GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

Alexandra House, Cheltenham General Hospital, Sandford Road,
Cheltenham, Gloucestershire, GL53 7AN

Dear Colleague

5th April 2018

The next meeting of the Council of Governors of the Gloucestershire Hospitals NHS Foundation Trust will be held on **Wednesday 18th April 2018**, in the **Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital** commencing at 5.30 p.m.

Yours sincerely

Peter Lachecki
Chair

AGENDA

			Approximate Timing
1.	Apologies		17.30
2.	Declarations of Interest		17.31
3.	Minutes of the meeting held on 21st February 2018	**PAPER**	17.32
4.	Matters Arising	**PAPER**	17.34
	Items for Discussion		
5.	Chair's Update	**PAPER** (Peter Lachecki)	17.40
6.	Report of the Chief Executive	**PAPER** (Deborah Lee)	17.50
7.	Reports from Board Committees		
	Finance Committee – March Board Report & Chair's Report from 28th February 2018	**PAPER & PRESENTATION** (Steve Webster & Keith Norton)	18:00
	Quality and Performance Committee – March Board Report & Chair's Report from 22nd February 2018	**PAPER & PRESENTATION** (Suzie Cro & Claire Feehily)	18:10
	Workforce Committee – March Board Report & Chair's Report from 8th February 2018	**PAPER & PRESENTATION** (Deborah Lee & Tracey Barber)	18.20
8.	The Role of The Audit and Assurance Committee	**PRESENTATION** (Rob Graves)	18.30
9.	Deloitte Recommendations	**PAPER** (Deborah Lee)	18.50
10.	Governors' Log	**PAPER** (Deborah Lee)	18.55
11.	**Any Other Business**		

	Close 19.00
	Date of the next meeting The next meeting of the Council of Governors will be held on **Wednesday 20th June 2018** in the Lecture Hall, Sandford Education Centre, Cheltenham General Hospital commencing at 17.30pm.
	Public Bodies (Admissions to Meetings) Act 1960 "That under the provisions of Section 1 (2) of the Public Bodies (Admissions to Meetings) Act 1960, the public be excluded from the remainder of the meeting on the grounds that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted."
	Voting at Meetings Elected Governors may not vote at a meeting of the Council of Governors unless, before attending the meeting, they have made a declaration in the form specified by the Council of Governors that they are qualified to vote as a member of a particular public constituency or of the patients' constituency or of a particular class of the staff constituency as the case may be and are not prevented from being a member of the Council of Governors by any of the provisions contained in paragraphs 11.17.4 to 11.17.11 of the Constitution. All Governors made such a declaration before the first Council meeting and are asked to renew it each year. An elected Governor shall be deemed to have confirmed the declaration upon attending any subsequent meeting of the Council of Governors.

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE COUNCIL OF GOVERNORS HELD IN THE LECTURE HALL, SANDFORD EDUCATION CENTRE, CHELTENHAM GENERAL HOSPITAL ON WEDNESDAY 21st FEBRUARY 2018 AT 5.15PM

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	Mrs S Attwood	Staff, Nursing and Midwifery
Governors	Mr R Baker	Staff, Other and Non-Clinical
	Mr G Coughlin	Public, Gloucester
	Mrs A Davies	Public, Cotswold
	Mrs P Eagle	Public, Stroud
	Ms C Glasspool	Staff, Allied Health Professionals
	Cllr A Gravells	Appointed, County Council
	Mr C Greaves	Appointed, Clinical Commissioning Group
	Ms M Harris	Public, Out of County
	Mrs J Hincks	Public, Cotswold
	Mrs A Jones	Public, Forest of Dean
	Mrs A Lewis	Public, Tewkesbury
	Dr T Llewellyn	Staff, Medical and Dental
	Mr J Marchant	Public, Stroud
	Ms S Mather	Staff, Nursing and Midwifery
	Mrs M Powell	Appointed, Healthwatch
	Mr A Thomas	Public, Cheltenham (Lead Governor)
	Mrs V Wood	Public, Forest of Dean
Directors	Mr P Lachecki	Chair of the Trust/ Chair
	Ms D Lee	Chief Executive
	Dr C Feehily	Non-Executive Director
	Mr T Foster	Non-Executive Director
	Mr R Graves	Non-Executive Director
	Mr K Norton	Non-Executive Director
	Ms A Moon	Non-Executive Director
IN ATTENDANCE	Mr L Bohdan	Director of Corporate Governance
	Suzie Cro	Deputy Director of Quality
	Dr S Elyan	Medical Director
	Mr M Hutchinson	Digital Recovery Consultant
	Ms N Judge	Board Administrator
	Ms C Landon	Chief Operating Officer
	Mr S Webster	Director of Finance
	Ms E Wood	Director of People and Organisational Development and Deputy Chief Executive
APOLOGIES	Dr L Berragan	Public, Gloucester
	Mr G Cave	Public, Gloucester
	Mr N Johnson	Staff, Other and Non-Clinical
	Mr J Marstrand	Public, Cheltenham
	Ms T Barber	Non-Executive Director
PRESS/PUBLIC	None	

001/18 DECLARATIONS OF INTEREST

There were none.

002/18 MINUTES OF THE MEETING HELD ON 18TH OCTOBER 2017 AND 6TH DECEMBER 2017

RESOLVED: The minutes of the meeting held on 18th October 2017 were agreed as an accurate record subject to an amendment to the attendance list.

RESOLVED: The minutes of the meeting held on 6th December 2017 were agreed as an accurate record.

003/18 MATTERS ARISING

DECEMBER 2017 092/17 MINUTES OF THE MEETING HELD ON 18TH OCTOBER 2017 - THE MINUTES WERE PRESENTED FOR INFORMATION AND WOULD BE SIGNED BY THE CHAIR AT THE NEXT COUNCIL MEETING
Board Administrator to include within the papers.
Completed

DECEMBER 2017 096/17 REPORTS FROM BOARD COMMITTEES - THE LEAD GOVERNOR FELT THE COUNCIL WOULD WELCOME A PRESENTATION REGARDING MEDICAL PRODUCTIVITY
The Board Administrator would note for June 2018.
Completed: This has been noted for the June Meeting.

DECEMBER 2017 096/17 REPORTS FROM BOARD COMMITTEES - AUDIT AND ASSURANCE COMMITTEE - THE LEAD GOVERNOR ACKNOWLEDGED THE WORK UNDERWAY AND FELT A PRESENTATION DETAILING THIS TO THE COUNCIL WOULD BE WELL RECEIVED.
Mr Graves said that he would be happy to do this alongside the external auditors if possible.
Completed: Included as part of the February Agenda.

DECEMBER 2017 098/17 NEW CONFLICTS OF INTEREST POLICY - THE LEAD GOVERNOR QUERIED WHETHER BEING A GOVERNOR AT TWO FOUNDATIONS TRUSTS WOULD CONSTITUTE A CONFLICT OF INTEREST.
The Director of Corporate Governance would investigate and advise outside of the meeting.
Ongoing: NHS England guidelines do not cover this explicitly but it is acknowledged that different Trusts have interpreted the guidance in slightly different ways. Further guidance from NHS England is expected in late spring to further guide Trust's in managing Conflicts of Interest. Similarly, this is not mentioned within Monitor's Foundation Trust Code of Governance nor the Monitor Statutory Duties Reference Guide for Governors. The Lead Governor requested the Director of Corporate Governance review the Constitution and take a view as to what this Trust would do.

DECEMBER 2017 099/17 GOVERNOR'S LOG - IN FUTURE ONLY ENTRIES RECEIVED SINCE THE LAST COUNCIL WOULD BE INCLUDED AS OPPOSED TO THE ENTIRE RECORD.
Board Administrator to note.
Completed: This will be actioned moving forward and has been adopted for the February Meeting.

DECEMBER 2017 100/17 UPDATE FROM GOVERNORS ON MEMBER ENGAGEMENT - THE COUNCIL AGREED THAT THIS AGENDA ITEM WOULD BE BEST SERVED UNDER THE GOVERNORS' STRATEGY AND ENGAGEMENT GROUP.
The Board Administrator would therefore remove this from future agendas and include within the agenda for the Strategy and Engagement Group.
Completed: This has been added to the Strategy and Engagement Group moving forward.

DECEMBER 2017 101/17 ANY OTHER BUSINESS - THE LEAD GOVERNOR NOTED THAT THE PRESENTATION OF BOARD REPORTS AND CHAIRS' REPORTS TO THE COUNCIL MAY NEED TO BE CONSIDERED AS ON SOME OCCASIONS THIS CAN RESULT IN FAIRLY HISTORIC INFORMATION BEING RELAYED.
Chair to consider.
Ongoing: Advance development of CoG agenda will enable identification of papers which could be deemed to be dated and seek to provide additional later versions where possible. This will be addressed from April CoG.

004/18 CHAIR'S UPDATE

The Chair presented the paper detailing his activities since the last Council of Governors meeting in December. This aimed to provide governors with a snapshot of the wider perspective of Chair activities undertaken. He commented on the balance between Trust activities and Gloucestershire Health Economy activities and shared that he was trying to increasingly look across the health economy.

The Chair welcomed any questions or comments from governors. In response:

- The Lead Governor requested the Chair brief the Council on his recent meeting with Tim Poole from Gloucestershire Carers. The Chair advised that he had met with Tim Poole to discuss the option of a member of Gloucestershire Carers becoming the Trust's fourth appointed governor. The Chair confirmed that Tim Poole had nominated a member of the team and further information would be disseminated shortly. The Chair thanked Mrs Hincks for her input in involving Gloucestershire Carers.
- Mr Greaves queried whether the Chair's meeting with Alex Chalk, MP for Cheltenham, was productive. The Chair answered that this had been very productive and helpful and that he and the Chief Executive had updated the MP on the Trust's successes including the recent Trauma and Orthopaedic reconfiguration. The Chair informed the Council that he and the Chief Executive met with Local MPs on a regular basis as key stakeholders.
- Mrs Lewis queried what the Gloucestershire 2050 Launch Event involved. The Chair shared that this was a big initiative by the Council and University. He noted that this was a well-attended event though he acknowledged that it was just the start and that he felt there would need to be wider input as the strategy develops. Conversations are ongoing with Cllr Mark Hawthorne regarding how the Trust could be further involved.

The Chair reminded the Council that should any governor wish to know further details of any of the listed activities then they were welcome to contact him directly.

005/18 REPORT OF THE CHIEF EXECUTIVE

The Chief Executive presented the report providing an update to the Council regarding:

- The challenging operational week of half term (where ultimately, performance suffered, however quality did not).
- A&E performance measures compared to this time last year, with note to the improvements in ambulance conveyance.
- The Trust's re-categorisation from Category 4 to Category 2 in relation to A&E performance.
- Positive perception of Gloucestershire Hospitals following conversations with James Kent, Specialist Advisor to the Prime Minister, who advised that Gloucestershire was being increasingly described as an "up and coming" health system.
- Improvements in relation to mortality thanks to the improvement journey for fractured neck of femur.
- Sepsis improvements.
- A recent Trust visit from Lord Carter to review the success of the Trauma and Orthopaedic reconfiguration.
- Success and improvements in Stroke Care.

In response to the Chief Executive, the following points were raised by governors:

- Cllr Gravells was pleased to hear about the ambulance handover improvements and reflected on the benefits this had for patients and ambulance targets. The Chief Executive requested Dr Llewellyn share the praise with the Team. The Chair would also seek to praise and recognise the team's efforts. **TL/PL**
- The Lead Governor noted the proposal put forward by the Sustainability and Transformation Partnership (STP) to become an Integrated Care System. He noted the rebranding of the Accountable Care System and reflected on how confusing this must be for the general public. He also noted the lack of timescale and wondered if the Chief Executive knew any further details regarding this. The Chief Executive answered that she did not, and the only timeline published was that around the submission of expression of interest; she further reflected that there was also an absence of detail around what resources, opportunities and bureaucracies that it may bring. She noted that one aspect of single Accountable Care Systems was a single Financial Control Total. The Chief Executive noted the risk this imported for Trust partners.

006/18 REPORTS FROM BOARD COMMITTEES

Finance Committee – January Board Report & Chair's Report from 20th December 2017

The Director of Finance reported the key highlights of the January Board report to the Council, in particular that the Trust had identified £5.1m of the additional £6m Cost Improvement Plans (CIPs) required, the revision to the Trust's 2017/2018 forecast and the £5m Capital Loan the Trust had been awarded.

Mr Norton reported the key highlights of the December Finance Committee Chair's Report and noted in particular the changes to the year end forecast. He advised that one of the challenges of the

Committee was whether the financial position could be explained by Executive Directors other than the Director of Finance. Mr Norton further advised that the Committee received positive assurances in this respect. He also reflected on the conversations about CIP, the rigour around this and what could be learnt from the best CIP projects.

In response, the following points were raised by governors:

- Cllr Gravells shared that he found the verbal update provided difficult to follow and wondered if this could be made more straight forward. The Lead Governor echoed this, and reflected on the timing of reports and verbal contemporary updates. The Chair would further consider this. **PL**
- The Lead Governor reminded the Council that he attended the Trust Finance Committee as an observer and noted the portion of the Trust's deficit attributable to Trakcare. He assured the Council of the good debate amongst NEDs within the Committee and noted the excellent CIP report received by the Committee. The Lead Governor felt the progress made should be applauded. He felt a presentation around CIP would be of benefit to governors. **SS**
- Mr Greaves noted the point around income from specialist commissioners and wondered whether this was significant sum of money which changed the Trust's situation and wondered how the next financial year was looking. The Finance Director shared that the income from specialist commissioners was a multimillion figure known between the Trust and NHS Improvement (NHSI) and would be resolved. He shared that discussions were underway with the commissioners for 2018/19.

Quality & Performance Committee – January Board Report & Chair's Report from 8th December 2017

The Chief Operating Officer presented the highlights of the January Board Report noting that the paper was jointly authored by herself, the Medical Director, the Director of People and the Director of Quality and Chief Nurse. She updated the Council on recent performance figures noting increases in attendances, data quality issues around RTT, improvements against the two week wait standard, the blip in 62 day performance and the achievement of the diagnostic standard for January. The Deputy Director of Quality advised that NHS England would be visiting the Trust the week beginning the 26th February as the Trust had received £50k to improve the Friends and Family Test in Maternity.

Dr Feehily reported the key highlights of the December Quality and Performance Committee Chair's Report and commended the executives on the improvements in performance. She also reflected on the conversations around how patients experience delays and how the Trust communicated with them.

In response, Mrs Lewis observed the engagement of GLANSO and wondered how they were contributing to supporting cancer recovery. The Medical Director advised that GLANSO treated patients who had been waiting the longest; this supports delivery of quicker and more responsive care. The Chief Executive reflected on the different model of working imported by GLANSO and the difficulties of applying this to Trust staff but she felt there were opportunities yet to be captured.

The Medical Director acknowledged the rise in Emergency Department attendances and recognised the astonishing effort of staff.

Workforce Committee – January Board Report & Chair's Report from 8th December 2017

The Director of People presented the Workforce January Board Report to the Council, noting the improvements in appraisal rates, increases in turnover and deep dives into areas of concern and the resetting of Committee priorities. Six areas were discussed and debated as part of this and the recommendations made were accepted and therefore action plans will be implemented moving forward.

Mr Norton reported the key highlights of the December Workforce Committee Chair's Report and also reflected on the conversation around priorities, with a future focus on reviewing establishment need vs budget and improving recruitment and retention.

Mr Coughlin shared that he had seen an article recently around how appraisals were an outdated approach and that a focus on quality throughout the year was a better approach. The Director of People shared that appraisals were a mandatory requirement but reinforced the importance of quality conversations and shared that she would be focusing on redeveloping appraisals in with the talent management system.

Mrs Lewis noted the high turnover amongst health care assistants (HCAs) and felt encouraging the nurse care assistant role would help improve this. She wondered whether this was being implemented. The Director of People confirmed that itwas and added that the Trust had many HCA apprentices but that she would like to introduce nurse degree apprentices, which at the moment was not possible due to NMC require the route to be supernumerary (meaning the HCA is not allowed to work throughout the three years and would have to be a student).

007/18 NON-EXECUTIVE DIRECTORS' RECRUITMENT

The Director of Corporate Governance presented the paper on non-executive director recruitment, noting this had been received at the Governance and Nominations Committee.

He requested the Council approve the approach and the job description/person specification. He advised the Council that the Board undertook a stock take of skills and felt two particular skills sets were needed: digital skills and skills in estates and physical asset management and development. That view was shared by the Governance and Nominations Committee.

RESOLVED: That the Council agree the proposed approach.

008/18 FREEDOM TO SPEAK UP

The Deputy Director of Quality gave a presentation on the Freedom to Speak Up agenda and her work as a Freedom to Speak Up Guardian to support the paper received by the Council. She explained the background of the scheme, how this was being communicated to staff and what her role involves.

The following points were raised by governors:

- Mr Greaves felt there was a natural tension between the Deputy Director of Quality being employed by the Trust and this independent role, however acknowledged that as this is nationally mandated it must be recognised. He wondered whether any thought had been given to utilising an independent source. Dr Feehily advised that she was the nominated NED with responsibility for Freedom to Speak Up, and advised that a group met periodically to discuss the issues being identified.
- Mr Marchant queried how much resource was available to delve down into issues. The Deputy Director of Quality advised that her role was to support and advise, not to investigate, and she ensures that the appropriate individual takes investigation forward.
- Cllr Gravells wondered how the existence of the service could be amplified and the message communicated to staff. He shared that governors would be happy to help with this.

RESOLVED: That the Council endorse the approach being taken to improve the Speaking Up Culture being developed with the Trust.

009/18 THE ROLE OF THE AUDIT AND ASSURANCE COMMITTEE

The Council agreed this item would be postponed and presented at the April meeting. **NJ/ RG**

010/18 GOVERNORS LOG

The Chief Executive presented the Governors Log and noted that no new questions had been received since publication. The Council noted the log.

011/18 QUALITY ACCOUNT AND GOVERNORS' INDICATOR

The Deputy Director of Quality presented a paper to the Council regarding the Quality Account and the indicators to be chosen by governors as part of this. The Lead Governor shared that this had previously been discussed within the Governors' Quality Group and following this governors had reviewed the information and further discussed this with their pre-meeting. He shared the two indicators chose within the pre-meeting:

1. Responsiveness to inpatients personal needs
2. Patient discharge summaries sent to GP within 24 hours

Thoughts were welcomed from those who were unable to attend the Governors' Quality Group. The Chief Executive reflected that the second indicator should not be difficult to measure but wondered if this would be value adding. She cautioned that she was unsure whether any metrics existed around the first measure. She recommended the team investigate how this measure is nationally defined and aim to understand this more fully. The Council debated which indicators would be the most helpful; the Chief Executive noted that perhaps an indicator which highlights where the local approach does not follow the national approach might be helpful.

The Council agreed that this would be further discussed at the next Governors' Strategy and Engagement Group. Mr Graves raised concerns that the process had been somewhat untidy and needed to **SC/ NJ**

be clearer. The Chair shared that an annual work plan would be created for governors moving forward. **LB/ NJ**

012/18 ANY OTHER BUSINESS

No other business was noted.

013/18 DATE OF NEXT MEETING

The next meeting of the Council of Governors will be held on **Wednesday 18th April 2018** in the **Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital** commencing at **17:30pm**.

Papers for the next meeting: Papers for the next meeting are to be logged with the Board Administrator no later than **17:00pm** on **Monday 9th April 2018**

014/18 PUBLIC BODIES (ADMISSION TO MEETINGS ACT) 1960

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

The meeting ended at 18.50 pm.

Chair
18th April 2018

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MATTERS ARISING – COUNCIL OF GOVERNORS

APRIL 2018

CURRENT TARGETS

Target Date	Month/Minute/Item	Action with	Issue	Action	Update
February 2018	December 2017 098/17 New Conflicts of Interest Policy	**LB**	The Lead Governor queried whether being a governor at two foundations Trusts would constitute a conflict of interest.	The Director of Corporate Governance would investigate and advise outside of the meeting. The Lead Governor requested the Director of Corporate Governance review the Constitution and take a view as to what this Trust would do.	*Ongoing* *This will be addressed as part of the Constitution Review Group.*
February 2018	December 2017 101/17 Any Other Business	**PL/LB**	The Lead Governor noted that the presentation of Board reports and Chair's reports to the Council may need to be considered as on some occasions this can result in fairly historic information being relayed.	Chair to consider.	*Completed* *Addressed as part of the agenda.*
April 2018	February 2018 005/18 Report of the Chief Executive	**TL/ PL**	Ambulance Handover Improvements	The Chief Executive requested Dr Llewellyn share the praise with the Team. The Chair would also seek to praise and recognise the team's efforts.	*Completed* *By Specialty Director.*

April 2018	February 2018 006/18 Reports from Board Committees	**PL**	Cllr Gravells shared that he found the verbal update provided difficult to follow and wondered if this could be made more straight forward. The Lead Governor echoed this, and reflected on the timing of reports and verbal contemporary updates.	The Chair would further consider this.	*Completed* *Reports will remain the same however executives will provide a presentation with contemporary updates.*
April 2018	February 2018 006/18 Reports from Board Committees	**SS**	Cost Improvement Plan (CIP) Presentation	Interim Director of Finance to provide a presentation around CIP.	*Completed* *Added to work plan.*
April 2018	February 2018 009/18 The Role of The Audit and Assurance Committee	**NJ/ RG**		Presentation postponed until the next meeting.	*Completed* *Added to agenda.*
April 2018	February 2018 011/18 Quality Account and Governors Indicator	**SC/ NJ**		To be discussed at the next Strategy and Engagement Group.	*Completed* *Discussed at an extraordinary Council of Governors.*
April 2018	February 2018 011/18 Quality Account and Governors Indicator	**LB/ NJ**	Governors Annual Work Plan	To be created	*Completed* *Created and will be included within the confidential papers moving forward.*

FUTURE TARGETS

None.

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS – APRIL 2018

CHAIR'S ACTIVITIES UPDATE

In order to present Governors with a snapshot of the wider perspective of Chair activities undertaken, it was agreed at Council of Governors (CoG) in September 2017, that a written summary would be prepared and presented for comment at every CoG meeting. This excludes regular meeting attendances at Board, CoG, Committees and 1:1s with Directors.

The latest of these appears below and covers the period since the CoG meeting on February 21st 2018.

Trust Activities

DATE	EVENT
1-3-18	SubCo Staff Briefing * 2 (Gloucestershire Royal Hospital)
7-3-18	Governor 1-1
9-3-18	SubCo Chair Meeting
13-3-18	Meeting re. school volunteers
14-3-18	Serving teas on Ward 6A (part of National Hydration week)
26-3-18	Communications Meeting – Ian Mean (Media Expert)
29-3-18	Rob Graves (Non-Executive Director) annual appraisal and development meeting
4-3-18	Visit to Gloucestershire Royal Hospital with Mark Pietroni (Speciality Director – Unscheduled Care)
5-4-18	Chair of Urology Consultant recruitment panel
6-4-18	Mini-Military Leadership Challenge – Colerne Barracks
9-4-18	Visit to Materials Management Cheltenham General Hospital

Gloucestershire Health Economy

DATE	EVENT
26-2-18	Meeting with Chris Creswick (Sustainability and Transformation Partnership Chair)
27-2-18	Gloucestershire Strategic Forum (Sustainability and Transformation Partnership)
27-2-18	Sustainability and Transformation Partnership Advisory Group
1-3-18	Gloucestershire Care Services Chair appraisal feedback call
6-3-18	Health and Care Overview and Scrutiny Committee
20-3-18	Health and Well Being Board
3-4-18	Meeting with David Drew MP

National Stakeholders + others

DATE	EVENT
26-2-18	NHS Improvement Oversight call
8-3-18	NHS Improvement Financial Governance Interview
16-3-18	Worcestershire Health and Care Trust Non-Executive Director panel - external assessor
22-3-18	NHS Providers Chairs' and Chief Execs' Network meeting - London
27-3-18	NHS Improvement Oversight call

Peter Lachecki
Trust Chair

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS MEETING – APRIL 2018

REPORT OF THE CHIEF EXECUTIVE

1. Current Context

1.1 Thankfully, there are finally signs that winter is beginning to recede with the first significant drop in new cases of influenza since the season began; it has been both an unusually protracted flu season as well as there being high volumes at its peak. Operational performance has remained volatile though positively as a Trust our performance compares to outperform the South of England though we have not achieved our goal of 90% for the last two months and this therefore remains a huge focus. Of particular note however, remains our current performance contrasted to last year which shows us just how far we have come.

Nov 2017	Dec 2017	January 2018	Feb 2018	March 2018
95.3%	90.7%	89.7%	88.5%	86.94%
Nov 2016	**Dec 2016**	**January 2017**	**Feb 2017**	**March 2017**
86.62%	73.86%	74.69%	77%	77.86%
% Point Improvement				
+ 8.68%	+16.84%	+15.01%	+11.5%	+9.08%

Figure 1: Performance against the four-hour standard - *95% of patients attending an A&E department must be seen, treated, and admitted or discharged in under four hours.*

2. National and Regional

2.1 Nationally, there has been much (welcome) debate on the long term funding model for the NHS and this has culminated in a commitment from the Government to set out its approach in a ten year plan. In the shorter term however, there was very positive news for staff following the Government's announcement that it would be moving away from the previous approach to public sector pay restraint for NHS staff. This has resulted in a commitment to a pay rise of 6.5% for NHS staff over the next three years which, if supported by staff, would see increases from April 2018. Within this headline are some very significant increases for individual staff groups with some of the lowest paid staff in the NHS benefitting the most. More than half of staff will receive between 9% and 29%, including a 15% pay increase for some of the lowest paid staff working in areas like estates and facilities – of note, given our local circumstances, this will also apply to staff who have transferred to our new subsidiary company and this group will also get an immediate £2,000 rise this year; a nurse with one year's experience will see their basic pay rise by 21%. It's not all 'give', the Government is expecting to see staff and unions work with them to address the high sickness rates that affect the NHS. Evidence points to both low morale and high vacancy rates contributing to sickness absence and so I am hoping that this pay award will go some way to addressing both of these issues, in time.

2.2 Trust staff have recently been recognised in a number of national awards with nominations for the Health Service Journal Efficiency Awards and the Patient Safety Awards. These awards attract huge numbers of entrants nationally and shortlisting itself is a huge achievement. Our entry from the Gloucestershire Quality & Safety Academy, was shortlisted in the Communications Category for their bid entitled A *Communication Strategy to Create an Improvement Movement in an Acute Hospital Trust* and the Trauma and Orthopaedic Service was shortlisted in the Acute Service Redesign Category for their entry setting out the recent approach and early outcomes following the reconfiguration of elective and urgent care services. Both teams will now go to London to present their work, hoping to be one of the finalists (and maybe even

winners) announced in July of this year.

