GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

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

Dear Colleague December 2019

The next meeting of the Council of Governors of the Gloucestershire Hospitals NHS Foundation Trust will be held on **Wednesday 18 December** in the **Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital** commencing at **17:30**.

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 16 October 2019	**PAPER**	17.32
4.	Matters Arising	**PAPER**	17.35
	Items for Discussion		
5.	Chair's Update	**PAPER** (Peter Lachecki)	17.40
6.	Report of the Chief Executive	**PAPER** (Deborah Lee)	17.45
7.	Electronic Patient Record (EPR) *Including plan for rollout*	**PAPER** (Mark Hutchison)	17.55
8.	Staff Retention	**PRESENTATION** (Emma Wood)	18.15
9.	Governor Engagement – Task and Finish Group	**VERBAL** (Geoff Cave)	18:25
	Break		18.40
10.	Reports from Board Committees		
	<u>Finance and Digital Committee</u> - Chair's Reports from the meetings held on 31 October 2019 and 28 November 2019 - November Board Report	**PAPER** (Rob Graves)	18.50
	<u>Estates and Facilities Committee</u> - Chair's Report from meeting held on 11 November 2019	**PAPER** (Mike Napier)	19:00

	People and Organisational Development Committee - Chair's Report from the meeting held on 21 October 2019 - November Board Report	**PAPER** (Balvinder Heran)	19.10
	Quality and Performance Committee - Chair's Reports from the meetings held on 30 October 2019 and 27 November 2019 - November Board Report	**PAPER** (Alison Moon)	19.20
	Items for Information		
11.	Governors' Log	**PAPER** (Sim Foreman)	19.30
12.	Confirmation of Lead Governor Appointment Process	**VERBAL** (Sim Foreman)	19.35
13.	Result of Governance and Nominations Committee Election	**VERBAL** (Sim Foreman)	19.37
14.	**Any Other Business**		19.40

Close 19:45

Date of the next meeting

The next meeting of the Council of Governors will be held on **Wednesday 19 February 2020** in the Lecture Hall, Redwood Education Centre, Gloucester Royal Hospital commencing at 17.30.

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."

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE COUNCIL OF GOVERNORS HELD IN THE LECTURE HALL, REDWOOD EDUCATION CENTRE, GLOUCESTERSHIRE ROYAL HOSPITAL ON WEDNESDAY 16 OCTOBER 2019

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

Alan Thomas	AT	Public Governor, Cheltenham (Lead)
Tim Callaghan	TC	Public Governor, Cheltenham
Marguerite Harris	MH	Public Governor, Out of County
Anne Davies	AD	Public Governor, Cotswold
Geoff Cave	GCa	Public Governor, Tewkesbury
Kedge Martin	KM	Public Governor, Tewkesbury
Jeremy Marchant	JM	Public Governor, Stroud
Pat Eagle	PE	Public Governor, Stroud
Graham Coughlin	GCo	Public Governor, Gloucester
Liz Berragan	LBe	Public Governor, Gloucester
Hilary Bowen	HB	Public Governor, Forest of Dean
David Adams	DA	Public Governor, Forest of dean
Colin Greaves	CGr	Stakeholder Appointed Governor, Clinical Commissioning Group
Maggie Powell	MPo	Stakeholder Appointed Governor, Healthwatch
Matt Babbage	MB	Stakeholder Appointed Governor, Gloucestershire County Council
Charlotte Glasspool	CGl	Staff Governor, Allied Health Professionals
Tom Llewellyn	TL	Staff Governor, Medical and Dental
Nigel Johnson	NJ	Staff Governor, Other and Non-Clinical
Julia Preston	JP	Staff Governor, Nursing and Midwifery

IN ATTENDANCE

Peter Lachecki	PL	Chair
Deborah Lee	DL	Chief Executive Officer
Sarah Stansfield	SS	Director of Finance
Rachael de Caux	RDC	Chief Operating Officer
Steve Hams	SH	Director of Quality and Chief Nurse
Mark Pietroni	MP	Director of Safety and Medical Director
Simon Lanceley	SL	Director of Strategy and Transformation
Claire Feehily	CF	Non-Executive Director
Rob Graves	RG	Non-Executive Director
Mike Napier	MN	Non-Executive Director
Balvinder Heran	BH	Non-Executive Director
Elaine Warwicker	EWa	Non-Executive Director
Bilal Lala	BL	Associate Non-Executive Director
Carolyne Claydon	CC	Corporate Governance (minutes)

APOLOGIES

Sarah Mather	SM	Staff Governor, Nursing and Midwifery

PRESS / PUBLIC

None present.

186/19 WELCOME AND APOLOGIES **ACTION**

PL welcomed all to the meeting.

187/19 DECLARATIONS OF INTEREST

There were none.

188/19 MINUTES OF THE MEETING HELD ON 21 August 2019

MN made reference to page 3 of the minutes and that the emergency 4 hour performance standard at the beginning of the Report of the Chief Executive Officer was incorrect. MN stated that this was an achievement for ICS but that the other targets referenced were for the Trust. DL added that, with reference to the 4 hour A&E standard, the performance of our partner organisations contribute to the national standard which is a system measure, unlike others. By including the Minor Injury Unit activity delivered by Gloucestershire Health & Care Trust, it gives the System a positive improvement of about 3%. **Action**: to be amended.

Corporate Governance

RESOLVED: The Council NOTED the minutes as an accurate record subject to the above amendment.

189/19 MATTERS ARISING

All matters arising were closed as detailed on the attached Matters Arising Log. The following items received additional comments:

June 2019 166/19 - Reports from Board Committees - People & OD Development Committee (April 2019): AT stated that the retention issues update had not been received. **Action**: DL to look in to *[closed directly after the meeting and forwarded to AT].*

August 2019 - 182/19 Reports from Board Committees – Q&P Committee: AT to circulate the CQC plan.

AT

190/19 CHAIR'S UPDATE

PL explained that the purpose of his report is to provide a snapshot of activities he has undertaken since the last Council of Governors meeting in August. PL invited the Council members to raise any questions directly for discussion outside the meeting.

RESOLVED: The Council NOTED the report.

191/19 REPORT OF THE CHIEF EXECUTIVE OFFICER

To maximise time for questions and comments, the report was taken as read and DL focused on items that were different:

<u>The Big Green Conversation</u>

- DL commented that she was struck by the levels of engagement with this initiative with the event being attended by members of staff who are not usually seen at Trust wide engagement events. It was a great session, aided by remote access technology to ensure that national speakers were able to join the session including speakers and presenters from the National Sustainability Unit and the Newcastle NHS Foundation Trust, who were the first Trust to have declared a "climate emergency".

- A representative from Gloucestershire County Council (GCC) also joined the session which helped DL to understand how much GCC

had achieved in terms of carbon emissions reduction: it had exceeded its own carbon emissions' reduction target of 60% by 2020, by already achieving 70% and is now well on its way to exceeding its 2030 target of an 80% reduction. DL continued that the GCC is keen to partner the Trust as an "anchor organisation" in recognition that the Trust is the largest employer in the county. Following on from this, conversations and meetings have been established and the Board is to consider declaring a climate emergency in order to support the agenda over and above BAU.

Freedom to Speak Up Month

- DL noted that the culture of the organisation has moved significantly over the past three years, and that Suzie Cro (Freedom to Speak Up Guardian (FSUG)) and her team are busy with staff reporting that they feel safe to raise any concerns with someone like Suzie. Nationally, an index to measure the effectiveness of speaking up and the FSUG role has been developed and the Trust is coming out positively in that regard. Two additional guardians have also been recruited to support Susie and work is underway to recruit a fourth and ideally someone form a more diverse demographic.

Our System

- In relation to the national and regional context, it looks like the country is not going to have a "No Deal Brexit" but the Trust is still preparing for it, just in case. Presentations have been made to the Main Board, and the information is available if wanted.

Questions in response:

- MPo commented regarding point 1.1 of the report regarding the Two Week Wait Cancer Standard and the fact that out of all patients who are assessed at this two week appointment, 90% will go on to be advised that they do NOT have cancer, although in contrast the Press reports that many cancers are not diagnosed until stages 3 and 4. DL advised that GPs are following the new national referral guidance and as a result more patients are being referred with the hope of detecting more cancers earlier. This approach puts more pressure on GHT but the evidence is that you have to see more patients in order to catch those with cancer. MP further explained that training is increasing for GPs to filter out some of these patients. The next step with dermatology, for example, will be GPs taking pictures, emailing them in for a specialist to look at using dermascopes.

- NG asked whether the Board is likely to endorse the "climate emergency" to which DL responded that she does not know yet as it will need to be thoroughly debated but she would be advocating that the Board gives it very serious consideration. She advised that we must guard against "over promising" and to be careful not to sign up to something symbolic without substance. It is planned to take to the Board meeting in November. Post meeting note – deferred to December due to pre-election period.

RESOLVED: The Council NOTED the report.

192/19 ICS FIVE YEAR PLAN

- SL presented a progress update on the ICS Five Year Plan in line

with every System being asked to supply a response to this with timescales. The key points highlighted were:

- The System narrative plan and timeline;
- The One Gloucestershire approach;
- The One Gloucestershire response structure;
- The refreshed challenges;
- Prominence of Place illustrating that there are 74 GP practices which group themselves in to six Integrated Locality Partnerships (ILPs);
- The Digital Plan illustrated on slide 10 will become the Programme Plan;
- The Financial Summary on slide 12 is a work in progress with prioritisation currently being considered as well as opportunities to improve.

Questions in response:

- PL commented that it might be helpful to put a link to the long term plan in the minutes as it forms the basis of what the NHS is doing and how closely our Trust is aligned to it. *[In response to this suggestion, the link is embedded herewith:]*

- https://intranet.gloshospitals.nhs.uk/news/nhs-long-term-plan/

- GC asked whether some of the plan will be made available for the public and the Trust members to understand and SL confirmed there will be a public version. DL added that it is likely to be early December before the public version will be available and that it will be on the website. We need to be creative as to how to make it accessible and digestible as possible. Post meeting note – submission deadline deferred due to pre-election period.

- TL asked whether, having all these components in the System working in an integrated way and they are all under pressure, will this not cause a problem with collaboration? SL responded by referring back to using existing groups and doing this through already established forums, the key ones being respiratory, dementia and frailty. Prioritisation is to be established within the ICS Board and limited to a small number of big priorities.

