD team.
Reduce colleague absence specifically for MSK and mental health illnesses	Sickness absence rate for the Division 3.96%. Higher sickness absence areas continued to be monitored and managers supported by HRA team. MSK absence and Mental health illness in line with Trust trends top two reasons for absence in the Division	Progress monitored, MSK and Mental Health illness now included in revised scorecard.
ER Activity	3 active formal cases (1 disciplinary/2 performance management) 3 organisational change processes in place 6 formal sickness cases	Progress will be monitored through regular reports from Selenity casework tracker . Meetings arranged to review reports and reporting timescales in February.
Appraisal & Mandatory Training	No figures available for December . Appraisal rates remained at 79% for November. Initial feedback from the trial of the new appraisal paperwork is positive IG compliance was is 88%.	Division are focusing on improving appraisal rate and the 95% IG target; concerted efforts have taken place to dramatically improve the appraisal rate with managers being held accountable at divisional meetings, particularly those recorded as being out of date.
Enabling Pillar: Transformation	**Divisional Narrative**	**Actions in Place and Progress to Note**
Organisational Change Update	Endoscopy 7 day working – consultation in progress ED – change to 12.5 hour shifts due to commence Neurology proposed moves – work in progress	In progress with HRA support Project progressing - meetings scheduled weekly; joint working with surgery colleagues
Workforce Planning	Service line workforce plans in development with workshops to be scheduled for Feb/March 2020	Ongoing

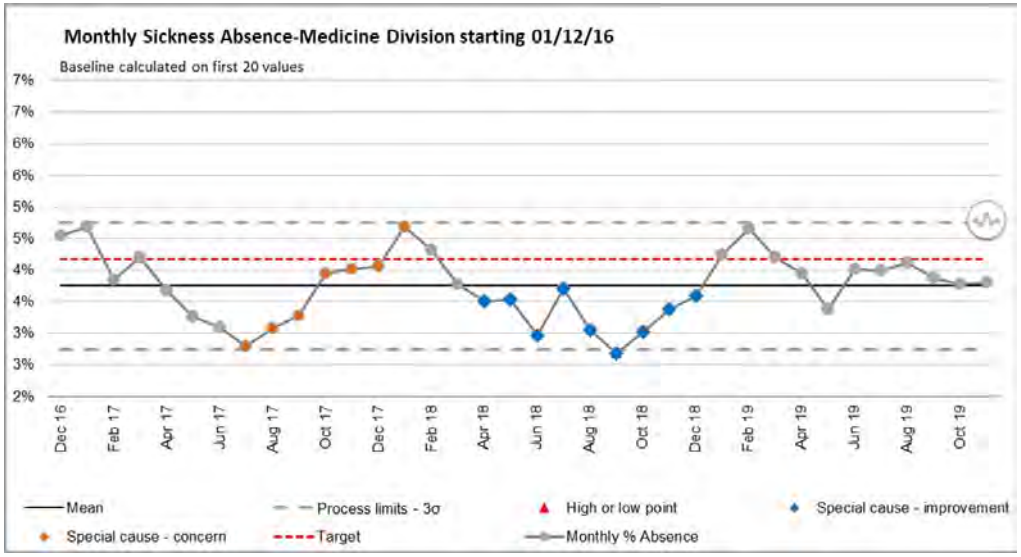
Gloucestershire Hospitals NHS Foundation Trust

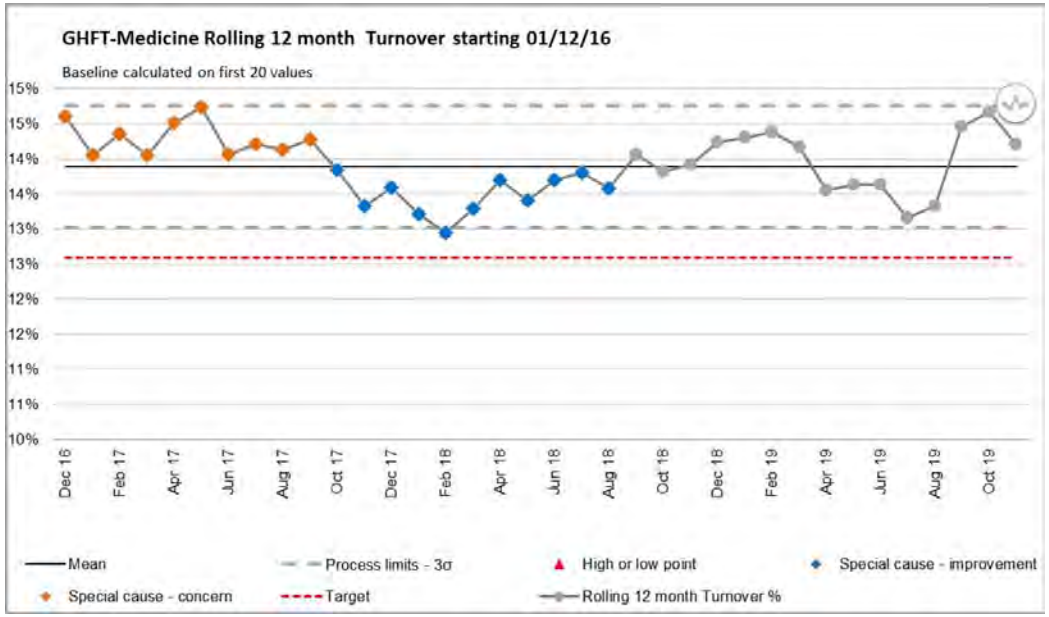
Medicine Division- People & OD Metrics

Measure	Score	Notes	Apr 2019 Actual	May 2019 Actual	Jun 2019 Actual	Jul 2019 Actual	Aug 2019 Actual	Sep 2019 Actual	Oct 2019 Actual
12 Month Rolling Turnover % (link to SPC chart)	1	Target is top quartile of Model Hospital recommended Peer Group. Data from 'Annual Turnover from Organisation benchmarking tool, August 19' published by NHS Digital	13.67%	13.75%	13.76%	13.28%	13.36%	14.70%	14.68%
12 month Nurse retention rate	1	Target is University/Teaching hospital Peer group rate	83.68%	83.33%	83.71%	83.11%	82.51%	82.07%	81.69%
HCA Turnover	1	Target is Trust HCA Turnover rate minus 1% at 31 March 2019	22.61%	24.81%	23.78%	20.64%	21.81%	23.33%	24.44%
A&C Turnover	1	Target is Trust A&C Turnover rate minus 1% at 31 March 2019	9.50%	8.90%	9.19%	10.17%	8.84%	9.71%	10.59%
Sickness Absence % (link to SPC chart)	1	Target is average of Model Hospital recommended Peer Group. Data from 'NHS Sickness Absence Rates July 2019 Monthly tables' published by NHS Digital	3.96%	3.55%	3.53%	3.61%	3.62%	3.71%	3.84%
Stress & Mental Health Absence proportion of time lost to sickness		Target is Trust rolling 12 months to 31 Mar 2019	16.60%	17.50%	17.90%	18.50%	19.00%	19.00%	19.40%
MSK Absence Absence proportion of time lost to sickness		Target is Trust rolling 12 months to 31 Mar 2019	17.60%	17.80%	17.90%	18.00%	18.40%	19.30%	19.10%
Appraisal Completion %	1	Targets set by Training Dept Red is below 70%	77.00%	79.00%	82.00%	82.00%	80.00%	79.00%	79.00%
Mandatory Training Completion %	1	Targets set by Training Dept Red is below 70%	88.00%	89.00%	89.00%	89.00%	90.00%	89.00%	89.00%
IG Mandatory Training Completion %	1	Targets set by Training Dept Red is below 95%	90.00%	90.00%	90.00%	90.00%	92.00%	86.00%	86.00%

Medicine Division- SPC Charts

Gloucestershire Hospitals
NHS Foundation Trust





P&OD Exception Report – D&S

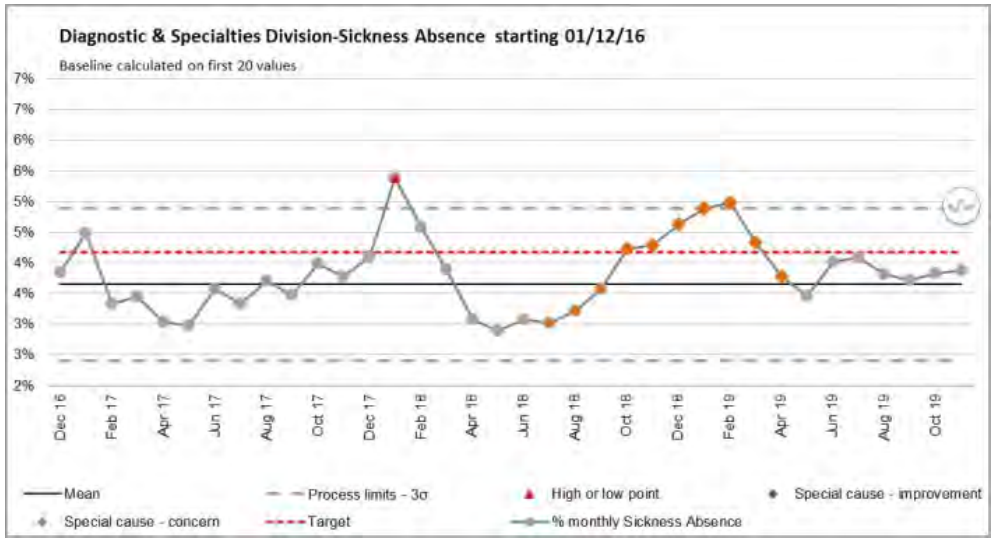
Enabling Pillar: Workforce Sustainability	Divisional Narrative	Actions in Place and Progress to Note
Workforce Supply/ Vacancies / Retention	Vacancy rate across the Division 5.30% (as at Nov 19) Nursing and Midwifery vacancy rate 10.98%. Radiography vacancy rate 13.21%. Turnover rate 10.52% - highest areas AHPS 15.96% (Radiographers 9.38%) and Healthcare Scientists 12.32% . Nursing Turnover 9.67%	Recruitment and Retention is a significant challenge for the Division , recruitment and retention plans being developed. 'Grow you own' embedded in the Division. Radiology Trainee Asst Practitioners and apprenticeship BMS roles in Haematology Radiology - revised bank rates recently launched to improve internal bank cover
Embedding new roles/Alternative Role Development	Develop service line workforce plans , identifying scope and opportunities for developing new roles and embedding ACPs and Physicians Associates.	In progress
Advanced Development Pool Membership	Division currently have 5 ADP members.	Discussions with L&OD team and Divisional representatives at Staff Patient Experience Group to promote the ADP pool and promotion at Divisional meetings and appraisals.
Apprenticeships	Currently 46 Apprenticeships. Majority in Healthcare support (Radiology/Haematology) and Business administration, committed to improving numbers.	Continuing to support embedding apprenticeships and reviewing opportunities through the VCP process
Enabling Pillar: Colleague Experience	**Divisional Narrative**	**Actions in Place and Progress to Note**
Improved reporting of bullying and harassment resolution and ensure faster resolution of cases.	Currently no active cases of reported bullying and harassment with the HR team.	Triangulate with FTSU data and review with the 2019 staff survey results when released . This will be followed by action planning in conjunction with the L& OD team.
Reduce colleague absence specifically for MSK and mental health illnesses	Sickness absence rate for the Division 4.10%. Sickness action plan included. MSK absence and mental health illness (in line with Trust) top two reasons for absence in the Division	Progress monitored, MSK and mental health illness included in revised scorecard. .
ER Activity	4 active formal cases (1 disciplinary/1 performance management/2 grievances) 1 formal flexible working request 1 Org change redeployment case (Sickness management cases summarised separately in the action plan)	Progress will be monitored through regular reports from Selenity casework tracker . Meetings arranged to review reports and reporting timescales in February.
Appraisal & Mandatory Training	No figures available for December . Appraisal rates improved from 82% in October to 84% in November. Initial feedback from the trial of the new appraisal paperwork is positive IG compliance is 94% .	Division are focusing on improving appraisal rate and reaching the 95% IG target by reviewing those non-compliant staff , particularly those recorded as black on the reports recently circulated .
Enabling Pillar: Transformation	**Divisional Narrative**	**Actions in Place and Progress to Note**
Organisational Change Update	Radiology rota (medical staff) consultation currently underway	In progress
Workforce Planning	Service line workforce plans to be developed	In progress