2.3 Building on this success, Gloucestershire Hospitals were also runners up in not just one but two categories in this year's National Patient Experience Network (PEN) Awards. The PEN Awards are the first and only awards programme to recognise best practice in the experience of care across all facets of health and social care in the UK. However, not only were we runners up but our entry of the 'Small Steps, Big Changes' project won the *Using Insight for Improvement* category and amazingly also won best entry overall, beating 16 other Trusts nationally. The project, which was led by staff on Ward 7a and fantastically supported by Jean Tucker from our Patient Experience Team, is now being rolled out to other areas in the Trust and is a credit to all those involved; not least, as it stemmed from a period of adversity when the ward was recovering from a particularly challenging time and the team chose to move forward by embracing this improvement project.

2.4 Week commencing the 5th March 2018 was National Apprenticeship Week and the Trust took the opportunity to celebrate its own apprentices and what they are achieving – this month the Trust employed its 100th apprentice and as such is leading the way in this regard. This group of staff play an increasingly important role in the Trust and changes to the requirements of apprenticeships means that in the future, the Trust is likely to be retaining many more. Emma Wood, Director of People & Organisation Development will be leading the development of an Apprenticeship Strategy to ensure that we make the most of this workforce and that we have valuable opportunities for them when their training comes to an end.

3. Our System and Community

3.1 Work continues to develop the *One System Business Case* (OSBC) though progress is not as had been hoped due to the complexity of the modelling required. There remains the risk that the revised consultation timeline may not be met and therefore internal work has commenced to consider the Trust priorities that need to be addressed in advance of next winter. The Trust recently presented a review of winter to the Health and Care Overview & Scrutiny Committee (HCOSC) including the interim evaluation of the Trauma and Orthopaedic (T&O) pilot. Members were very positive about the achievements of the system this year when compared to last and have agreed to a continuation of the T&O pilot for a further 12 months to allow for any permanent change to be considered as part of the wider OSBC. Key achievements are set out below

NHS
Gloucestershire Hospitals
NHS Foundation Trust

EARLY OUTCOMES: IMPACT ON PATIENT CARE

Metric	Winter 16/17	Winter 17/18	Improvement
Patient Experience	80%	90%	+12.5%
Trust wide 4 hour performance	78.39%	91.9%	+17%
Admitted pathway performance	50.9%	81.9%	+61%
15 minute triage	57.9%	91.9%	+59%
Ambulance handover delays >30 mins	642	172	- 470
Ambulance handover delays >60 mins	13	0	-13
Compliance with ED Safety checklist (GRH)	24%	72%	+300%
Sepsis six pathway	52%	96%	+90%
Sepsis 1 hour to antibiotics	49%	91%	+86%
Mixed Sex Breaches (Jan 18 over Jan17)	19	5	-14
Elective Orthopaedic activity	466	558	+20%
Delayed Transfers of Care	12.4	6.8	-45%

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3.2 However, to ensure that progress continues, and the OSBC is informed by local circumstances, we shall be commencing a number of 'Test and Learn' projects aimed at evaluating a the key components of the proposed future models of care such as Urgent Treatment Centres (UTC), Clinical Assessment & Advice Services (CAAS) and the Trust's Acute Care Centre of Excellence (ACCE). These will commence in the next few months and provide invaluable insights into the impact of these models on activity levels and future care pathways.

3.3 Following an unsuccessful first wave bid, the Sustainability and Transformation Partnership (STP) has been invited to resubmit its proposal to becoming an Integrated Care System (formerly Accountable Care System). If successful the system would join wave two systems (known as fast followers) and in doing so gain access to support, development opportunities and potentially additional resources to expedite our work on developing integrated commissioning and service provision. Feedback and outcomes from the Gloucestershire bid are still awaited.

4. Our Trust

4.1 On the 1st April 2018, the Trust established its subsidiary company (SubCo), Gloucestershire Medical Services (GMS) under the leadership of its new Chair, Kathy Headdon. Kathy is currently acting in an interim capacity to support GMS in its first six months, during which a substantive Chair will be recruited. Kathy brings a wealth of highly relevant experience having worked as a non-executive director and chair in the NHS as well as professional experience and expertise in estates and facilities – both public sector (including NHS) and commercial. As expected, the first two weeks of GMS have reflected the 'business as usual' approach heralded by the team in the preparation phase. The new GMS Board has met for the first time and is now scoping its initial priorities and focus for the coming year. Communication and support for those that have transferred and those embarking upon the *colleague to customer* journey, is in hand.

4.2 After a protracted process, it has been confirmed that the Trust's bid for Sustainability and Transformation (STP) capital funding of £39.5m was successful. This is a huge achievement by the Trust, not least given the number of bids and limited funds available – the Trust secured the fourth highest award of all those who were allocated funds. Huge credit goes to the Trust team who have worked on this proposal and its numerous iterations. Next steps are to develop the Outline Business Case (OBC), followed by the Full Business Case (FBC), both of which will require Board and external approval by NHS England and others. The timeline for completion of these next stages is not yet finalised but we are aiming to complete both steps by the end of this calendar year with works commencing in Spring 2019; not unusually this requires some parallel work to develop the business cases whilst procuring a construction partner. The proposal will be the first major 'test' of the Trust and its subsidiary company, Gloucestershire Managed Services (GMS), working together on a project of this scale and represents an exciting opportunity for both.

4.3 Whilst the benefits of the capital case and the return on capital invested are not negotiable, the OBC provides an opportunity for the Trust to revisit the scheme and ensure the current design meets our developing vision for services across the county. Once complete, the scheme will provide improved facilities and optimise models of care, in line with our vision for Centres of Excellence, at both our Cheltenham General and Gloucestershire Royal hospitals.

4.4 Local recognition for two more staff members was achieved last month when local radio station, The Breeze, celebrated 'local heroes' and recognised two of our staff. Firstly consultant Dr Tanya De Weymarn won the *999 Award*, for her inspiring work in our Emergency Department which aims to ensure that older people (who make up around one in three of presentations to ED) are cared for respectfully and in line with

the very best practice; Tanya's 'red sheet' initiative, which is aimed at flagging those at risk of falling whilst in ED, was commended as part of the award. Tracey Cullerne, Oncology Matron, was also recognised and awarded runner up in the *Carer of the Year* category for her work to raise funds and develop the scalp cooling treatment for patients undergoing chemotherapy. Congratulations to both.

4.5 A plaque was unveiled at Cheltenham Race Course Ladies Day to celebrate another staff member, Dr Gillian Rouse, Director of the LINC charity (Leukaemia and Intensive Chemotherapy) and the work she has done supporting cancer patients across Gloucestershire. The charity celebrates its 20th anniversary this year and will be marking this important milestone by commencing refurbishment work on Rendcomb ward which will see our side rooms spruced up and much needed new bathrooms installed.

4.6 The Trust's own recently launched approach to more regular staff recognition has just announced the second round of GEM (Going the extra Mile) award winners. Next month will see the awards for the team category being announced, reinforcing the importance of team work in our *Journey To Outstanding*. Preparation for our annual Staff Awards ceremony is also underway with nominations opening soon and judging taking place in September, culminating in the grand event on the 29th November; as last year governor representatives will be invited to join the evening. On a more informal basis, the Trust will also be repeating last year's **Big Staff Thank You** event at Over Barn; this year we will be targeting front line staff in recognition of the challenging winter many of them have been exposed to. Although we are only able to host 180 staff, last year's feedback tells us that the gesture will be appreciated by many more.

4.7 Finally, on April 13th we will be hosting our first formal *Journey To Outstanding* (# J2O) event with staff from across the Trust coming together to articulate what this means for them and their service. Our *Journey To Outstanding* is really starting to gather momentum and I was especially heartened to interview two doctors in training for their first consultant appointments, both who referenced J2O and their enthusiasm for supporting their service on this exciting journey. Staff in training are often the most difficult to reach with communications and so this awareness and enthusiasm is very heartening. A verbal update on the event will be provided to the Council when it meets.

Deborah Lee
Chief Executive Officer
April 2018

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – MARCH 2018
Lecture Hall, Sandford Education Centre commencing at 09:00am

Report Title
Financial Performance Report - Period to 31st January 2018
Sponsor and Author(s)
Author: Tom Niedrum, Associate Director of Financial Management Sponsor: Steve Webster, Director of Finance
Executive Summary

Purpose

This report provides an overview of the financial performance of the Trust as at the end of Month 10 of the 2017/18 financial year. It provides the three primary financial statements along with analysis of the variances and movements against the planned position.

Key issues to note

- The financial position of the Trust at the end of Month 10 of the 2017/18 financial year is an operational deficit of £29.5m. This is an adverse variance to budget and NHSI Plan of £6.5m.

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

- CIP delivery to Month 10 is £20.4m. This is £5.4m worse than the plan for the year to date.

- The current CIP delivery forecast for the year is £28.2m as compared to a £34.7m plan.

- The forecast outturn is £28.7m which is £14.1m adverse to plan. This is a £0.9m deterioration from the previous forecast outturn, which relates to the crystallisation of an existing income risk relating to specialist commissioning.

Conclusions

- The financial position for Month 10 shows an adverse variance to budget of £6.5m. The adverse variance is reflective of material income under-performance with commissioners partially offset by pay underspends which are non-recurring.

- The underlying financial position remains adverse to plan

Implications and Future Action Required

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

Recommendations
The Board is asked to receive this report for assurance in respect of the Trust's Financial Position.

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

Resource Implications			
Finance	✓	Information Management & Technology	
Human Resources		Buildings	

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

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

Gloucestershire Hospitals NHS
NHS Foundation Trust

Financial Performance Report
Month Ended 31st January 2018

Gloucestershire Hospitals NHS
NHS Foundation Trust

Introduction and Overview

The Board approved budget for the 2017/18 financial year is for a deficit of £14.6m.

During April, as part of the detailed budget reconciliation and review process and in support of agreeing a reflective control total the profiling of Income, Expenditure and CIP was considered and it was concluded that the monthly outturn profiles should be changed, the outturn deficit of £14.6m was not changed. NHSI have allowed a resubmission of the plan to reflect this change but would not allow change to Q1. As such the plan and budget are consistent in profile from Month 4 and this report reflects performance against the aligned budget and plan.

Statement of Comprehensive Income

2016/17 Outturn £000s	Month 10 Financial Position	Annual Budget £000s	M10 Cumulative Budget £000s	M10 Cumulative Actuals £000s	M10 Cumulative Variance £000s
433,665	SLA & Commissioning Income	439,649	363,904	356,402	(7,502)
4,604	PP, Overseas and RTA Income	4,734	3,904	3,924	20
66,388	Operating Income	62,270	51,921	52,930	1,009
504,657	**Total Income**	**506,653**	**419,729**	**413,256**	**(6,473)**
329,809	Pay	335,777	282,505	277,864	4,641
174,906	Non-Pay	160,607	139,374	146,457	(7,083)
504,716	**Total Expenditure**	**496,384**	**421,879**	**424,321**	**(2,442)**
(59)	**EBITDA**	**10,269**	**(2,150)**	**(11,064)**	**(8,914)**
(0.0%)	**EBITDA %age**	**2.0%**	**(0.5%)**	**(2.7%)**	**(2.1%)**
21,135	Non-Operating Costs	24,885	20,779	18,386	2,393
(21,193)	**Surplus/(Deficit)**	**(14,616)**	**(22,929)**	**(29,450)**	**(6,521)**
3,225	STF Funding				
(17,968)	**Surplus/(Deficit)**	**(14,616)**	**(22,929)**	**(29,450)**	**(6,521)**

In January the Trust has delivered an in-month deficit of £1.3m and a cumulative deficit of £29.5m

This represents a year to date adverse variance to plan of £6.5m as at Month 10.

The Trust has now reached agreement with both major commissioners for a block contract arrangement. This means that income for the six months outstrips budget for those commissioners and gives a favourable variance. Within income there is a year to date favourable variance on pass-through drugs and devices of £1.5m. This is addressed in further detail on pages 2 to 4 of this report.

Gloucestershire Hospitals NHS
NHS Foundation Trust

Detailed Income & Expenditure

Annual Budget £000s	Month 10 Financial Position	M10 Cumulative Budget £000s	M10 Cumulative Actuals £000s	M10 Cumulative Variance £000s
439,649	SLA & Commissioning Income	363,904	356,402	(7,502)
4,734	PP, Overseas and RTA Income	3,904	3,924	20
62,280	Operating Income	51,921	52,930	1,009
506,663	**Total Income**	**419,729**	**413,256**	**(6,473)**
	Pay			
312,180	Substantive	262,127	255,843	6,284
6,551	Bank	5,776	8,063	(2,287)
17,049	Agency	14,602	13,958	644
335,780	**Total Pay**	**282,505**	**277,864**	**4,641**
	Non Pay			
55,539	Drugs	46,808	51,376	(4,568)
40,159	Clinical Supplies	34,016	34,633	(616)
64,916	Other Non-Pay	58,549	60,448	(1,899)
160,614	**Total Non Pay**	**139,374**	**146,457**	**(7,083)**
496,394	**Total Expenditure**	**421,879**	**424,321**	**(2,442)**
10,269	**EBITDA**	**(2,150)**	**(11,064)**	**(8,914)**
2.0%	**EBITDA %age**	**(0.5%)**	**(2.7%)**	**(2.1%)**
24,885	Non-Operating Costs	20,779	18,386	2,393
(14,616)	Surplus/(Deficit)	(22,929)	(29,450)	(6,521)
	STF Funding			
(14,616)	Surplus/(Deficit)	(22,929)	(29,450)	(6,521)

The table opposite shows the detailed income and expenditure position.

SLA and Commissioning Income – a £7.5m adverse position. This adverse variance is driven by a combination of budget phasing, the impact of block agreements, material under-performance with commissioners other than GCCG and Specialised Commissioners and risk assessment and is addressed in detail on the preceding pages. Within this there is £1.5m over performance on pass-through income, resulting in an underlying under-performance on non-passthrough income of £6.0m. Pass-through drugs is £2.5m favourable, whereas devices are £1.0m adverse. Most of the underperformance on devices relates to ICDs moving to the zero-cost model.

Private Patient Income – continues to be on track.

Pay – expenditure is showing a favourable variance of £4.6m against budgeted levels. This is largely driven by vacancy factor, combined with under-spends in divisions against budget profile and is further analysed in the pay section of this report. The under-spend remains close to the peak level of £4.9m in month 7.

Non-Pay – Drugs expenditure is showing a £4.6m adverse variance (£2.1m excluding passthrough) whilst Clinical Supplies are £0.6m adverse (£1.6m excluding passthrough). Use of Glanso represents £0.7m of this variance. Other non-pay is £1.2m adverse of which £0.4m is a prior month increase to the bad debt provision.

Non Operating Costs – underspend is due to delivery of CIPs on depreciation, Interest Payable and PDC Dividend. This is reflected as part of CIP although is a non-cash saving for depreciation.

Cost Improvement Programme

At Month 10 we have delivered £20.4m* against the NHS Improvement plan target of £22.3m and the Trusts own target of £25.8m which is an under achievement of £5.4m against the trust plan.

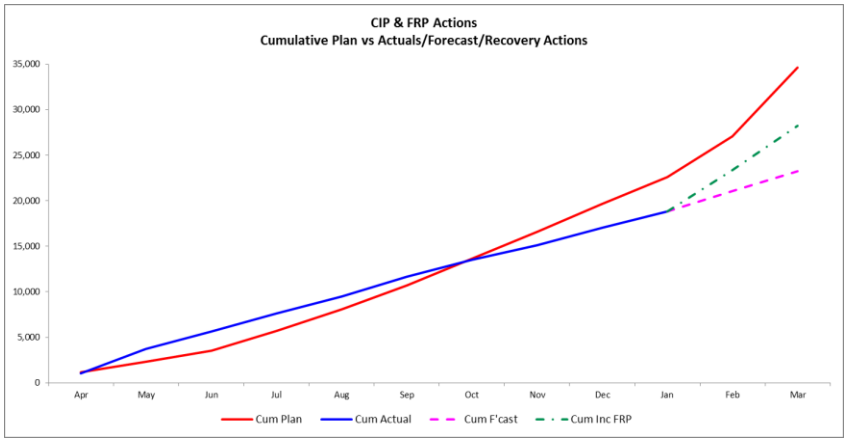
At Month 10, the divisional year end forecast figures indicate confidence in delivering £28.2m* against the Trust's target of £34.7m. The month 9 FOT was £28.1m, reflecting an increase of £0.1m.

Performance on the FRP has deteriorated by £0.1m in month along with other forecast cost pressures, the key areas are:

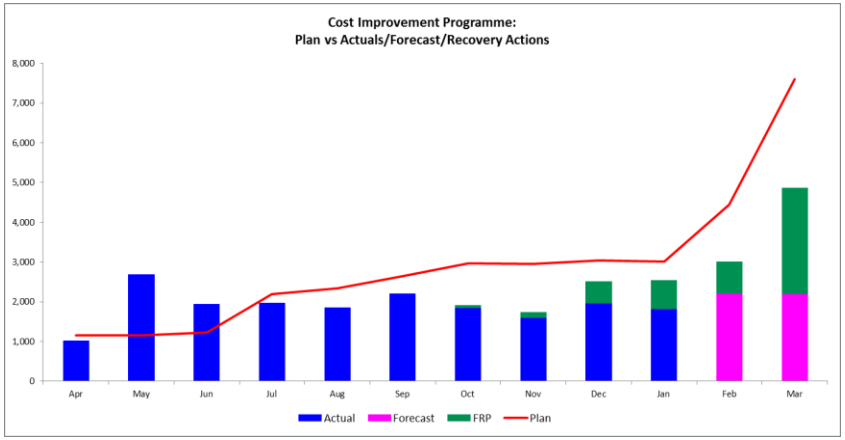
- Drugs expenditure has increased by £0.5m net of pass through income in month.
- MSE cost pressures net of pass through income have fallen by £0.1m in month.
- Glanso costs have increased by £0.1m in month.

The CIP FOT of £28.2m splits into £21.3m of recurrent schemes and £6.9m of non-recurrent schemes. This leaves a shortfall for 18/19 of £13.4m. The non-recurrent schemes include an agency scheme (no non-clinical agency over Christmas), annual leave accrual scheme and some vacancy factor.

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



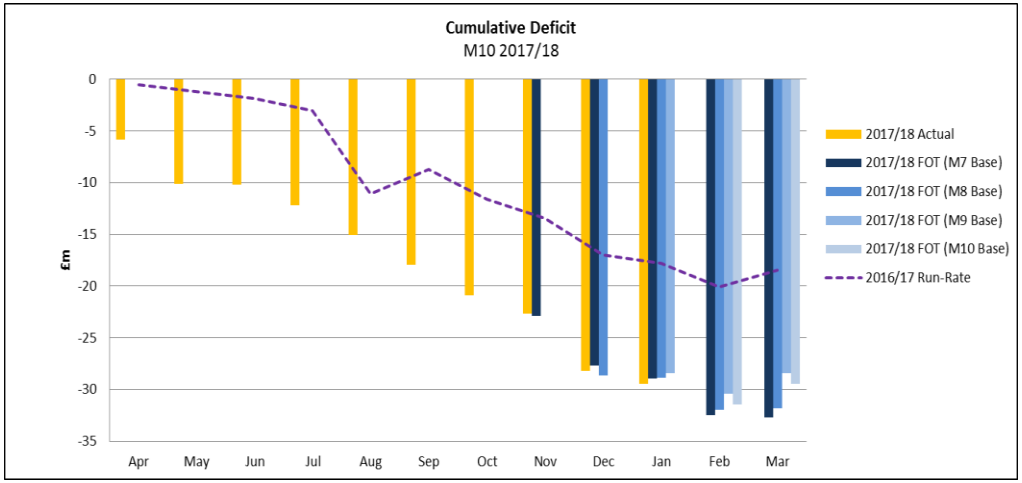
The graph below highlight the in-month actuals and forecast versus the in-month NHSI cost improvement plan



* This includes £6m recovery actions

Forecast Position

2017/18 Forecast	2017/18 Budget £000s	2017/18 Forecast £000s	Variance £000s
SLA & Commissioning Income	439,649	433,179	(6,470)
PP, Overseas and RTA Income	4,734	4,762	28
Operating Income	62,306	64,063	1,757
Total Income	**506,689**	**502,004**	**(4,685)**
Pay	335,777	334,227	(1,549)
Non Pay	160,622	176,090	15,467
Total Expenditure	**496,399**	**510,317**	**13,918**
EBITDA	**10,290**	**(8,313)**	**(18,603)**
EBITDA %	**2.0%**	**(1.7%)**	**(3.7%)**
Non Operating Costs	24,921	20,340	4,581
Surplus/(Deficit)	**(14,631)**	**(28,653)**	**(14,022)**



The Trust's forecast outturn for 2017/18 after month 10 is a deficit of £28.7m against the budget of £14.6m. This is £14.0m adverse, and a deterioration of £0.9m on last month.

The main drivers of the deterioration are:

- £0.9m specialist commissioning risk crystallising
- £0.6m pay increase (half relating to AMU/USC)
- £0.5m non-passthrough drugs increase
- £0.3m recognition of internal funds
- £0.1m continued increase in use of Glanso

These are partly offset by:

- £0.2m additional winter pressures funding
- £0.2m underlying income improvement
- £0.2m improvement to RTA bad debt provision
- £0.1m lower MSE costs across the trust
- Further CIPS/cost pressure reductions of £0.8m

The chart shows the cumulative deficit as it builds up each month and compares actuals (amber) and forecast (blue) against prior year actuals (purple dotted line).

Forecasts are updated each month. These show how the forecast profile is refined month on month. The oldest forecast (M7) is shown in dark blue with lighter colours reflecting the more recent forecasts.

The Trust is now forecasting a surplus in M12 of just under £2.5m. This is driven by back-ended CQUIN from GCCG (£1.4m) and a proportion of the anticipated receipt of winter pressures funding (£1.7m) as well as typically being a high activity month.

Forecast Position – Sensitivity Analysis

Gloucestershire Hospitals NHS
NHS Foundation Trust

Our current assessment of risks and mitigations indicate our forecast deficit is likely to be between £28.7 and £33.2m. The realistic stretch includes an offer that the Trust has made in respect of Specialist Commissioning which worsens the forecast by £0.9m but if accepted by NSHE will remove £1.1m of further risk from the worst case, bringing it to £32.1m.

	Upside	Realistic Stretch	Downside	Comments
Plan	**(14.6)**	**(14.6)**	**(14.6)**	
Month 6 divisional forecast	**(27.9)**	**(27.9)**	**(27.9)**	
Additional CIP & further measures assumed	6.0	6.0	4.1	
Deployment of CCG NR funding to GHFT	8.0			
Income recovery/blocking lower then forecast	(0.7)	(2.0)	(2.0)	
Winter pressures			0.0	
Month 6 forecast to Board	**(14.6)**	**(23.9)**	**(25.8)**	
Income risk recognised	(2.8)	(2.0)	(2.0)	
CQUIN - system risk reserve			(2.0)	Further NHSI guidance saying system risk reserve CQUINs should NOT be assumed by trusts not achieving their 16/17 control total. Need to consider including this loss in the realistic stretch forecast
Updated Month 6 forecast to NHSI in November meeting	**(17.4)**	**(25.8)**	**(29.7)**	
Movements - as per divisional forecasts for Month 7:				
£1.9m identified against £6m target	(4.1)	(4.1)	(2.2)	Total CIP and other cost reductions identified £1.9m
Cost pressures	(2.9)	(2.9)	(2.9)	
Total movement	**(6.9)**	**(6.9)**	**(5.0)**	
Month 7 divisional forecast	**(24.3)**	**(32.7)**	**(34.7)**	
Further CIP forecast to Month 8 against £6m target	1.6	1.6	1.6	Made up of £1.3m MEA and £0.2m other CIPs
Cost pressure improvement to Month 8	0.4	0.4	0.4	Takes cumulative CIP and other gains against £6m target to £3.9m
Month 8 divisional forecast	**(22.3)**	**(30.7)**	**(32.8)**	
Balance to £5m against £6m target -identified in M9	1.5	1.5	1.5	Takes cumulative CIP and other gains against £6m target to £5.4m.
Further CIPs or reduction of cost pressures	0.6	0.6	0.6	Takes cumulative CIP and other gains against £6m target to £6.0m
Winter pressures funding - tranche 1	1.2	1.2	1.2	Assumed to benefit bottom line but this is a risk given January Winter pressures on staffing costs
SubCo Set Up costs	(0.4)	(0.4)	(0.5)	Increase in net costs of implementing SubCo as company will not now be able to start in 2017/18. Previous matching savings assumed from ppre 1/4/18 start
Remove assumed blocking gain from South Worcs/Wales			(0.4)	South Worcs CCG insisting on full contract mechanisms including flex & freeze etc. £0.4m is impact of no block but flex and freeze set aside.
Failure to agree extension of spec comm block to M7-12			(2.0)	Spec comm block proposal does not recognise Trak issues, would give c£3m downside and is unacceptable to the Trust. £2.0m downside is estimated impact of variable contract M7-12 with no flex and freeze
Month 8 forecast	**(19.4)**	**(27.8)**	**(32.4)**	
Additional CIPS and reduction in cost pressures	0.0	0.0	0.0	£1.5m CIPS forecast but not fully identfied in M8 now firmly forecast at M9. £0.6m remains not fully identfied
MSE, Glanso and other minor cost pressures	(0.8)	(0.8)	(0.8)	These two Month 9 movements to the forecast are neutral taken together
Catch up in passthrough drugs income	0.8	0.8	0.8	
Month 9 forecast	**(19.4)**	**(27.8)**	**(32.4)**	
Cost pressure deterioration in M10	(1.3)	(1.3)	(1.3)	Incl. £0.6m pay, £0.5m drugs, £0.1m Glanso
Partially offest by income improvements in M10	0.5	0.5	0.5	Incl. £0.3m addtl Winter Pressures, £0.2m underlying activity improvement
Month 10 divisional forecast	**(20.2)**	**(28.6)**	**(33.2)**	
Additional CIPS and reduction in cost pressures	0.8	0.8		£0.8m of savings remain unidentified, but action is being agreed by Execs.
Month 10 underlying forecast	**(19.4)**	**(27.8)**	**(33.2)**	
Materialisation of SpecComm risk	(0.9)	(0.9)		Reflecting an offer which the trust has made to NHSE to attempt to reach resolution on the 17/18 income
Month 10 forecast	**(20.3)**	**(28.7)**	**(33.2)**	
Variance to plan	*(5.7)*	*(14.1)*	*(18.6)*	

Balance Sheet (1)

Gloucestershire Hospitals NHS
NHS Foundation Trust

Trust Financial Position	Opening Balance 31st March 2017 £000	Balance as at M10 £000	B/S movements from 31st March 2017 £000
Non-Current Assests			
Intangible Assets	7,393	8,643	1,250
Property, Plant and Equipment	296,272	294,747	(1,525)
Trade and Other Receivables	4,668	4,445	(223)
Total Non-Current Assets	**308,333**	**307,835**	**(498)**
Current Assets			
Inventories	7,400	7,545	145
Trade and Other Receivables	17,697	20,421	2,724
Cash and Cash Equivalents	7,974	3,441	(4,533)
Total Current Assets	**33,071**	**31,407**	**(1,664)**
Current Liabilities			
Trade and Other Payables	(44,355)	(47,880)	(3,525)
Other Liabilities	(2,089)	(2,006)	83
Borrowings	(5,356)	(5,355)	1
Provisions	(182)	(182)	0
Total Current Liabilities	**(51,982)**	**(55,423)**	**(3,441)**
Net Current Assets	**(18,911)**	**(24,016)**	**(5,105)**
Non-Current Liabilities			
Other Liabilities	(7,612)	(7,298)	314
Borrowings	(83,126)	(106,429)	(23,303)
Provisions	(1,524)	(1,462)	62
Total Non-Current Liabilities	**(92,262)**	**(115,189)**	**(22,927)**
Total Assets Employed	**197,160**	**168,630**	**(28,530)**
Financed by Taxpayers Equity			
Public Dividend Capital	166,519	167,439	920
Reserves	70,501	70,501	0
Retained Earnings	(39,860)	(69,310)	(29,450)
Total Taxpayers' Equity	**197,160**	**168,630**	**(28,530)**

The table shows the M9 balance sheet and movements from the 2016/17 closing balance sheet, supporting narrative is on the following page

Balance Sheet (2)

Gloucestershire Hospitals NHS
NHS Foundation Trust

Commentary below reflects the Month 10 balance sheet position against the 2016/17 outturn

Non-Current Assets

- The reduction in non-current assets reflects depreciation charges in excess of capital additions for the year-to-date.