- NJ asked whether the digital side of things will be localised in the Cotswolds or whether it will be aligned nationally, to which SL responded that all the ICS organisations are in Gloucestershire and are working on a joint information strategy called Joining Up Your Information (JUYI) which will allow practitioners to access the patient record of any ICS member organisation.

- AT commented that the summary is a lengthy document although contains lots of useful information. It still surprises him, however, that there is not more emphasis on mental health in these integrated plans. SL responded by explaining that we are trying to show how mental health is integrated rather than showing it as a separate work stream along with learning disability and end of life care; these three are referred to as “golden threads”.

- AT further asked for an explanation of the term, “not enough information to assess”, to which SL explained that at a point in time, there are requirements to set out the plans for mental health, but as a team, they had not received enough information at that point to be

able to carry out that assessment.

- AT commented on the public nature of the Five Year Plan and asked whether the plans are confidential, with particular reference to the financial parts? SL responded that these are public documents and will be on the agenda for the Governors' Strategy and Engagement meeting in December.

RESOLVED: The Council NOTED the report.

193/19 FIT FOR THE FUTURE UPDATE

SL presented an update on the Fit For The Future (FFTP) programme in order to brief the Council on the timeline and process for delivering and agreeing a final FFTP Pre-Consultation Business Case, the highlights of which were:

- SL would be grateful to hear what Governors are hearing from their constituents and colleagues in terms of what is or is not working well.
- The presentation presented to today's Council is a reminder of why we are going through the engagement phase.
- The key areas of focus currently are (as detailed on slide 4):
    - Strong patient and public engagement
    - Clear clinical evidence
    - Public sector equality and inequality duties
- With reference to slide 7, "Programme Timeline: Engagement to Consultation", the items marked in blue are explained in more detail in the meeting papers. The timescales to the right of the Citizens' Jury on the timeline are currently being reviewed for accuracy.

Questions in response:

- NJ asked about staff engagement to which SL responded that 1,100 members are staff and had been spoken to and that 820 surveys had been completed. NJ asked whether there were still opportunities for someone like him to have a walk-around to meet staff to which SL responded that once there is more clarity around the shortlisted options, there will be more staff engagement taking place.

- CGr asked whether it would be possible to do anything about the negative response received from the media and whether it would be possible to have a "Question Time" approach with both sides involved? DL responded that some of this will come through with the planned Engagement Hearing and the Citizens' Jury. We are currently in "listening mode" but people want us to get into presenting plans and solutions which would follow. In the meantime, we are trying to re-set the balance and narrative by correcting some of the misinformation circulating.

- MPo stated she is a Cheltenham resident and finds it difficult to counter some of the information circulating regarding CGH's A&E Department being "closed". DL responded that the Trust will continue to work to correct misinformation and looks forward to talking about the exciting things that will enthuse the county once we are in the next phase.

  MPo urged caution when detailing the number of people we had

spoken to. AT agreed adding that there is a difference between who we had spoken to and what we had spoken to them about, and that he was concerned about the inconsistency of approach. DL agreed to feed this back to those compiling the engagement feedback. **Action DL.** **DL**

- AT enquired about what groups had shown an interest in attending the engagement hearing, besides REACH, to which DL responded that Suicide Crisis, a representative from the Cheltenham Labour party, a former Non-executive of the Trust and a local councillor had shown an interest amongst others. Seven were expected.

- PL thanked SL for the update and encouraged attendance at the Governors' Strategy and Engagement session on 5 December which will be an informal forum focussing at this meeting on two agenda items.

RESOLVED: The Council NOTED the report.

194/19 GOVERNANCE AND NOMINATIONS COMMITTEE PROCESS

The Council of Governors was invited to agree the process for Governor nominations for the Governance and Nominations Committee. The Governance and Nominations Committee reviewed the process at its meeting on 14 October 2019 and agreed to recommend the process and timetable to the Council of Governors, which has been outlined in the accompanying paper.

- PL added that this is an important committee which has been well served this year.
- AT added that the Terms of Reference for the Governance and Nominations Committee would be circulated – **Action**. **Corporate Governance**
- AT continued that last year he was pleased that six individuals put their names forward to serve on the Committee and that he would encourage anybody to be part of it.
- There is no need to be nominated. If more than three individuals put themselves forward, there would be an election.
- The Committee stands four times a year.
- AT and PL were both happy to take questions, as were the current Committee members.

RESOLVED: The Council APPROVED the Governance and Nominations Committee process.

195/19 LEAD GOVERNOR APPOINTMENT PROCESS

The Council of Governors was invited to agree the process and timetable for the election of a Lead Governor. Previously, the Governance and Nominations Committee had reviewed the Job Description and Personal Specification at its meeting on 14 October 2019 and agreed that it was still relevant. The following additional points were raised:

- PL stated that this is an important role although does not have any delegated powers and responsibilities.
- PL continued that AT has done a fantastic job of liaising between himself and the Council of Governors.
- It is likely that someone who has been on the Council of Governors for at least a year would be more likely to do this role.
- You can nominate yourself although a seconder is needed, or

indeed someone else can nominate you.

- The timetable for the process is in the accompanying paper.
- AT added that the appointment for the role of Lead Governor is not a three year appointment, but is for the rest of the term of the Governor who is successful. This needs correcting in the accompanying paper – **Action**. **Corporate Governance**
- AT will put himself forward if someone nominates him and if he were to be elected, he will agitate at the next Governance and Nominations Committee for a Deputy Lead Governor.
- This would be his last term as Lead Governor.

PL asked the Council if anyone had any objections or abstentions to either the Governance and Nominations Committee process or the Lead Governor Election process. There were none although the following comments were made:

- MN made reference to point 2) Election Time in the accompanying paper and pointed out that the election taking place at the December Council of Governors meeting was incorrect. Instead, it should read that the "appointment" or "confirmation" will take place at the Council of Governors meeting. **Action**: to be corrected. **Corporate Governance**
- MN also made reference to point 3) Recommendation in the accompanying paper and highlighted that the election of a Lead Governor is for a term of three years was incorrect and instead should read, "for the rest of their term as Governor". **Action**: to be corrected. **Corporate Governance**
- MH asked for confirmation of who is the current Trust Secretary to which PL responded that it is Jill Hall, although the Trust is in the recruitment phase for a substantive post holder. Post Meeting Note Sim Foreman appointed as Interim Trust Secretary.

RESOLVED: The Council APPROVED the Lead Governor Appointment process subject to the above amendments.

196/19 REPORTS FROM BOARD COMMITTEES

FINANCE AND DIGITAL COMMITTEE

- **CHAIR'S REPORTS FORM THE MEETINGS HELD ON 29 AUGUST 2019 AND 26 SEPTEMBER 2019**

RG explained that two Chair's Reports for Finance and Digital Committee were being presented to today's Council and gave some background to new Governors regarding the context through which the reports were delivered. RG raised the following points:

- There are distinct differences between the Finance and Digital agendas.
- The Digital agenda has been refreshed so that there is in place a rolling programme to make good use of the Committee's and Executives' time.
- Some topics are looked at every month and others less frequently; the rhythm and cycle of the Committee is kept under review.

RG highlighted the following key areas from the Finance Committee:

- There is a favourable variation to plan at the end of month 5 with the deficit £0.5M less than was planned.
- It should be acknowledged that the trajectory of performance

becomes tougher as the year progresses.

- A key element of the Committee is to look at the future view as far as financial performance is concerned and the Trust is faced with a challenge in that there is a risk to Q4.
- Key risk is non-delivery of CIP target and winter cost pressures.
- In terms of assurance in the Committee, it is clear that the challenge is being embraced by the Executive Team and Divisions.
- Many questions are asked in the Committee around the balance sheet and sample questions have been added to RG's Chair's reports.
- The forward planner for the Committee has been refreshed with a view to ensure the planning sessions are dynamic and make the most of everyone's time.

RG highlighted the following key areas from the Digital Committee:

- The Digital Committee has a different rhythm of activity from the Finance Committee.
- The biggest topic is around the Electronic Patient Record (EPR) record deployment and this is reported on monthly.
- TrakCare was launched a couple of years ago and there were issues around poor communication to those using it. There is now very satisfactory input on work being done to ensure the same mistakes are not repeated and confidence levels are now high.
- There is a new system being deployed relating to chemotherapy care and there had been some risks raised regarding its deployment. However, by the September Committee, many of the issues had subsided due to the excellent work of the IT team, and confidence levels are now higher. The Committee continues to give this a lot of attention.
- RG wished to share that it has been a personal and professional pleasure to work with Sarah Stansfield, Finance Director, whose last day with the Trust will be at the Finance and Digital Committee on 31 October 2019.
- This was endorsed by all at today's meeting.

Questions in response:

- JM asked whether the possibility of the EPR system failing had been discussed to which RG responded that system failure and appropriate back-ups had been considered. DL added that the Trust has had significant experience of this due to the age of the Trust's infrastructure and that it is part of any business model to have contingencies, including service level business continuity plans in place, to ensure that safe care can continue to be delivered. The contingencies have been through Audit & Assurance Committee for internal and external auditing requirements and JM is welcome to see the output if he wishes.
- AT wished to assure his colleagues again that Finance and Digital Committee is very rigorous. In particular, the rigour with which CIP is pursued is commendable.

RESOLVED: The Council RECEIVED the reports ASSURANCE of the scrutiny and challenge undertaken by the Committee.

SEPTEMBER BOARD REPORT

RESOLVED: The Council NOTED the report.

ESTATES AND FACILITIES COMMITTEE

- **CHAIR'S REPORT FROM THE MEETING HELD ON 3 SEPTEMBER 2019**

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

- The Estates & Facilities Committee was originally established to oversee the new subsidiary of GMS.
- There is a new Managing Director of GMS and RDC, Chief Operating Officer, was the Lead Executive for the Trust in relation to the GMS contract.
- The Committee has been renamed to "Estates & Facilities" Committee and it has taken on the estates strategy, strategic site development programme and the condition of the estate.
- The way in which the Committee works has also been changed with it being held every other month together with the establishment of a Contract Management Group chaired by RDC.
- The Committee is looking at getting assurances in place for the process and controls around how the Trust manages GMS.
- Regarding the Committee on 3 September 2019, the following key points were discussed:
    - GMS Contract Management Group Report – issues were reported back around the ongoing review of security, in particular at GRH, and also around fire safety non-compliance.
    - Performing to national cleaning standards – there has been confusion over whether GMS is delivering to these standards or surpassing them. This is being monitored by the new Contract Management Group, and by the Infection Control Group in terms of quality, and a report will be submitted to the next Estates and Facilities Committee.
    - The outline case for the Strategic Site Development Programme will be reviewed at the next Committee.
    - The Committee is also looking at the Trust estate strategy as well as the ICS estate strategy.