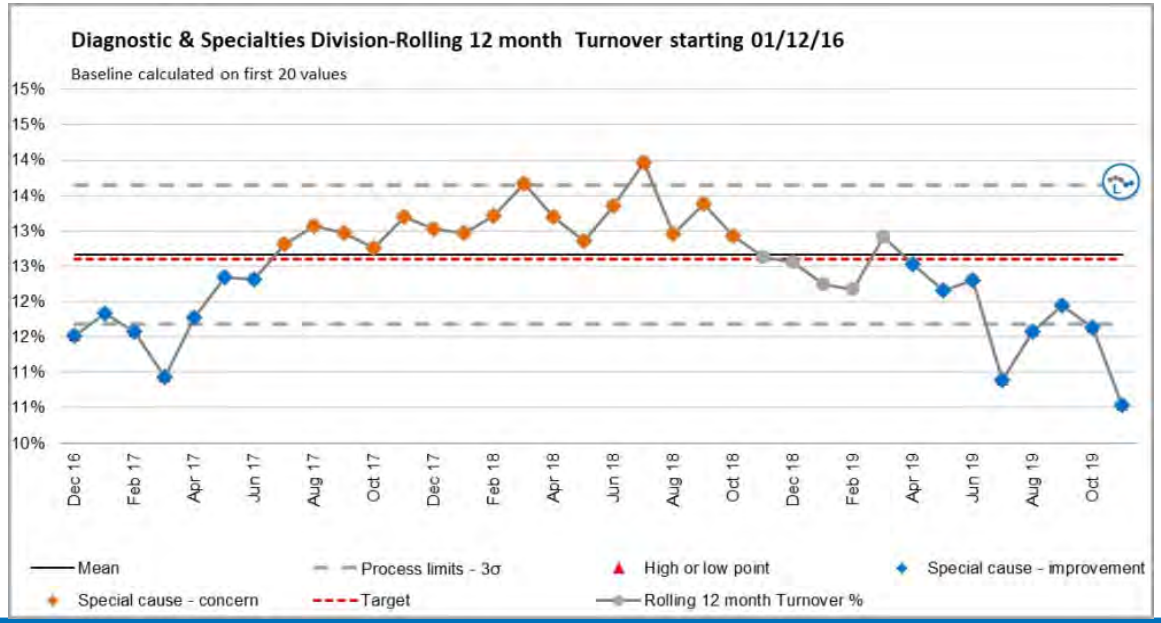
Diagnostic & Specialties Division- People & OD Metrics

Measure	Score	Notes	Apr 2019 Actual	May 2019 Actual	Jun 2019 Actual	Jul 2019 Actual	Aug 2019 Actual	Sep 2019 Actual	Oct 2019 Actual
12 Month Rolling Turnover % (link to SPC chart)	1	Target is top quartile of Model Hospital recommended Peer Group. Data from 'Annual Turnover from Organisation benchmarking tool, August 19' published by NHS Digital	11.66%	11.49%	10.95%	10.12%	10.41%	10.81%	10.50%
12 month Nurse retention rate	1	Target is University/Teaching hospital Peer group rate	83.08%	85.64%	85.35%	86.87%	87.50%	86.80%	86.15%
HCA Turnover	1	Target is Trust HCA Turnover rate minus 1% at 31 March 2019	16.22%	13.73%	13.59%	9.18%	10.63%	9.20%	7.67%
A&C Turnover	1	Target is Trust A&C Turnover rate minus 1% at 31 March 2019	11.63%	8.98%	8.01%	7.13%	7.12%	6.79%	6.03%
Sickness Absence % (link to SPC chart)	1	Target is average of Model Hospital recommended Peer Group. Data from 'NHS Sickness Absence Rates July 2019 Monthly tables' published by NHS Digital	3.84%	3.90%	4.10%	4.10%	4.15%	4.19%	4.13%
Stress & Mental Health Absence proportion of time lost to		Target is Trust rolling 12 months to 31 Mar 2019	18.10%	18.20%	17.70%	17.60%	17.90%	18.40%	18.50%
MSK Absence Absence proportion of time lost to sickne		Target is Trust rolling 12 months to 31 Mar 2019	20.70%	20.60%	20.00%	19.70%	19.30%	18.80%	18.20%
Appraisal Completion %	1	Targets set by Training Dept Red is below 70%	82.00%	83.00%	82.00%	82.00%	81.00%	81.00%	82.00%
Mandatory Training Completion %	1	Targets set by Training Dept Red is below 70%	94.00%	94.00%	94.00%	95.00%	94.00%	94.00%	95.00%
IG Mandatory Training Completion %	1	Targets set by Training Dept Red is below 95%		92.00%	93.00%	94.00%	94.00%	91.00%	93.00%

D&S Division- SPC Charts

Gloucestershire Hospitals
NHS Foundation Trust





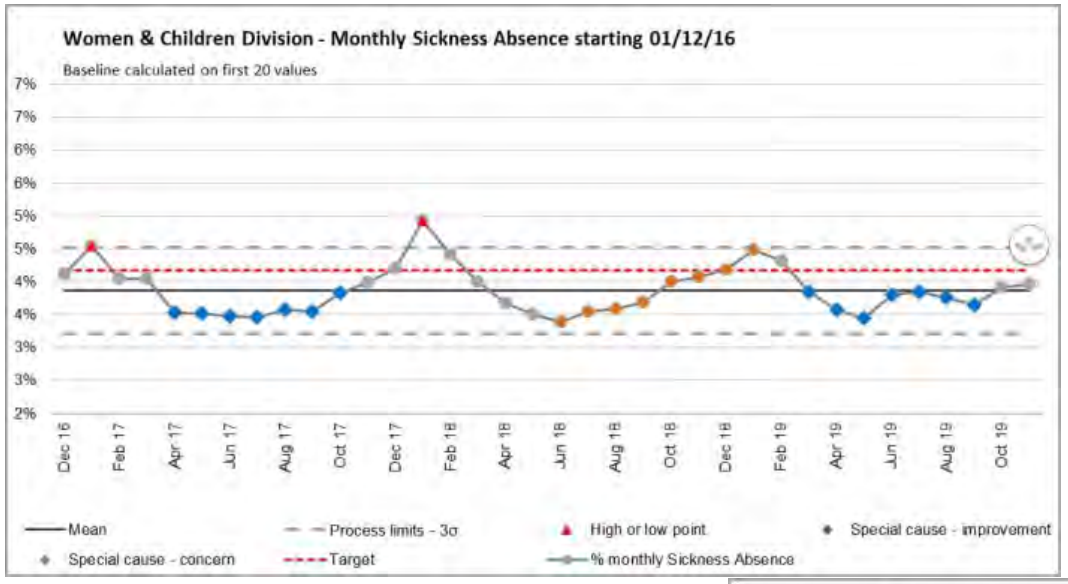
P&OD Exception Report – W&C		
Enabling Pillar: Workforce Sustainability	**Divisional Narrative**	**Actions in Place and Progress to Note**
Workforce Supply/ Vacancies / Retention	Vacancy rate across the Division 5.01% (as at Nov 19) Additional Clinical Services – highest vacancy rate at 15.46% Nursing and Midwifery vacancy rate 2.10&. Paediatric nursing vacancy rate 3.51% . Turnover rate 8.74% - highest areas Additional Clinical Services at 12.82% and Administrative and Clerical 11.55%. Nursing and Midwifery Turnover 7.62%	The Division has stable retention rates and vacancy rates. Continuity of Carer model of working is a potential risk . active staff engagement supporting the regular updates at team meetings , Facebook page, recently reviewed and agreed FAQS . Regular meetings with staff and RCM representatives Lead Nurse working with retention task and finish group to improve the process for exit data and reviewing recruitment and retention strategy for Paediatric Nursing. In progress.
Embedding new roles/Alternative Role Development	Reviewing the role of the Maternity support workers with a view to skill mix on maternity wards. Reviewing the Gynaecology leadership and the role of Advanced Nurse Practitioner.	In progress
Advanced Development Pool Membership	W&D Division have no ADP members at present , 2 applications have been submitted but were not successful.	Discussions with L&OD team and Divisional representatives at Staff Patient Experience Group to promote the ADP pool and promotion at Divisional meetings and appraisals.
Apprenticeships	Currently 9 Apprenticeships , majority in Healthcare support roles. Previous year , 6 so some improvement but committed to improving numbers.	Continuing to support embedding apprenticeships and reviewing opportunities through the VCP process
Enabling Pillar: Colleague Experience	**Divisional Narrative**	**Actions in Place and Progress to Note**
Improved reporting of bullying and harassment resolution and ensure faster resolution of cases.	Currently no active cases of reported bullying and harassment with the HR team.	Triangulate with FTSU data and review with the 2019 staff survey results when released. This will be followed by action planning in conjunction with the L& OD team.
Reduce colleague absence specifically for MSK and mental health illnesses	Sickness absence rate for the Division 3.99%. Sickness action plan included. MSK absence and Mental health illness in line with Trust trends top two reasons for absence in the Division	Progress monitored, now included in revised scorecard.
ER Activity	5 active formal cases (2 disciplinary/3 performance management) 1 formal flexible working request 1 medical case (Sickness management cases summarised in the action plan)	Progress will be monitored through regular reports from Selenity casework tracker . Meetings arranged to review reports and reporting timescales in February.
Appraisal & Mandatory Training	No figures available for December. Appraisal rates improved from 84% in October to 87% in November. Initial feedback from the trial of the new appraisal paperwork is positive IG compliance is 91% .	Division are focusing on improving appraisal rate and reaching the 95% IG target by reviewing those non-compliant staff , particularly those recorded as black on the reports recently circulated.
Enabling Pillar: Transformation	**Divisional Narrative**	**Actions in Place and Progress to Note**
Organisational Change Update	Continuity of Carer business case currently being reviewed.	.Project progressing - meetings scheduled fortnightly. Confirmation of implementation scope and delivery plan /staff consultation.
Workforce Planning	Continuity of Carer model of care is most significant workforce challenge. Service line workforce plans in development.	Ongoing

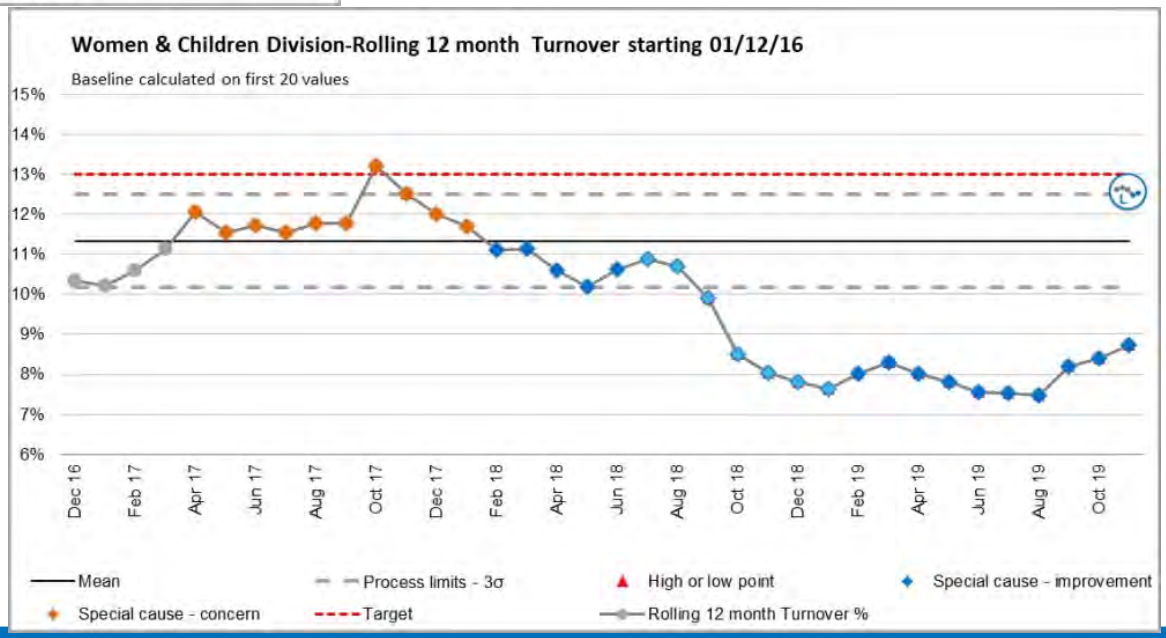
Women & Children Division- People & OD Metrics

Measure	Score	Notes	Apr 2019 Actual	May 2019 Actual	Jun 2019 Actual	Jul 2019 Actual	Aug 2019 Actual	Sep 2019 Actual	Oct 2019 Actual	Nov 2019 Actual
12 Month Rolling Turnover % (link to SPC chart)	1	Target is top quartile of Model Hospital recommended Peer Group. Data from 'Annual Turnover from Organisation benchmarking tool, August 19' published by NHS Digital	8.02%	7.81%	7.55%	7.53%	7.48%	8.19%	8.39%	8.74%
12 month Nurse retention rate	1	Target is University/Teaching hospital Peer group rate	91.30%	91.47%	92.58%	92.20%	92.05%	91.09%	91.26%	91.26%
HCA Turnover	1	Target is Trust HCA Turnover rate minus 1% at 31 March 2019	9.44%	10.20%	10.61%	10.32%	10.39%	9.40%	12.59%	12.92%
A&C Turnover	1	Target is Trust A&C Turnover rate minus 1% at 31 March 2019	10.16%	10.07%	10.74%	7.48%	8.72%	10.65%	10.36%	11.55%
Sickness Absence % (link to SPC chart)	1	Target is average of Model Hospital recommended Peer Group. Data from 'NHS Sickness Absence Rates July 2019 Monthly tables' published by NHS Digital	3.74%	4.34%	3.96%	4.19%	4.07%	4.01%	4.03%	3.99%
Stress & Mental Health Absence proportion of time lost to		Target is Trust rolling 12 months to 31 Mar 2019		19.60%	18.80%	18.90%	19.60%	20.40%	20.00%	19.70%
MSK Absence Absence proportion of time lost to sickne		Target is Trust rolling 12 months to 31 Mar 2019		15.20%	16.60%	19.10%	20.20%	21.10%	19.90%	22.40%
Appraisal Completion %	1	Targets set by Training Dept Red is below 70%	81.00%	82.00%	80.00%	82.00%	81.00%	79.00%	83.00%	87.00%
Mandatory Training Completion %	1	Targets set by Training Dept Red is below 70%	89.00%	90.00%	91.00%	92.00%	91.00%	91.00%	91.00%	91.00%
IG Mandatory Training Completion %	1	Targets set by Training Dept Red is below 95%	90.00%	90.00%	90.00%	90.00%	92.00%	86.00%	91.00%	91.00%