Current Assets

- Inventories show a decrease of under £0.2m.
- Trade receivables are £2.7m above their closing March 2017 level.
- Cash has reduced by £4.5m since the year-end, and increased by £1.3m in month.

Current Liabilities

- Trade payables have increased by £3.5m over the closing March level (a £2.3m decrease on the month 9 level).
- Other liabilities have decreased by £0.1m since year end.

Non-Current Liabilities

- Borrowings have increased by £23.3m. A further £4.3m of distress financing to fund deficit support was drawn down in December bringing the total of drawn down distress and capital funding and additional PDC to £27.8m. Total distress funding drawn to date is £25.8m, capital funding is £1m and additional PDC is 0.9m. The balance in the Trust's required funding is being financed by improvement in working capital (combination of working capital available from GP training, income over and above I&E balances and creditor/accruals balances). We are forecasting that our distress financing will need to be at least equal to the I&E deficit before taking account of the capital loan before the end of year.

Reserves

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

Cashflow : January

Gloucestershire Hospitals NHS
NHS Foundation Trust

Cashflow Analysis	Apr-17 £000s	May-17 £000s	Jun-17 £000s	Jul-17 £000s	Aug-17 £000s	Sep-17 £000s	Oct-17 £000s	Nov-17 £000s	Dec-17 £000s	Jan-18 £000s
Surplus (Deficit) from Operations	**(4,958)**	**(3,284)**	**935**	**(1,031)**	**(1,940)**	**(1,953)**	**(1,955)**	**(783)**	**(4,591)**	**(327)**
Adjust for non-cash items:										
Depreciation	946	1,719	975	975	975	975	975	975	975	975
Impairments within operating result	0	0	0	0	0	0	0	0	0	0
Gain/loss on asset disposal	0	0	0	0	0	0	0	0	0	0
Provisions	0	0	0	0	0	0	0	0	0	0
Other operating non-cash	(58)	(59)	(58)	(58)	(58)	(58)	(58)	(58)	(58)	(58)
Operating Cash flows before working capital	**(4,070)**	**(1,624)**	**1,852**	**(114)**	**(1,023)**	**(1,036)**	**(1,038)**	**134**	**(3,674)**	**590**
Working capital movements:										
(Inc.)/dec. in inventories	(150)	(1,118)	349	192	367	132	68	0	344	(371)
(Inc.)/dec. in trade and other receivables	(5,066)	1,200	(157)	633	379	1,940	(1,849)	(508)	877	(1,163)
(Inc.)/dec. in current assets	0	0	0	0	0	0	0	0	0	0
Inc./(dec.) in current provisions	0	0	0	0	0	0	0	0	0	0
Inc./(dec.) in trade and other payables	4,930	328	(2,109)	(530)	514	(3,132)	2,701	(2,337)	1,343	(5,806)
Inc./(dec.) in other financial liabilities	(562)	3,448	(58)	(181)	(129)	153	21	0	0	0
Other movements in operating cash flows	835	(995)	32	(31)	32	(79)	206	32	32	32
Net cash in/(out) from working capital	**(13)**	**2,863**	**(1,943)**	**83**	**1,163**	**(986)**	**1,147**	**(2,813)**	**2,596**	**(7,308)**
Capital investment:										
Capital expenditure	(148)	(989)	(348)	(214)	(909)	(608)	(1,636)	(1,365)	(1,759)	(515)
Capital receipts	0	0	0	0	0	0	0	0	0	0
Net cash in/(out) from investment	**(148)**	**(989)**	**(348)**	**(214)**	**(909)**	**(608)**	**(1,636)**	**(1,365)**	**(1,759)**	**(515)**
Funding and debt:										
PDC Received	0	0	0	0	0	0	0	0	0	920
Interest Received	4	3	2	3	3	3	2	3	3	3
Interest Paid	0	(162)	(42)	0	0	(1,329)	(29)	(163)	0	(87)
DH loans - received	0	0	0	2,355	0	8,864	1,664	3,452	4,321	6,233
DH loans - repaid	0	0	0	0	0	(1,318)	0	0	0	0
Other loans	0	0	0	0	0		0	0	0	0
Finance lease capital	(20)	(20)	(20)	(20)	(20)	(20)	(20)	(20)	(20)	(20)
PFI/LIFT etc capital	(181)	(181)	(181)	(181)	(181)	(181)	(181)	(181)	(181)	(181)
PDC Dividend paid	0	0	0	0	0	(3,091)	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0
Net cash in/(out) from financing	**(197)**	**(360)**	**(241)**	**2,157**	**(198)**	**2,928**	**1,436**	**3,091**	**4,123**	**6,868**
Net cash in/(out)	**(4,428)**	**(110)**	**(680)**	**1,912**	**(967)**	**298**	**(91)**	**(953)**	**1,286**	**(365)**
Cash at Bank - Opening	**7,974**	**3,546**	**3,436**	**2,756**	**4,668**	**3,701**	**3,999**	**3,908**	**2,955**	**4,241**
Closing	**3,546**	**3,436**	**2,756**	**4,668**	**3,701**	**3,999**	**3,908**	**2,955**	**4,241**	**3,876**

The cashflow for January 2018 is shown in the table opposite. The major movements are consistent with those already identified within income and expenditure and the balance sheet.

Key movements:

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

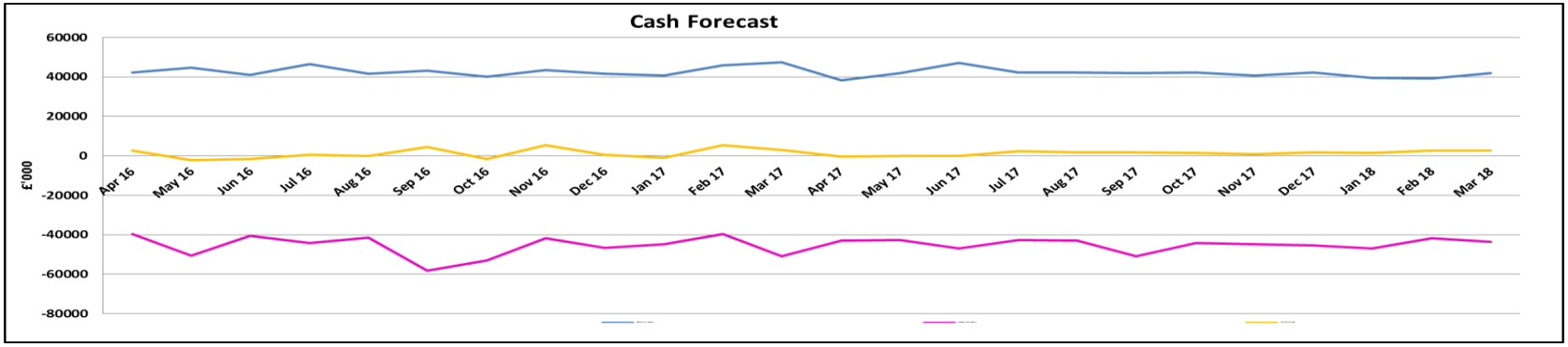
Current Assets – Invoiced debtor balances have increased in month, timely settlement of in-month SLA invoices offset by increase in Hosted Services income as a result of GP Payroll reporting timing.

Trade Payables – increased in month. Aged creditors shows decrease in creditors below 30 days and an increase for those above.

Short Term Cashflow Forecast

Gloucestershire Hospitals NHS
NHS Foundation Trust

	Jan 17 £'000	Feb 17 £'000	Mar 17 £'000	Apr 17 £'000	May 17 £'000	Jun 17 £'000	Jul 17 £'000	Aug 17 £'000	Sep 17 £'000	Oct 17 £'000	Nov 17 £'000	Dec 17 £'000	Jan 18 £'000	Feb 18 £'000	Mar 18 £'000	Apr 18 £'000	May 18 £'000
Opening Balance	**7,979**	**5,340**	**11,637**	**7,974**	**3,423**	**2,565**	**2,614**	**4,494**	**3,773**	**3,702**	**3,473**	**2,790**	**3,806**	**3,441**	**4,490**	**4,635**	**5,003**
Receipts																	
SLA Income	34,026	39,046	35,382	34,272	35,547	35,363	35,140	36,121	35,184	35,303	34,486	34,773	34,277	34,097	34,098	35,180	35,180
Other NHS	4,607	5,117	6,675	2,545	4,176	9,305	5,294	4,318	4,641	5,482	4,534	4,974	3,499	3,433	3,389	4,780	4,830
STF Funding																	
Other Non-NHS	1,327	1,260	4,252	1,406	1,255	1,861	1,217	1,342	1,198	1,098	1,073	1,238	1,329	895	3,860	1,200	1,260
VAT	646	408	1,135	0	805	607	618	535	875	378	586	1,242	334	634	500	550	550
Funding	1,506	3	3	4	3	3	2,358	3	8,867	1,667	3,455	4,328	7,159	3,917	2,000	3	3
Total Receipts	**42,112**	**45,834**	**47,448**	**38,226**	**41,786**	**47,138**	**44,627**	**42,318**	**50,765**	**43,927**	**44,134**	**46,555**	**46,598**	**42,975**	**43,847**	**41,713**	**41,823**
Payments																	
Payroll	(25,455)	(25,792)	(26,193)	(25,926)	(27,000)	(26,541)	(26,807)	(26,692)	(27,248)	(27,862)	(27,520)	(26,866)	(27,357)	(29,802)	(29,488)	(25,875)	(25,875)
Payables	(16,159)	(13,226)	(18,447)	(14,699)	(13,374)	(18,020)	(13,304)	(13,812)	(15,404)	(13,207)	(14,619)	(15,833)	(17,213)	(11,605)	(9,836)	(13,230)	(12,032)
Other payables	(1,542)	(520)	(1,133)	(633)	(365)	(784)	(848)	(793)	(858)	(1,344)	(772)	(1,096)	(561)	(520)	(500)	(400)	(500)
NHSLA	(1,595)	0	0	(1,743)	(1,743)	(1,743)	(1,743)	(1,743)	(1,743)	(1,743)	(1,743)	(1,743)	(1,743)	0	0	(1,811)	(1,811)
Loan & Interest	0	0	(5,337)	0	(162)	0	(45)	0	(5,582)	0	(163)	0	(87)	0	(3,877)	(29)	(218)
Funding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Payments	**(44,751)**	**(39,537)**	**(51,111)**	**(43,001)**	**(42,645)**	**(47,089)**	**(42,747)**	**(43,040)**	**(50,835)**	**(44,156)**	**(44,817)**	**(45,538)**	**(46,963)**	**(41,926)**	**(43,702)**	**(41,346)**	**(40,436)**
Net Cashflow	**(2,639)**	**6,297**	**(3,663)**	**(4,776)**	**(859)**	**49**	**1,880**	**(722)**	**(70)**	**(229)**	**(683)**	**1,016**	**(365)**	**1,049**	**145**	**368**	**1,388**
Closing Balance	**5,340**	**11,637**	**7,974**	**3,423**	**2,565**	**2,614**	**4,494**	**3,773**	**3,702**	**3,473**	**2,790**	**3,806**	**3,441**	**4,490**	**4,635**	**5,003**	**6,391**
Reserved Funds																	
TrakCare	(2,808)	(2,808)	(2,808)	(2,808)	(1,514)	(1,514)	(974)	(902)	(829)	(829)	(829)	(829)	(829)	(829)	(829)	(829)	(829)
Other	(3,600)	(3,600)	(2,600)	(1,100)	(1,100)	(1,100)	(1,100)	(1,100)	(1,100)	(1,100)	(1,100)	(1,100)	(1,100)	(1,100)	(1,100)	(1,100)	(1,100)
'Available' Balance	**(1,068)**	**5,229**	**2,791**	**(485)**	**(49)**	**(0)**	**2,420**	**1,771**	**1,773**	**1,544**	**861**	**1,877**	**1,512**	**2,561**	**2,706**	**3,074**	**4,461**



Receipts; SLA income has been forecast based on recent trend and with a view of monthly contract values

Payments; Payables are built from recent trends and accounts for significant movements such as capital and project spend.
The table highlights future forecast funding requirements based on latest forecast.

NHSI Single Oversight Framework

Gloucestershire Hospitals NHS
NHS Foundation Trust

	YTD Plan	YTD Actual
Capital Service Cover	(0.16)	(0.79)
Metric		
Rating	4	4
Liquidity	(22.28)	(22.76)
Metric		
Rating	4	4
I&E Margin	(5.52%)	(7.03%)
Metric		
Rating	4	4
I&E Variance from Plan		(1.51%)
Metric		
Rating		3
Agency	44.88%	37.65%
Metric		
Rating	3	3
Use of Resources rating	4	4

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

The performance reported here reflects that for M10, which is in line with Plan, and continues to show performance at a "4".

Recommendations

Gloucestershire Hospitals NHS
NHS Foundation Trust

The Board is asked to note:

- The financial position of the Trust at the end of Month 10 of the 2017/18 financial year is an operational deficit of £29.5m. This is a adverse variance to budget and NHSI Plan of £6.5m.
- The variance is reflective of both year to date pay underspends and phasing adjustments within the income position.
- The divisional Month 10 forecast is for a £28.7m deficit outturn assuming delivery of the FRP actions agreed through the weekly deep dives. This is a deterioration £0.9m on last month, relating to crystallisation of income risk relating to specialist commissioners.
- This forecast will be reported to NHSI through the usual monthly FSM meetings.

Author: **Tom Niedrum, Associate Director of Financial Management**

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

Date: **February 2018**

REPORT TO MAIN BOARD – MARCH 2018

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

This report describes the business conducted at the Finance Committee held 28th February 2018, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Financial Performance Report	Year to date deficit is £29.4m, a deficit against plan of £6.5m. The trend of recent pay expenditure reductions ended, partly due to January activity and partly due to December bank holiday enhancements paid in February. Year end forecast worsened by £0.9m to £28.7m due to crystallisation of existing specialist commissioning income risk outside Trust control. Further income risks may come into the forecast next month The non-income aspects of the forecast remain with a degree of risk.	How will NHSI see the income deterioration? What are the further income risks? What is the quantum of potential risk to the element of the forecast wholly within Trust control?	The risk has been extensively flagged and we do not believe it will be seen as a deterioration in the financial performance of the Trust. The risks around system CQUINS (£2m) and Worcestershire CCG (£0.4m), and the residual further specialist commissioning risk. The value of this risk is considered to be relatively small (the sensitivity analysis in the report indicates £0.8m).	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Regulatory Review Update	NHSI remains positive about the potential for the Trust to exit Financial Special Measures.			
Capital Programme Update	An underspend of £0.9m is projected, reflecting draw down of funding for the GP Streaming scheme at CGH, for which the vast bulk of spending will fall into 2018/19.			
Capital Expenditure Budget Setting 2018/19	The budget setting process was described, together with an outline of the range of scenarios being considered. These range from total expenditure of c £11m to c £18m, with NHS capital loan requirements of between £2m and £9m.	What are the trade-offs that will have to be made? Is £1m enough for enabling key service changes?	Key trade-offs are between the requirement for greater investment in IT than previous years (£6.1m proposed), backlog maintenance schemes(particularly the Apollo theatre scheme - £1.9m), equipment replacement, and enabling service change(£1m). It will not be sufficient to meet all requirements, but it is a manageable sum given the circumstances.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
CGH ED GP Streaming Proposal	Approval was sought to go to tender to seek firm values for the GP streaming scheme at CGH within the available NHSE funding of £920k. This will go to Trust Board for final approval.			
Cost Improvement Programme Update (CIP)	Total forecast CIPs have increased by £0.1m to £28.2m. CIPs provisionally identified for 2018/19 total £15.6m against the £28.6m draft plan expectation. There have been a number of reasons for a slow start to 2018/29 CIP development but this is progressing more strongly now.	What level of risk is there to the achievement of £28.6m CIPs in 2018/19?	The risk is such that the target is likely to have to be reduced, and the planned deficit increased commensurately.	The need to consider an amendment to the CIP target, and to the draft financial plan for 2018/19
Medical Productivity Update	The work being undertaken to develop the approach to medical productivity agreed at the previous Finance Committee was outlined.	The need to ensure the same level of focus on medical productivity as on other productivity improvement in other staff groups was emphasised.	Assurance was given on this point	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Trakcare Counting and Coding and Activity Recovery	The actions being taken to address the various areas of Trak recovery improving activity recording and delivery and income were outlined, which have ab expected impact of £10.6m in the draft financial plan.	Can assurance be given on the delivery of this level of improvement?	Insufficient assurance can be given at present. Detailed action plans are needed for each area, with timescales and responsible managers, and with tracking of the trajectory of improvement put in place.	
Matters to be Escalated to the Board	The proposed GP Streaming Capital Case.			
Governors Comments	The areas previously flagged as being of interest to governors were re-stated - particularly medical productivity and other CIP projects and overview.			

MAIN BOARD – MARCH 2018
Lecture Hall, Sandford Education Centre commencing at 09:00am

Report Title
Quality and Performance Report
Sponsor and Author(s)
Authors: Felicity Taylor Drewe, Director of Planned Care, Deputy Chief Operating Officer Sponsor: Caroline Landon, Chief Operating Officer Steve Hams, Executive Director of Quality and Chief Nurse

Executive Summary

Purpose

This report summarises the key highlights and exceptions in Trust performance for the January 2018 reporting period, with some indicators reported for November as they are one month in arrears. Given the earlier timing of the committee the report for Quality and Performance committee has some areas that are un-validated in terms of performance reporting.

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

Key Issues to note

During January, the Trust met the Trust and NHS I/E Trajectory for A&E 4 hour standard and Diagnostic 6 week wait. The Trust did not meet the national standards or Trust trajectories for; 2 week wait and 62 day cancer standard and the Trust have suspended reporting on the 18 week referral to treatment (RTT) standard. There remains significant focus and effort from operational teams to support performance recovery and sustained delivery. There remains the clinical review and oversight of patients waiting care to ensure that patients do not come to harm due to delays in their treatment in accordance with the Trusts Clinical Policy, which is under review, simultaneously with the Trusts Access Policy.

In January 2017, the trust performance against the 4hr A&E standard was 89.7% with an average of 400 attendances per day. This performance was above the agreed STF trajectory (80%). GHFT. Month to date performance (16 February) is currently 88.1% which is 8.1% above the agreed STF February trajectory (80%).
January attendances were 10.2% above last year's levels, an increase of 1,086 attendances with an average increase of 35 attendances per day. Thursdays and Saturdays have seen the biggest rise in attendances against last January.
In summary GHT's position against both National position and the South region is as follows:
National performance: 85.28%
South performance: 85.05%
Gloucestershire performance: 89.79%
Gloucestershire ranking in South: 5th out of 35 acute Trusts with type 1 ED
Gloucestershire ranking in England: 15th out of 137 acute Trusts with type 1 ED

In respect of RTT, we continue to monitor and address the data quality issues following the migration to TrakCare. We have started reporting the RTT position in shadow form and will continue to suspend national reporting of this target. Operational teams continue to monitor and manage the long waiting patients on the Referral to Treatment pathways; however, as reported

previously to the Board we will continue to see 52 week breaches until full data cleansing exercise is completed.

Our performance against the cancer standard saw an improvement against the 2 week standard with performance at 86.3% (Un-Validated), an improvement from November of 10.7%. The main tumour site that was compromised on the 2 week pathway was colorectal which continues to see a very high demand resulting in capacity issues.
We recognise the relatively low capacity resilience due to national staff shortages in some of our highly subscribed services. A revised Cancer Delivery Plan which identifies specific actions by tumour site to deliver recovery has been developed. In respect of 2 week wait whilst work continues with our primary care colleagues for managing demand on our colorectal services and the development of the straight to test pathway. The impact of the delivery in the 2 week wait pathway will impact on the 62 day pathway performance in the coming months.

Cancer 62 day Referral to Treatment (GP referral) performance for December was 74.9% (un-validated) and January at 68% (un-validated). The December figures did increase from reported last month 73.3%. A number of specialities continue to be impacted by demand on key specialities with significant breach numbers impacting the aggregate position.
Whilst the January percentage is a decline from November's & December's position, the number of breaches has decreased in the last 3 months, with the exception of January. For example 44 breaches in October; 38 in November and 35.5 in December. The Cancer trajectory and delivery plan has set out the delivery of this national standard across each tumour site this is monitored fortnightly alongside a weekly patient level challenge meeting to support the management of every patient over 40 days. We are reviewing our timescales for both initial booking at 7 days, on a 2 week wait pathway and also the decision to treat period from first seen which illustrates opportunity for delivery and improved patient care. We are addressing our longest waiting patients and reviewing the opportunities for how we can support a reduction in the 104 patient cohort.

The Trust met the diagnostics target in January at 0.64% (un-validated), the focus is on sustainability across the range of diagnostic tests we provide.

Alignment with the Trak Recovery Programme in relation to RTT operational management remains key as does the delivery against the agreed actions within the Cancer Delivery Plan.

Conclusions

Cancer delivery and sustaining A&E performance is the priority for the operational teams. A process of review for every patient over 40 weeks in their referral to treatment pathway and every patient over 40 days in their Cancer pathway (including non-cancer patients) in order to improve performance against the national standards at a weekly check and challenge meeting. Clinical oversight of patients awaiting care continues to ensure that no patients come to harm due to delays in their treatment.

Recommendations

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

Impact Upon Strategic Objectives

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

Impact Upon Corporate Risks

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

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

Finance		Information Management & Technology	
Human Resources		Buildings	
No change.			

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

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

Gloucestershire Hospitals NHS
NHS Foundation Trust

Quality and Performance Report

Reporting period January 2018

to be presented at February 2018 Quality and Performance Committee

Executive Summary

Delivery of agreed action plans remains critical to restore operational performance to the expected levels. During December, the Trust did not meet the national standards or Trust trajectories for 2 week wait and 62 day cancer standard and suspended 18 week referral to treatment (RTT) standard continues. There is significant focus and effort from operational teams to support performance recovery. There is clinical review and oversight of patients waiting care over 104 days to ensure that patients do not come to harm due to delays in their treatment, these are being reviewed to ensure we have fully reviewed these cases since 01 April 2017.
The Trust has met the 4 hour standard in January with the month to date position at 89.7% and delivered the Diagnostic target in December at 0.64% un-validated.
The Key areas of focus remain for delivery of Cancer quality and performance against speciality level trajectories. The Cancer Delivery plan is reviewed fortnightly and each tumour site has specific identified actions with an associated allocation in breach improvement numbers.
Cancer underperformance remains a significant concern relating to the 2 week wait and 62 day pathway. For the former, issues with capacity, some areas of referral increase and patient choice (sometimes due to short notice appointments) have impacted delivery. The February position is too early to report for the time of committee. But the positive signs continue from December. The January figures as yet un-validated that shows 2ww at 87.2%. Importantly the number of breaches have consistently decreased month on month from 451 in October, 436 in November, 309 in December and 227 in January. A significant contribution to this performance improvement is from the skin tumour site which has again delivered across both the 2ww and 62 day pathways.
For 62 day, again monthly improvements in breach numbers can be seen, from 44 in October, 38 in November, 35.5 in December and as at the time of writing 48.5 in January. December performance is currently 74.9% (un-validated) and January is at 68% un-validated. This performance relates to the continued issues in colorectal and issues within the lung pathway. So, we had seen positive developments in this pathway across tumour sites, but have January declined our performance.
The focus continues is on developing the joint work between the Central Booking Office and specialities to support appropriate booking for patients (now all clinics are available for booking for next year). We have committed to work to a day 8 escalation point for booking of patients and also there is significant development working with primary care on the re-launch of our 2ww electronic referral forms. For elective care, the levels of validation across the RTT incompletes, Inpatient and Outpatient Patient Tracking List (PTL) is significant.
Key areas where additional reports have been provided for the Quality and Performance Committee are:
• Cancer Services Management Group – escalation report (including Cancer Delivery Plan)
• Emergency Care Board – escalation report (including Emergency Care Dashboard)
• Planned Care Board – escalation report

In summary, the position for the Trust in a number of key performance metrics is significant.

Strengths

4 hour performance continues to perform well, delivering month to date 88.1% as of the 16th February.
Medically fit at 64 remains relatively stable during the winter period, work with system partners continues to progress this area for patient care.
Achievement of the national standard for % of patients seen within 6 weeks for Diagnostic tests, whilst not delivering against target at 0.86% for January (un-validated), is demonstrating a sustained recovery.
The engagement of Glanso has continued to support a number of RTT specialities (>52) and to release capacity in key cancer tumour sites, and diagnostics areas and is being utilised in the right operational "hot-spots". We are reviewing our requirements for 2018/19 in this area.
Overall clinic slot utilisation is positive, remaining at 87% this is still an area for further development but good progress is being made
Performance in the majority of the additional quality measures has been good
FFT scores are available to staff on the wards and they need to log onto the FFT system to see the results for their local areas as this indicates why people are reporting in the way that they have (positive of negative feedback) Divisions/ Specialities/Wards or clinical

areas will do improvement work in response to the feedback. Currently there are a number (approximately 20) of ad hoc projects across the Trust that have been commenced to improve patient's experience at a ward or clinical area level. FFT is one of the patient experience indicators.

Weaknesses

• Due to the implementation of the new EPR system we continue to shadow reporting the number of patients waiting 18 weeks from referral to treatment. We have a number of patients that are awaiting first out patient appointments around 45 weeks. We are mitigating booking out of chronological order, through a review of the clinics post 45 weeks available to book into by specialties; vetting; CBO processes and support. However this will continue as we make progress to validation and implementation of the correct utilisation of the system to prevent future errors.