There were no questions in response.

RESOLVED: The Council RECEIVED the report as ASSURANCE of the scrutiny and challenge undertaken by the Committee.

PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE

- **CHAIR'S REPORT FROM THE MEETING HELD ON 19 AUGUST 2019**

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

- BH is a relatively new Chair to this Committee but has been impressed with how it is working.
- The Trust wants to attract the best calibre staff and to retain them, and there is a lot of work taking place around rewards packages in this regard. Other areas of focus for the Committee are:
    - Strategic education issues
    - Diversity and equality
    - Employee engagement

- Health and safety objectives

- Regarding the Committee on 19 August 2019, the key points were discussed:
  - Workforce supply and whether it should be scored higher for inclusion on the Trust Risk Register.
  - Patient Safety
  - Staff grades
  - Staff survey – looking at improving the quality of appraisals and the appraisal experience and ensuring that appraisals are followed up on.
  - Staff engagement and ensuring that staff have the opportunity to influence how their services are run.
  - University Hospital status and the consideration whether the ambition to hold University status across the ICS in four to five years is too long. Partners are committed to the idea but keen to see how the Trust's application is received. It needs to be done at the right pace.

Questions in response:

- JM asked whether there was any way of measuring wellbeing to which BH responded that this area will be looked at more closely at the October Committee. DL added that the staff survey is a key measurement but that it only takes the temperature once a year. Several areas are being monitored including the 2020 Staff Hub which is looking at the numbers of people contacting the Hub and why they are contacting it. DL said that the organisation focus on staff wellbeing is greater than she can recollect but she remained concerned for staff given the unrelenting nature of operational pressures and therefore the focus remained.

- BH added that a good health check for the organisation is to see whether stress-related illness is increasing or decreasing. DL added that significant training has been provided around resilience which is positive. DL recalled introducing a "Happy App" at Bristol Hospital which had received a national award and would be keen to find the head room and capacity to introduce something similar in this Trust, aligned with other Committee priorities as it gave real time insights into how staff were feeling.

RESOLVED: The Council RECEIVED the report as ASSURANCE of the scrutiny and challenge undertaken by the Committee.

SEPTEMBER BOARD REPORT

RESOLVED: That the Council NOTED the report.

QUALITY AND PERFORMANCE COMMITTEE

- **CHAIR'S REPORT FROM THE MEETINGS HELD 28 AUGUST 20149 AND 25 SEPTEMBER 2019**

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

- There is a large range of scope of areas covered at this Committee.
- It is attended by three Non-Executive Directors (NEDs) being CF, AM and EWa.
- There is a different mix of items discussed each month and it is interesting to watch month on month as they develop.
- There are also items seen less often, such as the Infection Control

Report and Safeguarding.

- The Committee scrutinises and takes assurance in varying ways with one of the key roles of the Committee to understand and track the risks on the risk register and to keep an eye on risk mitigation.
- Never Events and Serious Incidents are scrutinised well and there is confidence that the executive apparatus which sits around them is functioning accurately.
- Delivery Groups are reported through the Quality and Performance Committee and there is challenge around whether the right exceptions and focus has been through these Delivery Groups.
- There has been a gradual and significant improvement across the board, for example, in cancer wait times, performance and the Delivery Groups.

- Other key issues discussed were:
    - The Winter Plan – the first iteration of the plan was in August. The view of the Committee was that it was not assured that there was the right level of community capacity planned and it was agreed that there is a need to engage early on this.
    - EPR – MH attended the September Committee and there was really positive communication. The Quality and Performance Committee is looking at EPR through different spectacles and is challenging the EPR programme in terms of staff impact. Quality and Performance Committee is working with Finance and Digital Committee in this respect.
    - C Diff – in relation to the serious incidents, the Committee received a reflective and hard hitting report as to what had happened on the ward in question. There was frustration from the ward level staff that things were not being fixed quickly and that their concerns were not being acted upon.
    - Learning from Deaths Report – this has been viewed positively by the Committee and the Trust is in a different place from where it was a couple of years ago in terms of learning from deaths with feedback coming through from reviews of deaths and also from families.

Questions in response:

- PL commented that it was useful for governors to see how NEDs are distributed across committees and to see progress through the different committees.

- TL commented on the Winter Plan and asked the NEDs to bear in mind, when looking at the numbers, the particular quality of care given to patients, particularly regarding mental health patients who spend a lot of time in ED waiting for care.

- AT expressed concern about the length of stay experienced by the mental health patient who was waiting in ED from 20:00 to 10:00 the next morning. A discussion took place regarding the lack of availability of overnight mental health services and the concern around staff working overnight and going home tired in the morning. Staff resourcing is being reviewed at an ED summit, convened as a result of a patient's experience of not receiving good enough care at the end of their life and who was a relative of a member of staff. This provoked reflection and support leading to the summit.

- PL asked whether it would be possible to use some of the new

mental health money for 24 hour mental health liaison, to which MP responded that a new consultant to the Psychiatric Liaison Team has just been recruited who is working on a new model of care. DL added that what TL has described was an internal incident and hopes that it has been reported in order to trigger an investigation.

- AT asked about the pathways for mental health emergencies and PL suggested that it would be good to have a closer look at this at the Governors' Quality Group. **Action**: to be added to the work plan. **Corporate Governance**

RESOLVED: The Council RECEIVED the reports as ASSURANCE of the scrutiny and challenge undertaken by the Committee.

SEPTEMBER BOARD REPORT

RESOLVED: The Council NOTED the report.

197/19 LEAD GOVERNOR'S REPORT

AT updated that he had attended the ICS Forum Group but was disappointed that several of those invited were not present. He raised the issue of how Governors could be more influential in the ICS but received the same answer as previously about having a meeting, but this has not yet taken place.

RESOLVED: The Council NOTED the Lead Governor's report.

198/19 GOVERNORS' LOG

RESOLVED: The Council NOTED the Governor's Log.

199/19 ANY OTHER BUSINESS

There was none.

200/19 DATE OF NEXT MEETING

The next meeting of the Council of Governors will be held on **WEDNESDAY 18 December 2019** in the **Lecture Hall, Redwood Education Centre, Cheltenham General Hospital** commencing at **17:00**.

[The meeting closed at 19:30]

Chair
18 December 2019

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MATTERS ARISING – COUNCIL OF GOVERNORS

OCTOBER 2019

CURRENT TARGETS

Target Date	Month/Minute/Item	Action with	Issue	Action	Update
December 2019	**October 2019 193/19 – Fit for the Future Update**	**DL**	MPo urged caution when detailing the number of people we had spoken to during the engagement process. AT agreed adding that there is a difference between who we had spoken to and what we had spoken to them *about*, and that he was concerned about the inconsistency of approach.	DL agreed to feed this back to those compiling the engagement feedback. **Action DL.**	*Closed:* DL has fed this back to CCG Engagement Lead, Becky Parish, who has reflected this in the way the feedback report has been developed.
December 2019	**October 2019 194/19 – Governance and Nominations Committee Process**	**Corp Gov**		**Action**: Terms of Reference for the Governance and Nominations Committee to be circulated to Governors.	*Closed*: Terms of Reference sent to Governors on 22 October 2019.
December 2019	**October 2019 195/19 – Lead Governor Appointment Process**	**Corp Gov**	AT added that the appointment for the role of Lead Governor is not a three year appointment, but is for the rest of the term of the Governor who is successful.	**Action**: Lead Governor Appointment Process paper to be corrected accordingly.	*Closed*: Lead Governor Appointment Process paper corrected and re-uploaded to Admin Control as a permanent record.

December 2019	**October 2019 195/19 – Lead Governor Appointment Process**	**Corp Gov**	MN made reference to point 2) Election Timetable in the accompanying paper and pointed out that the election taking place at the December Council of Governors meeting was incorrect. Instead, it should read that the "appointment" or "confirmation" will take place at the Council of Governors meeting.	**Action**: Lead Governor Appointment Process paper to be corrected accordingly.	*Closed*: Lead Governor Appointment Process paper corrected and re-uploaded to Admin Control as a permanent record.
December 2019	**October 2019 195/19 – Lead Governor Appointment Process**	**Corp Gov**	MN also made reference to point 3) Recommendation in the accompanying paper and highlighted that the election of a Lead Governor is for a term of three years was incorrect and instead should read, "for the rest of their term as Governor".	**Action**: Lead Governor Appointment Process paper to be corrected accordingly.	*Closed*: Lead Governor Appointment Process paper corrected and re-uploaded to Admin Control as a permanent record.
December 2019	**October 2019 196/19 – Reports from Board Committees – Quality & Performance Committee Chair's Report**	**Corp Gov**	AT asked about the pathways for mental health emergencies and PL suggested that it would be good to have a closer look at this at the Governors' Quality Group.	**Action**: to be added to the work plan.	*Closed*: Added to work plan for April 2020.

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS – DECEMBER 2019

CHAIR'S ACTIVITIES UPDATE

In order to present Governors with a snapshot of the wider perspective of Chair activities undertaken, a written summary is presented at every CoG meeting. This excludes regular meeting attendances at Board, CoG, Committees and 1:1s with Directors and Governors. Period from 5th October to 11th December 2019.