Women and Children Division- SPC Charts

Gloucestershire Hospitals
NHS Foundation Trust





P&OD Exception Report - Surgery		
Enabling Pillar: Workforce Sustainability	**Divisional Narrative**	**Actions in Place and Progress to Note**
	to include: outliers, hotspots, issues for escalation, context, service issues	what actions are being taken to resolve/ escalate
Workforce Supply/ Vacancies / Retention	Vacancy rates of 6.65% across the Division as of Dec19, with the 2 highest areas being Nursing & Midwifery and Additional Clinical Services. Prescott Ward amongst highest areas of B5 vacancies and turnover	Prescott Action Plan (attached for information) coaching and mentoring intervention to be considered. Targeted work for high vacancy areas with HRBP engaging with matrons to support plans Working closely with the recruitment lead regarding solutions and utilisations of bank more effectively.
	Turnover – currently 10.40% (as at end of Nov), considerably below target of 12.6% Retention - Recruitment & Retention strategy been drafted, including reviewing our Divisions exit interview process , how we welcome new staff, how we support them through their induction process and their ongoing employment with us.	L&OD team supporting with team intervention in areas of high vacancy factor e.g. Prescott Ward. Work underway to review bank and agency support/ availability Stepping Up programme/Ready Now – Leadership Development for BAME staff – reviewing number of applicants on the programme Progress on the Recruitment and Retention Strategy to be monitored and ongoing to support divisional need
	New Exit Interview process being trialled with better paperwork and process of sending Exit questionnaire as soon as resignation is confirmed - 18 questionnaires issued to staff who have left and had 7 returns with 4 wishing for an interview	Themes from those returned are generally, better work life balance, parking, poor educational opportunities and bullying but also the last minute requests to move from site to site and the opening of additional escalation beds and staffing around that. More data is required to get a truer comparative picture month on month.
Alternative Role Development	As part of the Service Line Workforce Plans, we will review the scope and opportunities for new roles and reviewing numbers for ACP's, Physician Associates, TNA's, NA's Trainee Theatre Associate Practitioner, HANA and grow your own in Audiology. Further intake happened in Sept 2019 to increase TNA and NA roles.	The division is actively supporting the development of these new roles and will continue to review opportunities to invest in creating new roles when reviewing vacancies and structures
Advanced Development Pool Membership (next update due February 2020)	14 applications received from Dec 18- Dec 19: A&C – 4 AHP – 1 M&D – 1 N&M – 8 ** 5 of which have been successful (1 of which was self-nominated) – 2 N&M and 3 A&C ** 1 nursing and midwifery member of staff was accepted but left the Trust, so Surgery has had 14 applications accepted, but currently 13 members in the ADP	Discussions being had with L&D team to promote further Further promotion of ADP to be done within the divisions which is ongoing – through Tri, service line tri's, matrons meetings, Promoting at the BAME sub group, Promoting to the Diversity Network as a whole, Promoting to the Equality and Diversity interview representatives, Promoting to the Stepping Up alumni – to achieve Trust target of 5% off staff to have completed the programme in the next 3-4 years. Further work to be done around BAME opportunities within ADP – currently this data is not asked at application stage, but targeted work to be done around this, this year by the L&D team.
Apprenticeships	Total 44 Apprenticeships undertaken in 2018 – 2019 (2nd highest division uptake) 40 currently on the Apprenticeship Programme in Surgery, with the highest number of Apprenticeships in Higher Apprenticeship Nursing Associates (HANA) 15, followed by Healthcare Support Worker 6, and Senior Healthcare Support Worker 5.	Role development and retention through apprenticeship pathway, such as 'grow your own' included within 5 year workforce plan to be reviewed regularly.

P&OD Exception report, Surgery continued…

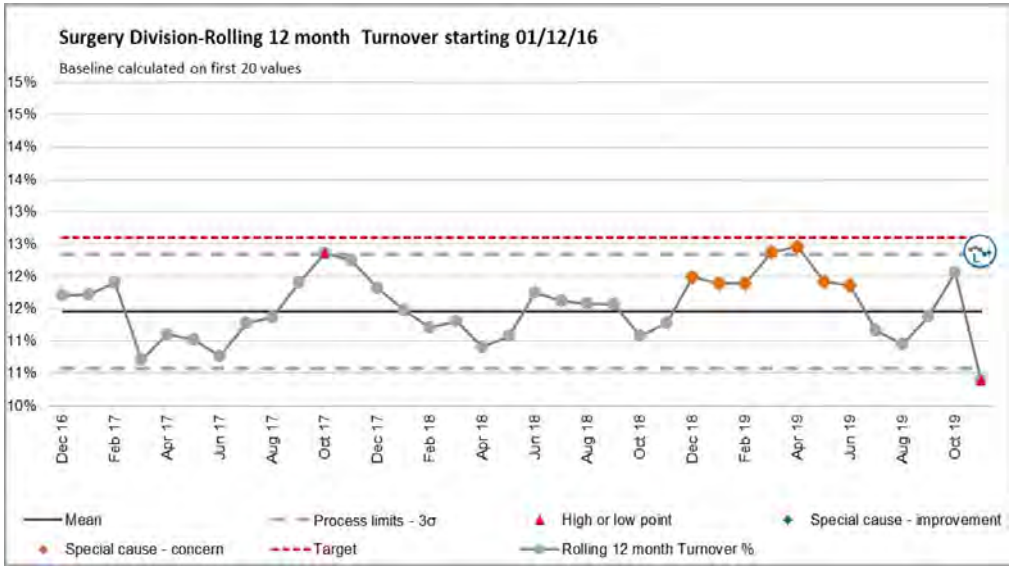
Gloucestershire Hospitals NHS Foundation Trust

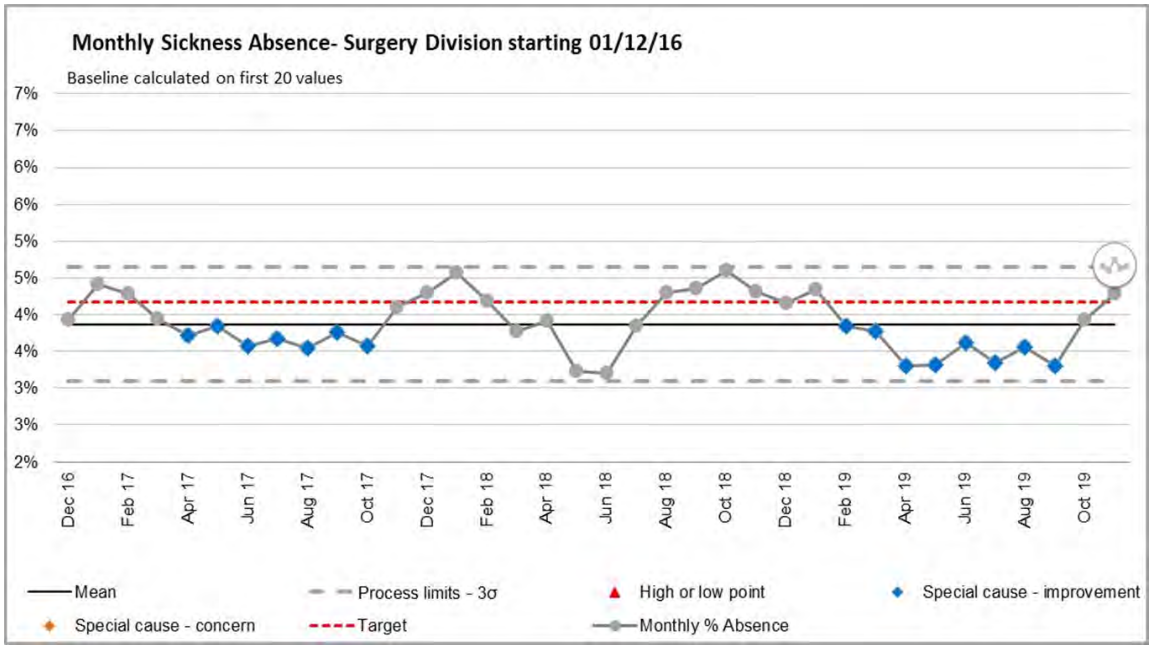
Enabling Pillar: Colleague Experience	Divisional Narrative	Actions in Place and Progress to Note
Improved reporting of bullying and harassment resolution and ensure faster resolution of cases.	Currently no active cases of reported bullying and harassment	To triangulate the FTSU data and review against the staff survey results from 2018 and 2019 results when released in February – This will be followed by action planning in conjunction with the L&D team
Reduce colleague absence specifically for Multiskeletal and mental health illnesses	Sickness absence – currently below target at 3.73 % (as at end of Oct and Nov). Action Plan in place to address sickness absence hotspot areas. MSK – is currently on target at 19.2% ASD – is currently above target at 27.9%	Jane Brookes(HRA for Surgery) is working with high sickness hotspot areas to get back to basics and ensure that processes are in place to manage sickness absence effectively and formal cases are being managed timely. Sickness Absence Action Plan in place to address the top 2 reasons for sickness HRBP to explore with the 2020 Hub further support for MSK and ASD absences
ER Activity	3 Disciplinary cases (1 of which is at fact finding stage) – 3 White British 1 SOSR (DBS Enquiry) – 1 White – any other white background	Jane Brookes (HRA Surgery) is working on managing cases effectively with managers, ensuring due process is followed within timescales, and utilisation of informal processes before escalating to formal process where possible.
Appraisal & Mandatory Training	No appraisal or training figures available for December. Appraisal rate improved by 1% from Oct to Nov 2019 – 83% The trial of the new appraisal paperwork is being received positively and seems to be helping with speeding up the process and less duplication. IG compliance has improved significantly since October from 86% to 92% as of Nov	Areas to be improved include Alstone Ward, Ward 2a, General Theatres CGH, Emergency Theatres GRH and Pre-assessments – new appraisal reporting process to help increase these areas – more time is required to trial this approach to show improvements. IG compliance still requiring improvement to reach 95% target – black list reports being used
Enabling Pillar: Transformation	**Divisional Narrative**	**Actions in Place and Progress to Note**
Organisational Change Update	Proposed Neurology moves: Development of support to staff and engagement process	Further actions to be through operational planning meetings - ongoing
Workforce Planning	Key workforce priorities include supply of nurses with the introduction of TNA's and NA's to bridge the gap and better use of new roles. Furthermore Recruitment and Retention is a key challenge within the division, which is now being reviewed as part of the new R&R Strategy to look at improvement of current processes, e.g. exit interview, rotational programme for B5's, HWB 2020 Hub (menopause), recruitment events for hard to fill areas.	In progress and regularly reviewed at Div Board

Surgical Division- People & OD Metrics

Measure	Score	Notes	Apr 2019 Actual	May 2019 Actual	Jun 2019 Actual	Jul 2019 Actual	Aug 2019 Actual	Sep 2019 Actual	Oct 2019 Actual	Nov 2019 Actual
12 Month Rolling Turnover % Link to SPC Chart	1	Target is top quartile of Model Hospital recommended Peer Group. Data from 'Annual Turnover from Organisation benchmarking tool, August 19' published by NHS Digital	12.43%	11.84%	11.83%	11.16%	10.95%	11.37%	12.06%	10.40%
12 month Nurse retention rate	1	Target is University/Teaching hospital Peer group rate	85.70%	85.60%	85.90%	86.00%	85.90%	85.18%	85.70%	85.88%
HCA Turnover	1	Target is Trust HCA Turnover rate minus 1% at 31 March 2019	18.32%	17.84%	17.21%	15.48%	13.91%	14.34%	13.45%	12.89%
A&C Turnover	1	Target is Trust A&C Turnover rate minus 1% at 31 March 2019	12.84%	11.30%	11.41%	10.18%	10.67%	12.09%	12.10%	11.02%
Rolling 12 month Sickness Absence % Link to SPC Chart	1	Target is average of Model Hospital recommended Peer Group. Data from 'NHS Sickness Absence Rates July 2019 Monthly tables' published by NHS Digital	3.96%	3.98%	4.01%	3.94%	3.88%	3.80%	3.73%	3.73%
Stress & Mental Health Absence proportion of time lost to sickness in month		Target is Trust rolling 12 months to 31 Mar 2019	22.00%	22.40%	22.80%	24.10%	25.70%	27.00%	27.50%	27.90%
MSK Absence Absence proportion of time lost to sickness in month		Target is Trust rolling 12 months to 31 Mar 2019	22.20%	22.80%	23.10%	23.00%	21.90%	20.70%	19.90%	19.20%
Appraisal Completion %	1	Targets set by Training Dept Red is below 70%	80.00%	81.00%	83.00%	86.00%	85.00%	82.00%	82.00%	83.00%
Mandatory Training Completion %	1	Targets set by Training Dept Red is below 70%	91.00%	91.00%	91.00%	92.00%	91.00%	91.00%	91.00%	91.00%
IG Mandatory Training Completion %	1	Targets set by Training Dept Red is below 95%	90.00%	90.00%	90.00%	90.00%	92.00%	86.00%	91.00%	92.00%