• Patient Treatment Lists (PTLs) have residual data quality issues which continues to impact management of patient journeys. This is being addressed through the deployment of additional clerical staff as approved at May Board. Despite this, teams are focused on reviewing patients >45 weeks, across most specialities and predicting potential breaches on a more routine basis. The validation team are now operating at >33 weeks for all specialities within the RTT PTL, which is one of 3 PTLs that are combined to support operational management. Work to support the Outpatient PTL validation team is being put in place to support the validation of this list which will support forward capacity planning.

• Achievement of the Cancer standards remains a risk as we plan to deliver the 62 day pathway from April 2018, breach numbers had decreased which was positive, the January position however is disapointing and we are working to tackle our 104 day patients. The risk to delivery is around capacity and any increases in referral numbers.

Opportunities

• Development of Standard Operating Procedure (SOP) for the Central Booking Office. This provides action cards supporting staff to enter it right first time and to provide corporate guidance on operating procedures e.g. DNA's. There is evidence that we are not operating our Access Policy in full and this has led to some breaches e.g. >52 week waits, which will be addressed through the development of further SOPs in alignment with the Trak Care Deep Dive Recovery Plan. This will be managed through the Planned Care Delivery group. We are also supporting the 2ww booking team to deliver by day 8 of the patient pathway a booked appointment in one pilot speciality in the spring.

• The Trust had a critical friend visit (09/17) that reviewed the current Cancer Recovery Plan, including some observations on the MDT role and the opportunities for patients at Day 49 plus. This remains an area that the Trust continue to explore around the Decision to Treat from initial appointment time period, this is being reviewed in terms of the speciality level plans to deliver.

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

- Referral rate increases (colorectal & dermatology) – CCG to support communication to targeted practices in the CGH area, this work continues.
- Clinical support for triage of 2ww pathway patients in Lower GI supporting communication with Primary Care on appropriate pathway utilisation, including a new 2 week wait referral form for primary care, supported by clinical information on G-Care (the CCG system for supporting primary care). Re-launch of the new 2ww forms, supporting us in utilising a cancer service for patients who are aware and ready to be referred on the relevant pathway.

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

Risks & Threats

Cancer performance remains a significant risk for the Trust. 2 week wait analysis shows a combination of factors have led to a decline namely: capacity; clinic cancellations and patient choice. Patient choice levels are being benchmarked as the Trust needs to ensure we are offering reasonable notice of appointments. The issue of patient choice has been raised with the LMC and working in partnership with the CCG new 2 week wait referral forms will be published at the end of February. Referrals that are appropriate for a suspected cancer service where our capacity meets demand is crucial to delivery
Looking forward into 2018, colorectal & urology remains key to delivery of aggregate 62d wait.
Dermatology has delivered performance, at 62 days at 100% for the last 3 months and this continues to be one of the best performing tumour sites in the country.
Fortnightly meetings are in place where delivery against plan is monitored. Joint work with the CCG is in place regarding the re-development of the 2 ww referral forms which support referral when cancer is suspected. Unplanned increases in activity remain a risk.
The validation volumes for the PTL and incorrect processes remain a risk, as does any change to the existing PTLs or change in practice. Operational colleagues are represented at the Governance structure relating to the Trak Deep Dive Recovery programme.

Performance Against STP Trajectories

* = unvalidated data

Indicator		Month											
		Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
ED Total Time in Department - Under 4 Hours	Trajectory	87.70%	89.50%	89.20%	88.30%	92.20%	91.00%	90.00%	88.10%	77.40%	80.00%	80.00%	83.50%
	Actual	82.85%	79.96%	79.90%	83.50%	88.13%	86.10%	88.93%	95.25%	90.76%	89.73%		
Referral To Treatment Ongoing Pathways Under 18 Weeks (%)	Trajectory	73.80%	75.00%	76.10%	77.20%	78.40%	79.50%	80.60%	81.80%	82.90%	84.00%	85.20%	86.30%
	Actual												
Diagnostics 6 Week Wait (15 Key Tests)	Trajectory	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%
	Actual	7.22%	5.30%	5.26%	5.30%	4.80%	2.90%	0.46%	0.51%	0.75%	0.64%*		
Cancer - Urgent referrals Seen in Under 2 Weeks	Trajectory	93.00%	93.00%	93.00%	93.10%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%
	Actual	91.40%	90.50%	85.90%	79.60%	70.40%	71.20%	74.60%	75.80%	81.20%	86.40%*		
Max 2 Week Wait For Patients Referred With Non Cancer Breast Symptoms	Trajectory	93.40%	93.00%	93.10%	93.50%	93.00%	93.50%	93.10%	93.10%	93.30%	93.20%	93.20%	93.30%
	Actual	90.40%	94.00%	94.10%	57.30%	89.70%	92.70%	89.00%	94.50%	96.30%	92.40%*		
Cancer - 31 Day Diagnosis To Treatment (First Treatments)	Trajectory	96.40%	96.20%	96.10%	96.20%	96.20%	96.10%	96.10%	96.20%	96.10%	96.30%	96.10%	96.30%
	Actual	94.90%	95.90%	95.40%	95.80%	96.20%	98.50%	95.10%	96.70%	97.30%	97.00%*		
Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	Trajectory	98.40%	100.00%	98.30%	98.10%	100.00%	98.40%	98.00%	98.00%	100.00%	100.00%	100.00%	98.40%
	Actual	100.00%	100.00%	100.00%	100.00%	100.00%	98.50%	100.00%	100.00%	100.00%	97.10%*		
Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	Trajectory	95.30%	95.70%	96.40%	94.90%	94.50%	94.90%	94.10%	94.60%	94.40%	94.40%	94.10%	94.20%
	Actual	98.50%	100.00%	100.00%	100.00%	98.40%	96.60%	97.10%	98.50%	98.10%	98.60%*		
Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	Trajectory	94.90%	94.80%	94.00%	95.80%	94.50%	95.20%	94.10%	94.90%	94.70%	94.10%	94.50%	94.10%
	Actual	90.00%	97.50%	97.90%	93.60%	91.50%	95.50%	94.60%	98.10%	94.90%	97.90%*		
Cancer 62 Day Referral To Treatment (Screenings)	Trajectory	92.00%	94.40%	90.00%	94.70%	91.20%	91.90%	92.90%	92.90%	90.50%	92.90%	92.90%	90.50%
	Actual	86.30%	91.80%	88.90%	89.10%	88.50%	94.90%	87.10%	93.80%	95.50%	98.00%*		
Cancer 62 Day Referral To Treatment (Upgrades)	Trajectory	100.00%	80.00%	100.00%	87.50%	80.00%	91.70%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Actual	100.00%	100.00%	100.00%	57.10%	77.80%	85.70%	50.00%	60.00%	100.00%	0.00%*		
Cancer 62 Day Referral To Treatment (Urgent GP Referral)	Trajectory	77.70%	79.40%	80.10%	85.40%	85.20%	85.20%	85.30%	85.50%	85.30%	85.40%	85.40%	85.20%
	Actual	78.30%	75.90%	71.20%	74.70%	80.10%	69.20%	71.40%	76.70%	73.40%	67.40%*		

Summary Scorecard

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

RAG Rating : Overall RAG rating for a domain is an average performance of lead indicators, where data is not available the lead indicator is treated as Red

QUALITY

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

OPERATIONAL PERFORMANCE

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

FINANCE

- Performance against CIP - % QIA's from PMO completed
- YTD Performance against Financial Recovery Plan

LEADERSHIP AND DEVELOPMENT

- Sickness Rate
- Workforce Turnover Rate

Trust Scorecard

* = unvalidated data

Category		Indicator	Target	Month												Quarter				Annual	
				Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	16/17 Q4	17/18 Q1	17/18 Q2	17/18 Q3	16/17	17/18
Quality	Key Indicators - Quality																				
	Friends and Family Test Score	Friends and Family Test Score - ED % Positive		80.3%	85.5%	86.9%	84.4%	75.6%	77.5%	84.9%	81.1%	81.0%	87.4%	85.9%		83.9%	81.7%	81.2%	84.7%	86.5%	81.3% *
		Friends and Family Test Score - Inpatients % Positive		100.0%	91.6%	89.3%	92.2%	91.2%	90.8%	90.9%	90.1%	91.2%	90.6%	91.6%		93.5%	90.8%	90.6%	91.0%	94.0%	90.8% *
		Friends and Family Test Score - Maternity % Positive		100.0%	98.9%	94.5%	96.8%	97.0%	100.0%	90.0%	94.7%	100.0%	100.0%	90.3%		99.1%	96.2%	96.3%	97.1%	98.6%	96.6% *
		Friends and Family Test Score - Outpatients % Positive								91.2%	91.5%	91.3%	92.2%	92.4%					92.0%		
	Infections	MRSA Bloodstream Cases - Cumulative Totals	0	2	3	0	0	0 *	1	1 *	1 *	1 *	0	0	0 *	3				3	0 *
	Mixed Sex Accommodation	Number of Breaches of Mixed Sex Accommodation	0	0	3	4	11	10	16	14	18	19	13	11	5	6	25	48	43	39	121 *

Mortality	Hospital Standardised Mortality Ratio (HSMR)	Dr Foster confidence level	113.5	110.7	111	109	109.2	105.5	103.9	99.7	97.1				110.7	109.2	99.7		110.7	97.1 *
	Hospital Standardised Mortality Ratio (HSMR) - Weekend	Dr Foster confidence level	116.8	115.1	116.5	114.6	115	111.8	110	108.9	103.9				115.1	115	108.9		115.1	103.9 *
	Summary Hospital Mortality Indicator (SHMI) - National Data	Dr Foster confidence level		111.5			112.3								111.5	112.3			111.5	112.3 *
Readmissions	Emergency Readmissions Percentage	Q1<6%Q2<5.8%Q3<5.6%Q4<5.4%	6.1% *	5.1% *	7.2% *	7.1% *	6.7% *	6.9% *	6.8% *	6.5% *	6.4% *	6.7% *	7.4% *		5.8% *	7.0% *	6.7% *	6.8% *	6.4% *	6.8% *
Venous Thromboembolism (VTE)	Adult Inpatients who received a VTE Risk Assessment	>95%								91.4% *	90.6% *	86.4% *	86.9% *	78.6% *				88.2% *		
Detailed Indicators - Quality																				
Dementia	Dementia - Fair question 1 - Case Finding Applied	Q1>86%Q2>87%Q3>88%Q4>90%								0.4% *	0.7% *	0.9% *	1.1%	0.7% *			0.4% *			0.6% *
	Dementia - Fair question 2 - Appropriately Assessed	Q1>86%Q2>87%Q3>88%Q4>90%								50.0% *	60.0% *	50.0% *	57.1%	100.0% *			50.0% *			57.1% *
	Dementia - Fair question 3 - Referred for Follow Up	Q1>86%Q2>87%Q3>88%Q4>90%								0.0% *	0.0% *	0.0% *	0.0%	50.0% *			0.0% *			0.0% *

ED checklist	ED Safety checklist compliance CGH		82%	77%	72%	68%	81%	74%	72%	79%		78%	92%							
	ED Safety checklist compliance GRH	>=80%	29%	42%	56%	60%	56%	57%	53%			68%	67%							
Fracture Neck of Femur	Fracture Neck of Femur - Time To Treatment 90th Percentile (Hours)		41.6 *	44.9 *	46.1 *	44.3 *	49 *	50.9 *	56 *	59.7 *	46.9 *	47.6 *	43.1 *		44.9 *	47.2 *	53 *	46.7 *		
	Fracture Neck of Femur Patients Seeing Orthogeriatrician Within 72 Hours		100.0% *	97.1% *	98.0% *	98.4% *	98.3% *	96.8% *	96.9% *	98.5% *	98.2% *		98.4% *		94.7% *	98.3% *	97.4% *	98.9% *		
	Fracture Neck of Femur Patients Treated Within 36 Hours		80.0% *	75.4% *	76.5% *	78.1% *	71.2% *	59.7% *	67.7% *	66.7% *	80.4% *	67.2% *	81.4% *		77.8% *	75.3% *	64.7% *	76.3% *		
Infections	C.Diff Cases - Cumulative Totals	17/18 = 37	34	42	1	5	8 *	10	18 *	24 *	29 *	35	41	45 *	42				42	5 *
	Ecoli - Cumulative Totals						20	37	103 *	119 *	146 *	175	200	222 *						
	MSSA Cases - Cumulative Totals	No target	105	114	6 *		7	15	44 *	54 *	63 *	68	78	89 *	114 *				114	6 *
Maternity	Percentage of Spontaneous Vaginal		61.1%	61.9% *	61.2% *	64.4% *	65.3% *	62.4% *	63.9% *	64.9% *	60.2% *	57.5% *	60.9% *	57.0% *	61.7% *	63.6% *	64.5% *	59.8% *	63.6% *	62.1% *

	Deliveries																		
	Percentage of Women Seen by Midwife by 12 Weeks	>90	86.9% *	88.8% *	89.3% *	84.9% *	89.2% *	83.2% *	88.1% *	85.9% *	87.8% *	89.5%	86.6% *	88.7% *	81.5% *	85.9% *	88.0% *	90.0% *	87.3% *	89.3% *
Medicines	Rate of Medication Incidents per 1,000 Beddays	Current mean																		
Never Events	Total Never Events	0	0	0	0	2	1 *	0 *	0	1 *	0 *		1 *		0				2	2 *
Patient Falls	Total Number of Patient Falls Resulting in Harm (moderate/severe)		7 *	6 *	3 *	4 *	9 *	5 *	8 *	11 *	7 *	4 *	13 *		8 *	5 *	8 *	8 *		
Patient Safety Incidents	Number of Patient Safety Incidents - Severe Harm (major/death)		0	3 *	3 *	0 *	4 *	2 *	2 *	3 *	1 *	1 *	1 *		3 *	2 *	2 *	1 *		
	Number of Patient Safety Incidents Reported		1,162	1,144 *	900 *	1,268	1,148	1,149 *	1,003 *	1,033 *	1,079 *	1,041 *	1,025 *		1,197 *	1,019 *	1,062 *			
Pressure Ulcers Developed in the Trust	Pressure Ulcers - Grade 2	R:=1% G:<1%	0.97%	0.87%	0.50%	1.23%	0.49% *	1.12% *	1.02% *	0.61% *	1.13% *	0.79% *	0.54% *							
	Pressure Ulcers - Grade 3	R: = 0.3 G: <0.3%		0.37%	0.13%	0.12%	0.12% *	0.50% *	0.38% *	0.37% *	0.00% *	0.13% *	0.14% *							

	Pressure Ulcers - Grade 4	R: =0.2% G: <0.2%			0.13%	0.12%	0.00% *	0.00% *	0.00% *	0.12% *	0.00% *	0.00% *	0.00% *						
Research Accruals	Research Accruals	17/18 = >1100	64	78	123	176	307 *	162 *	185 *	127 *	60 *	74 *	29 *	10 *	88				3,045	1,525 *
RIDDOR	Number of RIDDOR	Current mean	5	2	2	2	3 *	2 *	3 *	0 *	3 *	1 *	7 *		3	2 *	2 *	4 *	2	2
Safer Staffing	Safer Staffing Care Hours per Patient Day		7	7	7	7	9	7	7	7	7	7			7	8 *	7 *		8	7 *
Safety Thermometer	Safety Thermometer - Harm Free	R<88% A 89%-91% G>92%	90.6%	91.3%	94.0%	92.4%	92.7%	91.3% *	92.6% *	94.2% *	92.9% *	93.0% *	93.1% *		91.3% *	93.0% *	92.7% *	93.0% *		
	Safety Thermometer - New Harm Free	R<93% A 94%-95% G>96%	97.1%	97.0%	97.7%	95.8%	96.6%	95.0% *	96.0% *	97.4% *	97.4% *	97.0% *	96.9% *		97.0% *	96.7% *	96.2% *	97.1% *		
Sepsis Screening	2a Sepsis – Screening	>90%	98.0%	96.0%	88.0% *	88.0% *	98.0% *	94.0% *	96.0% *	98.0% *					96.0%	91.0% *				
	2b Sepsis - treatment within timescales (diagnosis abx given)	>50%	70.0%	64.0%	78.0% *	69.0% *	67.0% *	94.0% *	89.0% *	90.0% *					0.0% *	71.0% *				

	Number of Serious Incidents Reported		2			5	1 *	2 *	1	2 *	1 *	1 *	1 *							
Serious Incidents	Percentage of Serious Incident Investigations Completed Within Contract Timescale		100%			100%	100% *	100% *	100%	100% *	100% *	100% *	100% *				100% *			
	Serious Incidents - 72 Hour Report Completed Within Contract Timescale		100.0%			100.0%	100.0% *	100.0% *	100.0%	100.0% *	100.0% *	100.0% *	100.0% *				100.0% *			
	Rate of Incidents Arising from Clinical Sharps per 1,000 Staff	Current mean	1.4	2.1	1	1.2	2.2	2.7 *	1.9 *	.9 *	1.7 *	3.1 *	1.9 *		1.9	2 *	1.9 *	2.2 *		
Staff Safety Incidents	Rate of Physically Violent and Aggressive Incidents Occurring per 1,000 Staff	Current mean	1.9	2.6	2.3	3.1	4.2	2.4 *	3.1 *	2.9 *	2.1 *	2.4 *	1.5 *		2.4	3.3 *	2.8 *	2 *		
	High Risk TIA Patients Starting Treatment Within 24 Hours	>=60%	68.2%	68.4%	64.0%	41.9%	70.2%	69.1%	66.7%	61.5%	81.0%	78.1%	69.6%	67.7%		60.2%	65.2%	76.3%		66.7% *
Stroke Care	Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	>=50%			33.3% *	32.5% *	26.1%	38.0%	41.8%	45.5%	40.3%	37.1%	33.8%	46.2%		30.5%	41.5%	36.8%		37.2% *
	Stroke Care: Percentage Spending 90%+ Time on Stroke Unit	>=80%	87.3%	66.1%	81.8%	84.6%	92.9%	95.0%	92.3%	98.2%	89.3%	89.4%	74.0%		0.0% *	86.4%	95.0%	83.6%		88.3% *
Time to Initial	ED Time To Initial Assessment - Under	>=99%	68.5%	80.2%	81.9%	80.2%	75.9%	87.4%	91.0%	86.2%	86.7%	91.7%	89.9%	91.9%	69.1%	79.9%	88.2%	89.4%		83.4% *

	Assessment	15 Minutes																		
	Time to Start of Treatment	ED Time to Start of Treatment - Under 60 Minutes	>=90%	34.0%	31.2%	29.5%	28.8%	25.7%	32.3%	34.9%	31.2%	37.5%	41.5%	40.7%	43.3%	33.4%	28.0%	32.8%	39.8%		30.3% *
Operational Performance	**Key Indicators - Operational Performance**																			
	Cancer (62 Day)	Cancer 62 Day Referral To Treatment (Screenings)	>=90%	92.3%	95.5%	86.3%	91.8%	88.9%	89.1%	88.5%	94.9%	87.1%	93.8%	95.5%	98.0% *	90.1%	89.3%	90.6%	91.8%		
		Cancer 62 Day Referral To Treatment (Upgrades)	>=90%		100.0%	100.0%	100.0%	100.0%	57.1%	77.8%	85.7%	50.0%	60.0%	100.0%	0.0% *	100.0%	100.0%	76.7%	71.4%		
		Cancer 62 Day Referral To Treatment (Urgent GP Referral)	>=85%	70.0%	70.7%	78.3%	75.9%	71.2%	74.7%	80.1%	69.2%	71.4%	76.7%	73.4%	67.4% *	68.5%	75.2%	75.1%	74.4%		
	Diagnostic Waits	Diagnostics 6 Week Wait (15 Key Tests)	<1%	1.8%	4.6%	7.2%	5.3%	5.3%	5.3%	4.8%	2.9%	0.5%	0.5%	0.8%	0.6% *	2.5% *	5.9%				5.5% *
	ED - Time in Department	ED Total Time in Department - Under 4 Hours	>=95%	76.96%	77.86%	82.85%	79.96%	79.90%	83.50%	88.13%	86.10%	88.93%	95.25%	90.76%	89.73%	76.56%	80.87%	85.87%	91.58%		82.87% *
	Referral to Treatment (RTT) Performance	Referral To Treatment Ongoing Pathways Under 18 Weeks (%)	>=92%													74.3% *					

Detailed Indicators - Operational Performance

Ambulance Handovers	Ambulance Handovers - Over 30 Minutes	< previous year	104	47	34	54	57	47	19	30	38 *	33	56		352	145	96	127	1,884	279 *
	Ambulance Handovers - Over 60 Minutes	< previous year	1	0	1	0	4	0	1	1	0 *	0	0		8	5	2	0	26	7 *
Cancelled Operations	Number of LMCs Not Re-admitted Within 28 Days	0																		6 *
Cancer (104 Days)	Cancer (104 Days) - With TCI Date	0	12	11	10	8	10	8	9	19	17	6	9	10						
	Cancer (104 Days) - Without TCI Date	0	42	42	47	80	32	35	30	26	23	34	34	19						
Cancer (2 Week Wait)	Cancer - Urgent referrals Seen in Under 2 Weeks	>=93%	94.7%	94.6%	91.4%	90.5%	85.9%	79.6%	70.4%	71.2%	74.6%	75.8%	81.2%	86.4% *	91.9%	89.1%	73.6%	77.1%		
	Max 2 Week Wait For Patients Referred With Non Cancer Breast Symptoms	>=93%	95.0%	97.1%	90.4%	94.0%	94.1%	57.3%	89.7%	92.7%	89.0%	94.5%	96.3%	92.4% *	94.0%	92.8%	79.0%	93.4%		
Cancer (31 Day)	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	>=96%	93.6%	96.8%	94.9%	95.9%	95.4%	95.8%	96.2%	98.5%	95.1%	96.7%	97.3%	97.0% *	93.8%	95.5%	96.6%	96.2%		

	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	>=98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.5%	100.0%	100.0%	100.0%	97.1% *	100.0%	100.0%	99.6%	100.0%		
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	>=94%	100.0%	98.6%	98.5%	100.0%	100.0%	100.0%	98.4%	96.6%	97.1%	98.5%	98.1%	98.6% *	99.1%	99.5%	98.5%	98.5%		
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	>=94%	97.7%	87.8%	90.0%	97.5%	97.9%	93.6%	91.5%	95.5%	94.6%	98.1%	94.9%	97.9% *	89.2%	94.5%	93.3%	96.2%		
Delayed Discharges	Acute Delayed Transfers of Care - Patients	<14	44	37	28	30	32	27	29	32					37	32	32		33	30 *
Diagnostic Waits	Planned / Surveillance Endoscopy Patients Waiting at Month End		694 *	681		963 *	522		883 *	1,298	1,062	867	733	239 *	681				7 *	
Discharge Summaries	Patient Discharge Summaries Sent to GP Within 1 Working Day	>=85%	52.9% *	57.4% *	63.2% *	64.5% *	61.5% *	63.8% *	61.0% *	59.9% *	60.1% *	61.1% *	60.0% *		51.7% *	63.1% *	61.6% *	60.4% *	75.4% *	61.6% *
ED - Time in Department	CGH ED - Percentage within 4 Hours	>=95%	88.42%	88.50%	91.80%	92.30%	88.10% *	94.40%	95.00%	93.20%	93.80%	97.10%	96.60%	93.60%	88.00% *	90.70%	94.20%		91.60%	92.30% *
	GRH ED - Percentage Within 4 Hours	>=95%	70.56%	71.80%	77.90%	72.90%	75.30%	77.70%	84.60%	82.40%	86.60%	94.40%	88.00%	87.90%	70.00% *	75.30%	81.50%	89.60%	79.20%	77.70% *

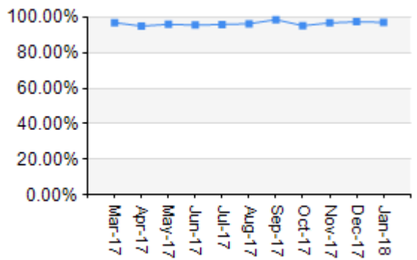
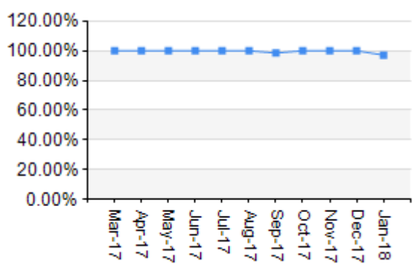
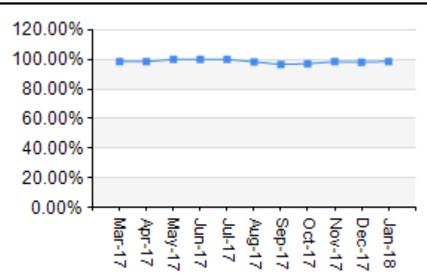
Inpatients	Stranded Patients				397	420	441	451	461	487	479	447	446	472				457		466 *
Length of Stay	Average Length of Stay (Spell)		5.57 *	5.33 *	5.11 *	4.87 *	4.96 *	4.96 *	4.86 *	4.79 *	5.1 *	5.02 *	4.79 *	5.12 *	5.55 *	4.98 *	4.87 *	4.97 *	5.37 *	4.96 *
	Length of Stay for General and Acute Elective Spells	<=3.4	3.03 *	2.8 *	2.83 *	2.66 *	2.84 *	2.73 *	2.98 *	3.15 *	3.29 *	2.86 *	2.82 *	3.07 *	2.87 *	2.78 *	2.95 *	2.99 *	3.08 *	2.92 *
	Length of Stay for General and Acute Non Elective Spells	Q1/Q2<5.4 Q3/Q4<5.8	6.3 *	6.19 *	5.78 *	5.48 *	5.58 *	5.62 *	5.35 *	5.24 *	5.56 *	5.6 *	5.27 *	5.56 *	6.35 *	5.61 *	5.41 *	5.48 *	6.08 *	5.5 *
Medically Fit	Number of Medically Fit Patients Per Day	<40	84	68	59	55	58	63	58	60	62	60	64	55	75	56	60	64		59 *
Referral to Treatment (RTT) Performance	Referral to Treatment Number of Ongoing Pathways Over 18 Weeks																			
Referral to Treatment (RTT) Wait Times	Referral To Treatment Ongoing Pathways 35+ Weeks (Number)																			
	Referral To Treatment Ongoing Pathways 40+ Weeks (Number)																			
	Referral To Treatment Ongoing Pathways Over 52 Weeks (Number)	0	7 *	4 *	13 *	9 *	9 *	13 *	27 *	30 *	30	64 *	74 *	50 *						