Trust Activities

DATE	EVENT
18 10 19	100 Leaders' event
23 10 19	Shadowing Cheltenham General Hospital (CGH) porters
6 11 19	Brain injury team fundraising event
11 11 19	Armistice Day event in Gloucestershire Royal Hospital Atrium – Sir John Kiszely
14 11 19	Hosting visit by Matt Hancock – Secretary of State, and Alex Chalk to CGH
20 11 19	Library and Knowledge Service Randomised Coffee Trial meeting (with a nurse fellow)
21 11 19	Welcome Kidney Research UK to GHT Organ Donation Committee Meeting
26 11 19	Anna Rarity – Patient and Public Involvement Manager
27 11 19	Personal appraisal with Senior Independent Director and Lead Governor
27 11 19	GHT Staff Awards Evening
28 11 19	Strategic Site Development Meeting
4 12 19	Hosting visit by prospective MPs – Max Wilkinson and George Penny

Gloucestershire Health Economy

DATE	EVENT
16 10 19	Chairing Research4Gloucestershire Steering Group
24 10 19	Fit for the Future Engagement Hearing
29 10 19	Integrated Care System (ICS) Board meeting
4 11 19	Integrated Care System Independent Chair recruitment panel
19 11 19	Gloucestershire County Council Health Overview +Scrutiny Committee meeting
26 11 19	Integrated Care System (ICS) Board meeting

National Stakeholders + others

DATE	EVENT
8 10 19	NHS Providers' Annual Conference - Manchester
5 12 19	NHS Providers' Chairs' and Chief Executives' Quarterly meeting - London

Peter Lachecki
Trust Chair – 4 October 2019

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS – DECEMBER 2019

REPORT OF THE CHIEF EXECUTIVE

1. Context

National politics continue to shape the context in which we are operating and no less so this month than previously with the majority of political parties putting the NHS at the centre of their election campaigning. For the NHS, and other public services, the announcement of a General Election means that we are required to observe the period prior to an election known as *Purdah* are permitted from conducting any business which could be considered politically controversial and/or appear to be aligned to one party above another; decisions about strategy and resources should also be postponed until after the General Election.

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

Finally, the obligations associated with *Purdah* also mean that this month's report is more limited in nature to avoid any communication which might be considered to breach best practice but verbal updates will be given on anything of relevance.

2. The Trust

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

This month also saw the start of our first phase of roll-out of our Electronic Patient Record programme with deployment of electronic nursing documentation on our adult wards at Gloucestershire Royal. One week post deployment, the signs are very positive with numerous benefits for staff and patients being reported; many of these benefits such as reduced falls and fewer call bells being rung relate to the increased presence of nursing staff in the ward bays undertaking electronic note taking rather than being remotely located at the nurses station or in offices. Nursing staff have also described the system as intuitive and whilst medical staff are not yet using the system, many are choosing to access it. Next steps are for roll out of nursing documentation at Cheltenham General followed by electronic observations later next year.

The programme also received a boost last month with the award of additional funding to support the roll out of electronic prescribing, following a bid by the Trust almost a year ago.

Since my last report we have enjoyed yet another VERY successful staff awards ceremony. Every year, I reflect on the evening being the "best one so far" and this year was no different. However, the aftermath of the event was definitely different and very positively so in that I have had as many emails and Tweets from those that watched from afar, as I have from those in the room. It's clear that the live streaming of the event went down very well and viewers included both work colleagues and family members. The *Lifetime Achievement Award,* went to a very popular recipient in nursing colleague and former staff governor, Sandra Attwood; during my time in the Trust, I don't recollect two standing ovations. Sandra has not only been a phenomenal nursing colleague – characterised, as all said, by her unrelenting pursuit of high standards – but she has also devoted considerable time (often at the expense of friends and family) to leading and supporting the Cheltenham League of Friends and serving six years as one of our most committed Staff Governors. Click here to see the befitting video testament from just a few of Sandra's colleagues.

On the 9th December, we held our inaugural conference to celebrate our Black, Asian and Minority Ethnic (BAME) workforce and community. The event, sponsored by our Diversity Network and organised by nurse and Ethnicity Sub-group Chair, Coral Boston was incredibly well attended with more than a 100 staff coming together to explore the issues affecting BAME staff and patients. The Conference opened with a presentation describing the experience of BAME staff which compares poorly on a number of dimensions to staff as a whole. Of particular note were the moving stories from three BAME staff and Sandra Samuels, Inclusion and Diversity Officer from Gloucestershire Constabulary who described their own personal and professional journeys. Whilst the Trust has a Workforce Race Equality Scheme and action plan, it is clear from yesterday that we need to work harder and be bolder in our plans and responses to the issues raised by BAME staff. Overall, however, it was celebrated as a very positive start to a different way of working with this specific staff group.

For more than 12 months, colleagues in our Organisational Development Team have been working with staff from across the organisation on our values and most importantly describing the behaviours that we expect staff to display (and not display). This work is coming to fruition and will be considered by the Board at its development session on the 12th December when the Board will be joined by national expert Michael West, a Kings Fund Fellow who has published much work in this important area including a recent report, commissioned by the General Medical Council, into the health and wellbeing of junior doctors. Views on how Governors would like to engage in this work will be an important topic for discussion at the forthcoming council meeting.

On the 20th December we will hosting our second *Big Green Conversation* following the inaugural meeting in September. A number of actions have been progressed since the last meeting, including identifying a Board "green" champion in Elaine Warwicker, which will be updated at the conference. Staff who attended the first event submitted more than 100 individual ideas for ways in which the Trust can reduce its carbon emissions and the team is working through these now. An update will be provided to the Council on proposals being put to the Board on the 19th December 2020.

The staff survey period has also now concluded and more staff than ever before completed the online survey entitled *What's It Like To Work here? 50%* of staff completed the survey, 4% points more than last year and 3% points better than the acute Trust average. The Trust has also been in touch with the two best performing Trusts to understand more about their approach with a view to informing next year. Unfortunately, results take some time to be analysed and published and so we will continue to focus on the priorities developed from last year's feedback and other, more contemporary insights.

Our approach to staff health and wellbeing includes huge efforts to vaccinate a minimum of 80% of our front line staff against influenza. Despite some challenges with access to the vaccine this year, we have had a very successful campaign this year with more staff than ever before being vaccinated. To date, 80.4% of front line staff have been vaccinated which, given just three years ago, we struggled to achieve 60% is phenomenal. Without doubt the success is down to two things – strong leadership and our innovative model of utilising peer vaccinators. Thanks to Steve Hams, Craig Bradley and the 276 peer vaccinators.

I am delighted to share the news that the University of Worcestershire's Professorial Titles' Committee has conferred the honorary title of Visiting Professor to the Three Counties School of Nursing and Midwifery to Steve Hams, Director of Quality & Chief Nurse. The title of *Visiting Professor* is awarded to individuals of high standing who are closely associated with the work of the University. The appointment is intended to provide a basis for collaborative working with colleagues, primarily in the Three Counties School of Nursing and Midwifery, but also within the wider University and as such is another positive step towards our ambition of becoming a University Hospitals' Trust.

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

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

3. The System

Given the pause in our *Fit For The Future* programme, the system focus has been on preparing for winter and developing our Long Term Plan (LTP) submission which we are required to submit on the 12th December. On the former, as already mentioned, system capacity to cope with demand is already proving a challenge and the current focus is on mobilising further actions and mitigations to ensure patient safety and experience is not compromised at peak times. The LTP submission continues to challenge with parties not yet in a position to submit a financially balanced plan or one that delivers all of the national standards.

Deborah Lee
Chief Executive Officer

8 December 2019

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

COUNCIL of GOVENORS – DECEMBER 2019
THE LECTURE HALL, REDWOOD EDUCATION CENTRE, GRH
commencing at 5.30pm

Report Title									
Sunrise EPR update									
Sponsor and Author(s)									
Author: Leah Parry, Digital Transformation Lead Sponsoring Director: Mark Hutchinson, Exec. CDIO									
Audience(s)									
Board members	✓	Regulators		Governors		Staff		Public	

Executive Summary

Purpose of Report

- The paper provides an update to the Committee an overview of the Sunrise EPR programme go live at Gloucestershire Royal Hospital on the 4th December
- Go Live has been extremely successful with staff at Cheltenham keen for roll out as soon as possible.
- Benefits have already started to be realised across the early adopters and nursing leaders now taking the reins with monitoring and ensuring usage of the system
- Next steps for the EPR programme- Roll out to Cheltenham, Electronic Observations and Ordering/ messaging of pathology and radiology investigations

Recommendations

The Group is asked to:

- **NOTE** the progress to date and planned next steps;
- **NOTE and SUPPORT** the support and engagement of Trust leadership in EPR adoption and embedding business change, including supporting release of staff to support project activity including testing and training.

Impact Upon Strategic Objectives

EPR implementation is a key enabler to delivering GHFT, ICS and National strategic objectives. Digital technology adoption will enable GHFT to provide safer, more reliable care by enabling the timely sharing of accurate information to the health care professionals that deliver services on our behalf. The development of our EPR will also enable us to share information with our partners across the Gloucestershire Healthcare community enabling improved patient care, efficiency and system wide collaboration.

Impact Upon Corporate Risks

EPR implementation will improve patient safety and reduce risk significantly across all sites. There are a number of risks on the corporate risk register that would be removed, mitigated or significantly improved by the continued roll out of EPR.

Regulatory and/or Legal Implications

n/a

Equality & Patient Impact

Improved, timely access to clinical information leading to improved patient care, better outcomes and the consistent delivery of safe, reliable treatment.

Resource Implications

Finance	✓	Information Management & Technology	✓
Human Resources	✓	Buildings	

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

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

Outcome of discussion when presented to previous Committees
Acknowledged

COUNCIL OF GOVERNORS – DECEMBER 2019

SUNRISE EPR UPDATE

More than seven million steps were walked by a team of 50 floorwalkers, covering 24 hour shifts, as Sunrise EPR went live in GRH adult inpatient wards. After five months of hard work – a record timescale for implementation of an EPR for the provider Allscripts – an intense three week rollout period has gone better than we could have hoped.

We began with two early adopter wards in November, starting the day with a symbolic removal of paper into a back office – hidden away, but accessible 'just in case'. The two wards embraced the system and all the challenges a new way of working brings, providing us with an essential opportunity to test every aspect of the system and support, from the wider IT infrastructure, to the practicalities of encouraging staff away from paper notes, and from user logins to the terminology of flowsheets and documents. The lessons learned during the pilot proved invaluable when it came to delivering an effective, efficient and successful rollout.

Reputationally, we knew that success for the early adopters would help us get an important message out to staff – that this implementation is different to previous, that we've learned lessons from the past and that direct support to staff on wards is our absolute priority. Training continued throughout this period for the remaining 22 wards preparing to go live in December, with real-time changes being made to the way we taught and briefed staff. Through classroom, ward and online based training we hit our target of 75% of staff trained ahead of go live – with many wards reporting 100% attendance.

Entering into go live on 4th December, everything had been fully tested and thanks to 24 hour working from our specialist teams here and the Allscripts team globally, we felt quietly confident all would go well. The pilot had not been without issues, throwing up some big challenges and critical issues that needed fixing or improving. But that's why early adopters were key.