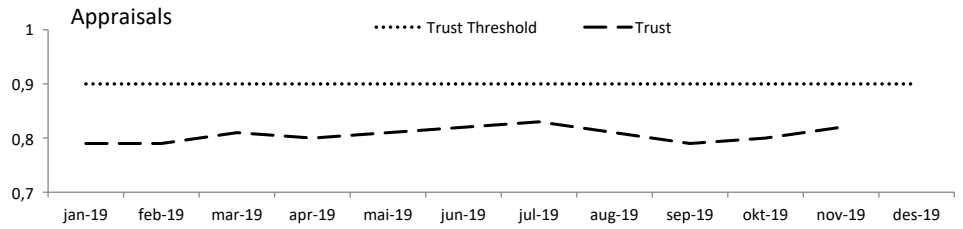
Surgery Division- SPC Charts

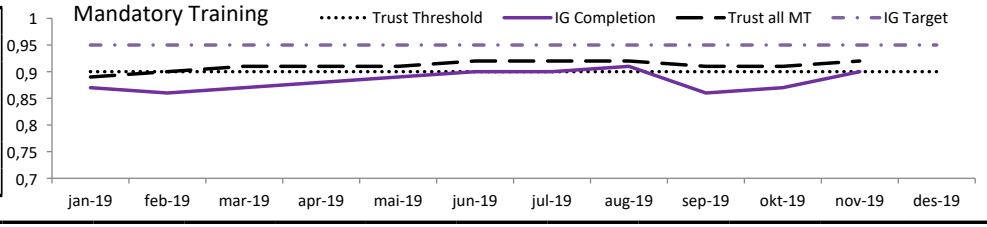


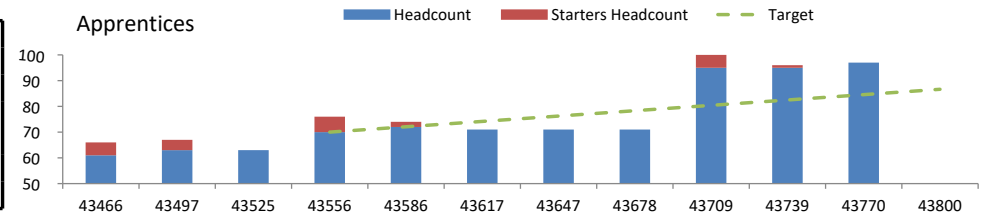


Gloucestershire Hospitals NHS Foundation Trust Dec 2019

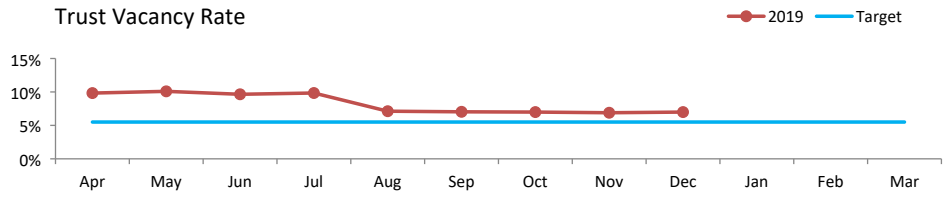
No Figures were reported by the Training Systems team for December 2019

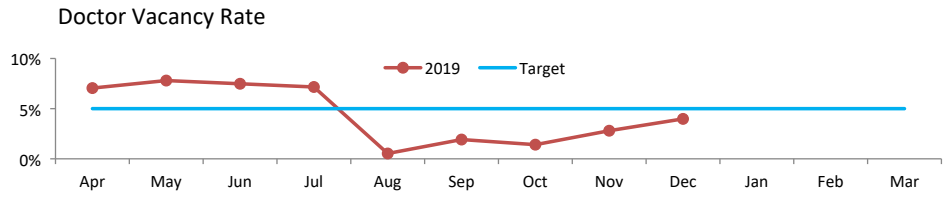
Measure	Description	nov-18	nov-19	Trend	Variation
Appraisals	% of Appraisals completed in previous 12 months. Excludes: Bank, staff joining Trust in the last 10 months (12 months for Medical staff) , staff on Maternity & adoption leave, suspended, external secondment, career break, Junior medcal staff.	79,00%	80,00%		Lowest Divisional Appraisal rate is Corporate with 73% completion. No Division has reached target, Women & Children is closest with 87%.

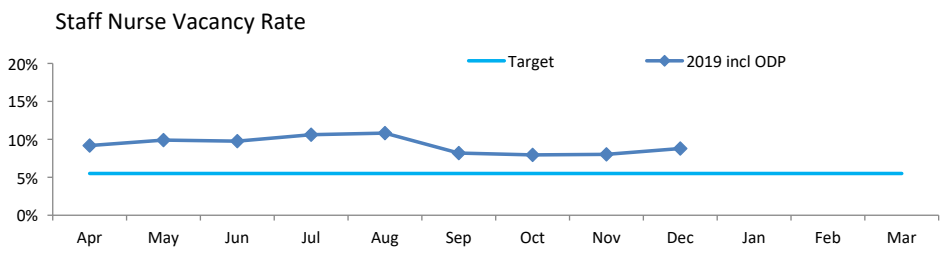
Measure	Description	nov-18	nov-19	Trend	Variation
Mandatory Training	Compliance rate is expressed as a percentage of number of completions meeting requirement /number of completions required. NHS Digital have set a national requirement to achieve a compliance target of 95% for Information Governance Training.	91,00%	91,00%		Only Medicine Division is below target at 89%. By Staff Group, Additional Clinical Services and SAS Doctors are at 87%, Training Grade Medical staff are at 81%. All other groups are over target.

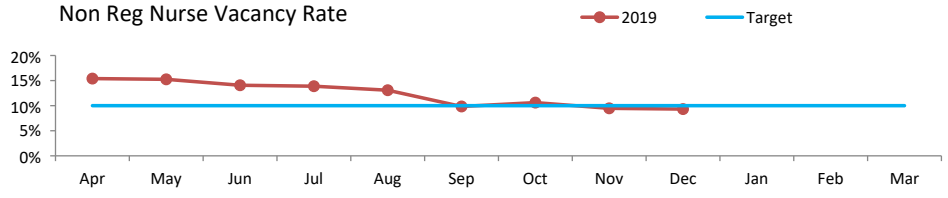
Measure	Description	aug-18	okt-19	Trend	Variation
Apprentice Recruitm'n t	The number of apprentices in post including starters per month. The target is an additional 10 apprentices in each Division by Y2.	60	95		The Apprentices in this report are those employed into an Apprentice post or a current employee who has transferred into one. Excluded are those who are undertaking training funded by the Apprenticeship levy in their current role - there are a further 92 staff in this category.

Gloucestershire Hospitals NHS Foundation Trust Dec 2019

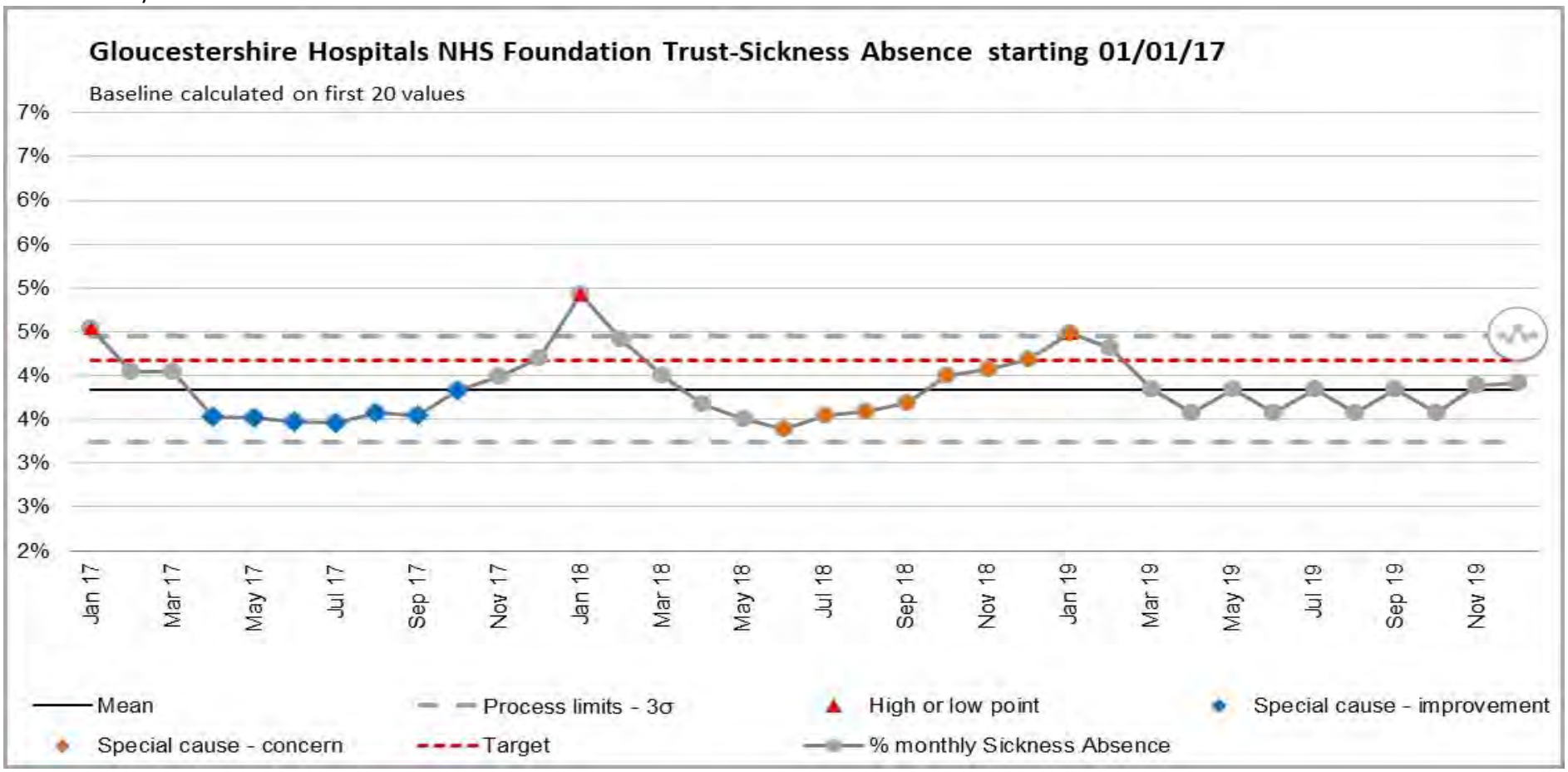
Measure	Description	des-18	des-19	Trend	Variation
Trust Vacancy Rate	The difference between the establishment and the staff in post as a percentage of establishment.	6,37%	5,50%		December's vacancy rate at 5.5% has decreased by 4.34% since July and remains within trend for the year to date. Despite an increase of 250 fte in Dec 19 compared to Dec 18, our vacancy rate has not reduced dramatically because of an establishment increase in April 19. We therefore have a shortfall of 476 fte in Dec 2019 compared to a shortfall of 413.5 fte in Dec 18.

Measure	Description	des-18	des-19	Trend	Variation
Doctor Vacancy Rate	The difference between the establishment and the staff in post as a percentage of establishment.	2,39%	2,80%		August's vacancy rate at 0.53% has greatly decreased since July . It has increased slightly since, but remains under target. Despite an increase of 51 fte in the Medical establishment in April 19 (to 904.94 inc on site GP Trainees), we are now only 36 fte below that establishment. In December 2018, we were 20.4 fte short of an establishment of 853.72).

Measure	Description	des-18	des-19	Trend	Variation
Staff Nurse /ODP Vacancy Rate	The difference between the establishment and the staff in post as a percentage of establishment.	9,24%	8,79%		Staff nurse vacancy has risen slightly to 8.79%, however the next cohort of newly qualified nurses should reduce that for January/February. In Dec 2019 we are 112.29 below establishment -last December the figure was 120.83. However establishment has reduced from 1307.58 to 1277.32 so we have fewer staff nurses/ODPs than last year (1186.75 v 1165.03).