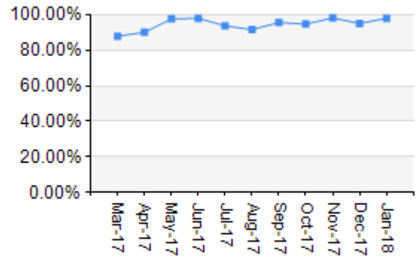
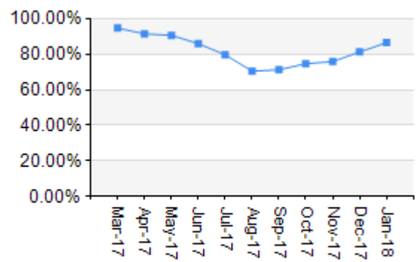
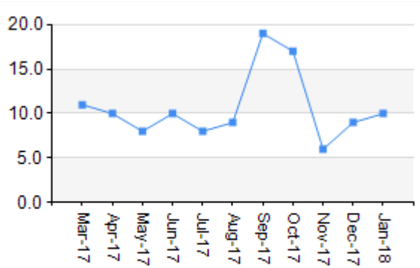
	SUS	Percentage of Records Submitted Nationally with Valid GP Code	>=99%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0% *			100.0%	100.0%	100.0%		100.0%	100.0% *
		Percentage of Records Submitted Nationally with Valid NHS Number	>=99%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%				99.8%	99.8%	99.8%		99.8%	99.8% *
	Trolley Waits	ED 12 Hour Trolley Waits	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0 *
Finance																					
	Key Indicators - Finance																				
	Finance	YTD Performance against Financial Recovery Plan		-18 *	.07	-.95	-10.15	3.36	4.35	4.24	1.87	-.27 *	-2.1 *								
	Detailed Indicators - Finance																				
		Agency - Performance against NHSI set agency ceiling				3	3	3	3	3	4	3	3 *								
	Finance	Capital Service				4	4	4	4	4	4	4	4 *								
		Liquidity				4	4	4	4	4	4	4	4 *								

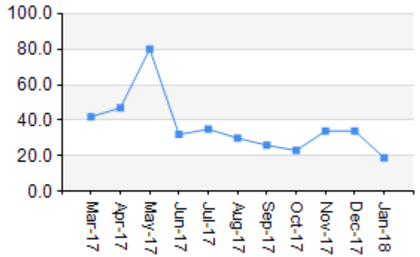
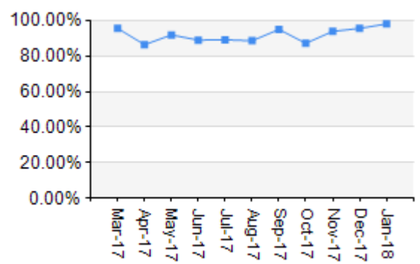
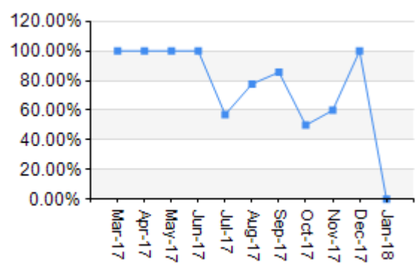
		NHSI Financial Risk Rating	3	1		4	4	4	4	4	4	4	4 *									
		Total PayBill Spend		27240		27.67	27.52	27.5	27.46	28.25	27.94	27.9	27.9 *									
Leadership and Development	**Key Indicators - Leadership and Development**																					
	Sickness	Sickness Rate	G<3.6% R>4%	3.9%	4.0%	4.0%	4.0%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9% *	3.9%	3.9%	3.9%	3.9%			
	Staff Survey	Staff Engagement Indicator (as Measured by the Annual Staff Survey)	>3.8	3.71	3.71	3.71	3.71	3.71	3.71	3.71	3.71	3.71	3.71	3.71	3.71	.04	3.71	3.71	3.71			
	Turnover	Workforce Turnover Rate	7.5% - 11%	12.0%	11.5%	12.1%	12.0%	12.3%	12.3%	12.4%	12.3%	12.4%	12.1%	11.9%	11.5% *	11.8%	12.3%	12.3%	11.9%			
	Detailed Indicators - Leadership and Development																					
	Appraisals	Staff having well-structured appraisal Indicator	>3.8	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3			
		Staff who have Annual Appraisal	G>89% R<80%	82.0%	82.0%	80.0%	79.0%	78.0%	79.0%	79.0%	79.0%	83.0%	84.0%	84.0%	83.0%	81.6%	79.0%	79.0%	82.0%			

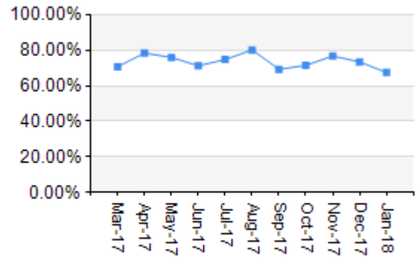
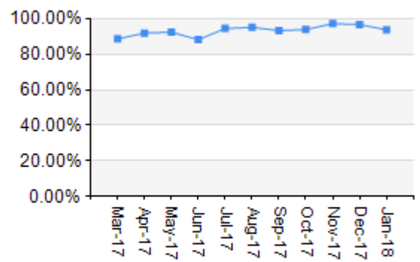
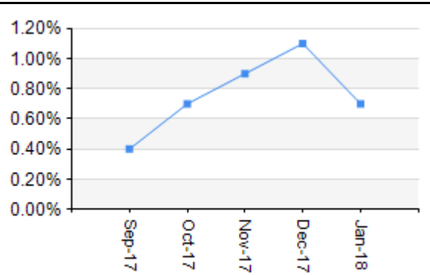
Staff Survey	Improve Communication Between Senior Managers and Staff (as Measured by the Annual Staff Survey)	>38%	34.0%	34.0%	34.0%	34.0%	34.0%	34.0%	33.0%	34.0%	34.0%	34.0%	34.0%	34.0%	34.0%	34.0%	34.0%	34.0%				
Staffing Numbers	Total Worked FTE		7,239 *																			
Training	Statutory/Mandatory Training	>=90%	89%	90%	89%	89%	89%	89%	89%	88%	88%	88%	88% *	73%	89%	89%	89%	88%				

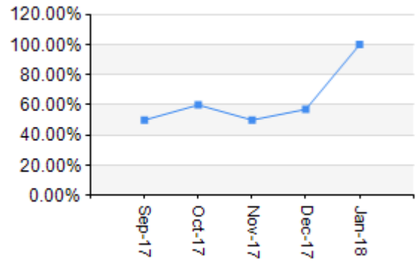
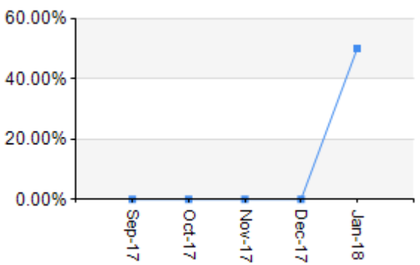
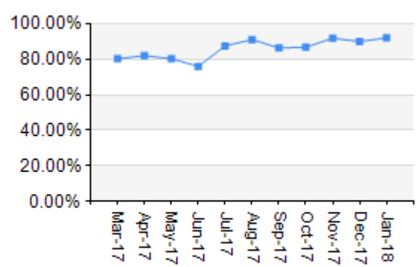
Exception Report

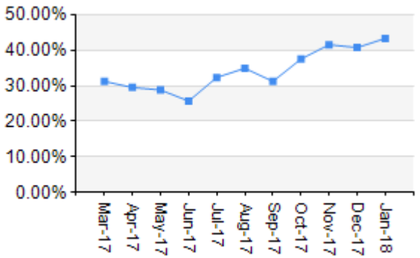
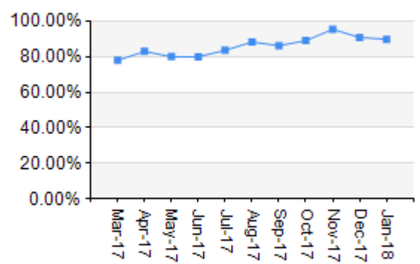
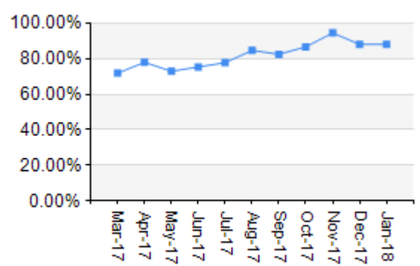
Metric Name & Target	Trend Chart	Exception Notes	Owner
Cancer - 31 Day Diagnosis To Treatment (First Treatments) **Target: >=96%**		Indicator is green no exception report required	Deputy Chief Operating Officer
Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug) **Target: >=98%**		Indicator is red at 97.1% un-validated perforamnce	Deputy Chief Operating Officer
Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy) **Target: >=94%**		Indicator is green no exception report required.	Deputy Chief Operating Officer

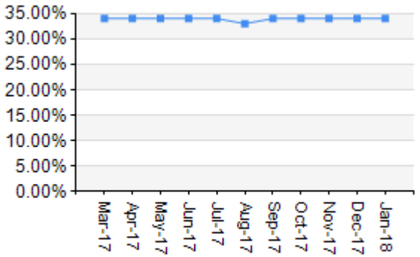
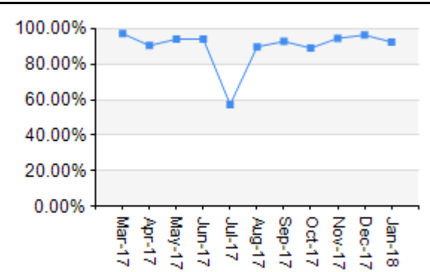
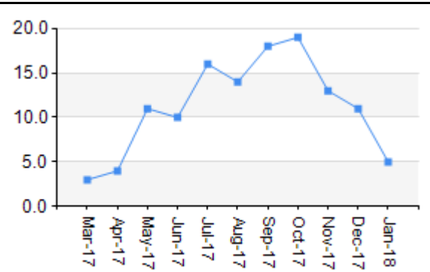
Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery) **Target: >=94%**		Indicator is 97.9% un-validated	Deputy Chief Operating Officer
Cancer - Urgent referrals Seen in Under 2 Weeks **Target: >=93%**		Jan performance = 87.2% (unvalidated); target = 93% Performance has improved since October(74.6%) and it is anticipated that all tumour sites (except colorectal) will deliver the standard by the end of February. There are recovery plans for colorectal, with delivery anticipated by the end of February 2018 but this will require additional clinics to manage the increased demand. - 2ww PTL developed (go live before end of January)to emailed daily to stakeholders - 2ww Ops meeting every Monday to discuss reconciliation/ DNA/ breach report - 2ww SPC charts developed and disseminated to each specialty See Cancer Delivery Plan & Cancer Escalation report.	Deputy Chief Operating Officer
Cancer (104 Days) - With TCI Date **Target: 0**		Performance - 10 There are currently 10 patients with a TCI date with plans.A number of patients are urological patients and there is a specific urology recovery plan that addresses long waiting performance which has been previously provided. Of those 9, there are a number have already been treated and are awaiting histology results and those are awaiting Robot Assisted Laparoscopic Prostatectomy (RALP). There is a plan to provide more RALP capacity from December onwards. See Cancer Delivery Plan.	Deputy Chief Operating Officer

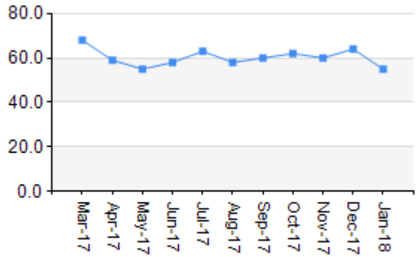
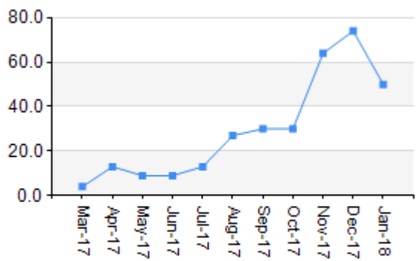
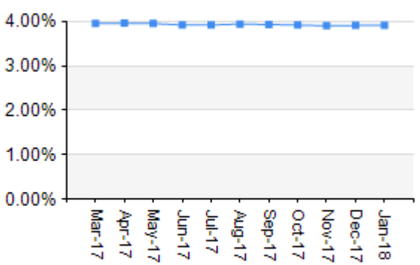
Cancer (104 Days) - Without TCI Date **Target: 0**		Performance 19 patients, without a TCI. 19 patients over 104 days with no TCI. A weekly process to review those patients on the 104 list that is accurate is now in place which relates to the national submission. Alongside this there has been progress to treat the longest waiting patients. A few patients during the month have been late referrals into the Trust and / or waiting specialist care in other Hospitals. The appointment of a locum urology consultant will continue to positively impact the performance in future months. Of the non-urology patients, all of the remainder were waiting due to complex pathways, shared pathways with other Trusts, patient choice for a specific procedure or unfit for treatment. All of these patients are being monitored. The Trust has developed a Clinical Validation Policy which includes a review of all patients waiting 104 days or more on a 62 day pathway, the processes by which this policy is adhered to is being reviewed for April 2018/19. In addition the policy is under review and aligned with the Patient Access Policy.	Deputy Chief Operating Officer
Cancer 62 Day Referral To Treatment (Screenings) **Target: >=90%**		Indicator is green. No exception report required. See cancer exception report for full cancer delivery plan.	Deputy Chief Operating Officer
Cancer 62 Day Referral To Treatment (Upgrades) **Target: >=90%**		Relates to 3 patients and all are treated	Deputy Chief Operating Officer

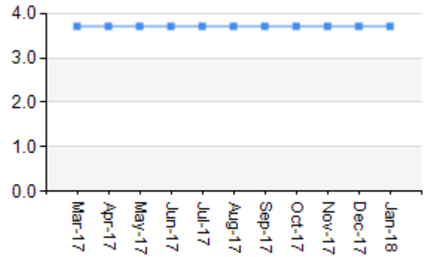
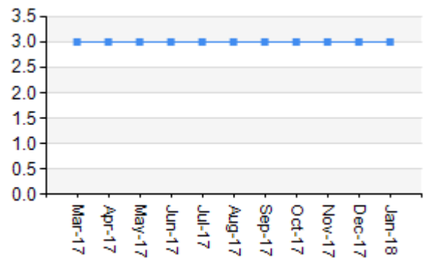
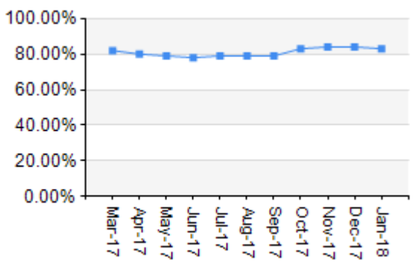
Cancer 62 Day Referral To Treatment (Urgent GP Referral) **Target: >=85%**		Dec breaches 35.5 (Uro 15.5 Gynae 5.5 UGI 3 LGI 3) Jan breaches 48.5 (H&N 5, LGI 9.5, Lung 6, Uro 19)	Deputy Chief Operating Officer
CGH ED - Percentage within 4 Hours **Target: >=95%**		See Emergency Care Delivery Group report	Deputy Chief Operating Officer
Dementia - Fair question 1 - Case Finding Applied **Target: Q1>86%Q2>87%Q3>88%Q4>90%**		Trakcare process for recording engaged, but outside of other clinical clerking. Junior Medical staff reminded to access this field in Trak to enter this data.	Deputy Nursing Director & Divisional Nursing Director - Surgery

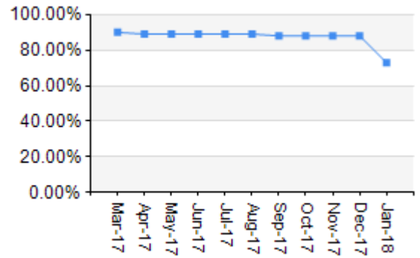
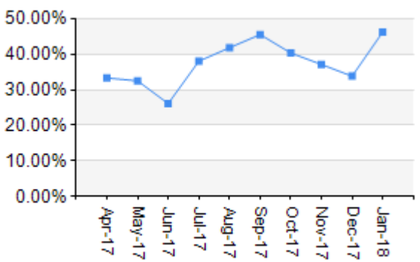
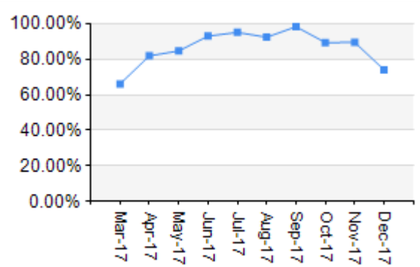
Dementia - Fair question 2 - Appropriately Assessed **Target: Q1>86%Q2>87%Q3>88%Q4>90%**		Trakcare process for recording engaged, but outside of other clinical clerking. Junior Medical staff reminded to access this field in Trak to enter this data.	Deputy Nursing Director & Divisional Nursing Director - Surgery
Dementia - Fair question 3 - Referred for Follow Up **Target: Q1>86%Q2>87%Q3>88%Q4>90%**		Trakcare process for recording engaged, but outside of other clinical clerking. Junior Medical staff reminded to access this field in Trak to enter this data.	Deputy Nursing Director & Divisional Nursing Director - Surgery
ED Time To Initial Assessment - Under 15 Minutes **Target: >=99%**		Performance against the 15 minute standard for initial triage has slightly decreased but continues to fall below the standard required at both sites, with performance failing following surges in ambulance arrivals. The physical space at GRH is being altered along with the staffing support to enable this key safety metric to be achieved. Alterations to the physical space was completed in early November, staffing model due to be implemented during December. Performance against the 15 minute standard for initial triage continues to fall below the standard required at both sites, with performance failing following surges in ambulance arrivals.	Deputy Chief Operating Officer

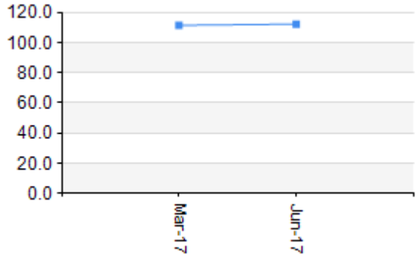
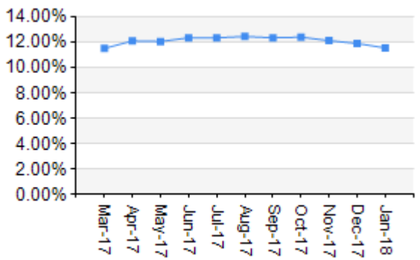
ED Time to Start of Treatment - Under 60 Minutes **Target: >=90%**		Performance against this standard is still not being met on either side of the county. A detailed review of the data has confirmed that we are underreporting against this key safety metric as we are not coding all of the senior decision makers appropriately. This is in the process of being rectified by the ED team. Time for escalation is now reviewed on the daily escalation reports and conference calls. Performance against this standard is still not being met on either side of the county. Detailed focus is required on this key safety metric to improve time to first assessment. A short term task and finish group has been established.	Deputy Chief Operating Officer
ED Total Time in Department - Under 4 Hours **Target: >=95%**		Please see Emergency Care Delivery Group Exception Paper 4hr performance January 89.7%	Deputy Chief Operating Officer
GRH ED - Percentage Within 4 Hours **Target: >=95%**		GRH failed to achieve the performance standard for ED in December due to operational challenges that are internal to ED and wider GHT areas. A detailed action plan is in place to rapidly improve processes within GHT both within the Emergency Department but also across the key clinical inpatient and support services. Performance for December has delivered the Trust STP trajectories at aggregate level.	Deputy Chief Operating Officer

Improve Communication Between Senior Managers and Staff (as Measured by the Annual Staff Survey) **Target: >38%**		This indicator is proposed to be removed as it is annual measure. it will therefore be reported in the month of the survey.	Director of Human Resources and Operational Development
Max 2 Week Wait For Patients Referred With Non Cancer Breast Symptoms **Target: >=93%**		Performance has improved since November (93.9%). Our December position is 183 First seens with 11 breaches. January performance shows a deterioration with 225 First Seens with 17 breaches.	Deputy Chief Operating Officer
Number of Breaches of Mixed Sex Accommodation **Target: 0**		Performance for December has delivered the Trust trajectories at aggregate level. The routine mixing of sexes in inpatient clinical areas is unacceptable and must only happen in exceptional circumstances. A total of 5 breaches declared by the Trust for the month of January 2018 (a decrease), impacting on 23 occurrences. The analysis shows that all 11 breaches were within the Critical Care departments. All breaches were due to the inability to move patients out of Critical Care areas once they had been made wardable. This is particularly prevalent at the GRH site where the operational OPEL status is often at level 3 (red) or 4 (black) and bed availability poor. The Standard Operating Plan has been developed and this issue has been escalated to the Chief Nurse.	Head of Capacity and Patient Flow

Number of Medically Fit Patients Per Day **Target: <40**		The number of medically fit patients has increase over the past month against last month's performance. One of two reasons behind this has been the surges during the week in ED attendances & admissions which leads on to a back log of Social Care Assessments. Mitigations for this have been an increase in the number of social workers working on Saturday and Sundays and OCT working over both Saturday and Sunday each week. The second reason to note is that we appear to have an increase in the number of patients awaiting Community Social Work assessment. We are discussing this with our partners, as this may be an impact of community social work having to focus in late January on community hospital discharges in support of the Trust Flow. A number of work streams continue to support reduced LoS through Stranded patient reviews. January position is 55 medically fit patients.	Deputy Chief Operating Officer
Referral To Treatment Ongoing Pathways Over 52 Weeks (Number) **Target: 0**		See Planned Care Exception Report.	Deputy Chief Operating Officer
Sickness Rate **Target: G<3.6% R>4%**			Director of Human Resources and Operational Development

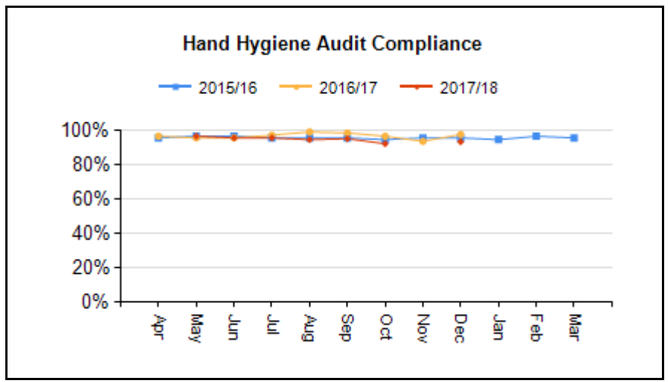
Staff Engagement Indicator (as Measured by the Annual Staff Survey) **Target: >3.8**		Annual Staff Survey	Director of Human Resources and Operational Development
Staff having well-structured appraisal Indicator **Target: >3.8**		Appraisals as at Dec = 84% 2017 staff survey expected Spring 2018. Talent Management project starting in January to include Appraisals.	Director of Human Resources and Operational Development
Staff who have Annual Appraisal **Target: G>89% R<80%**			Director of Human Resources and Operational Development

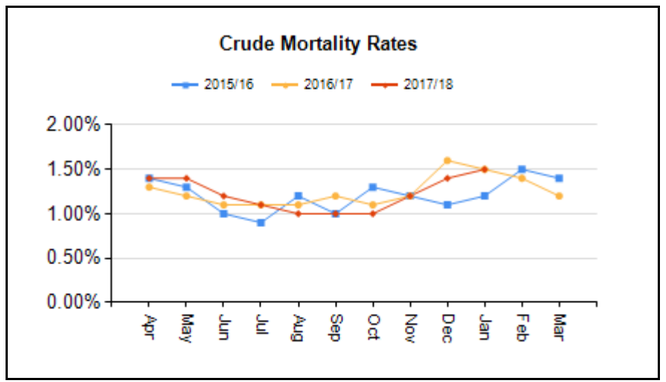
Statutory/Mandatory Training **Target: >=90%**		As predicted, overall compliance is lower (73%) primarily due to the need to refresh Safeguarding Adults Awareness, Safeguarding Children Awareness and Prevent Basic Awareness due to changes in legislation and government guidelines. A global email has been sent to staff and staff will be chased with the aim of compliance being back up by the end of March.	Director of Human Resources and Operational Development
Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour **Target: >=50%**		The organisation is still striving to achieve the target of scan within 1 hour of arrival. Stroke champions have been created within the ED nursing and medical teams to ensure all staff are aware of the quality standards for this service and improved communication, escalation and response times for patients awaiting diagnostic tests features on the ED task and finish action plan. As a result of the performance, the Director for Operations, Medicine is meeting with all parties involved to address the performance position. Update for March 2018 to be provided.	Director of Operations - Medicine
Stroke Care: Percentage Spending 90%+ Time on Stroke Unit **Target: >=80%**		Performance has deteriorated in this field, in January due to increased bed pressures across the organisation, resulting in less patients being admitted directly into the Stroke Ward. The Director of Operations, Medicine, is working closely with the Deputy COO, Unscheduled Care to ensure the policy of having a ring-fenced stroke bed is adhered to and through the ward appropriate step-down patients are identified.	Director of Operations - Medicine

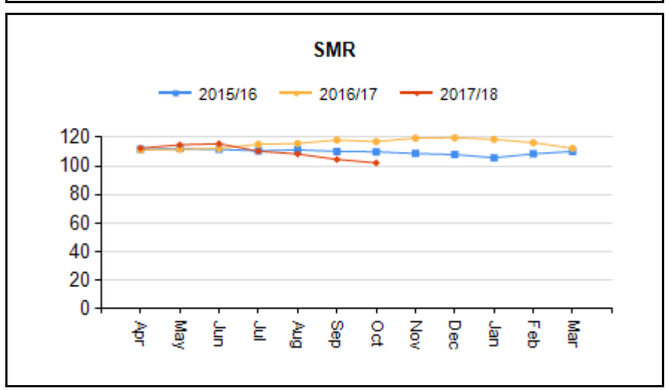
Summary Hospital Mortality Indicator (SHMI) - National Data **Target: Dr Foster confidence level**			Medical Division Audit and M&M Lead
Workforce Turnover Rate **Target: 7.5% - 11%**			Director of Human Resources and Operational Development

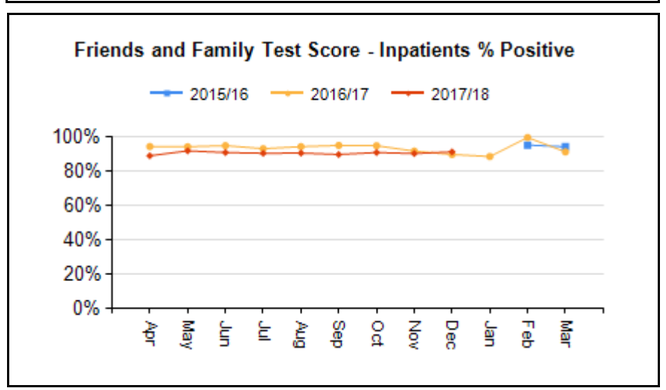
Contextual Indicators

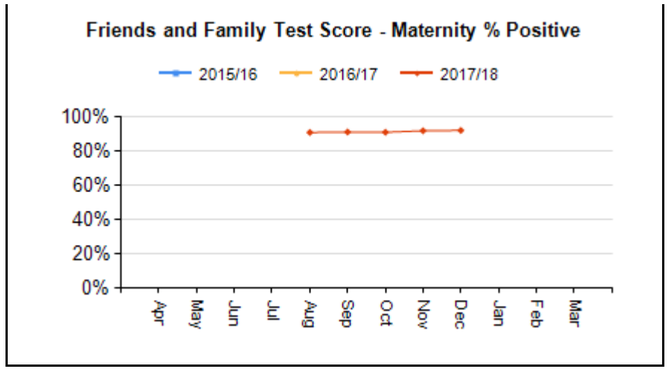
This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, relative to that of previous months and years.