The main go live has involved staff from all areas of the trust, not just the specialist team set up to deliver EPR. Teams from CITS, wider IM&T teams and clinical staff put

themselves forward for roles within the command centre or walking the floors. The demands on AMU in particular meant that we put our most experienced leads on the ward – including the Chief Nursing Information Officer and Digital Transformation Lead, to support staff with go live.

A mammoth team effort has resulted in (as of 10/12/19):

- 38828 documents created in EPR.
- 1173 different users have accessed the system
- 1742 different patient records have been accessed

24 hour support has now been greatly reduced thanks to the hard work of nursing staff and their commitment to get to grips with Sunrise. We will continue to monitor benefits, challenges and be on hand to provide support whenever or wherever it is needed. The success in GRH and the lessons learned has provided a lot of confidence for the rollout in Cheltenham in 2020 with the chief executive quoting that she has moved from being cautiously optimistic to truly grateful to the team that have delivered such an exciting step in our journey to outstanding and the true transformation of care.

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS (CONFIDENTIAL) – 18 DECEMBER 2019
THE LECTURE HALL, REDWOOD EDUCATION CENTRE, GRH
commencing at 19.55

Report Title
STAFF RETENTION - PRESENTATION
Sponsor and Author(s)
Author: Sim Foreman, Trust Secretary Sponsor: Emma Wood, Deputy Chief Executive and Director of People and Organisational Development (OD)
Executive Summary
In June 2019 the Council of Governors discussed staff retention as part of the update from the People and OD Committee. It was agreed that the Council should receive presentation of staff retention and the attached slides cover: • Our Promise • Our Strategy • Progress • Performance • Next Steps The People and OD Committee provides oversight and assurance, on behalf of the Board, on matters related to staff retention.
Recommendations
The presentation is provided for INFORMATION.
Impact Upon Strategic Objectives
Links to Compassionate Workforce and Involved People
Impact Upon Corporate Risks
Poor staff retention can impact the quality of care provided and also, through recruitment, divert management time away for leading for care towards recruitment.
Regulatory and/or Legal Implications
There are no regulatory or legal implications arising from this presentation.

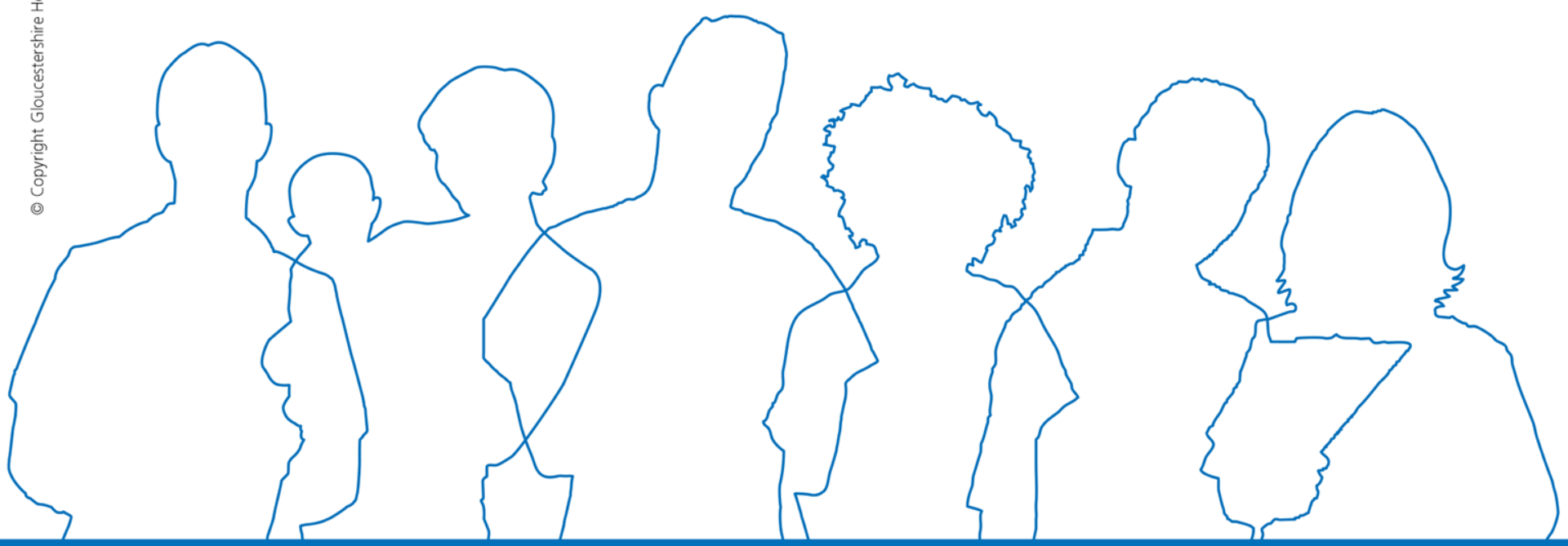
Resource Implications			
Finance		Information Management & Technology	
Human Resources	X	Buildings	

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

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

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Retention



Our Promise

People and Organisational Development Strategy

We will be an employer of choice and recognised as such by being the best in our peer group for attraction, retention and stability indices. We will be among the best University Hospitals in the UK

Our Strategy

Enabling Pillar: Workforce sustainability

Key initiatives	Year 1–2 milestones	Years 3–4 milestones	Year 5
Recognise the talent of colleagues and retain	Improve nurse retention by 1% Reduce vacancy factor for nurses 0.75-1% per annum	Improve nurse retention by 1% Reduce vacancy factor for nurses 0.75-1% per annum	Improve nurse retention by at least 2% in line with NHS Long Term Plan and a Vacancy Factor of 5%
	Reduce overall trust turnover to benchmark with peers in the top quartile		Reduce overall trust turnover to be the best in top quartile
	Reduce turnover in Health Care Assistants and Admin and Clerical roles by at least 1% per annum to ensure parity with other Trusts		Reduce turnover in Health Care Assistant roles by at least 5% and admin and clerical by 3%
	Improve retention measured by stability index by 1% each year Embed and improve the visibility of our talent pools and Accelerated Development pool		Improve retention measured by stability index. Aim to be in top quartile of good and outstanding large University Status Trusts

Progress

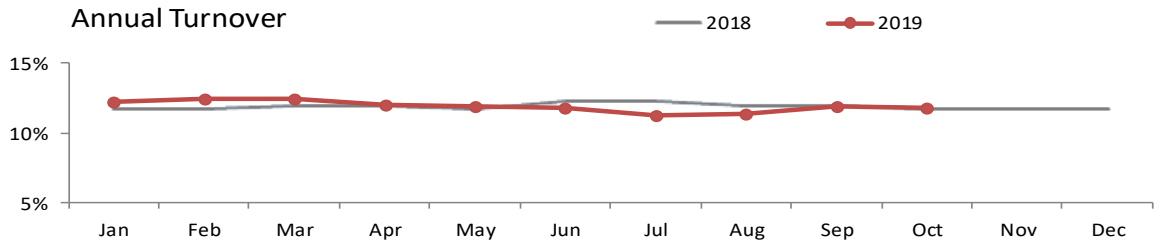
- ✓ Appointed Lead Nurse for Recruitment and Retention
- ✓ Joined NHSI Retention workshops (Cohort 5)
- ✓ 400+ Nursing colleagues completed the ‘What makes you stay’ Questionnaires .
- ✓ Examination of Turnover divisional ‘hotspots’ through the Executive Review Process
- ✓ Deep Dive Retention Reports to People and OD Committee
- ✓ Strengthened employee onboarding through the appointment of a dedicated onboarding recruitment lead.
- ✓ Staff and Patient Experience group targeting hotspots with tangible improvement for groups such as Non-Registered Nursing.

Performa

Model Hospital Comparison:
Model Hospital Recommended Turnover rate: 1.30%
GHNHSFT Monthly Turnover : 1.28%
University/ Teaching Peer Hospitals: 1.21%

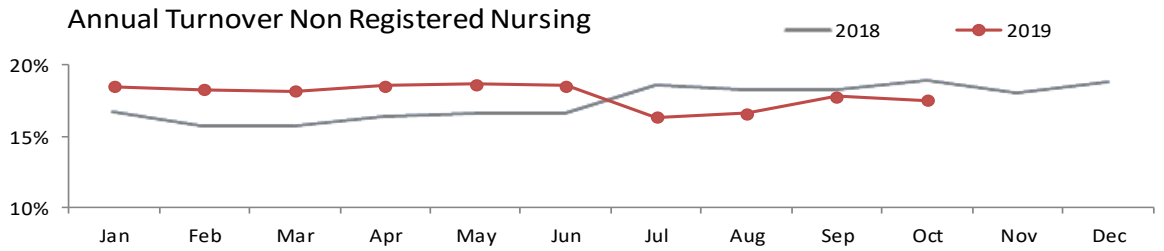
12 Month Rolling Turnover

11.91%	11.82%



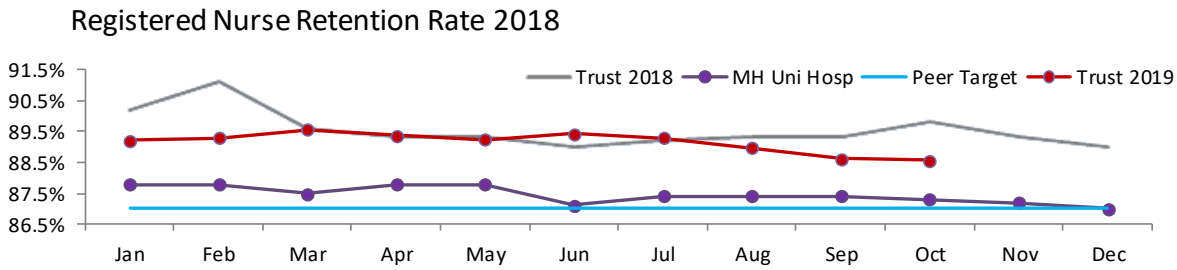
Non- Reg Nursing 12 Month Turnover

18.86%	17.56%



Nurse Retention Rate %

89.61%	88.56%



2019 saw a **reduction in Turnover across Non-Registered Nursing**, whilst we cannot be certain of the cause this does co-inside with the decision to provide an Occupational Sick Pay provision to this group of employees (implemented in May 2019.)
AHP's as a Staff Group have the highest turnover to Aug 19 at 15.71%.
The Trust exceeds the retention rates of Model Hospital University Peers and the Peer Target Rate.