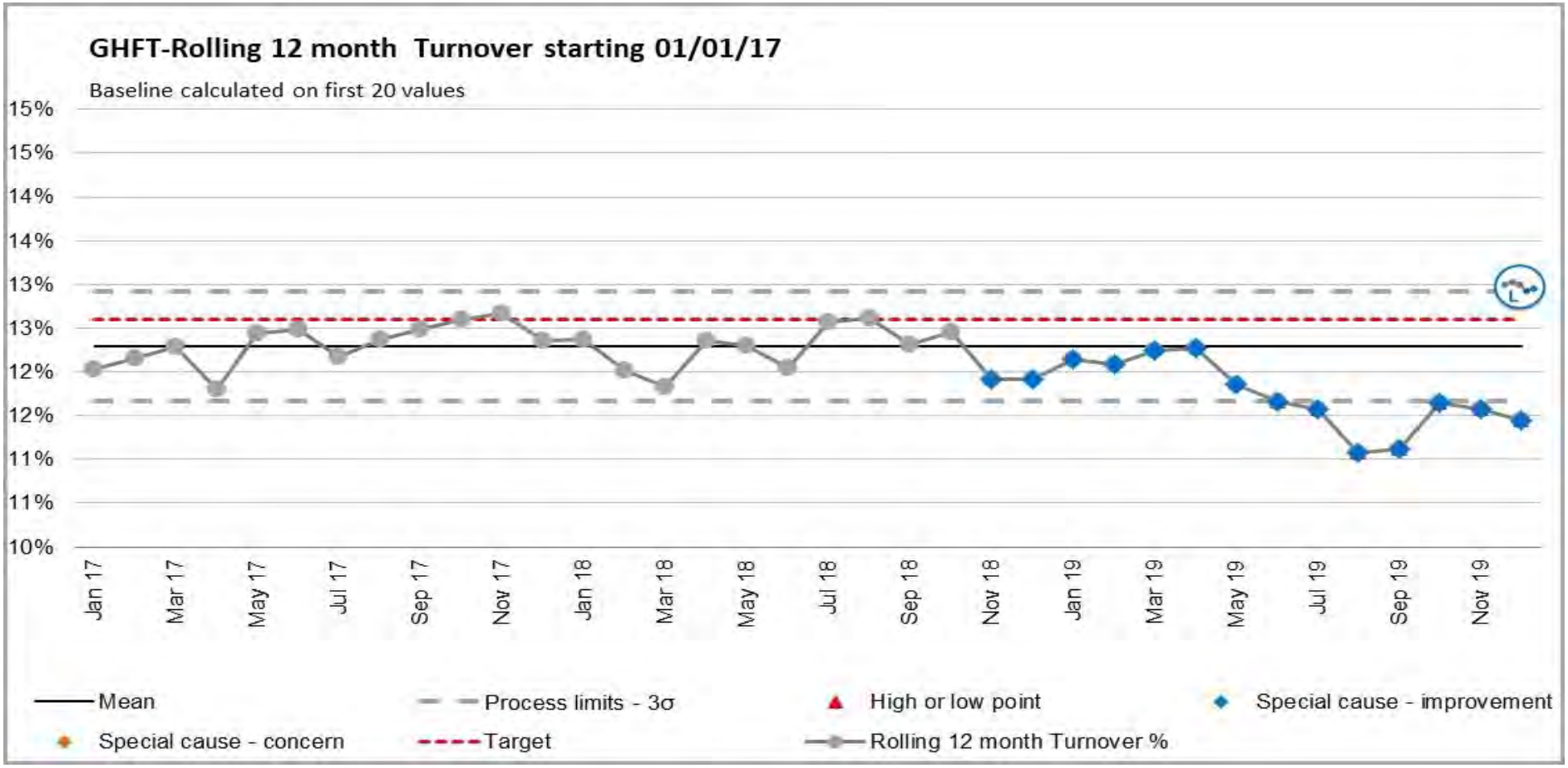
Measure	Description	des-18	des-19	Trend	Variation
HCA Vacancy Rate	The difference between the establishment and the staff in post as a percentage of establishment. Target revised to 10%	15,90%	9,32%		December's vacancy rate at 9.32% continues the general downward trend for the year to date (now lower than September). Surgery has the highest number of vacancies (34.37/9.88%) followed by Medicine (30.53/8.74%). The shortfall in contracted HCA fte has reduced to 86.3 fte from 138.4 fte in Dec 2018, despite an increase of 37.5 fte in establishment.

GHFT monthly sickness Absence SPC chart



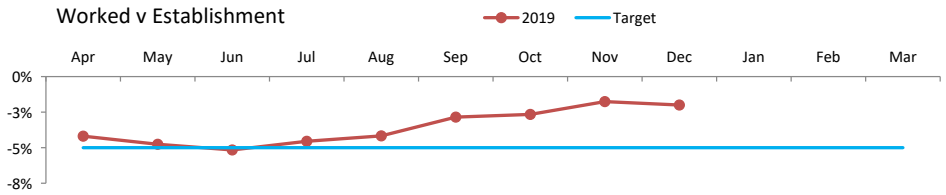
The SPC chart clearly demonstrates the seasonal variations in sickness absence rate. Although This could be illustrated equally well on a simple run chart, this report will continue with SPC charting to monitor high/low points.

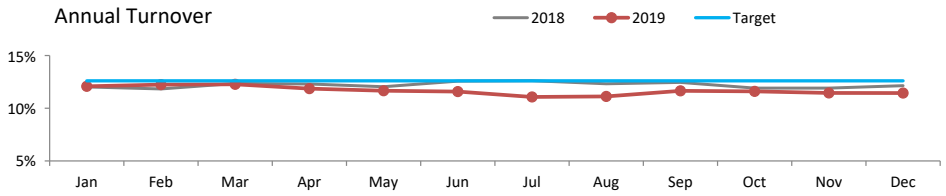
GHFT 12 month rolling turnover SPC chart

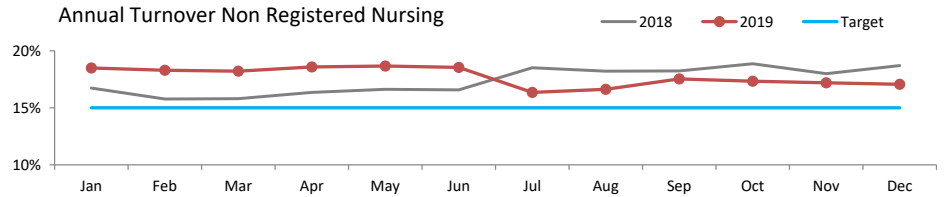


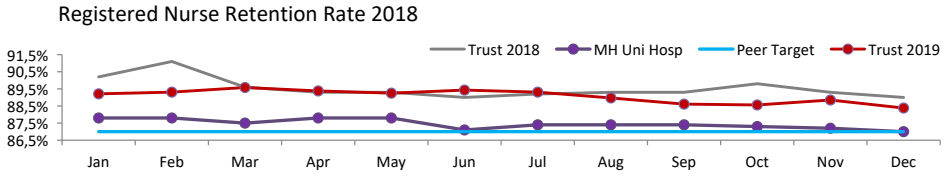
There has been a statistically significant reduction in Trust Turnover since April 2019

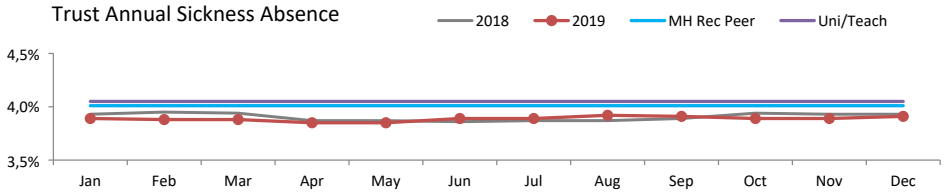
Gloucestershire Hospitals NHS Foundation Trust Feb 2020

Measure	Description	des-18	des-19	Trend	Variation
Worked vs Establishment %	The difference between the establishment and worked fte as a percentage of establishment. Target in line with Monthly BI reporting. (below -5% is 'green'))	-3,02%	-2,00%		Worked fte has increased steadily since June 2019, with a slight reduction in December. The Admin & Clerical Staff Group is the furthest from Target at -4.54%, this has reduced from 5.58% in November. In November 2018 the difference between worked & establishment was 3.02%. This represented a shortfall of 196 fte - in 2019 the figure is down to 135 fte (although establishment is higher this year).

Measure	Description	des-18	des-19	Trend	Variation
12 Month Rolling Turnover Link to SPC chart	Turnover is the no of leavers (in fte) expressed as a % of the ave numbers (fte)over the period. It is based on permanent contracts only.Trust target 12.6% (Top quartile of Model Hospital Peer Group)	12,14%	11,44%		Additional Clinical Services as a Staff Group have the highest turnover to Dec 19 at 14.90%. All other Staff Groups with the exception of AHPs(14.72%) are below the 12.6% threshold. Medicine Division is above the threshold, at 14.10. Women & Children Division have the lowest turnover (8.34%). Turnover since Mar 19 has been consistently lower than at the same period last year.

Measure	Description	des-18	des-19	Trend	Variation
Non- Reg Nursing 12 Month Turnover	Non - registered nursing includes HCAs, Apprentice HCAs, Trainee Nursing Assistants. Threshold 15% This figure not avail from MH.	18,07%	17,06%		Medicine Division has the highest Turnover rate for non registered nursing staff at 23.56%. The next highest Division is Surgery at 13.17%. Within Medicine , GOAM has a TO rate of 26.9% (22.8 fte leavers) Respiratory's rate is 26.5% (7.81 fte leavers). The lowest rate within Medicine Division is Gastroenterology at 17.7% (7.8 fte leavers).

Measure	Description	des-18	des-19	Trend	Variation
Nurse Retention Rate %	The percentage of nursing and health visitors that remained stable over 12 months period. Latest data from Model Hospital is Dec 18. University/Teaching Peer rate was 87%, MH recommended Peer rate 86.8% (NB excludes Midwifery)	89,00%	88,38%		Model Hospital data is calculated slightly differently to ESR, resulting in a figure approx 0.5% higher. The latest available from MH is December 18. Trust Nurse retention has redced very slightly (by 0.47%) since Nov 19 and remains lower than 2018. An analysis of nurse leavers for 2018 to 2019 shows that the monthly leaving average was 22 for 2018 & 22.7 for 2019. However the number of retirements has risen from 50 in 2018 to 70 in 2019.

Measure	Description	des-18	des-19	Trend	Variation
Annual Sickness Absence % Link to SPC Chart	Sickness Absence is expressed as a percentage of fte lost /available fte. The Uni/Teaching Hospital Peer rate from MH is 4.05%. MH recommended peer rate is 4.01%	3,93%	3,91%		Trust annual sickness absence is relatively stable and there are no major changes to the 2018 figures. Corporate has the lowest annual rate at 3.75%. Diagnostics Div has the highest rate at 4.03%. By Staff Group, Nursing & Midwifery 4.36% and Additional Clinical Services (HCAs etc) 5.46% have the highest rates whilst Add Prof Sci Tech, AHPs, Health Scientists & Medical & Dental staff are below 3.5%.

REPORT TO TRUST BOARD – March 2020

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

This report describes the business conducted at the People and Organisational Development Committee on 17 February 2020 indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Risk Register	Cross referencing of risks under our main themes continues Closed risks reviewed and a new one relating to the capabililty of Datix added (C3084P+OD)	Should People and OD hold the risk on Datix or another committee? Should the risk be separated into two: One risk - obsolete system. 2nd risk – efforts capturing data and reliability of this	Linked to Director People and OD portfolio as executive lead for Risk Management.	Move risk to Digital and Quality and Performance once separated. People and OD to separate out the risk into 2 and referred to Finance and Digital to monitor system issue and QPC for the issues relating to capturing information
	IRMER risk will change given the	Can Committee have tracking	Not possible with current	

	successful visit from CQC	of the risk and when a change happens	Datix system which is why it has been added to a risk and to the intolerable risks investment list.	
	S3036: suboptimal care for patients with specialist care and sub-specialist conditions caused by lack of ability to create sub-specialist rotas	What does inequitable care mean?	Links to EGS risk and issues with rotas.	
		Is there a medical risk for inadequate staffing levels? It was a request from Quality and Performance. What is the level of pastoral support for international colleagues?	There is a divisional risk which Director of Nursing will need to be reviewed	Director of Nursing to review.
	C1437P+OD: The risk of being unable to match recruitment needs with suitably qualified clinical staff (including: AHP's, Nursing and Medical), impacting on the delivery of the Trusts strategic objectives.		2 on-boarders in place and a review of processes and experiences underway. Recruiters also provide assistance.	
BAF Quarterly report	Progress in People and OD directorate was noted as positive with work streams progressing as planned	Can the feel of what concerns the department outside of programmes of work be added to future reports?	Assurance taken and progress noted	Chair to invite team to reflect on the agenda at the start of the meeting and if anything else needs to be escalated

				. .
Sustainable workforce review	Positive progress against the strategic objectives. RAG rated green bar one linked to partnership working. Highlights: Embedding ACP pathway and ICS work to join up at a system level Grow our own higher apprentices degree level nursing Pathway successes mean GHT has more content on why it is a great employer	Would divisions agree with progress and rating? How noticeable is impact of ACP's? Are these opportunities to sell our progress via media outlets. Can we link in the attrition and retention rates for programmes as a measure of success?	Extremely encouraging progress. Deputy Divisional Nurse confirmed it was and the new ways of working to resolve sustainable workforce issues celebrated within the organisation. Flow, care and collaborative working is very successful such as Frailty Lead Nurse playing a greater role in Comms and relationships with universities.	To be added into the next report.
Education, Learning and Development	<u>Highlights</u> Apprenticeships: Met and exceeded government target (210) Breadth of programme (34)	Does the service include GMS?	Apprenticeships continue in GMS. Need to consider the workforce profile and	