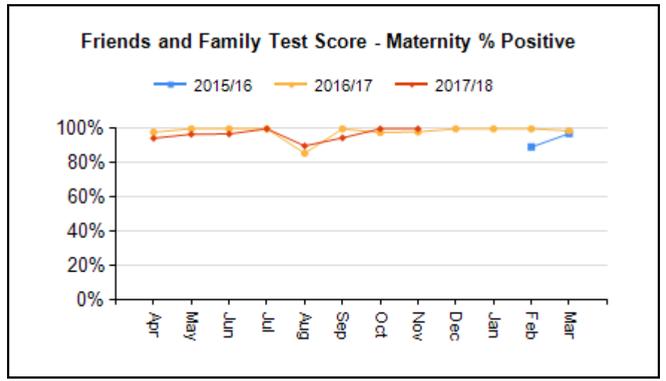


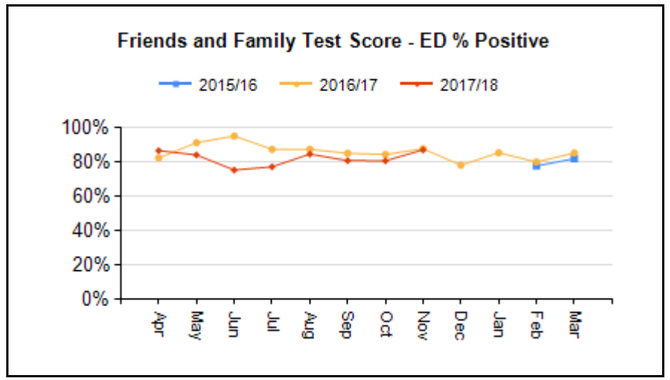


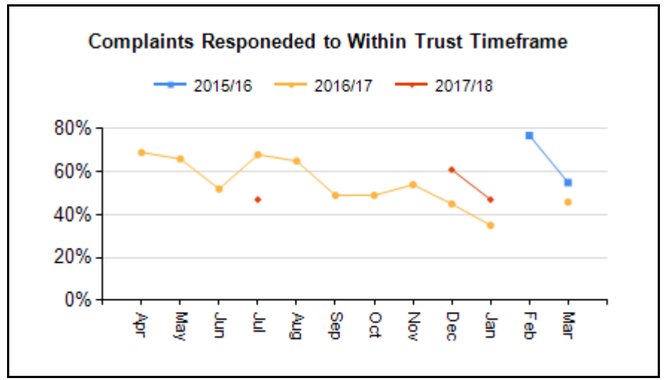


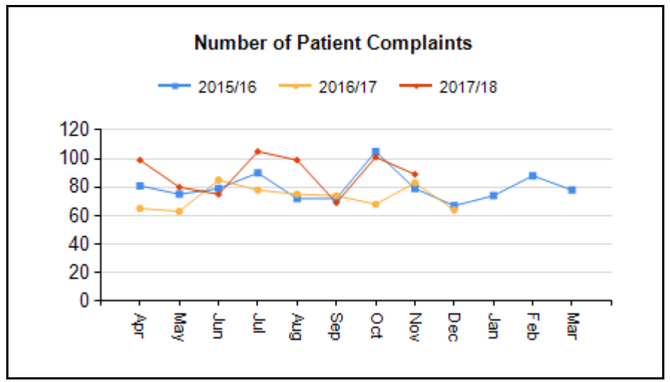


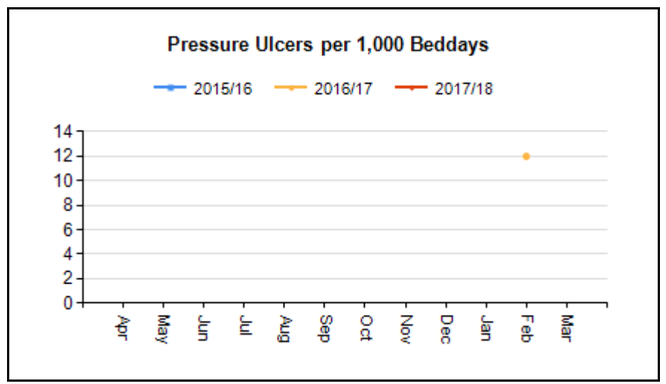

Friends and Family Test Score - Maternity % Positive
2015/16
2016/17
2017/18
100%
80%
60%
40%
20%
0%
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar

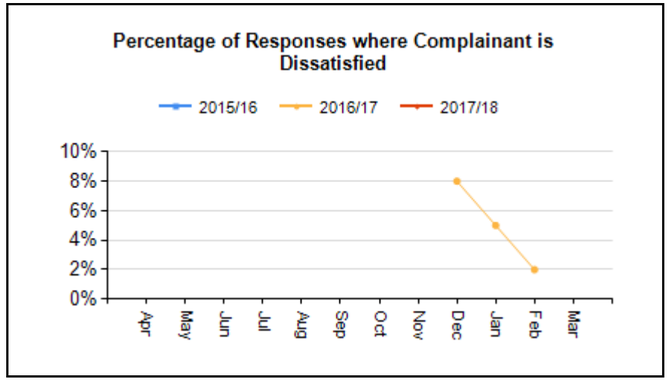

Friends and Family Test Score - Maternity % Positive
2015/16
2016/17
2017/18
100%
80%
60%
40%
20%
0%
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar

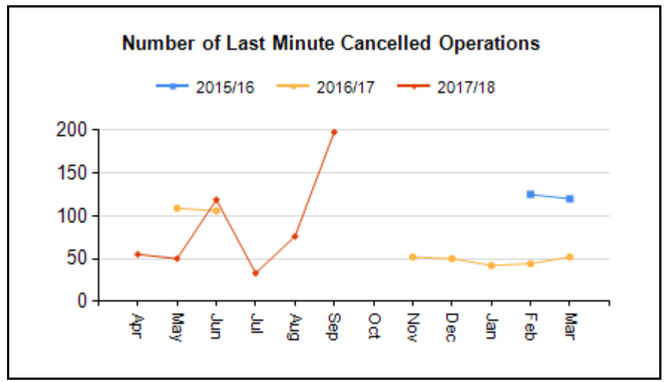

Friends and Family Test Score - ED % Positive
2015/16
2016/17
2017/18
100%
80%
60%
40%
20%
0%
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar

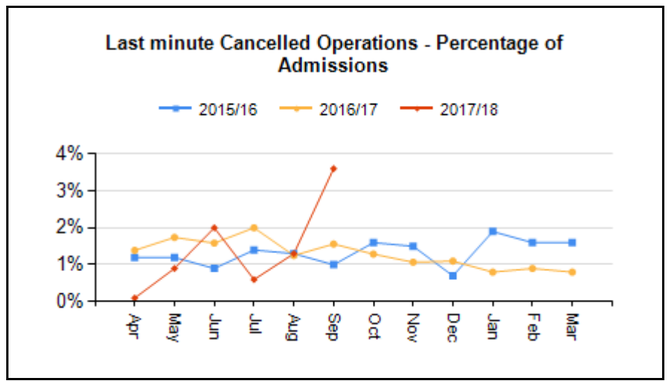

Complaints Responeded to Within Trust Timeframe
2015/16
2016/17
2017/18
80%
60%
40%
20%
0%
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar

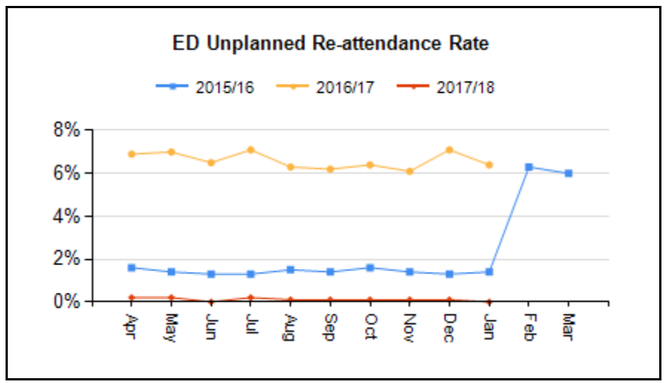

Number of Patient Complaints
2015/16
2016/17
2017/18
120
100
80
60
40
20
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar

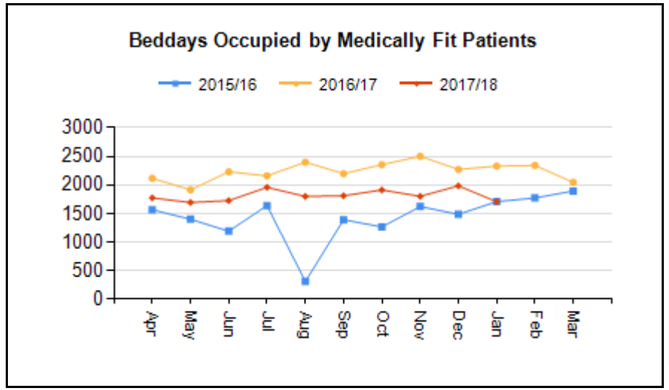

Pressure Ulcers per 1,000 Beddays
2015/16
2016/17
2017/18
14
12
10
8
6
4
2
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar

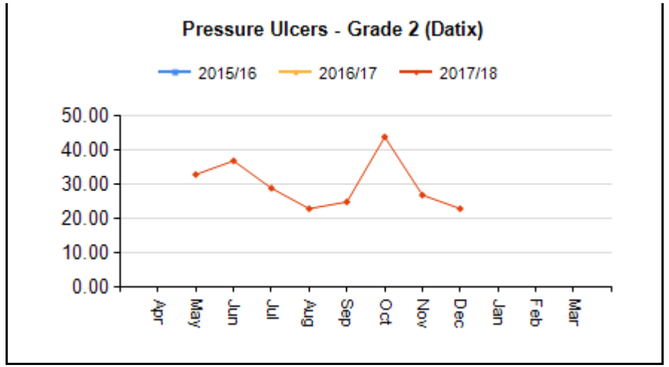

Percentage of Responses where Complainant is Dissatisfied
2015/16
2016/17
2017/18
10%
8%
6%
4%
2%
0%
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar

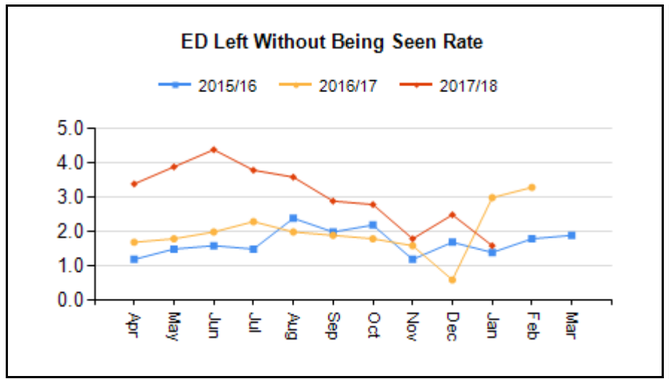

Number of Last Minute Cancelled Operations
2015/16
2016/17
2017/18
200
150
100
50
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar

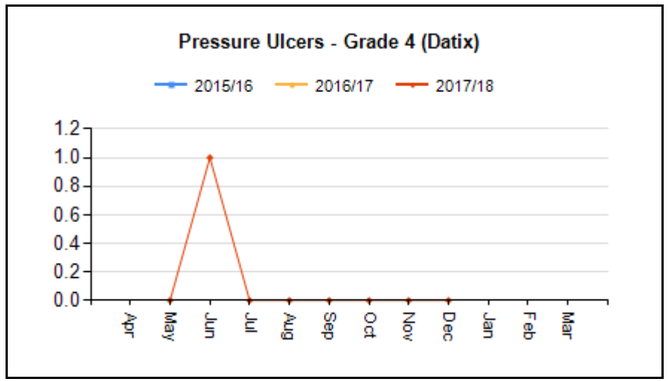

Last minute Cancelled Operations - Percentage of Admissions
2015/16
2016/17
2017/18
4%
3%
2%
1%
0%
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar


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


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


Pressure Ulcers - Grade 2 (Datix)
2015/16
2016/17
2017/18
50.00
40.00
30.00
20.00
10.00
0.00
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar


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


Pressure Ulcers - Grade 4 (Datix)
2015/16
2016/17
2017/18
1.2
1.0
0.8
0.6
0.4
0.2
0.0
Apr
May
Jun
Jul
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Sep
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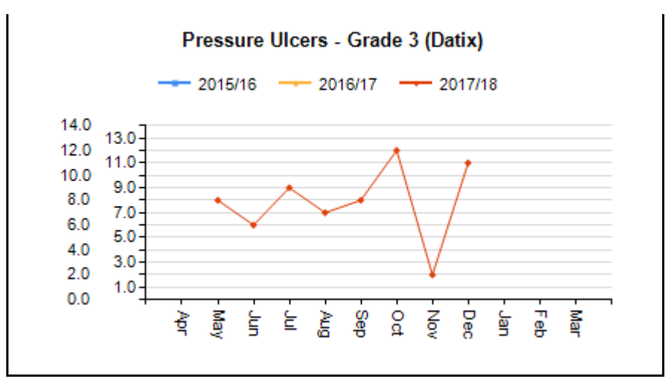
Nov
Dec
Jan
Feb
Mar


Pressure Ulcers - Grade 3 (Datix)
2015/16
2016/17
2017/18
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
13.0
11.0
9.0
7.0
5.0
3.0
1.0
Apr
May
Jun
Jul
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Sep
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Nov
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Mar

REPORT TO MAIN BOARD – MARCH 2018

From Quality and Performance Committee Chair – Claire Feehily, Non-Executive Director

This report describes the business conducted at the Quality and Performance Committee on 22 February 2018, 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
Risk Register	Further improvements to the reporting format, enabling identification and discussion of emerging themes and lessons being learned and embedded.	Re falls: what is the robustness of arrangements for observation and escalation, especially at night?	Re falls: Deep dive to be undertaken and action plan produced.	Further specific investigations to take place; enhanced surveillance by Committee agreed, and future reporting confirmed for specific risks.
	Specific issues reported related to risks arising from: - Sequence of surgical related never events - Inpatient falls, including discussion of coronial interest - C-diff - Delayed treatment and diagnosis arising from delays to follow-up care	Need to maintain urgent and sustained progress to address and clear backlogs as well as effective oversight of patients whose treatment has been delayed.	Re never events: Trust's report and action plan to include input from an external expert for additional assurance Arrangements for identifying, reviewing and prioritising patients were described. Improvement and recovery trajectories are in place.	Review of cases where follow-up has not taken place or been delayed to be undertaken. CCG to participate. Update reporting through Committee.

		Although numbers of such delayed patients are relatively small, are we clear of sources of ongoing risk from historic cases?	Actions to remedy difficulties with patient lists being addressed within TrakCare project	
Quality and Performance Report	Emergency Care: In January Trust achieved 89.7%, well in excess of its trajectory (80%) for 4 hour standard. Significant growth in demand (10.2% increase on Jan 2017) Strong A&E performance regionally and nationally. Achieved diagnostic 6 week wait target.	Committee commended team for evidence of significant and sustained improvement in A&E and diagnostics. Particular mention was given to improvements in performance of care and treatment for stroke patients. What is our progress in meeting the 60 minute target time for patients seeing a clinical decision-maker? What current feedback do we have from patients about their experience of emergency care and any specific issues?	Further report received on good compliance with NHSI Enforcement Undertakings re A&E performance. Trust rating for A&E moved from Cat 4 (most challenged) direct to Cat2. Trust not yet where it needs to be on this, particularly when the emergency department is crowded. Main theme is from families identifying difficulty in accessing Emergency Dept and AMU by phone, especially locating patients once transferred.	Performance to be the subject of a task and finish group to secure improvements in coordination; embedding of best practice; and consistency of practice within and between teams. New telephony system planned during 2018 that should improve call management.

		What efforts are being made to understand and respond to such a scale increase in demand and what are we learning about planning for the next holiday period?	In part we are seeing what is being experienced nationally. There is more that the Trust can do to anticipate demand and improve the planning of staffing. More system-wide planning coordination needed for staffing availability in non-acute services too.	Opportunities for further coordination and joint planning to be investigated.
	Planned Care: 18 week RTT standard Reporting remains suspended. Improvements to management of patient lists were described, together with a targeted training programme to improve staff confidence and understanding with relevant elements of TrakCare. 50 cases of waiting times in excess of 52 weeks were reported in January and we will continue to see these occurring in near future. Some areas of typing backlog were reported.	Where does the team feel improvement efforts are most challenged?	Notwithstanding efforts and commitment, in high volume areas, especially Trauma and Orthopaedics, where the task of booking clinics correctly is challenging. Good evidence of cooperation with IT colleagues for system enhancements. Urology is also experiencing capacity problems. Evidence of much improved coordination of improvements with divisional clinical leadership.	Revised recovery plan in preparation.

		Are there any specific current themes from patient feedback?	Fewer issues being raised with PALS than previously relating to booking and appointments.	
	Cancer standards: Trust did not achieve 2 week wait and 62 day cancer standard. Particular capacity problems for colorectal treatment on 2 week pathway. Discussion of delays arising from exercise of patient choice and delays in patients' readiness to be booked into 2 week pathway. Valuable recent work with CCG Dep Clinical Chair to strengthen how "we" (Trust and GPs) communicate with patients about the importance of timely actions to optimise use of specialist cancer resources. Specific commendation to Dermatology and Gynaecology Teams for their innovation and level of sustained improvement.	Are we satisfied *that we are* and *with how we are* communicating with people whose cancer treatment has been delayed	New patient letters were described as well as types of conversations that are being had with patients about their delays. It was recognised that such communication is more straightforward for some types of treatment (e.g. Dermatology) than others.	
	Areas of concern include Urology and lower and Upper GI tumour sites.	What is the specific concern about Urology and can it be resolved?	Problem of capacity to maintain current activity while also addressing backlog. Plans for extended and weekend lists are in place.	Revised recovery plan to Committee.

		How can the Straight to Test plans be accelerated?	Process maps are currently being prepared to help determine a proposal	Focused support and advice to specific GP surgeries being planned.
CQC Action Plan Progress Report	Comprehensive quarterly report updating Cttee on progress against Must Do and Should Do actions from last CQC inspections.	Authors were commended for detail and transparency of the report and its evidence of close supervision of progress.		
	RAG rating against current status and description of how Executive have assured themselves re progress, including intention to use Internal Audit and Audit Cttee to test and review aspects of implementation.	Given level of activity, occupancy and pressure, how can we be assured that CQC matters receive priority and attention in the daily work settings?	The sense of priority is understood and there is good team understanding and engagement. However there are difficulties that arise from a transient workforce and from challenge of tackling some estate matters because of "busyness".	Plan to renew flooring in 9th floor in GRH in hand which need a ward to be freed up.
	Some difficulties were described in ensuring implementation,, arising from pressure on some areas of service, mix of permanent and temporary staff and estate and equipment needs.	Be sure to use Charitable Funds options where appropriate additional investment might be mobilised quickly,		
	Progress on two specific recommendations was escalated, relating to cleaning and equipment, and to a backlog of typing.	Are we making sure we make good connections on these staffing challenges to Workforce Committee where they have not yet been flagged?		Consider at Workforce Committee.

Mortality Report	HSMR and SMR are now within the expected range (likely to lead to very early achievement of Trust strategic goal). Evidence was reported of a better understanding of the factors that are driving the improvement in Trust performance. Update on measures to extend family involvement in reviews of deaths, including suggestions for collecting feedback in the most empathetic way that we can. Improvements in database for recording review details, enabling learning.	Update on very valuable NED meeting with Dr Elyan and Dr Foster team to extend our understanding of reporting arrangements and potential for further improvement. What are the arrangements in the event that someone with learning disabilities dies and are we confident that correct triggers to conduct review will be applied? How will themes be reported and extracted?	Yes, the Trust is strong in this area and separate reporting and review arrangements apply. Quarterly reporting format in development.	
Safer Staffing	Briefing provided on overview of staffing position. January had been particularly demanding with relatively high sickness rates. Specific recruitment pressures were described, especially concerning A&E nursing. Specific pressures in AMU re permanent to temporary ratios.	Need for closer cross-reporting into Workforce Committee		Closer examination of this topic at next Q&P.

Claire Feehily
Chair of Quality and Performance Committee
28 Feb 2018

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – MARCH 2018
Lecture Hall, Sandford Education Centre commencing at 09:00am

Report Title
Workforce Report
Sponsor and Author(s)
Author: Alison Koeltgen, Acting Deputy Director of People & OD Sponsor: Emma Wood, Director of People and Deputy Chief Executive
Executive Summary

Purpose

This report provides Trust Board with an overview of current performance, against key performance indicators and outlines progress against the short term strategic objectives as identified in November 2017.

Key issues to note

Further **reductions in turnover** taken the Trust rolling total to 11.88%. This is **closer to the target of 11%,** this goes against typical trends experienced at this time of year.

The Trust **annual sickness absence rate** of 3.93% remains **significantly lower than the national average for Large Acute Trusts (4.57% to Nov 17).** Despite the usual increase in winter sickness absence, reported levels remain below those experienced in previous years.

Appraisal compliance deteriorated in January, with EFD being the only division to achieve compliance above the 90% Trust target. This is largely expected due to seasonal pressures and will be considered as part of the talent management system development.

Mandatory training figures suffered similar deterioration, however it is noted that this is largely due to a requirement to refresh safeguarding training for all employees, therefore we expect to see this improve again in coming months.

6-12 month priorities: Progress is noted within the report against all of the projects identified in November 2017 to the Main Board and Workforce Committee these include:

- Establishment realignment
- CIP Delivery
- Talent Management System Development
- Staff Health and Wellbeing
- Staff Engagement

The development of the Subco proposals has been excluded from this summary due to the extraordinary Trust Board meeting being held at the time of writing this paper.

Conclusions

Performance against both Sickness Absence and Turnover targets is promising, reflecting a more positive position compared to previous years. Appraisal compliance is of concern and is being considered as we develop a revised talent management process. Whilst mandatory training compliance has declined, we understand this dip in performance to be temporary due to a safeguarding training requirement in month.

Implications and Future Action Required

Full Staff Survey results will be discussed at TLT 7th March 2018.
Update on key projects to next Trust Board and Workforce Committee.

Recommendations

The Trust Board is asked to NOTE performance against our key indicators and the progress made against our 6-12 month priorities.

Impact Upon Strategic Objectives

- Supporting Financial Recovery and Cost improvement activity
- Supporting Increased Staff Engagement, Wellbeing
- Ensuring we attract and retain a sustainable workforce

Impact Upon Corporate Risks

Ensuring staff turnover remains at an acceptable level supports the mitigation of the risk of being unable to match recruitment needs with suitably qualified staff, impacting on the delivery of the Trusts strategic objectives.

Similarly, through reduced sickness absence and turnover we reduce the demand for temporary staff in both clinical and non-clinical professions.

Regulatory and/or Legal Implications

NHSI scrutiny of agency spend and financial recovery.

Equality & Patient Impact

N/A

Resource Implications

Finance	✓	Information Management & Technology	
Human Resources	✓	Buildings	

Action/Decision Required

For Decision		For Assurance		For Approval		For Information	✓

Date the paper was presented to previous Committees

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

Outcome of discussion when presented to previous Committees

N/A

MAIN BOARD – MARCH 2018

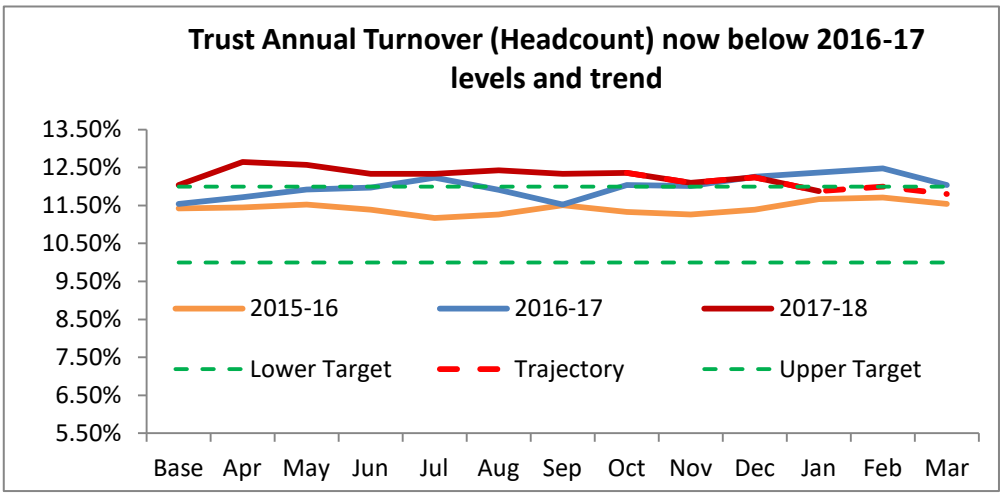
WORKFORCE REPORT

1. Aim

This report provides Trust Board with an overview of current performance, against key performance indicators and outlines progress against the short term strategic objectives as identified in November 2017 to the Workforce Committee.

2. Staff Turnover

Current performance places us at 11.88%, whilst this is above the target of 11% it falls within a range of turnover (10-12%) which we have identified as reasonable, based on benchmarking with other acute trusts. This reduction in turnover goes against previous trends, as we often see a slight increase in turnover at the beginning of the calendar year.