Next Steps

- People and OD Delivery Group monitoring Nurse Led Retention activity and detailed information on Divisional priorities to improve Nurse and HCA retention.

- Executive Review process will continue to scrutinise local actions to address hotspot areas/ groups (i.e. AHPs)

- Pilot Nurse Rotational programme is being implemented from February 2020.

- Staff Survey results released February 2020, to inform 2020 staff survey action plans.

- Exit Interview project aiming to increase completion of the exit feedback process to 60%, to improve reporting of trends and themes, by 31 March 2020.

- NHSI/E Retention Cohort 5 Action Plan (due for submission 30 November)

ITEM 09

GOVERNOR ENGAGEMENT TASK AND FINISH GROUP

VERBAL

Geoff Cave

REPORT TO COUNCIL OF GOVERNORS – DECEMBER 2019

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

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

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

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

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

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

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

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

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

Rob Graves
Finance & Digital Committee

REPORT TO PUBLIC COUNCIL OF GOVERNORS – DECEMBER 2019

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

This report describes the business conducted at the Finance and Digital Committee held on 28 November 2019, indicating the NED challenges, the assurances received, and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Digital Care Board Project Report	Progress report presented for current projects with RAG ratings of their current status - Trakcare Optimisation (Green) - TCLE Pathology implementation (Amber) - Document Viewer (Green) - ICNet PAS & Lab (Amber) subject to scoping and timeline establishment - Pharmacy Stock Control System (Green)	Will this feed the financial system? What is best practice in this area?	Comprehensive status report detail provided assurance that progress remains on plan for all key projects Outputs will provide stock control and balance sheet information Limited number of suppliers – solution selected met specification in terms of patient centred connection and system interface capability	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Sunrise EPR Highlight Report	Report presented focused on the activities and progress following the decision on 18th November to "Go Live" on Wards 7A & 2B at GRH. Key points: - 80+ critical issues identified pre Go Live fixed - Support and engagement from clinical teams fantastic - Small number of technical issues arose at ward level - addressed - 24/7 floor walking support provided for first week and very effective	Wide ranging questions covering: - Had expectations of Roll Out t 1 been met? - To what extent were any issues technical versus human factors - How are the measures of success being developed? - Given the enthusiastic response from clinicians how are users' expectations to be managed - What is the opportunity for partners' access across the system	Strong assurance that, at this stage, the roll out is predominantly meeting expectations and early indications are that benefits will be realised at least at the originally planned level. The importance of ensuring that staff understand this is a marathon not a sprint has been and will continue to be appropriately stressed.	Work to be undertaken to formalize benefits tracking
IM & T Programme Board Update	Programme by programme status review covering existing projects - Desktop Imaging - Imprivata implementation - Next Generation telephony - Windows 2003 Upgrade - Fax replacement - MDT video conferencing - PC Refresh - Firewall replacement - Back up solution - Email archiving		Comprehensive report received detailing project status and issues. Windows 2003 replacement programme remains "Red", and Telephony amber pending detailed review.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	- Network remediation - WiFi Review - DOCMAN10 Transfers of Care 2 new projects opened - Multi Functional Devices - Medical Photography Video Portal	What is the scale of the opportunity for Multi Functional Devices	Considered a very large opportunity but access methodology and information governance implication will need careful consideration as scoping is progressed	
Cyber Assurance Report	Report presented covering the output from recently completed centrally funded cyber security audits. Overall 76 vulnerabilities identified in the February audit with 8 remaining not mitigated at the time of the report	How are relevant issues communicated to the wider heath community (e.g. GPs)? How is remote access to critical systems controlled? Is the risk covering network access control correctly rated?	Action plan in place to address remaining vulnerabilities. Liaison with the CCG provides the principal link Only possible using approved machines Rating considered appropriate but the most difficult area to address taking in to account the cost and practicalities of monitoring and restrictions	Continued regular scrutiny essential and planned

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Board Assurance Framework - **Digital**	Quarterly update of the strategic and corporate risks relating to the Committee's terms of reference. No new risks or issues added this quarter	Would there be value in seeking third party assurance?	It would be preferable to consider utilising internal audit in the assurance process.	Identify additional sources of assurance evidence
Finance Performance Report	7 months' cumulative deficit at £9.1 million (on a Control total basis) is a £0.7 million favourable variance against plan. Key favourable variances: - Commissioner income £4.1m - Other income £1.2m Partially offset by non-pay adverse variance Detailed variance analysis presented Cash balance (£23 million) continues to be relatively high representing cash held following loan receipts for committed capital expenditure Balance sheet commentary Challenges and opportunities for	What is the status of the Medical Division forecast?	This is under close scrutiny	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	balance of year described in detail. Currently a downside risk identified in Quarter 4			4th Quarter forecast to be reviewed in detail in Decemer meeting
Capital Programme Update	Current plan for the year £25.7 million c. £0.3 million lower than the original forecast. Detailed plan by project reviewed			
Cost Improvement Programme Update	CIP at Month 7 at £9.2 million, a £0.8 million gain over target. Detailed analysis by division presented. Outturn for the year continues to shows a significant shortfall form plan reflecting the significantly higher requirement in the 4th quarter's plan. Planning approach for 20/21 reviewed	What is the deadline for committing to the 20/21 plans? With little change now between months is there real progress? Can the narrative on new opportunities be expanded to Describe progress and increase confidence?	Current expectation is December 12th but timetable may change Strong assurance that all opportunities are being pursued	Supporting schedule narrative to be expanded

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
West of England Pathology Network	Review of the Outline Strategic Business Case for the Trust's participation in the West of England Pathology network. Summary of options presented	How robust is the scoring system applied to the options and how can this be best addressed in the business case? Can the option descriptions be better expressed to more accurately reflect the compelling nature of the proposal as described during the committee discussion? What are the IT resource needs associated with the proposals?		Documents to be further refined to reflect the challenges raised and incorporate additional costing information
Board Assurance Framework - **Finance**	Detailed presentation of the Quarterly update of the strategic and corporate risks relating to the Committee's terms of reference.	In relation to the risk "Failure to Deliver Return on Investments what is the status of Post Implementation reviews?	The Project Management Office is addressing this and will start with smaller projects and progress to Employee Patient Record	
Finance Risk Register	One new risk added - risk of "No Deal Exit" from the EU at the end of January			

Rob Graves – Finance and Digital Committee

Enabling Pillar: Transformation

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

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

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

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

REPORT TO COUNCIL OF GOVERNORS – December 2019

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

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

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

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

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

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

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

Alison Moon
Chair of Quality and Performance Committee

REPORT TO COUNCIL OF GOVERNORS – December 2019

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

This report describes the business conducted at the Quality and Performance Committee on 27 November 2019, indicating the NED challenges, the assurances received, and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Adult Inpatient Nursing and Maternity Workforce Review	Six monthly report to provide assurance of compliance to National Quality Board expectations for nursing and midwifery staffing • Tool (summer review) indicates under establishment of 8.02 WTE Registered Nurses across the Trust, with over establishment within Surgery and under establishment in Medicine • Summer review broadly consistent with winter 2018/19 review • Several recommendations from May 19 implemented, including uplift at night on 7B, AMU increased Band 6s, Trainee Nursing associate roles • Overall shortfall in maternity of 21.48 WTE of which 12.76 are maternity support workers and	Risks within Medicine Division, how do we ensure risk driven equal distribution? Is there anything the Board needs to know re the level of risk in Medicine and does the risk need reviewed? Tangible actions in place since May review, will be important to see specific actions planned for next six months What are the immediate risk mitigations in place to minimise risk until such times as future planned staff in place	Difficult to simply move staff from one Division to another in large numbers, plan for Medicine includes £500k identified for Nurse staffing, held with 'intolerable risk' line, all of which will go to Medicine. Previously agreed 2-3 year plan to normalise Medicine staffing Daily and multiple risk assessments on staffing levels, reviewed by People and Organisational Development Committee Staffing levels currently managed well within maternity,	Issue if funding not identified for £500k Wider discussion about varied issues seen within Medicine including some key quality and performance indicators. Executives to review risk profile of Medicine Division and brief next committee Maternity dashboard coming to December

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	8.72 WTE non-clinical and specialist roles • Risks of delivery of plans outlined with high level mitigations		with midwife to birth ratio within national expectations	committee
National Patient Safety Strategy	Briefing on strategy published in Summer 2019 and Trust gap analysis. Trust Quality Strategy reflects direction, key is implementation and setting expectation of engagement of staff and patients to co – design approaches.	Trust quality strategy has focus in strong and continuous quality improvement, how do we ensure we are able to assure safety 'in the moment?' Is there merit in developing an ICS response and approach to national strategy in which the systems owns safety and the risks within it?	Evidence of day to day and operational safety risk management with internal work to do, however biggest gains will be in reducing factors which create the risks, e.g. demand External funding secured from the Health Foundation for ICS to develop joint working on 'wicked issues' Evidence of recent system review of urgent and unscheduled care with agreed actions	Director of Quality and Chief Nurse and Director of Safety and Medical Director to reflect on how the national strategy could enable more effective system working
Learning Report	First report of this type received by Committee, providing high level and specialty specific summary bringing together upheld and partially upheld complaints, moderate and serious incidents, settled claims and death reviews.	How do we know we are a learning organisation? In our journey to outstanding, would be good to see near misses and	Report welcomed, clear benefits of bringing functions together under one leadership team In the Committee work plan for future reports.	Future reports (six-monthly) to consider the' so what' question in terms of assurance and evidence of a learning approach, focus on analytical rather than

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	High level themes: • Patient falls • Delays in diagnosis in diagnosis and treatment • Delays and cancellations of outpatient appointments	low/no harm events being considered in the round Very time consuming to create the report, what would make it easier to generate in future? Is the current risk assessment of falls accurate?	The current Datix system is being reviewed with a view to procuring the latest version that will support better agility in reporting. Risk assessment deemed correct, issue is in the effectiveness of the controls and actions	description
Corporate Risk Register	Review of Register, new, downgraded and removed risks noted. Never Event noted.	Re delay to follow up care, is there any learning about safety, is the risk accurately scored? Should specialties be risk assessed separately e.g. ophthalmology? Are we confident in treating with urgency? Noting the incident highlighted practice which sits between a formal procedure and an injection,	Ophthalmology risk reviewed regularly at Divisional Board. These questions will be raised at planned care delivery group in December. Monitoring of patient experience, clinical review and validation in place. All patient incidents recorded, no themes coming though for other specialties. Previous safety alert received, local and wider review under way and will go to Quality Delivery Group in December	Detailed review on ophthalmology to December committee meeting Further update to committee in December