	Attrition is good.		consider new apprenticeship routes with external providers	
		How do you assess success for apprentices and the value of the scheme?	Retention and success of the programme including placement support, face to face meetings, mentorship and our own surveys.	
	Chief Nurse Fellowships:			
	Placement capacity: 650 Adult nursing P.A	How do you assess placement quality?	University surveys, pulse checks and mentor support.	
	Statutory Mandatory Training is currently at 90%. - GMS low - Information Governance training compliance at 90%, not 95% - Amber: reviewing topics like Moving and Handling.	How do we address Amber rating How does the organisation support staff to do training in work time	GMS aware of low compliance New training and each division now has an implementation plan. Divisions and Managers must plan time to support abstractions	
	Serious Injury Report:			

HSE/ Wheelchair incident	Submitted to coroner with action plan. 4 questions at inquest, who, where, when and how? Legal advice is being sought on possible enforcement and clarity on thoroughness of action plan.	Will the Trust review roles of the Trust, GMS, Apelona before the inquest?	Coroner not exploring the contractual relationships and the interest in determining roles and responsibilities is for the Trust predominately.	
Gender Pay Gap	Pay gap has reduced in medics when CEA Awards are removed With CEA awards being in the base salary, it will take years to address. Career grade gaps are influenced by recruitment and retention premium (RRP)and the application of this permanently in the past (made for males) CEA will change and will be an annual only. On entry to the Trust pay parity exists.	What is your wording for RRP	Tested assumptions on ability to negotiate pay for international recruits and if this has impacted pay gaps. Noted this was not the case That it is renewable and subject to review	Very well assured and given inability of us being able to amend some of the issues for a number of years, committee recommends scaling back on analysis.
Performance Dashboard	Vacancy detail provided on actuals vs purchase ledger numbers.	Divisional review for Medicine hasn't provided information on fill rates or safer staffing. It's not joining the dots up on	From divisional reports there is a need to understand the issues of concern and how assurance can be given on	To improve Executive Summary on key issues and matters arising

	Actual vacancies significantly less than purchase ledger Improved position on vacancy and turnover within the Trust Included divisional exception reports to show challenge SPC use welcomed	matters relating to committee risks and mitigation or the matters raised at Quality and Performance Committee.	how these are being resolved	

Board note/matter for escalation

None

To Committee

Risk relating to Datix – to become 2 risks: System to be reviewed by Finance and Digital and Process (data Quality) to be overseen by Quality and Performance

Balvinder Kaur Heran
Chair of People and OD Committee, 17 February 2020

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – March 2020
Redwood Education Centre, Gloucestershire Royal Hospital commencing at 09:00

Report Title
Gloucestershire Cancer Institute Strategy (GCI) – One year on Progress Update
Sponsor and Author(s)
Sponsors: Dr Rachael De Caux (COO),Simon Lanceley – Executive Director & Felicity Taylor-Drewe, Deputy COO Authors: James Curtis - GM, Cancer Services, Dr Charles Candish (Specialty Director, Oncology)
Executive Summary

Purpose

The presentation aims to provide a summary to senior stakeholders of the work of Cancer Services in achieving the aims set out in Gloucestershire Cancer Institute Strategy that was approved just over a year ago at Trust Main Board (8 November 2018).

Key issues to note

There has been considerable progress by Cancer Services in respect to the actions set out in the strategy.

1) *Improve waiting times performance*
   Improvements have been shown in Cancer Wait Times performance particularly within 2ww standard but also in specific specialities within the 62 day pathway. Namely in Lung, Lower and Upper GI. Some of these improvements have masked the national challenge of delivering the prostate pathway. By implementing the RAPID prostate pathway, it gives the Trust the optimum opportunity of delivering the 62 day standard. We have a COO chaired Task and Finish group to support delivery of this pathway.

2) *Review our regional presence as a Cancer Service*
   The presentation clearly defines our regional pathways and how our MDTs interact on a regional level. The current commissioning climate requires the Trust to understand our services in respect to its regional dependencies. We continue to engage with both Cancer Alliances that we straddle.

3) *Continue work on approval for improving our oncology environment*
   Significant progress has been made in the last year with large transformational projects such as the approval of the Strategic Outline Case for the Gloucestershire Cancer Institute programme.

4) *Improve our intelligence and IT infrastructure*
   Cancer Services with the support of IT have progressed three major projects to improve our IT infrastructure and therefore our ability to support clinical services. OPMAS has now been replaced successfully with Chemo Care with InfoFlex being upgraded in December 2019. The Trusts videoconferencing equipment will also be upgraded to give the very best teleconferencing equipment to three MDT rooms over both sites. These improvements will directly benefit our patients and the staff that use them.

5) *Improve our patient experience across all of our pathways*
   The Strategy reinforces its objective of improving patient experience. Cancer Services has formed partnerships with similar Trusts with strong Cancer Patient Experience Survey results and has recruited a Lead Cancer Nurse with a strong background in patient experience to drive improvements forward.

6) *Continue to embed Living With and Beyond Cancer programme*
The Trust goes from strength to strength with the Trust 7th out of 134 Trusts for completion of Holistic Needs Assessment, aimed to identify and support patients with issues and concerns following diagnosis.

7) *Cancer outcomes*
The Trust is committed to work with ICS partners around improving survival outcomes through earlier diagnosis in line with the Long Term Plan for cancer.

Conclusions

In order to respond to the key actions set out in the NHS Long Term Plan whilst experiencing high demand for services in an ever changing commissioning environment, the Trust will need a concerted, focused and coordinated approach for the next three to five years.

The Trust continues to be an active member of the Cancer Clinical Programme Commissioning Group to support the implementation of the LTP within the county.

Recommendations

That Trust Board receive this presentation and NOTE the progress within Cancer in the organisation within the last year.

Impact Upon Strategic Objectives

The strategy has dependencies with a number of strategic objectives and programmes of work (i.e. Centres of Excellence, Journey to Outstanding). The strategy has a direct impact on the Trusts ability to achieve national waiting times standards related to cancer care.

Impact Upon Corporate Risks

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

Regulatory and/or Legal Implications

Potential for regulatory intervention.

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	X	Information Management & Technology	X
Human Resources	X	Buildings	X

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

Date the paper was presented to previous Committees and/or Trust Leadership Team (TLT)							
Audit & Assurance Committee	**Finance & Digital Committee**	**Estates & Facilities Committee**	**People & OD Committee**	**Quality & Performance Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
				27/11/19		04/12/19	
Outcome of discussion when presented to previous Committees/TLT							

NHS
Gloucestershire Hospitals
NHS Foundation Trust

PRESENTATION

Gloucestershire Cancer Institute Strategy One year on

A year on…What did we say we would do?

- Improve waiting times performance
- Review our regional presence as a Cancer Service
- Continue work on approval for improving our oncology environment
- Improve our intelligence and IT infrastructure
- Improve our patient experience across all of our pathways
- Continue to embed Living With and Beyond Cancer programme

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Overview of services - CGH

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Cheltenham General Hospital (CGH)

Regional Cancer Surgery Centre including:

- Gynaecological Oncology Centre
- Urological Cancer Services
- Lower GI Cancer Surgery including regional ERCa service
- Breast Cancer Surgery

Home of the Gloucestershire Oncology Service

- Radiotherapy (4 LINACs with additional LINAC at Hereford County Hospital)
- Chemotherapy
- Palliative care
- Two Oncology/Haem wards

- Cheltenham has 5 General theatres including robotic surgery

Overview of services - GRH

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Gloucestershire Royal Hospital (GRH)

Regional Cancer Surgery Centre including:

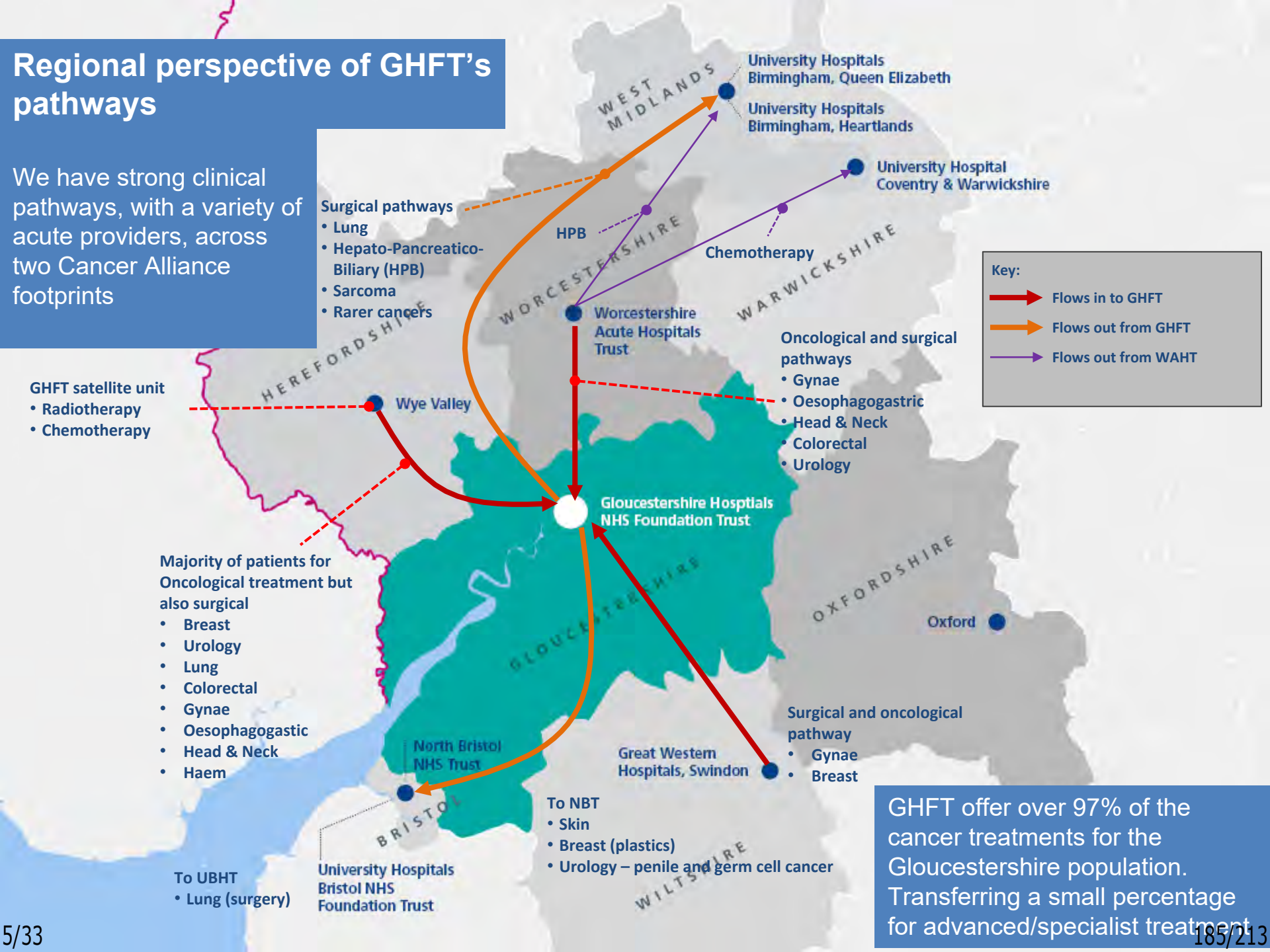
- Three Counties Oesophagogastric Cancer Centre
- Head and Neck Cancer Services
- Lower GI Cancer Surgery
- Breast Cancer Surgery

- Home to the Edward Jenner Haematology Unit
- Gloucester has 4 General and 4 Head & Neck theatres (2 ENT and 2 OMF)

GHFT also utilise a number of community hospitals within Gloucestershire for surgical procedures and outpatient follow up