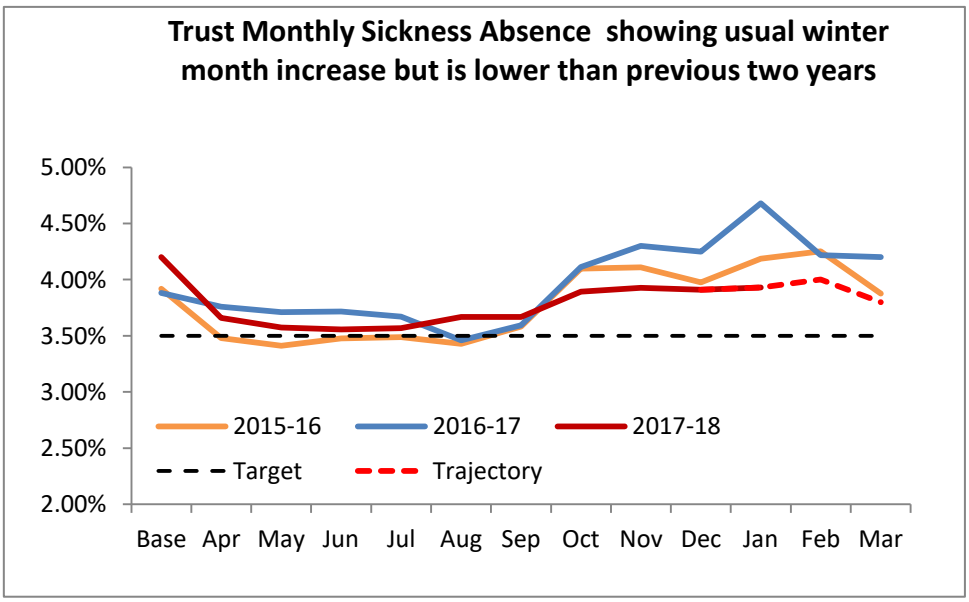


Description	Current Performance		Movement since last Month	
Turnover is measured using the total leavers (heads) as a percentage of the average headcount for the reporting period. The Trust target is 10% - 12% with the red threshold above 15% and below 6%.	12 months to 31 January 2018	**Actual % TO**		
	Trust Total	**11.88%**	↘	Decrease
	Corporate	13.77%	↘	Decrease
	Diagnostics & Specialty	11.38%	↘	Decrease
	Estates & Facilities	7.65%	↘	Decrease
	Medicine	13.25%	↘	Decrease
	Surgery	11.74%	↘	Decrease
	Womens & Children	12.36%	↘	Decrease
	Add Prof Scientific and Technic	8.71%	↗	Increase
	Additional Clinical Services	14.48%	↘	Decrease
	Administrative and Clerical	14.49%	↘	Decrease
	Allied Health Professionals	12.34%	↘	Decrease
	Estates and Ancillary	8.80%	↘	Decrease
	Healthcare Scientists	10.70%	↗	Increase
	Medical and Dental	5.87%	↘	Decrease
	Nursing and Midwifery Registered	10.89%	↘	Decrease
	Staff Nurses	12.13%	↘	Decrease
	Significantly above upper target limit (>15%)			
	Above upper target limit (12%)			
	Between target limits (10-12%)			
	Within target or below (10%)			

3. Sickness Absence Management

The Trust annual sickness absence rate of 3.93% remains significantly lower than the national average for Large Acute Trusts (4.57% to Nov 17). Despite the usual increase in winter sickness absence, reported levels remain below those experienced in previous years. This improvement in overall performance is influenced by a number of factors including the introduction of a revised sickness absence management process in February 2017. This has had a notable impact on manager's ability to swiftly and proactively support and manage absent staff.

With long term absence accounting for approximately 49% of absence it is essential that all Line Managers follow the process outlined in the Trust Sickness Absence policy, to support the reduction in long term absence levels. Further HR support has been made available to a number of managers to facilitate the management of this absence, alongside a peer review of our absence policy to ensure the toolkit available is both appropriate and efficient. The estimated cost of annual sickness absence is circa £7.2m (in lost hours, not including backfill costs).



Description	Current Performance			Sickness Absence by month						Movement Dec to Jan	
Sickness Absence is measured as percentage of available Full Time Equivalents (FTEs) absent against available FTE. The Trust target Is 3.5% with the red threshold 0.5% above this figure.	12 months to Jan 18 (Annual)	**Actual**	**KPI**	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18		
		% Abs	**% Abs**								
	Trust Total	3.93%	3.50%	3.67%	3.67%	3.88%	4.05%	4.24%	4.81%	↗	increase
	Corporate	4.10%	3.50%	3.88%	3.90%	4.26%	4.06%	4.61%	5.14%	↗	increase
	Diagnostics & Specialty	3.78%	3.50%	3.66%	3.56%	4.06%	3.90%	4.15%	5.04%	↗	increase
	Estates & Facilities	4.40%	3.50%	3.96%	4.11%	3.87%	4.32%	3.81%	4.60%	↗	increase
	Medicine	3.66%	3.50%	3.08%	3.28%	3.94%	4.01%	4.07%	4.64%	↗	increase
	Surgery	4.13%	3.50%	3.82%	4.05%	3.81%	4.26%	4.61%	4.79%	↗	increase
	Womens & Children	3.72%	3.50%	3.99%	3.17%	3.13%	3.70%	3.70%	4.51%	↗	increase
	Add Prof Scientific and Technic	3.48%	3.50%	4.32%	2.79%	2.47%	2.67%	2.57%	2.89%	↗	increase
	Additional Clinical Services	4.81%	3.50%	4.64%	4.73%	5.25%	5.16%	5.83%	6.38%	↗	increase
	Administrative and Clerical	4.24%	3.50%	3.73%	3.70%	3.97%	4.10%	4.22%	4.96%	↗	increase
	Allied Health Professionals	2.83%	3.50%	3.08%	3.24%	3.01%	2.55%	3.02%	3.34%	↗	increase
	Estates and Ancillary	4.39%	3.50%	4.17%	3.97%	3.93%	4.44%	4.32%	5.02%	↗	increase
	Healthcare Scientists	2.84%	3.50%	2.66%	3.80%	3.42%	2.85%	2.37%	4.18%	↗	increase
	Medical and Dental	1.67%	3.50%	1.28%	1.68%	1.44%	1.65%	1.58%	1.48%	↘	decrease
	Nursing and Midwifery Registered	4.37%	3.50%	4.05%	3.94%	4.39%	4.84%	5.03%	5.70%	↗	increase

4. Appraisals and Mandatory Training

In January we observed a decline in both Appraisal and Mandatory Training Compliance. Whilst the decline in these figures can be largely predicted at this time of year, it remains a concern. EFD remain the only Division to have met the 90% appraisal rate.

The requirement for all staff to renew Safeguarding training impacted on the Mandatory Training rates in January, which are now showing a decline across all divisions.

Appraisals	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Movement since last Month	
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%		
Corporate	82%	86%	82%	82%	75%	76%	77%	77%	80%	82%	83%	82%	↘	decrease
Diagnostics	88%	88%	86%	84%	84%	83%	83%	83%	85%	85%	84%	84%	→	stable
Estates & Facilities	77%	74%	63%	60%	59%	60%	68%	72%	94%	95%	93%	92%	↘	decrease
Medicine	77%	79%	78%	79%	79%	79%	78%	77%	81%	82%	81%	79%	↘	decrease
Surgery	83%	82%	80%	79%	78%	80%	79%	77%	79%	83%	82%	81%	↘	decrease
Women & Children	80%	78%	77%	81%	83%	82%	81%	80%	85%	85%	86%	85%	↘	decrease
Trust	**82%**	**82%**	**80%**	**79%**	**78%**	**79%**	**79%**	**79%**	83%	84%	84%	83%	↘	decrease

Mandatory Training	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Jan-18	Movement since last Month	
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%		
Corporate excl Bank	92%	92%	92%	92%	92%	92%	91%	91%	90%	90%	76%	↘	decrease
Diagnostics	94%	94%	94%	94%	94%	93%	93%	93%	92%	92%	74%	↘	decrease
Estates & Facilities	88%	89%	87%	83%	80%	85%	88%	86%	86%	89%	65%	↘	decrease
Medicine	88%	89%	89%	89%	89%	88%	88%	87%	86%	86%	73%	↘	decrease
Surgery	90%	90%	90%	91%	91%	90%	90%	90%	89%	90%	77%	↘	decrease
Women & Children	89%	89%	88%	88%	89%	89%	88%	88%	87%	87%	75%	↘	decrease
Trust	**89%**	**90%**	**89%**	**89%**	**89%**	**89%**	**89%**	**88%**	**88%**	**88%**	**73%**	↘	decrease

5. Staff Survey

Quality Health confirmed the Trust overall response rate as 47%, sitting above the National Average response rate of 44% for Acute Trust. This fell just below the response rate for last year (50%) with 168 *fewer* staff completing the survey overall.
Full Staff Survey results will be discussed at TLT 7th March 2018; an initial breakdown for Divisions and individual staff groups has been distributed to the relevant Divisonal/ Department Heads. The survey themes and proposed actions will be available in full in March 2018.

6. Update on 6-12m Priorities

Establishment Realignment

Our current establishment data is held in both the Electronic Staff Record system (ESR) and on the purchase ledger. These data sets vary, which results in inaccurate establishment reporting, poor quality workforce information and restricted vacancy profile reporting. Through a review of establishment need versus budget and the agreement of a baseline funded position financial control would be improved as would workforce planning and design. Services, such as recruitment, education, learning and development could be proactive (and longer term orientated) rather than reactive.

Progress Nov-Jan 18:

- **Resource Identified**

Both HR and Finance Leads have determined the scope of the project and identified resource within existing teams to lead on key aspects of the data cleanse and process mapping work.

- **Benchmarking and Streamlining Programme Input**

An informal review of other Trusts work in this area (Derby, Devon and GCS) and an understanding of the requirements of the Doctors in Training Streamlining Programme have helped to inform our understanding of the steps required and the lessons other Trusts have learnt when integrating establishment data into the ESR.

Right-sizing the Establishment

Finance Business Partners are currently working with Divisions, as part of the 18/19 Budget setting process; to validate Establishment figures and determine the 'true data' set to feed into the ESR system.

Next Steps (progress expected by April 2018):

- Finalise the 'right size' establishment information (FBP's)
- Stakeholder engagement: fully scope the potential impact of changes within ESR on other system users (i.e.: payroll, training systems)
- Confirm data input solution (into ESR) with IBM
- To commence long term plan development for critical roles such as nursing

CIP Delivery

There are a number of ways in which we contribute to the delivery of CIP and the Trusts financial recovery programme.

Progress Nov- Jan 18

- **Revised vacancy control measures** were put in place in November 2017, placing vacancies on hold, where appropriate and safe to do so. To date, a significant number of vacancies have been identified as critical to the safe delivery of services. Further challenge at Divisional level ensures that the only posts now presented to VCP Panel are identified as requiring debate at executive level. A Divisional summary of the posts that have been rejected, postponed or recommended for approval is now presented to the Director of People before the VCP meeting for approval.

- **HR Business Partners** are embedded as critical attendees in the revised CIP Deep Dive meetings, working with Divisions to scrutinise business plans, opportunities and support the development of new working models.

- **The former 'Sustainable Workforce Group' and 'ELD'** have now merged and meets in early March to determine how this agenda can best support the Trusts financial recovery and CIP programme, whilst delivering workforce and education solutions that support the Trusts overarching strategic priorities.

- **Reducing Bank and Agency Expenditure**
  The Bank and Agency project has moved under the portfolio of Steve Hams, Chief Nurse however the People and OD department will be working closely with this team to ensure our temporary staffing offer and incentives are attractive and remain competitive.

Next Steps (progress expected by April 2018):

- Departmental schemes and restructures to improve service reconfiguration and efficiencies will be agreed.
- The identification of further workforce CIP opportunities for 2018/19
- A clear development plan which articulates the priorities of the Sustainable Workforce/ ELD group, against the backdrop of CIP challenge and Financial Recovery Plans.

Talent Development

A new system of talent management and succession planning is currently being refined, with initial proposals shared with the Trust '100 Leaders' forum in January 2018. The principle of meritocracy underpins the design, as does the ability for staff to be both recommended as 'talent' and also 'self-identify.'

Next Steps (progress expected by April 2018)

- 4 Focus groups with key stakeholders are taking place in March, with representatives from 100 Leaders and individual staff members (both with and without appraisal responsibility) to discuss the proposals and hear the latest update on progress.
- Update planned to 100 Leaders 27 April 2018

Staff Health & Wellbeing

Health and Safety agenda now falls under the portfolio of the Deputy CEO and Director of People, The Health and Wellbeing agenda was previously split between *public* and *staff* Health and Wellbeing priorities (divided between the Director of HR& OD and the Director of Clinical Strategy), under the new model this will be merged as part of the complete Health and Safety portfolio.
A new emphasis on diversity has commenced and this should remain a key focus to ensure all our staff are embraced and reflect the patients we serve.
The two greatest causes of staff absence are MSK and psychological issues. The Trust has many channels of support however the accessibility of these and our response to immediate need seems challenging. A review of services will commence to determine if more can be achieved within our financial envelope.

Progress Dec- Jan 18

The Trust Staff Health & Wellbeing Group spent time in December 2017 reassessing priorities and establishing key areas of focus, which link to employee absence. In particular focussing on stress/ mental wellbeing and musculoskeletal issues.

Next Steps (progress expected by April 2018):

- Identification of the current return on investment for employee Health and Wellbeing services. To include: Occupational Health, Staff Support, Physiotherapy services. – Review February 2018, redesign with business case to DOG/TLT in March 2018.
- Begin benchmarking with other organisations 'one stop shop' provisions.

Staff Engagement

The Trust prides itself in open and transparent communication, two way feedback and listening. Staff are actively encouraged to contribute to the Trust decision making and have a voice.
With so much change and information sharing the Trust must be certain that two way feedback is preserved and all opportunities to capture staff opinion noted and exploited. With this in mind a review of staff engagement models will be undertaken to see if we can build upon our current practice.

Progress Dec- Jan 18

- Staff recognition awards (GEM) Awards were launched divisionally in January 2018.
- Junior doctor engagement/ listening events launched within acute medical areas from December 2017
- Diversity Network launched in November 2017. Over 45 members joined so far. First network meeting and presentation to 100 Leaders presentation took place in January.
- Investigations into a staff engagement app in conjunction with One Gloucestershire STP partners. STP funding is available to support this. A free app is also being explored which is currently used with some success in a number of Trusts around the country including St George's and Guy's & St Thomas'.
- Trust-wide listening events ran Jan-Feb focusing on Travel to Work

Next Steps

- Continue investigations into engagement App to determine suitability.
- Merging a number of current forums into a new 'staff involvement and engagement forum' to be the central point for capturing inputs from staff engagement and listening events.

7. Conclusion

Performance against both Sickness Absence and Turnover targets is promising, reflecting a more positive position than in previous years. However appraisal compliance is of concern and this is being considered as we develop a revised talent management process. Whilst mandatory training compliance has declined, we understand this dip is associated with a requirement to refresh safeguarding training, therefore we expect this to improve again in future reports.
Progress has been made against all of our key priorities that were identified to the Workforce Committee in November 2017 including the development of proposals to create a Subco, the detail of which has been excluded from this report. The challenge in delivering against these objectives against the backdrop of 'business as usual' is considerable, however it is important to recognise that these priorities are critical to meeting the overarching strategic aims of the Workforce Strategy.

The Trust Board is asked to NOTE performance against our key indicators and the progress made against our 6-12 month priorities.

Author: Alison Koeltgen, Acting Deputy Director of People & OD
Sponsor: Emma Wood, Deputy Chief Executive and Director of People & OD.

REPORT TO MAIN BOARD – MARCH 2018

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

This report describes the business conducted at the Workforce Committee on 8th February 2018 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
Temporary Staffing	Functional and operational changes recommended as part of a drive to re-launch Bank. Focus on reducing the cost of agency and attracting more people to the bank.	How are we ensuring the new approach is taken and used? How are we attracting and targeting people to join the Bank Have we mapped the end to end recruitment and on boarding process and understood the cultural impact of change?		Current approach to driving staff to register for the bank needs strengthening – with a new Comms strategy. But we need to ensure we have the capacity to deliver as a new brand and look and feel is needed along with a new approach Need to consider target market outside own staff. Progress update requested to ensure assurance that the innovations described have embedded.
Sickness absence	Deep dive into Orthopaedic outpatients' sickness absence at request of committee.	How can we ensure issues are progressed effectively and people supported in the right way.		

Appraisals **PWC Audit Prevention of illegal working**	Discussion around how we are measuring performance effectively. And if appraisals as a single measure really offers assurance on performance management success. Actions all complete bar one. Engaged with Diversity group to ensure lessons learnt regarding handling strategy to audit recommendation.	What is the best way to measure performance and understand what success looks like to drive performance?	6 month governance report to this committee.	We need to consider a new framework for defining success.
Strategic priorities on BAF	Reduced and removed risks into two residual open risks. Divisional risks being reviewed and need to ensure divisional risks are brought to Workforce.	How are divisions grading their risks and how are HRBPs engaged in that process.	Updated risk register to come back to workforce.	
Establishment	1to1 positioning codes being developed and used to enable us to identify establishment.	Aware could be a complex journey but a step forward. How could we use VCP process better with such controls in place?		
Staff health and wellbeing	Update received on plan to create a business case to improve staff wellbeing services.	Are we able to resource and support staff in the right way to deliver against their needs? Where should the focus and energy be in helping staff?		Business case will be available for information at April committee.

Subco	Received an update on Subco. One of the main staff questions is around identity – which is being progressed. The Board will be looking at not just how or when but is this the right thing to do.	Important to engage with Governors. How do we ensure we have the comparative POV from other Trusts? Have we engaged the customer effectively		
Talent Management	Objective to get better at having conversations with staff. Appraisals are only part of our talent management system.	How do we ensure we deliver what the divisions need as well as the organisation needs?	TLT to review and approve the process as it is developed	Committee will be appraised of programme for information.
HCA **Freedom to speak up Guardian** **Equality report**	A clear methodology was presented and endorsed by the committee to understand HCA sickness absence and related turnover The committee received an update which would come again in 6 months. Hugely impressive and reassuring start Received and noted progress		Applying the same approach and deep dive to other professional groups	

Board to note specifically:

Work against the strategic priorities and incorporation into the BAF
Talent Management recommendations and plan to move forward
Work of the Freedom to Speak up Guardian

Gloucestershire Hospitals
NHS Foundation Trust

The Role of the Audit and Assurance Committee

Rob Graves – Non-Executive Director

February 21st 2018

Gloucestershire Hospitals
NHS Foundation Trust

The Role of the Audit and Assurance Committee
Key Questions

- **Why** have an A & A Committee?
- **Who** is involved?
- **What** does the Committee do?
- **How** is it done?
- **When** & **Where** does the Committee meet?

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Why have an Audit And Assurance Committee?

- A formal requirement for every NHS Board to establish an Audit Committee originated in the *Codes of Conduct and Accountability* issued by the Department of Health in April 1994

- While Boards are responsible to put in place governance structures and processes their Audit Committee can review and report on the relevance and rigour of those structures and processes

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Who is involved with the A & A Committee

- **Members:**

  All Non-Executive Directors are members

  3 are specifically assigned to the Committee as regular members

  - Tony Foster (link to Finance Committee)
  - Alison Moon (link to Quality and Performance Committee)
  - Rob Graves (Audit Chair)

- **Attendees:**

  Internal Audit representative

  External Audit representative

  Counter Fraud Service representative

  Chief Executive

  Finance Director & Director of Operational Finance

  Director of Corporate Governance

  Chief Operating Officer

  Governor observer

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What does the A & A Committee do?

- Monitor the integrity of the financial statements and the annual report
- Review the Trust's financial and general internal controls and risk management systems and ensure an effective Assurance Framework is deployed
- Review the adequacy of policies and procedures in respect of all counter fraud work
- Review whistleblowing arrangements
- Monitor corporate governance compliance
- Monitor and review the effectiveness of internal audit including approving the internal audit strategy and annual programme
- Monitor and review the effectiveness of the external audit process taking into account professional and regulatory requirement
- Review compliance with standing orders and financial instructions
- Examine matters referred to the Committee by the Board

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How is it done?

- Utilisation of:
  - Internal Audit
  - Local Counter Fraud Services
  - External Audit
- Executive and management appearance at the Committee at the request of the Committee
- Specialist outside legal or other professional advice

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The Chair's Expectations – Rob's 5 C's

- Challenging
- Comprehensive
- Concise
- Conclusive
- Courteous

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When and Where does the Committee meet?

- The full Committee meets a minimum of 6 times a year
- A special meeting dedicated to a detailed review of the accounting year end was instigated in 2017 and will continue
- Meetings take place at Trust Headquarters

Gloucestershire Hospitals
NHS Foundation Trust

Thank you

Questions welc☺me

COUNCIL OF GOVERNORS – APRIL 2018
Lecture Hall, Redwood Education Centre commencing at 17:30

Report Title
Financial Governance Review Action Plan
Sponsor and Author(s)
Author and Sponsor: Deborah Lee, Chief Executive
Executive Summary

Purpose

The purpose of this report is to present the Council of Governors with an update on progress towards completing the actions arising from the recommendations of the Deloitte Review into financial governance arrangements at the Trust.

Key issues to note

- The Board accepted the vast majority of the recommendations arising from the review at its July 2017 Board meeting.
- Three recommendations were not accepted in full though actions arise from them, in part, and are underway.
- The Board reviewed the report at its March 2018 meeting accepted the report as a source of assurance that good progress was being made against the recommendations.
- The report evidences that 17/18 actions are completed; the nature of many actions means they will remain ongoing e.g. Board development. The final action will be completed by the end of April 2018, when the Executive Quarterly Reviews are established.

Conclusions

The Trust has made good progress in responding to the recommendations of the Governance Review and as such the governance failings identified in the report, have been addressed.

Future Action Required
NHS Improvement will now consider the necessity for the Financial Enforcement Undertakings to remain in place. A regional panel will consider this at their meeting in Q1 2018.

Recommendations
The Council is asked to accept this report as a source of assurance that good progress is being made against the recommendations of the Financial Governance Review.
Impact Upon Strategic Objectives
Supports delivery of the Objective to ensure the Trust is no longer subject to regulatory enhanced and enhanced oversight.
Impact Upon Corporate Risks
Mitigates the risk of failing to achieve the relevant strategic objectives.

Regulatory and/or Legal Implications
The Trust is subject to NHSI Financial Special Measures as a result of the unexpected decline in its financial position and the contributory failings in governance.

Equality & Patient Impact
N/A

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 Board**	**Other (specify)**
	February 2018				March 2018	
Outcome of discussion when presented to previous Committees						
Accepted for assurance.						

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Independent Review of Financial Governance

Action plan

DECEMBER 2017 UPDATE

Ref. Section	Deloitte recommendation	Management response	Lead(s)	Date for completion
R1 D.1.1	Throughout the Review Period, we noted silo working at the Executive level. Silo working presents a risk that Board members do not have sufficient oversight of developments outside of their portfolios and, as such, are unable to identify or challenge areas of concern. The concept of joint corporate responsibility should be continuously enforced by the CEO and EDs should be actively encouraged to take on responsibilities, and make contributions, outside of their respective portfolios.	**Recommendation Accepted In Full** • Incoming CEO and Chair have reinforced importance of unitary Board model and ways of working now reflect this model. • Recent recruitment to Board has reflected the importance of this skill set and behaviours in those appointed. • Chair approach to Board and Committee meetings seeks views of all members, on all topics • Board development programme includes support for unitary Board model through collective and individual training on giving and receiving effective and constructive challenge.	**Chair and Chief Executive**	**Completed** (Some completed actions are ongoing)
R2 D.1.1	Our review identified a lack of challenge or debate between Executive Directors in relation to the finance agenda, which presents a risk that effective challenge, if at all, only originates from NEDs who do not have the same day-to-day knowledge of performance throughout the organisation. The CEO should actively promote Executive to Executive challenge in key executive and Board forums including Board, committee, the DOG and the TLT meetings (previously Executive team and TMT).	**Recommendation Accepted In Full** • CEO has reinforced importance of executive challenge within the executive team and providing ongoing support to individuals to enable them to feel comfortable operating in this way. • Appointment of four new Executive Directors has responded to the need to recruit to a personal profile which is supportive of this way of working. • Individual Executive Director appraisals reinforced message for executive challenge, including challenging the CEO • Minutes of Trust Leadership team (TLT) shared with Board to enable better understanding of executive and Board agendas to support challenge across all areas	**Chief Executive**	**Completed** (Some completed actions are ongoing)

R3 D.1.1	We found that the lack of challenge and debate amongst Executive Directors was exacerbated by the split site nature of the Executive team.
	