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
		therefore needing local systems of working, was this a surprise to us and are there any other areas across the Trust where this may be at play?		
Quality and Performance Report	Exception reports received from **Quality Delivery Group** Quality summit approach noted	Falls an area of concern. Histopathology, what risks if any with cases awaiting allocation and how mitigated? Is there an issue with phlebotomy at weekend if mentioned within an SI? Deteriorating patient, previous meeting have indicated an urgency, is the timing indicated reflecting this?	Improvement plan being reviewed Cases are currently risk assessed Action being taken now, not waiting for next meeting. In situ simulations targeted at areas with previous concerns/issues.	More detail in next report requested Lack of clarity if was an SI but phlebotomy not identified as a cause, further review requested
	Planned care delivery group RTT performance stable and above NHSE/I trajectory 52 week wait x 62, within trajectory and lowest since re reporting.	Aim for zero March 2020, what is confidence in achieving this? Do Not Breach data, what is the risk profile? Are these the same patients?	Position improving, will be a challenge but full focus on daily basis and priority to deliver. Mechanisms in place for individual review.	Next level of detail to be included for next committee meeting.
	Cancer delivery group Achievement of 2ww for three		Positive reporting noted and commended.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	consecutive months, first time since 2015, optimism for Q3. 31 days also achieved. 62 day work in progress			
	Emergency delivery group 4 hour performance challenging despite best efforts, high demand, not achieved by the Trust or system in month Change in patterns of attendance within month New data on length of stay in ED post 4 hours and also those with mental health needs.	Good use of SPC charts. Deteriorating picture last 2 points, what additional action if any would be considered if becomes statistically significant? Can it be broken down? Has something changed with external behaviours/ practice to explain the changing pattern of attendances? What is the split of stays between 4- 12 hours? Concern of colleague fatigue as no demand respite through the year, what can we do to support staff?	System wide emergency and urgent care summit held last week. Demand profile has changed with increasing an increasing number of attendances seen towards the late afternoon and early evening. Risk register currently captures specific pressure points with work force but needs regular review to ensure covers all relevant aspects F2SU had been helpful for individuals. Example given of rotation of clinical site team to minimise fatigue	 To be included in future reports

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
CQC action plan	Update on CQC action plan which outlined 52 recommendations, 12 of which were 'Must Dos'. Eight actions closed Four actions require continued monitoring, proposal to do this through routine governance and reporting processes. • ED time to treatment Exception reporting through performance report • Cardiology reconfiguration Exception reporting through planned care delivery group • Mental capacity Act • DOLs assessments Exception reporting into QDG	What is evidence base for closing eight actions?	Site visits, discussions with accountable individuals, targeted use of audit to confirm compliance with must dos. Proposal to close the plan and receive regular updates on four outstanding 'Must Dos' at Q and P Committee agreed	Report on 'Should Dos' to February 2020 committee meeting in line with aim for outstanding

Alison Moon
Chair of Quality and Performance Committee

COUNCIL OF GOVERNORS – DECEMBER 2019
THE LECTURE HALL, REDWOOD EDUCATION CENTRE, GRH
commencing at 5.30pm

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

Purpose

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

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

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

Quality Summits

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

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

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

Performance

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

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

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

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

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

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

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

<u>Key issues to note</u>

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

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

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

Improvements to the Quality and Performance Report continue with further changes and reviews in

the first & second quarter of 19/20, noting exception reports have been developed to support additional areas alongside the full QPR.
Recommendations
The Trust Board is requested to receive the Report as assurance that the Executive team and Divisions fully understand the current levels of poor performance and have action plans to improve this position.
Impact Upon Strategic Objectives
Current performance jeopardises delivery of the Trust's strategic objective to improve the quality of care for our patients.
Impact Upon Corporate Risks
Continued poor performance in delivery of the two national waiting time standards ensures the Trust remains under scrutiny by local commissioners and regulators.
Regulatory and/or Legal Implications
Non delivery of 52 week waiting patients subject to National fining regime.

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

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

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report

Reporting period September 2019

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

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Gloucestershire Hospitals NHS Foundation Trust

Executive Summary

Gloucestershire Hospitals NHS Foundation Trust

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

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

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

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

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

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

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

Performance Against STP Trajectories

Gloucestershire Hospitals NHS Foundation Trust

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

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

Summary Scorecard

Gloucestershire Hospitals NHS Foundation Trust

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

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

Safe

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

Effective

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

Caring

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

Responsive

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

Well Led

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

Demand and Activity

Gloucestershire Hospitals NHS Foundation Trust

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

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

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

Trust Scorecard – Safe (1)

OVERALL SCORE

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

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

Trust Scorecard – Safe (2)

OVERALL SCORE

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

Trust Scorecard – Effective (1)

OVERALL SCORE

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

Trust Scorecard – Effective (2)

OVERALL SCORE

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

Trust Scorecard – Caring (1)

OVERALL SCORE

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

Trust Scorecard – Responsive (1)

OVERALL SCORE

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

Trust Scorecard – Responsive (2)

OVERALL SCORE

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

Trust Scorecard – Responsive (3)

OVERALL SCORE

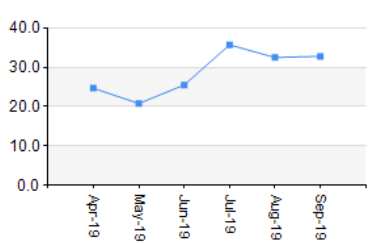
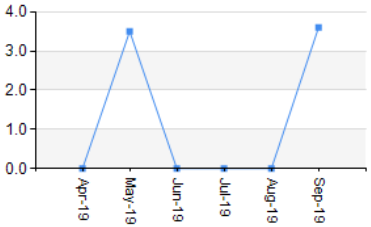
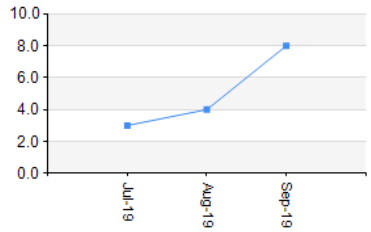
	18/19	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	19/20 Q2	19/20	Standard Threshold
RTT																	
Referral to treatment ongoing pathways under 18 weeks (%)								79.75%	79.46%	80.63%	81.11%	81.80%	81.41%	81.38%	81.38%	81.38%	>=92%
Referral to treatment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

Trust Scorecard – Well Led (1)

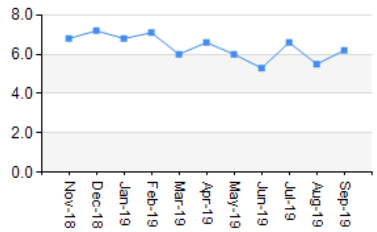
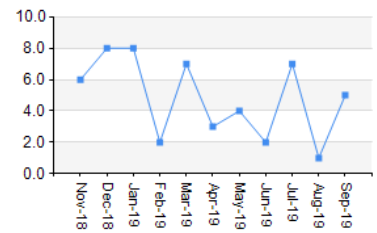
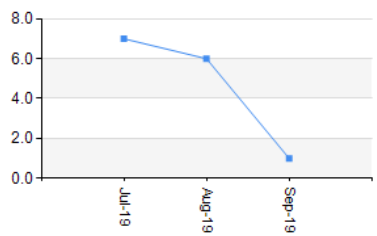
OVERALL SCORE

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

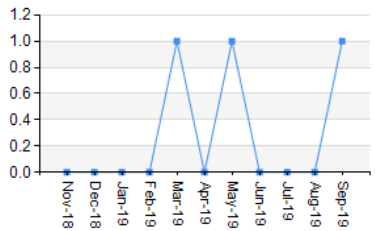
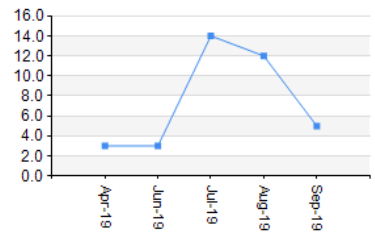
Exception Reports – Safe (1)

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

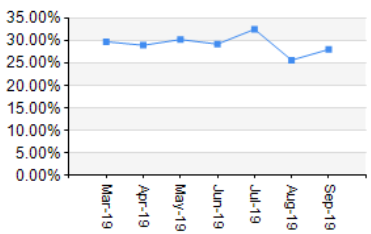
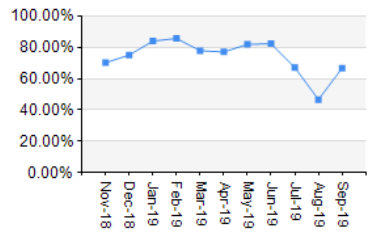
Exception Reports – Safe (2)

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

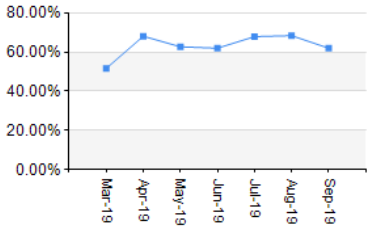
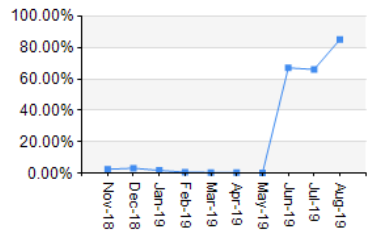
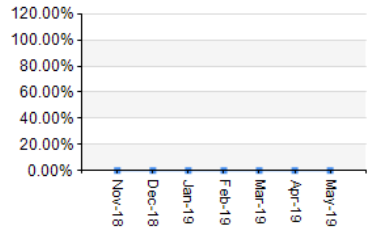
Exception Reports – Safe (3)

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

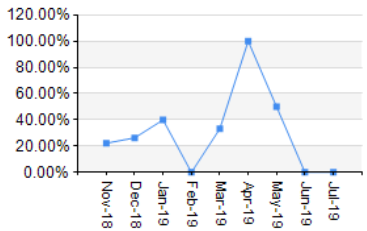
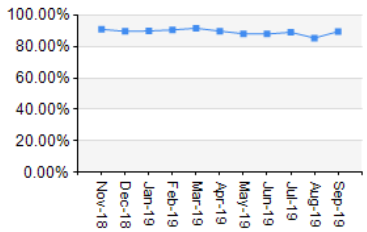
Exception Reports – Effective (1)