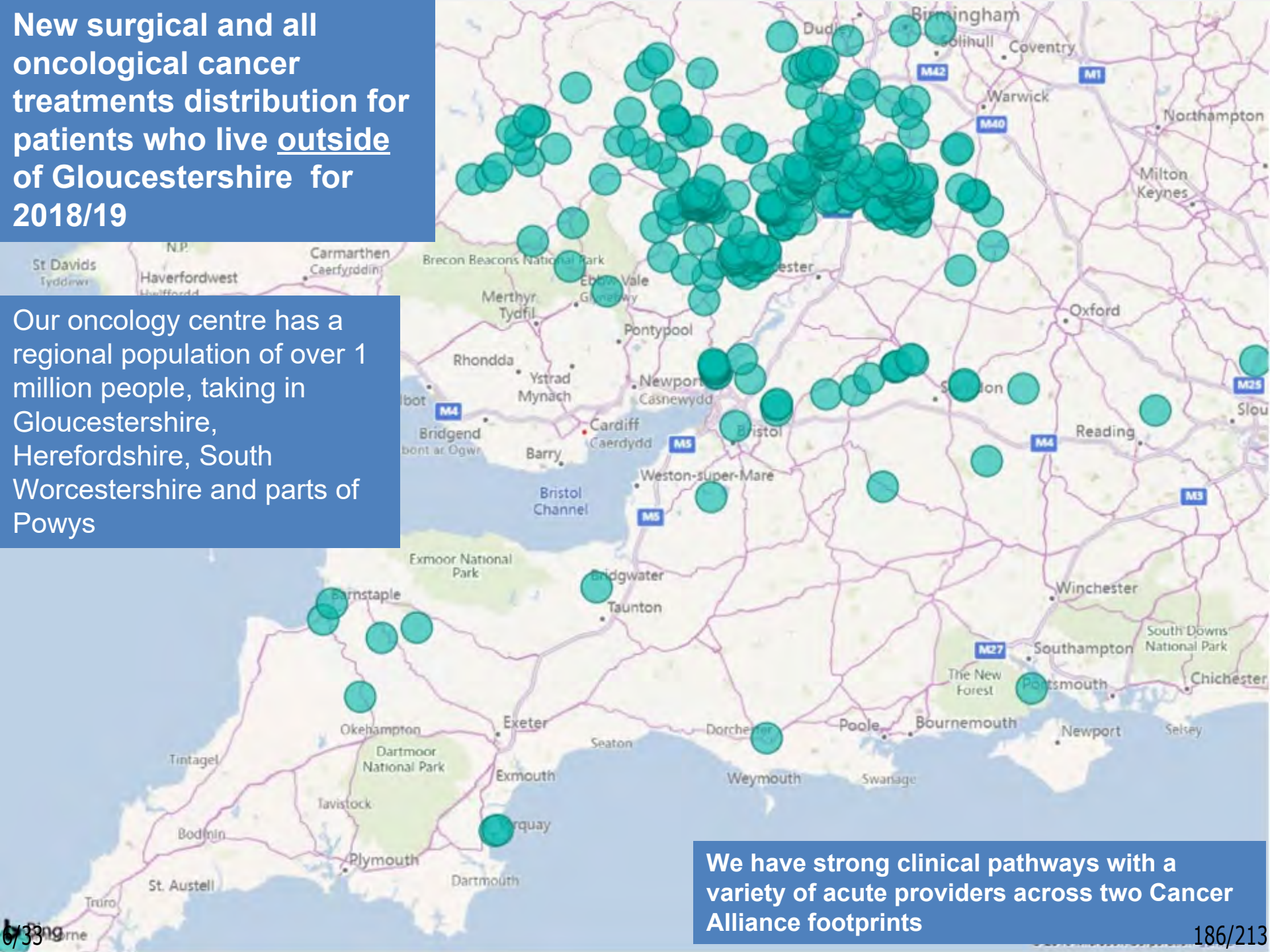
Regional perspective of GHFT's pathways

We have strong clinical pathways, with a variety of acute providers, across two Cancer Alliance footprints



GHFT offer over 97% of the cancer treatments for the Gloucestershire population. Transferring a small percentage for advanced/specialist treatment

New surgical and all oncological cancer treatments distribution for patients who live outside of Gloucestershire for 2018/19



Regional Context - Surgery

NHS
Gloucestershire Hospitals
NHS Foundation Trust

- GHFT is a large surgical centre delivering laparoscopic, endoscopic and robot assisted cancer surgery
- A number of our consultant surgeons attend MDTs based in other providers e.g. Hereford and Worcester
- GHFT cancer surgery teams are well above specified resection rates
    - **Prostate** – 168 prostatectomy procedures, 164 of which were robot assisted (target >100) and on course to deliver in excess of target in 19/20 – 3rd largest in the West Midlands
    - **Bladder** – Second largest in the West Midlands with 46 procedures recorded in 18/19 (target >30)

Regional Context - Surgery

Gloucestershire Hospitals NHS Foundation Trust

- **Renal** – 80 procedures recorded in 18/19 (target >30)
- **Colorectal** – Largest in the South West and 5th largest in England, 224 procedures recorded in national database 18/19. All surgeons meet minimum curative resection rate (>20)
    - **Early Rectal Cancer** – high volume specialist regional service delivering >35 local excision procedures 18/19 (26 TEMS 9 others)
- **Gynaecology** – 630 gynaecological surgical procedures in 18/19 with 49 ovarian procedures (standard contract >15 ovarian procedures. Regional centre for advanced multivisceral operations

Regional Context - Surgery

Gloucestershire Hospitals
NHS Foundation Trust

- **Upper GI** – 64 OG/stomach resection procedures recorded in 18/19 (standard contract >60 procedures)* On course to deliver in excess of target in 19/20. The centre also provides early oesophageal and gastric cancer endoscopic resections which account for an additional 10-20 cases per annum that are excluded from surgical rates

- **Head and Neck** – 117 Upper Aerodigestive Tract cancers (standard contract >100). On course to deliver in excess of target in 19/20

- Enhanced recovery after surgery routinely offered for abdominal operations

*

Regional Context - Oncology

Gloucestershire Hospitals NHS Foundation Trust

- GHFT is a large regional provider of Oncology Services: -
  - Currently delivering around 1,700 SACT treatments per month
  - Currently delivering around 3,800 radiotherapy fractions (treatments) per month

- In 2018/19, the Oncology Service saw 35,971 attendances, which was the highest activity per centre in the SW region, comparable with Bristol at 35,899

- The number of radiotherapy patients at GHFT for 2018/19 was 2,863, second regionally to Bristol with 3,067

Regional Context - Oncology

NHS
Gloucestershire Hospitals
NHS Foundation Trust

- GHFT are the only Radiotherapy Department within the South West region with a Satellite Centre – Renton Unit in Hereford (pictured)
- GHFT have an Oncologist daily presence in Hereford
- GHFT have a sealed source Brachytherapy Unit which provides internal treatments for patients with gynaecological cancers for all patients from Herefordshire, Gloucestershire and Worcestershire.

Oncology Service striving to deliver the best care for everyone

- Strategic Outline Case approved at Main Trust Board for refurbing existing facilities and providing the space to grow our SACT treatment offering for our patients
- 2 new Bedded Iodine Suite for inpatient care
- JACIE accredited Transplant Service, with dedicated 8 bedded Neutropenic Unit recently undergone 350k refurbishment
- Acute Oncology - Dedicated 24 hour/7 day a week assessment service
- GHFT were also the first Trust to deliver the concept of Mobile Cancer Care Unit, delivering SACT treatments closer to home (pictured)

NHS
Gloucestershire Hospitals
NHS Foundation Trust

GHFT Oncology Service striving to deliver the best care for everyone

NHS
Gloucestershire Hospitals
NHS Foundation Trust

- All Linacs are capable of delivering arcing, intensity modulated, image guided radiotherapy treatments to all sites.
- Three machines are capable of flattening filter free (FFF) delivery
- Two new Linear Accelerator installed in last year
- Ambitions to provide SABR treatment for Gloucestershire lung cancer patients
- Active participants of the SWAG Cancer Alliance Radiotherapy Network. Our Radiotherapy Manager will be taking on the Networks operational role.

Screening

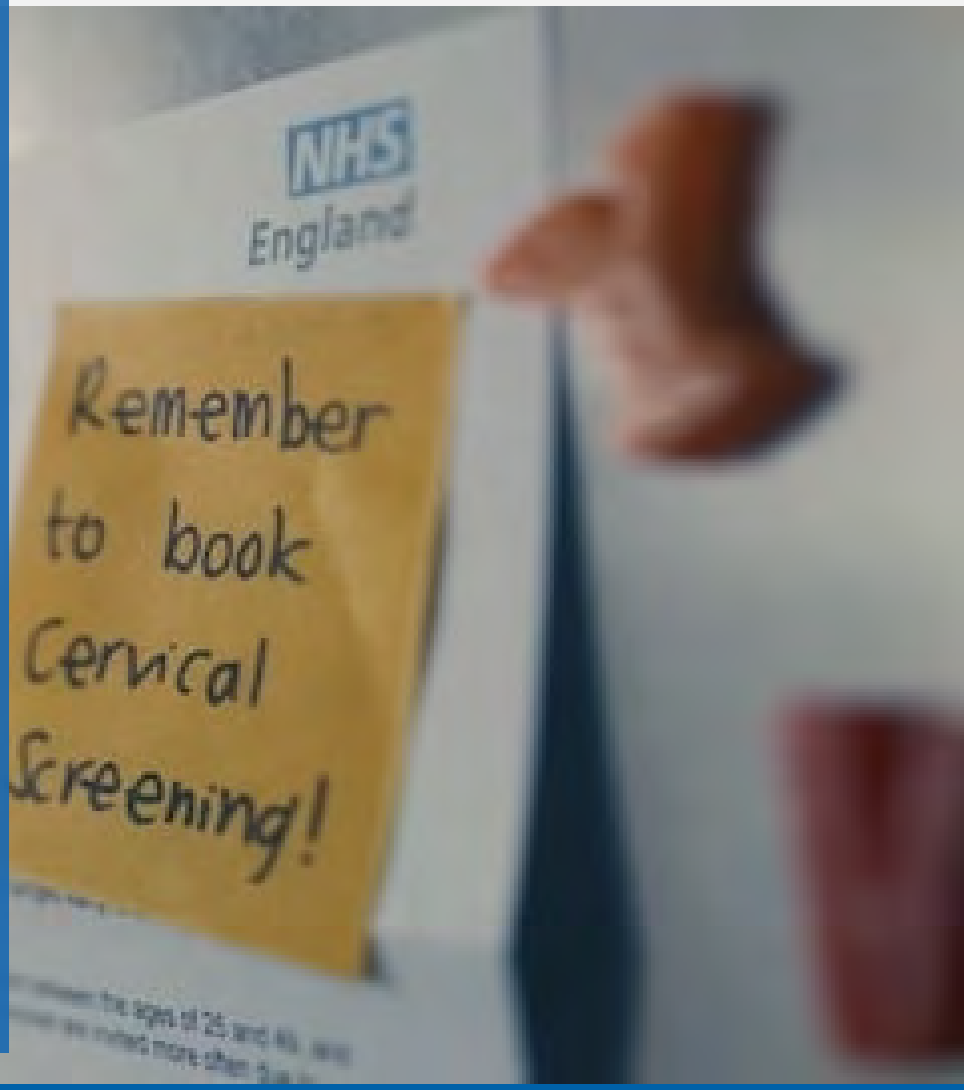
- The Bowel Cancer Screening Programme has continued to be one of the highest performing in the South West
- Breast Screening Service maintained good performance despite considerable challenge regarding national screening data incident
- The Trust has now agreed a replacement programme for ageing mammography equipment

Screening

- For the Cervical Screening Programme it was an uncertain and challenging period, due to the national decision to convert from cytology to HPR HV testing as the primary screening test

- Despite the challenges, key indicators, standards and accreditation were maintained, with very positive feedback from a recent QA visit

- Once screened the Trust has a history of excellent performance regarding treating patients following suspicious screening results. Last year the Trust recorded 342 treatments with only 10.5 breaches (96.5% performance – Standard 90%)



Diagnostics - Radiology

- In most cases, patients will require at least one set of imaging (CT/MRI/US) in order to confirm a cancer diagnosis and often requiring additional imaging prior to treatment
- Analysis on cancer wait times performance shows time from request to imaging event should be no more than 10 days and is critical for 28 day and 62 day delivery
- The Trust has invested in increasing capacity to shorten wait times for imaging and recent National Capital Funding awarded for renewal of CT, MRI and Breast Screening equipment
- Specific pathway work conducted to focus on prioritising cancer patients for imaging
- Local advanced imaging techniques provided in house or through local charity provider (Cobalt) e.g. TRUS, EUS, EBUS and PET

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Diagnostics - Pathology

- Where a clinician suspects cancer often a biopsy is taken to ascertain or confirm a cancer diagnosis
- Pathology has had a challenging year however the service has worked hard to eliminate the technical backlog
- The service has implemented Biomedical Scientist dissection and currently training to BMS staff to be able to report which will improve pathology reporting capacity
- Expansion into Cytology space has increased the services dissection facilities including dissection for genomics and iodine seed specimens
- Digital pathology project will ensure the service is fit for the future
- Cancer Services over the last year has strengthened its ties with the service with shared coordinators and weekly operational meeting to discuss cases

NHS
Gloucestershire Hospitals
NHS Foundation Trust

MDT specific overview
Surgery

Gloucestershire Hospitals
NHS Foundation Trust

Breast

4th largest Breast service*

Breast symptomatic 2ww performance, 62 day performance and screening performance in the top percentiles nationally

Advanced surgical pathway with NBT, Oncology pathway with Wye Valley

Consultant surgeon, Oncologist, CNS Lead and Ops Manager representation at SWAG Breast CAG

Upper GI

3rd largest UGI service*

Three Counties Oesophageal Regional Treatment Centre

Shared Consultant Surgeon with WRH

HPB patients treated in UHBirmingham for resection

National timed OG cancer pathway currently being implemented

Lower GI

4th largest Lower GI service*

Regional Transanal Endoscopic Microsurgery and complex polyp treatment centre

Straight to Colonoscopy launched in June 2018

** Cancer Wait Times 62 day June – Aug 19 data. Analysis included NBT, UHBristol, UHBirmingham, RUH, WRH, Coventry, GWH, R&DE*

MDT specific overview
Surgery and W&Cs

Gloucestershire Hospitals
NHS Foundation Trust

Urology

3rd largest Urology Service*

Shared surgical pathway with Wye Valley and North Bristol (Penile and Germ Cell cancers)

Currently meeting all spec comm's activity related standard for urology procedures