	We recognise that steps have been taken to address this split and the CEO should ensure that, going forward, this approach is consistently adopted and embedded by all EDs.
		Finding not accepted.
		• The Board accepts the previous finding in respect of a lack of executive to executive challenge but does not accept this was exacerbated by split site working.
		• The CEO has however, taken a number of steps, that ensure there are appropriate opportunities for effective team development and working given the split site nature of the Trust's operations and this includes:
		  • All directors have the opportunity to work from both sites
		  • Weekly executive team meetings
			N/A	**N/A**

Ref. Section	Deloitte recommendation	Management response	Lead(s)	Date for completion
R4 D.1.1	Throughout the Review Period, we found that there had been a lack of Executive team development. This compounded silo working and made it difficult to forge links between portfolios. The CEO should introduce a formal executive team development plan to build on the ED Away Day already undertaken.	**Recommendation Accepted In Full** • Quarterly executive away days instigated. Session occurred in July 2017 (including incoming directors).and further sessions planned. • Content for away days developed in liaison with executive team and priorities influenced by the findings of this review – most recent focussing on executive ways of working and effective challenge.	**Chief Executive**	**Completed** (Some completed actions are ongoing)
R5 D.1.1	Historically, the Trust's Leadership Team meeting and Directors Operational Group (previously TMT and Executive team) meetings have been conducted on an information-sharing basis, with little opportunity for discussion amongst the senior leadership team. We understand that these meetings have now been reviewed and that new arrangement are in place. The CEO should continue to monitor the new meeting format, to ensure that all participants benefit from the meetings.	**Recommendation Accepted In Full** • Meeting formats revised to ensure clarity of purpose and delegated authority for each meeting • TLT and DOG both have agenda and minutes with former circulated widely (including to the Board) • Membership revised to reflect purpose of meeting • Meeting reflection incorporated into Trust Leadership Team format to enable regular opportunity to review ongoing effectiveness of forum. • Executive away days review effectiveness of team working and team meetings including TLT, DOG and ETM	**Chief Executive**	**Completed** (Some completed actions are ongoing)
R6 D.1.3	Our review found that, historically, there has been a Board culture where challenge and scrutiny was not actively encouraged. The Board should actively seek to build trust and mutual respect across Executive Directors and Non-Executive Directors and develop an environment where constructive challenge and scrutiny is actively encouraged from NEDs.	**Recommendation Accepted In Full** • Formal and informal board development sessions instigated with aim of building relationships and developing trust amongst members. • Chair approach to Board and Committee meetings seeks views of all members, on all topics • Active review of the effectiveness and appropriateness of non-executive challenge by Chair and CEO resulting in development of approaches. • Governor role developed incorporating training to support evaluation of NED performance and increase in opportunities for Governors to review NED effectiveness e.g. observer status at Board Committees.	**Chair and Chief Executive**	**Completed** (Some completed actions are ongoing)

Ref. Section	Deloitte recommendation	Management response	Lead(s)	Date for completion
R7 D.1.3	During our review, we found that there was a tendency at the Trust of sharing 'good news' with the Board. This presents a risk that performance deterioration is not identified at an early stage and that appropriate mitigating actions cannot be put in place by the wider leadership team. The Board should actively promote the open and transparent sharing of information across all Board members, including the good and the bad news and build a sense of collective responsibility across the Board.	**Recommendation Accepted in Full** • Chair and CEO have reset the culture and expectations of Board meetings, including nature of business transacted through Board with a shift to more business being conducted in public session. • CEO report has been developed and expanded to ensure early notification of risks and any threats emerging • Trust Risk Register revised to include greater numbers of prevailing risks to support increased oversight of risks facing the organisation and reviewed at every Board including escalation of safety risks triggering a rating of High Risk (score 12+) • Revision to approach to Board questioning to incorporate opportunity for governors to ask questions verbally at Board as well as historical approach to written questions.	**Chair and Chief Executive**	**Completed** (Some completed actions are ongoing)
R8 D.1.3	We recognise that the NED cohort has undergone significant change, with two further NED appointments recently confirmed. In light of these changes, we recommend that the Board instigates formal development for NEDs in relation to holding to account and effective challenge. We also note that the current NED cohort does not include a representative with previous clinical experience, as is good practice. We recommend that the Board considers the recruitment of a clinical NED, to ensure appropriate challenge on clinical and quality matters.	**Recommendation Accepted in Full** • Board development instigated • Chair instigated regular one to one meetings with NEDs to support personal development including development in this area • NED objectives agreed with each individual setting out clearer expectations in respect of NED role and contribution. • NED (including Chair) appraisal process embedded. • The Board has recruited a clinical NED; start date September 2017	**Chair**	**Completed** (Some completed actions are ongoing)
R9 D.1.3	Our review noted that the Trust currently lacks very senior responsibility for the corporate governance portfolio, which presents a risk that this core portfolio does not receive appropriate attention or ownership at Board level. The Trust should assign executive level responsibility to the corporate governance portfolio or appoint a very senior manager into a Corporate Governance role.	**Recommendation Accepted in Full** • Review of benchmarked Trusts approach to corporate governance undertaken • Investment ring fenced within FY18 budget for increased capacity and capability within team • Director of Corporate Governance recruited and commenced November 2017.	**Chief Executive**	**Completed** (Some completed actions are ongoing)

Ref. Section	Deloitte recommendation	Management response	Lead(s)	Date for completion
R10 D.1.4	Historically, we noted a number of issues in relation to engagement between the Board and the Council of Governors, which presents a risk that the Governors are not in a position to sufficient discharge their statutory duties. The Board should put in place a development programme to improve engagement and links between the Board and the Council of Governors. This programme should aim to ensure that there is absolute clarity over respective roles and responsibilities between NEDs and Governors.	**Recommendation Accepted in Full** • Significantly closer working between Lead Governor, Chair and CEO • Governor development programme instigated including training in respect of NED oversight – first programme completed June 2017 • All NEDs expected to attend Council of Governor meetings to support joint working • Board Committee Chairs required to attend Council of Governors to present assurance reports • Roles of NEDs and Governors within Board committees redefined and incorporated into role description for Governors. Role development supported through Governor training programme.	**Chair and Chief Executive**	**Completed** (Some completed actions are ongoing)
R11 D.2.1	Our review observed a lack of HR and clinical involvement at the Trust's Finance committee from EDs or their deputies. This presents a risk that the financial agenda is isolated from clinical and workforce matters. . We recommend that the Board ensures that there is HR and clinical participation in every Finance Committee, as well as finance participation in Quality Committee (we note the DoHR has recently joined the Finance Committee).	**Accepted in Principle (not in detail) – with a properly functioning Board, the Board does not accept it is a necessary use of limited director time to be members of every Board sub-committee.** • HR Director now member of Finance Committee • Clinical executives invited to attend Finance Committee for relevant items and Finance Director invited to attend Quality and Performance Committee on open basis • Strengthened reporting from Committees to Board to ensure all Board members have opportunity to scrutinise all agendas and minutes irrespective of committee membership	**Chair and Chief Executive**	**Completed** (Some completed actions are ongoing)
R12 D.2.1	We noted that, throughout the Review Period, there has been no cross-committee attendance from NEDs and a lack of attendance from certain EDs at key committees. We understand that committee membership has now been formally revised to ensure that there is overlapping NED membership across each of the four Board committees. It is critical that NEDs and, in particular, the Chair, as well as EDs, periodically attend a range of Board committees that they are not members of to gain direct assurance over issues and to consider cross-dependencies. This should include a more comprehensive Audit Committee programme of activities to promote executive participation and to increase transparency.	**Recommendation Accepted in Full** • NED membership of all committees reviewed and revised to ensure overlap between committees • Chair and Chief executive attend all Board Committees on regular basis • All Executive Directors invited to participate in Audit & Assurance Committee (A&AC) to ensure triangulation of business across committees • Internal audit reports referred to relevant Board Committees for review and on-going monitoring, following review by A&AC.	**Chair and Chief Executive**	**Completed** (Some completed actions are ongoing)

Ref. Section	Deloitte recommendation	Management response	Lead(s)	Date for completion
R13 D.2.1	Our review found a lack of informal interaction between Board Committee Chairs, which presents a risk that links between key matters of performance are not made. We understand that the Trust Chair has now implemented a programme of quarterly meeting between committee Chairs, to ensure that interdependencies across committees are reviewed and to consider the need to build specific activities into the Audit Committee job plan.	**Recommendation Accepted in Full** • Quarterly meetings of committee chairs established and overlapping membership of committees now in place • Audit and Assurance Committee work plan incorporates inclusion of a review of all major systems of internal control supporting relevant Board Committee agendas and priorities	**Chair / Audit and Assurance Chair**	**Completed** (Some completed actions are ongoing)
R14 D.2.1	We found that, throughout the Review Period, committee NED attendance remained relatively consistent. This presents a risk that perceptions are not refreshed and that there is a degree of comfort to proceedings. The Chair should ensure regular turnover in committee membership with a new NED member at least every two years and a new Chair every three years. Given recent events, the Finance Committee would benefit from a refresh of all NED membership.	**Recommendation Accepted in Full** • Rotation of membership incorporated into Terms of Reference for Board Committees • Finance Committee membership recently refreshed, resulting in new NEDs joining the committee including a financially qualified NED and others with significant expertise in this area	**Chair**	**Completed** (Some completed actions are ongoing)
R15 D2.3.2	We note that the Board is currently undertaking a review of risk management. We concur with this and the Board must ensure that this is addressed as a priority to ensure appropriate Board and the committee oversight of risk.	**Recommendation Accepted in Full** • Internal Audit Review completed – report reflects that 25/27 of the Institute of Risk Management Standards are now being met by the Trust • Actions to respond to findings of the review in hand and oversight in place through CEO chaired Risk Management Group • Trust Risk Register amended to lower threshold for when risks are escalated to the Board – register now received in public session of the Board • Relevant risks are reviewed by each Board Committee	**Chief Executive**	**Completed** (Some completed actions are ongoing)

Ref. Section	Deloitte recommendation	Management response	Lead(s)	Date for completion
R16 D.3.1	During our review, we found the divisional structure and triumvirate to be relatively immature, with capacity and capability gaps in senior leadership roles. We recommend that the Board puts in place a programme of development for divisional leadership teams. This should be designed and implemented with a view to providing leaders with the appropriate skills as well as promoting ownership and accountability.	**Recommendation Accepted in Full (noting extends beyond the scope of the Review)** • Leadership development programme established and open to all senior leaders including Divisional Leaders • Key gaps in senior roles filled with no vacancies in senior roles in any of four Divisions. • Review of Divisional leadership model undertaken by incoming Chief Operating Officer. Reporting lines revised. Review of number of Divisions and Tri model undertaken and current arrangements to remain for current year. • 100 Leaders programme developed to focus on leadership and team development. • Support to ILead community strengthened (clinical leaders forum – speciality directors)	**Director of Human Resources and Organisational Development**	**Completed** (Some completed actions are ongoing)
R17 D.3.2	We were informed that Executive Review meetings (ERM) did not function at an optimal level throughout the Review Period, with inconsistent ED participation and a lack of detailed discussion. This presents a risk that divisional performance concerns are not appropriately challenged, escalated and addressed. We understand that a review of the ERMs has been undertaken, with new, COO-led arrangements being introduced in March 2017. The Board should ensure that the refreshed approach contains appropriate ED participation and the right balance between support and challenge.	**Recommendation Accepted in Full** • Executive Review Meetings revised to include enhanced frequency, revised agenda and greater Executive Director involvement • Performance management framework developed with aim of a single suite of information available at both Board, Divisional and Service Line level. • CEO to Chair formal Accountably Review on a quarterly basis in addition to monthly ERM yet to commence – start April 2018.	**Chief Operating Officer**	**Partially Completed** **April 2018**

Ref. Section	Deloitte recommendation	Management response	Lead(s)	Date for completion
R18 D.3.3	Throughout the Review Period and into FY17,we noted a consistent lack of grip in relation to the delivery of CIP savings. We found a non-delivery culture and the consistent need to implement non-recurrent savings or cover shortfalls from contingency. We recommend that the Board reflects on the findings of the recent Internal Audit report into CIPs and puts in place a programme of development to ensure that ownership and delivery of CIP schemes is consistent across the Trust.	**Recommendation Accepted in Full** • Programme Management Office (PMO) established including appointment of PMO Director, to support monitoring, reporting and delivery of CIP programme • Investment in dedicated support for CIP delivery • CIP oversight and reporting arrangements revised, to reflect Deloitte and Internal Audit findings • Training for CIP leads implemented • CIP oversight by Executive, Finance Committee and Board strengthened and supported by enhanced reporting • Review of current CIP oversight undertaken and changes instigated from September onwards, including CEO Chair of Turnaround Improvement Board (TIB).	**Director of Finance**	**Completed** (Some completed actions are ongoing)
R19 D.4	Throughout the Review Period, we noted that the finance function suffered from capability and capacity issues and relied heavily on interims to compensate for the gaps. This issue has not been fully addressed and remains a weakness for the Trust. This challenge is acknowledged by the CEO and Interim Finance Director. We understand that a review of capability and capacity has been undertaken, with a view to defining roles	**Recommendation Partially Accepted – capacity gap acknowledged but capability assessment of current team not undertaken.** • New Director of Finance recruited with proven track record of financial turnaround • Capacity review undertaken and structure revised with associated investment in additional post • Recruitment to senior posts now completed • Use of interim continues to provide additional capacity but all substantive posts recruited to • Subsequent review of less senior posts undertaken and revised structure out for consultation	**Director of Finance**	**Completed** (Some completed actions are ongoing)

Gloucestershire Hospitals
NHS Foundation Trust

Questions?

If you have any questions or queries regarding this document, please email the Communications team at ghn-tr.comms@nhs.net

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS – APRIL 2018

GOVERNORS LOG

Included below are submissions received via the Governor's Log for the period since the CoG meeting on.

A document explaining the Governor's Log as well as the standard operating procedure are included as appendices for information.

Ref: 11/18	**Governor:** Maggie Powell	**Lead:** Felicity Taylor-Drewe
Submitted: 13/02/18	**Deadline:** 27/02/18	**Responded:** 19/03/18
Theme: Large Print		**Status:** Closed

Question:

The leader of the local branch of the Macular Society has told me that the Ophthalmology Department does not send out appointment letters in Large Print? Is this the case? And, if so, why not? I am advised that, though using large print throughout could result in multiple pages, even having just the time, date and, perhaps, doctor's name in large print (pt 26 – pt30) would be of great assistance.

Answer:

Your colleague from the local Macular Society is indeed correct that at present Gloucestershire Hospitals NHS Foundation Trust does not send out letters to Ophthalmology patients that is in large font. Currently, the situation is that where a patient is identified as having requirements for large font then a letter in this format can be generated. However this is currently on a patient by patient basis rather than a global approach to Ophthalmology clinics.

I am therefore grateful for you raising this query as we will look to consider how we could change our approach to our outpatient letters for Ophthalmology clinics.

Ref: 12/18	**Governor:** Nigel Johnson	**Lead:** Simon Lanceley
Submitted: 14/02/18	**Deadline:** 28/02/18	**Responded:** 05/03/18
Theme: Haematology Screening and Diagnosis		**Status:** Closed

Question:

The Tests and services provided by the Department of Haematology have a wide range of clinical implications, what provisions have been put in place to make sure that screening and diagnosis can still be expedited?

Answer:

There is no expected impact on our routine Haematology diagnostic service due to the loss of CPA accreditation.

The CPA accreditation was lost on aspects of assurance around quality management but there is no suggestion or evidence of poor quality service - the service has good EQA (external quality

assurance) results.

The implications are therefore limited to elements of the service that contractually require accreditation. We are in discussion with Public Health England with respect to maintaining our haemoglobinopathy screening service with the aim that we continue to provide this whilst accreditation is restored given there are no concerns about the quality of the service.

We are working up an action plan to address all issues raised by the recent inspection and once we have agreed timescales we will set up a re-inspection date.

Ref: 13/18	**Governor:** Nigel Johnson	**Lead:** Simon Lanceley
Submitted: 14/02/18	**Deadline:** 28/02/18	**Responded:** 05/03/18
Theme: Cancer Standards		**Status:** Closed

Question:

Does the Trust acknowledge that this will have an impact on the 62 day cancer standard and 18 week referral to treatment (RTT) standard?

Answer:

RTT and the 62 day cancer target performance will not be impacted by this.

We are reviewing the contractual obligations of all our clinical trials to understand the impact on patients and it may be we need to send certain tests to our partners within the South West Pathology network to maintain some of these.

Ref: 14/18	**Governor:** Richard Baker	**Lead:** Simon Lanceley
Submitted: 28/02/18	**Deadline:** 14/03/18	**Responded:** 28/03/18
Theme: Cardiology (Further comments)		**Status:** Closed

Question:

In response to your answer there are some points that I think still warrant addressing.

The 120 minutes target is not being achieved as the data from BRI is showing the average is 338.03 minutes which is the slowest of the hospitals transferring to BRI. However this point will become irrelevant when the 24hr service starts up.

It says staff in A&E have been consulted but there is evidence of consultants saying the service needs to be In GRH not CGH. See below:-

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ED Consultant comments regarding PPCI 30/10/2017

"A large Trust like this should have access to 24/7 PCI based at GRH

Anything other than this is a poor compromise of clinical standards"

"As others have said, the lack of 24hr PCI is a huge issue for our local population. Trusts smaller

than ours have been doing this for years, but I expect the two site problem doesn't help. Should we Datix every patient that requires transfer out for PPCI?"

"The business case for 24hr PCI has been resubmitted and is clearly still a hot topic in cardiology. We have a number of datixed incidents to support the bid, with potential harm caused to patients. Agree – the sooner it can be started the better"

"Huge concerns in this area as it seems clear it affects outcomes. I have shared with many of you that it seems unacceptable to me to accept that an entire county of the UK cannot manage a heart attack after 5pm. Number one priority is 24 hour on-site PCI for two reasons - transfer/other delays with a time critical event such as MI and PCI are unacceptable. We also know that the practicalities of referring to a tertiary centre inevitably mean patients do not get timely PCI who would do if they were in Bristol already.
It seems sensible to have PCI based where the majority of acute patients go (GRH), but this is less of an issue"

"24/7 PCI a good thing, even if it's at CGH. I've experienced a number of delayed transfers etc"

"A hospital our size should be providing 24 hr pci. Ideally on the GRH site"

"It is a compromise to patient safety and care to not be able to offer primary PCI 24 hours a day within our Trust. I welcome the business plan to look at providing this but question why it is to be provided in CGH, accepting that there is already a functional cath lab there, when acute services are provided 24 hours a day in the ED at GRH. Transfer of patients between hospitals is fraught with multiple problems potentially compromising patient care (even just down the A40) and it would mean that patients would have to bypass the ED at CGH after 10pm at night as there are no doctors as it becomes an MIU and go direct to Hartpury suite"

I think you will agree they are very happy for the 24hr service but think it should be provided at GRH.

Having the Cath Lab at CGH will still mean that patients who present at GRH with chest pain out of hours will need to be transferred and this then puts the outcome for the patient reliant on SWAST which is introducing an element of risk which is not under the trusts control (and us relying on a service that is struggling to perform). Also it introduces major risk to the patient while they are waiting for the procedure, who will be looking after them while waiting at CGH? If it is a registrar then what will happen if they are very busy? Should ED doctors be looking after these patients as the risk of arrest rises significantly after ECG changes?

When a patient arrests and needs urgent intervention they need to be moved quickly to the Cath Lab, sometimes whilst carrying on CPR and then they can have the restriction removed whilst still undergoing CPR if needed. If the Lab is upstairs then a lift is one of the biggest hurdles but if the Lab is on the other site the risks are much higher of irreversible damage or even death. Being mindful in this situation every minute can be causing irreversible harm and risk to the patient.

So knowing that out of hours the ambulance crews will default to GRH do we have assurances in place that this will not happen?

The answer it is still unclear as to the main reasons for having the service at CGH when we have the option of putting it right next to where it is needed and would be more beneficial.

It almost seems like a half measure, whilst it is great you are giving the 24hr service, would it be

better to make sure it is the best service? Does this issue need to be looked into with more detail as it would seem getting it right first time would be preferable for everyone?

Answer:

As part of the STP One Place Programme we are reviewing our models of care and how services are provided across all our sites.

The One Place programme will create Centres of Excellence for Urgent & Emergency care, Paediatrics & Obstetrics, Elective and Cancer care.

The case can be made for centralising Cardiology in an Urgent & Emergency Care or Elective Centre of Excellence – Urgent and Emergency given the ED and chest pain pathway links and elective given the planned nature of some Cardiology interventions and the need to be able to rely on consistent access to cath labs and cardiology beds.

The decision on where to locate Cardiology in the long term has not yet been agreed. The cost of building or reconfiguring an existing clinical space to centralise cath labs at GRH may mean Cardiology services continue to be provided on both sites in the short-term, but we are actively exploring all options with the aim of centralising Cardiology on one site. We are working to be able to confirm the long-term configuration plan for all our services by April and will share this with Governors.

As mentioned in the previous reply, ambulance and GP referrals can be routed to either site, it is walk-in patients that would be impacted most by any service centralisation and this would need to be mitigated by good public engagement and communication.

Ref: 15/18	**Governor:** Anne Lewis	**Lead:** Deborah Lee
Submitted: 29/03/18	**Deadline:** 12/04/18	**Responded:** 29/03/18
Theme: SubCo Pay Award		**Status:** Closed

Question:

Now the Government has agreed a pay rise for NHS workers, how will that reflect on pay and conditions for those employees of the Trust who will be part of SUBCO? Will they receive this new benefit, what if any, (considering the proposal is so new), is the Board's stance on this matter?

Answer:

Staff transferring to SubCo have been guaranteed protection of their current terms and conditions and this includes a link to the national Agenda For Change pay regime. This means that any national pay award, such as the one currently being consulted upon, will apply to this staff group. Terms and Conditions for new staff are yet to be developed and whilst they will not reflect Agenda for Change they will need to reflect market conditions and reflect the requirement for equal pay for equal work between the existing and future staff group.

Ref: 16/18	**Governor:** Valerie Wood	**Lead:** Steve Hams
Submitted: 29/03/18	**Deadline:** 12/04/18	**Responded:**
Theme: Nurse Ward Rounds		**Status:** Closed

Question:

Why don't nurses come with the Consultant on ward rounds? This is frustrating to the consultant and patients' relatives as the nurses are unable to answer questions about patients' care because they don't know what the Consultant has discussed or written.

Answer:

Ref: 17/18	**Governor:** Valerie Wood	**Lead:** Dr Sean Elyan
Submitted: 29/03/18	**Deadline:** 12/04/18	**Responded:**
Theme: Requesting Named Consultants		**Status:** Closed

Question:

Patients are not aware that they can request to see a named Consultant. I suggest that a leaflet could be given to patients and relatives explaining this?

Answer:

Ref: 18/18	**Governor:** Valerie Wood	**Lead:** Caroline Landon
Submitted: 29/03/18	**Deadline:** 12/04/18	**Responded:**
Theme: Edward Jenner Phlebotomists		**Status:** Closed

Question:

With regards to Edward Jenner, when will phlebotomists be moved? Immune-compromised patients are very much at risk when mixing with the general public.

Answer:

Ref: 19/18	**Governor:** Valerie Wood	**Lead:** Simon Lanceley
Submitted: 29/03/18	**Deadline:** 12/04/18	**Responded:**
Theme: Haematology in CGH		**Status:** Closed

Question:

Is there any likelihood of the Haematology service being on one site, possibly Cheltenham, in the near future? I feel this would benefit patients and Consultants.

Answer:

Natashia Judge
Board Administrator
April 2018

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

Governor's Log of Communications Explained

The Governors' Log of Communications was established as a means of improving communications between Governors and the Trust. It provides a central resource for recording questions from Governors and the corresponding responses. A summary report of communications registered on the log is produced on a regular basis and presented for review at the Council of Governors.

The log is not intended to replace the established methods for face to face communication with Governors and members of the Board – these are set out in more detail overleaf.

Questions Appropriate for the Log

There are no hard and fast rules for what questions are appropriate for the log, however, the following are intended as a guide. Of note, the governor role is not operational and governors should not use the log to request detailed operational information which, whilst potentially of interest to individual governors, is not consistent with the function of governors. Where questions are not deemed appropriate for the log, attempts will always be made to answer individual governor's questions providing this does not incur significant executive time but they will not be posted on the log.

The log should be used in the following ways:

- Clarification of anything raised at Board or at Council of Governors or other meetings where an answer could be given at the time or a supplementary question following discussion of a topic at a Governors' meeting.

- Governors are encouraged to give some context around their question and, where possible, the reason for asking the question.

- Governors are encouraged to consider why they are asking the question and most importantly, what they intend to do with any answer provided. How will this help me fulfil my role as a Governor?

- Questions should typically be likely to be of interest to the wider governor group. How will the wider group use this question and answer?

- Questions should not pertain to a Governor's personal experience of care, unless that experience gives rise to a wider, more strategic issue

- The log is not intended to address complex issues that would be more appropriately handled through the Council meeting or Governor working groups. Such issues should be flagged to the Lead Governor as possible future agenda items.

- Questions which are likely to be addressed in a forthcoming meeting should be held over until the meeting has occurred

Further Information & Engagement Channels

There are a number of different routes through which the Board and wider organisation engages with Governors and where Governors are afforded an opportunity to ask their questions. Governors should utilise these communication channels before putting forward a question for the log. These are as follows:

- **Public Board**
  Governors are invited and encouraged to attend Public Board. These are meetings held in public that are open to members of the public and press. Protocol allows governors to ask questions related to the business transacted without the need for prior written submission. Papers are available for all to read via the Trust Website.

- **Board Committees**
  Those these are private meetings, a named (and nominated) Governor attends which affords Governors an opportunity to observe NEDs in action, hear the business of the Trust and where Governors are formally invited to reflect back to the Committee there views and any questions on the business transacted. This includes an opportunity to request Committee papers are made available to the Council.

- **Council of Governors**
  A formal meeting of the Governors to which the members of the Board are invited to be in attendance and/or present items, held in public six times a year. A range of standing items such as Finance, Quality & Performance and Workforce are discussed and these are supported by the respective reports which have gone to the most recent Public Board. There is wide opportunity for discussion and questions. In addition to standing items, there are topical items each month reflecting the Trust's priorities and Governors interests / issues.

- **Governor Working Groups**
  The Trust currently runs two Governor Working Groups. Governors' Quality and Performance Group looks at issues relating to quality of care and service performance. Governors' Strategy and Engagement Group focuses upon strategic matters and our engagement activities. All governors are welcome to attend either or both of these meetings and each has a nominated lead Governor who is invited to shape the agenda based on the issues concerning or of interest to the Council of Governors. These meetings are each held quarterly and are not held in public.

- **Lead Governor Meetings**
  The Lead Governor runs regular Governor only meetings which provide an opportunity for Governors to discuss any issue of relevance, agree priorities and also ask questions of named Governors who are attending Board Committees. These are held in private and typically before the main Council of Governor Meetings for convenience. These meetings can also provide an opportunity to find out whether any queries have been asked previously in any forum, and for help from other governors in formulating or directing queries to the most appropriate place.

- **Patient Advice and Liaison Service and the Complaints Team**
  Any concerns or complaints about the care given to an individual from governors or members of the public should always go to the PALS team or complaints team.

Governors' Log Standard Operating Procedure

Background

The Governors' Log of Communications is being established as a means of improving communications between Governors and the Executive Team. It provides a central resource for recording questions from Governors and the corresponding responses from Executives. A summary report of communications registered on the log will be produced on a regular basis and presented for review at relevant meetings. The log is not intended to address complex issues that would be more appropriately handled through the Council meeting or Governor working groups.

Standard Process

In summary, the process for administering the Governors' Log is as follows:

1. Governors email their question to the Trust Secretariat; the question may have been self-generated or have come via a constituent member. Governor to advise of the 'Origin' of the query when submitted to them to enable query to be documented and reported.
2. Trust Secretariat checks that the question has not been previously raised and responded to. If the question has already been asked the Governor will be informed and the question closed.
3. Trust Secretariat to check appropriateness of question e.g. to ensure it does not breach Information Governance or Data Protection requirements or whether it should be directed to another route such as Patient Advice and Liaison Service (PALS) or Complaints Team. The Trust Secretariat will then register the question on the Governors' Log accordingly and inform the Governor.
4. The Trust Secretariat summarises the question as required and agrees the final question for addition to the log, with the relevant Governor.
5. Trust Secretariat emails Executive Lead who has responsibility for providing response.
6. A return of response from the Executive Lead is required within a maximum of 10 days. The Trust Secretariat updates the Governors' Log with the information provided. If the 10-day standard cannot be achieved, a reason for the delay will be recorded on the Log.
7. The Trust Secretariat emails the originating Governor with detail of the response.
8. The Trust Secretariat will send an e-mail to Governors and the Board when the Log is updated. New entries to the log will be presented at each Council of Governors Meeting for comment/information.
9. If the response provided is determined to be adequate by the Governor the query is closed on the Log. If further or supplementary questions are asked, the Log is updated to reflect this and the process from Point 3 above is repeated.

Monitoring & Escalation Process for the Governors' Log

The procedure for ensuring timely response is as follows:

- Question submitted and added to the log:10 working day deadline applied
- Further reminder sent at 10 working days and delayed response escalated to the Chief Executive Officer

Intended benefits of the Governors' Log

The Governors' Log is a practical mechanism for supporting a good two-way communication flow between Governors, on behalf of their Constituents, and Executives. It can run continually throughout the year, and enables queries to be addressed in real-time, without the need for a formal or scheduled meeting.

In addition, the Governors' Log facilitates a transparent process that demonstrates Governors fulfilling their duty of accountability to their local community.

It is on this basis that the responsibility of the Executive team to provide comprehensive and timely responses to the Governors queries is required.

The Governors' Log should be viewed by the Trust as a tool for enabling accountability, and for supporting staff, patient and public engagement.

ITEM 11

ANY OTHER BUSINESS

DISCUSSION