Penile and Germ Cell cancer patients treated at NBT

Currently implementing the RAPID prostate pathway

Head and Neck

4th largest H&N Service*

Shared oncology pathway with Wye Valley

Gynae

Largest Gynae Service*

Regional Treatment Centre for oncology and advanced gynaecological surgery

MDT Lead also Clinical Lead for the West Midlands Cancer Alliance

** Cancer Wait Times 62 day June – Aug 19 data. Analysis included NBT, UHBristol, UHBirmingham, RUH, WRH, Coventry, GWH, R&DE*

MDT specific overview
Medicine & Oncology based services

Gloucestershire Hospitals NHS Foundation Trust

Lung

2nd largest lung service*

MDT Lead also SWAG Cancer Alliance Lung Cancer Lead

One of the first Trusts to go live with Straight to CT in region

Achieved 62 day standard for the whole year in 18/19

Thoracic surgery provided by Heartlands and UHBristol and a Wye Valley oncology pathway

Skin

5th largest Skin Cancer Service*

Link with NBT for advanced plastics

Haematology

4th largest Haematology Service*

MDT Lead also SWAG Cancer Alliance Haematology Clinical Advisory Group (CAG) Lead

** Cancer Wait Times 62 day June – Aug 19 data. Analysis included NBT, UHBristol, UHBirmingham, RUH, WRH, Coventry, GWH, R&DE*

MDT specific overview
Oncology based services

Gloucestershire Hospitals
NHS Foundation Trust

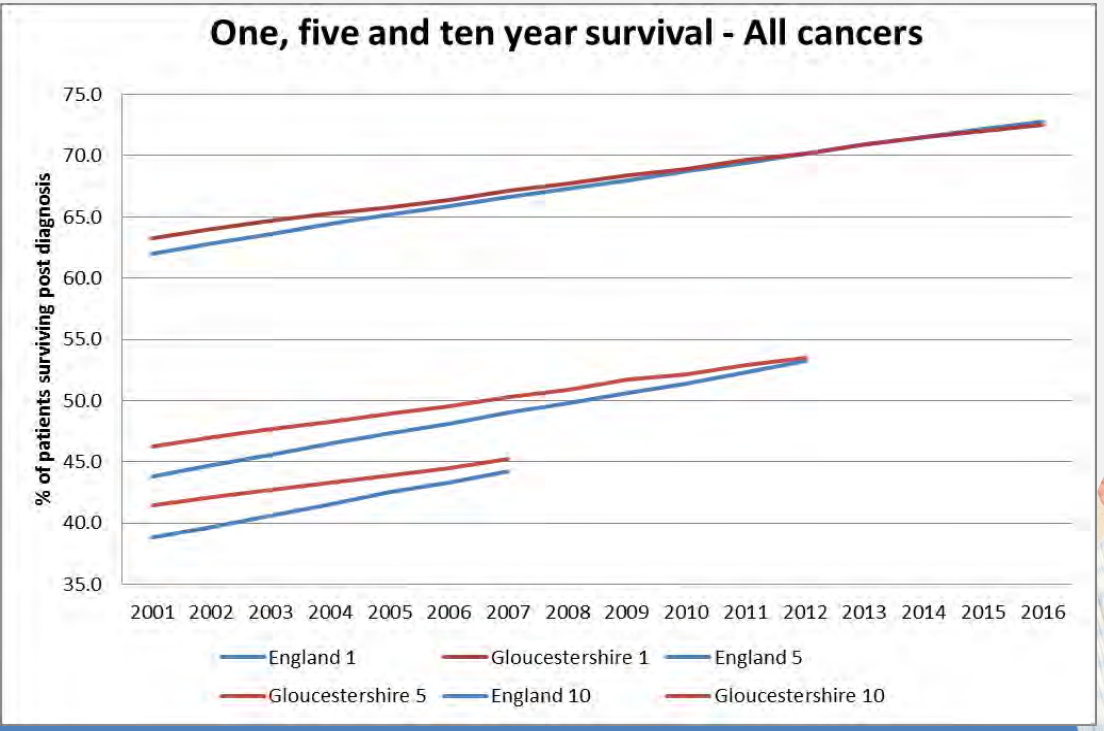
Sarcoma
Established pathway with Royal Orthopaedic Hospital and QE Hospital for surgery
Oncology treatments provided in house

Brain/CNS
Surgical pathway to UHBristol with oncology treatments provided in house
Brain/CNS MDT Lead, Consultant Oncologist and CNS Lead attend SWAG Brain/CNS CAG

Cancer of Unknown Primary
CUP MDT Lead attends SWAG CUP CAG

Survival rates higher than national average

Gloucestershire Hospitals
NHS Foundation Trust



45% of patients survive cancer for **10 or more years**

Cancer Services is committed to working with health partners to improve this further and shifting more patients to being diagnosed earlier in line with NHS long term plan for cancer

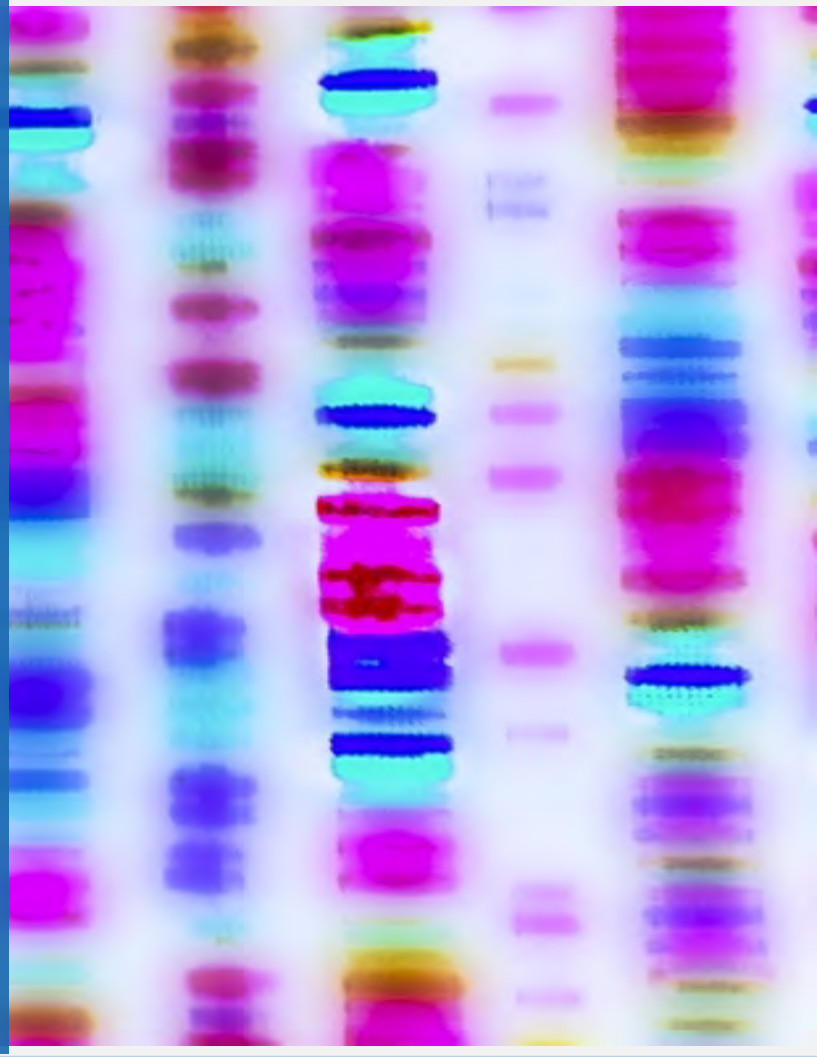
Genomics

NHS
Gloucestershire Hospitals
NHS Foundation Trust

- Whole Genome Sequencing provides a huge step forward in the diagnostic information available. It involves looking at an individual's entire DNA, rather than looking at specific genes or groups of genes. It offers a greater understanding of the underlying causes, triggers and drivers of disease as well as the likely success or failure of drugs and interventions.

- The Trust has delivered objectives set out by the 100,000 genomes project with Trust representatives Mr Bristol and Gill Hopkins as Senior Research Nurse actively collaborated on regional level in the development of the West of England Genomic Medicine Centre

- GHFT Oncologist Dr Nelmes is the South West Cancer Genomics Lead - South West Genomic Laboratory Hub



Patient experience

- Cancer Services places the patient at the centre of all aspects of the service and improving the patient experience is a key part of the GCI Strategy
- The National Cancer Patient Experience Survey tells us our main areas of focus should be:-
  - Improve our waiting times (referral to treatment but also treatment times for radiotherapy or SACT treatment for example)
  - Ensuring the patient is involved in decision making and aware of the next steps
  - Providing information in a variety of ways to help inform patients and carers of their condition and issues surrounding treatment such as consequences of their individual treatment plan
  - Improve our environment to ensure patients are comfortable when using our hospital (within the estate limitations)
- The Trust is focused on improving methods to gain cancer patient experience to inform our services now and into the future

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Recruitment and Retention

NHS
Gloucestershire Hospitals
NHS Foundation Trust

- There is a national workforce issue that relates to a number of key personnel that contribute to the care of patients with cancer
- The Trust is working with ICS Partners to focus on key areas such as Radiology and Pathology
- Oncology prides itself on it's stable workforce, attracting and retaining high calibre staff, with no vacancies in recognised hard to fill positions. The Service has recruited four new Consultant Oncologists in the last two years in a notoriously hard area to recruit

Nursing workforce

Gloucestershire Hospitals
NHS Foundation Trust

- The Trust is committed to investing in Clinical Nurse Specialists (CNS's) and Advanced Nurse Practitioners (ANP's) across all specialties that diagnose and treat cancer including Oncology
- The Trust recognises the clinical and patient experience benefits that are associated with access to a CNS or ANP
- The Trust has recently invested in a Secondary Breast Cancer Nurse (only 20 similar nurses in the country)
- The Trust also has a number of Consultant Nursing positions within Cancer Services
- Business case approved to invest in more Chemotherapy Nurses and ANPs

Allied Health Professional (AHP) workforce

Gloucestershire Hospitals
NHS Foundation Trust

- The Trust recently recruited an AHP Cancer Lead to recognise the impact AHP's have on patients who provide critical support pre, during and post treatment
- Our Oncology Consultant Radiographer has just won a national prize for her Quality Improvement projects
- The Trust is aiming to implement prehabilitation across surgical pathways in the next year to improve surgical outcomes and reduce bed days post surgery

Supporting people living with and beyond cancer

NHS
Gloucestershire Hospitals
NHS Foundation Trust

- The Trust is on course to deliver the long term plan objectives around supporting people living with and beyond cancer and personalised care

- The Trust is currently 7th out of 134 Trusts for completion of Holistic Needs Assessment, aimed to identify and support patients with issues and concerns following diagnosis. The quality of Care Plans have been recognised by Macmillan as an example of good practice nationally

- Community partnerships developed with services to ensure continuity of care and support outside of the acute setting, including community based Cancer Rehabilitation Service Macmillan Next Steps

National and local cancer charities

- The Trust is proud to work closely with a number of Cancer Charities
- Our local Cancer Charity Focus have funded Sky Ceilings in the Radiotherapy Suites and new Iodine Treatment Suite
- The Trust works in close partnership with Macmillan Cancer Support with pump priming CNS and Support worker roles as well as working in collaboration to set up the new Macmillan Information Hub

Support Groups

NHS
Gloucestershire Hospitals
NHS Foundation Trust

- The Trust recognises that for many cancer patients treatment is only the start of their journey to find a new 'normal'
- Many specialties run support groups following treatment such as: -
  - GUTSY which is a patient support group in Gloucester and Worcester for patients and carers after radical treatment for oesophageal and gastric cancer
- Our Clinical Teams also work closely with other charities such as Maggie's, Charlie's and Great Oaks that provide invaluable support for patients during and post treatment

Cancer Services Infrastructure

Gloucestershire Hospitals
NHS Foundation Trust

- The Trust is committed to providing Cancer Services the best IT operating systems in order for clinicians and non clinicians to deliver the best care for everyone
- Oncology have just gone live with Chemo Care System that replaces OPMAS. Infoflex was upgraded in December 2019
- Trust is renewing all videoconferencing equipment in three MDT rooms across both sites in order to improve connectivity across sites and ability to connect into regional specialist MDT's
- The arrival of All Scripts Sunrise EPR will bring these systems together to ensure joined up care

Risks and Challenges

NHS
Gloucestershire Hospitals
NHS Foundation Trust

- Demand on cancer services is rising and is set to rise further given national drive to improve detection rates to improve survival rates
- Ensuring services have the right kit to diagnose and treat patients in the most efficient and clinically effective way possible
- Capital build hurdles and process
- Coordination and implementation of a wide variety of transformational change projects across all pathways in line with long term plan
- Non-recurrent transformation monies supporting 28 day/62 day delivery and LWBC/Personalised Care

What will we be saying we have done in a year's time?

- Completed pathway developments to ensure 28 day and 62 day compliance especially RAPID prostate pathway
- Continue networking with Health Partners to ensure the best care for our patients within and outside of Gloucestershire
- Implementation of phase 1 and elements of phase 2 of Living With and Beyond Cancer programme
- Embed Genomics within our pathways to enable personalised medicine
- Implementation of Rapid Diagnostic Service for vague symptoms and select 2ww pathways
- Progression to Outline Business Case and Full Business Case for Gloucestershire Cancer Institute site development

NHS
Gloucestershire Hospitals
NHS Foundation Trust