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

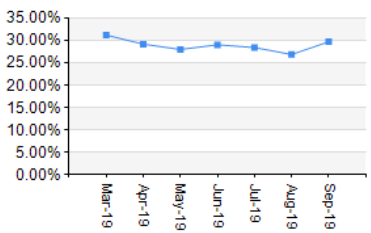
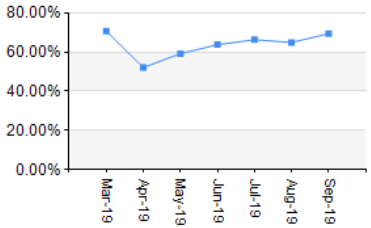
Exception Reports – Effective (2)

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

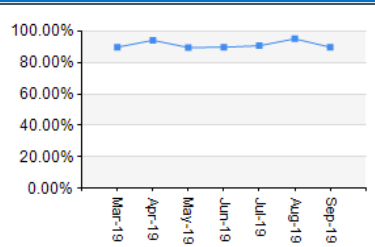
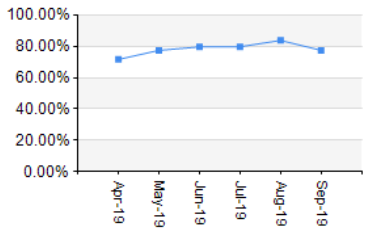
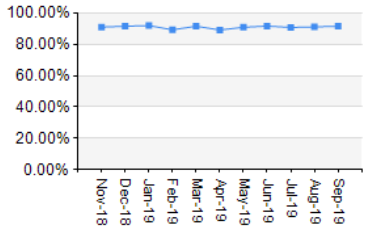
Exception Reports – Effective (3)

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

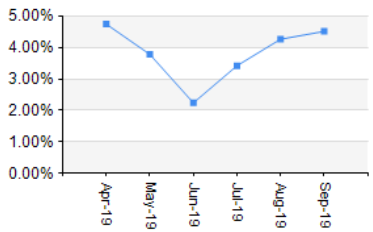
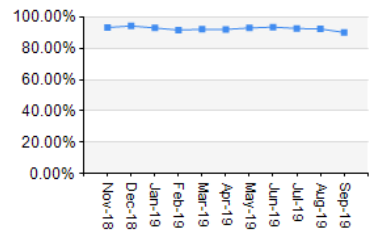
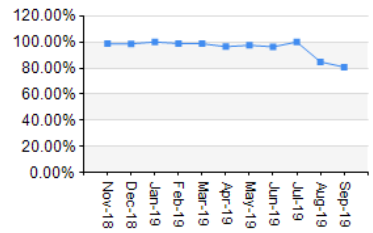
Exception Reports – Effective (4)

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

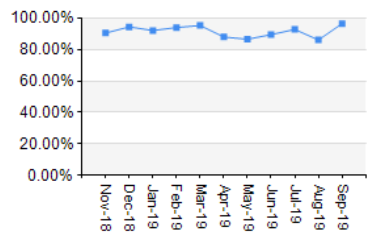
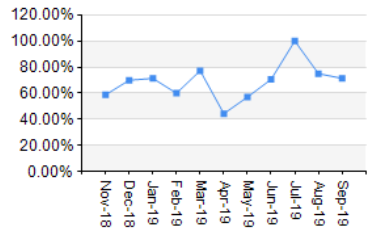
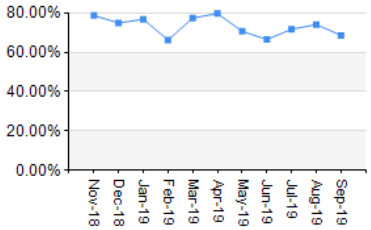
Exception Reports – Caring (1)

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

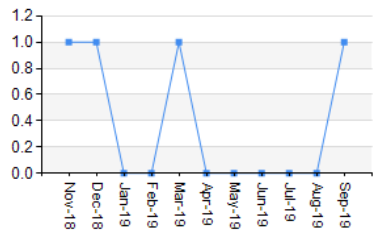
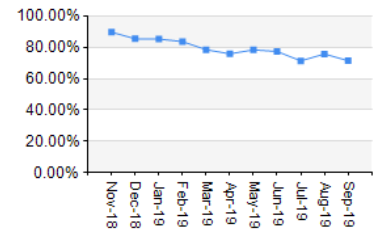
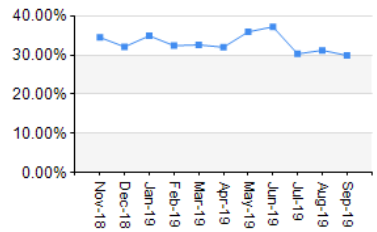
Exception Reports – Responsive (1)

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

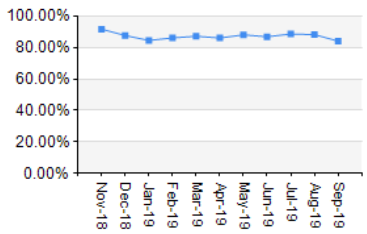
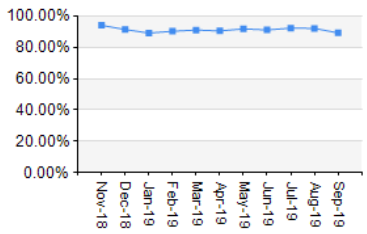
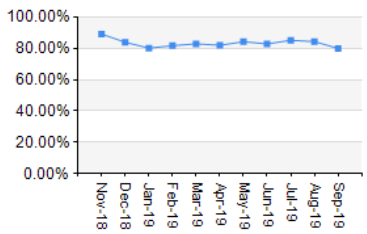
Exception Reports – Responsive (2)

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

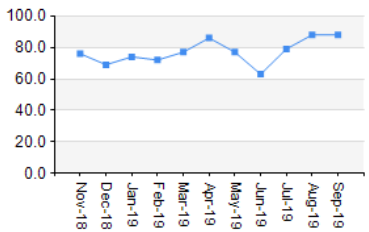
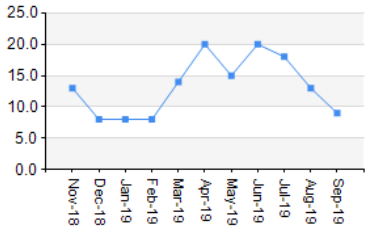
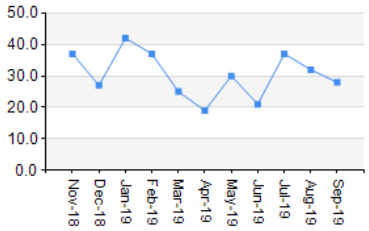
Exception Reports – Responsive (3)

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

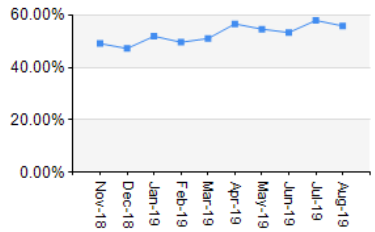
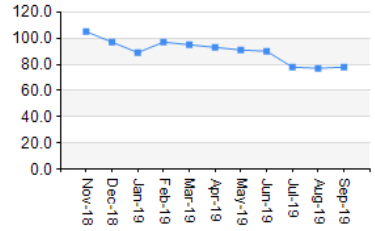
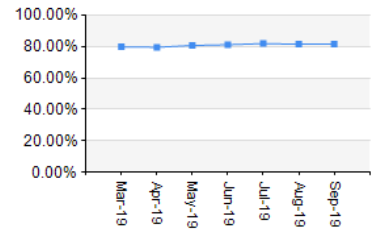
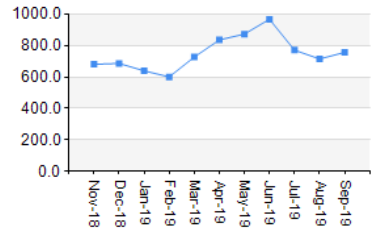
Exception Reports – Responsive (4)

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

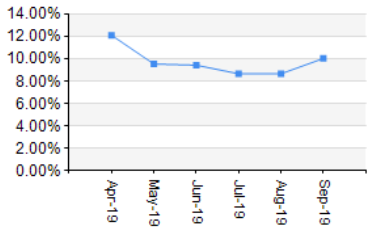
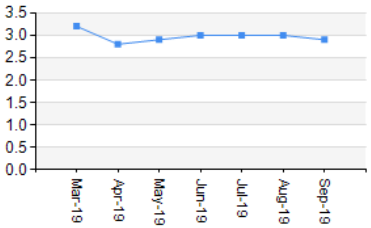
Exception Reports – Responsive (5)

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

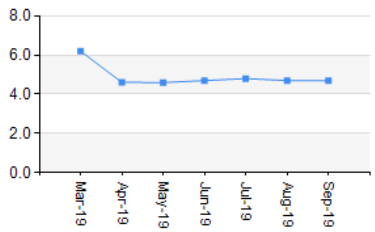
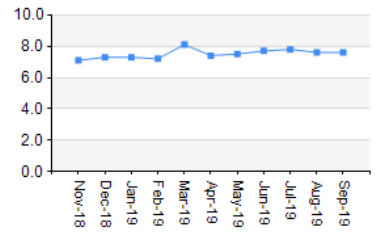
Exception Reports – Responsive (6)

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

Exception Reports – Well Led (1)

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

Exception Reports – Well Led (2)

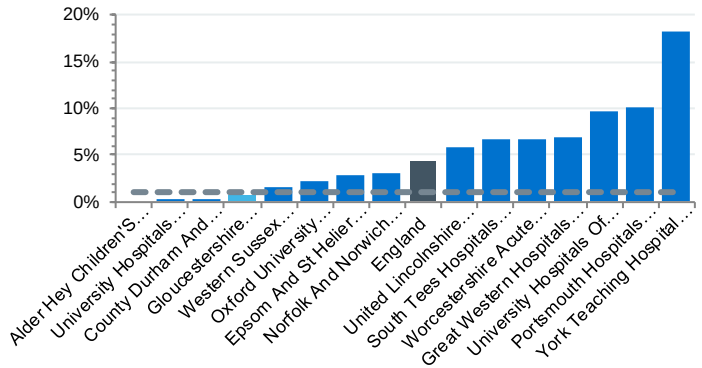
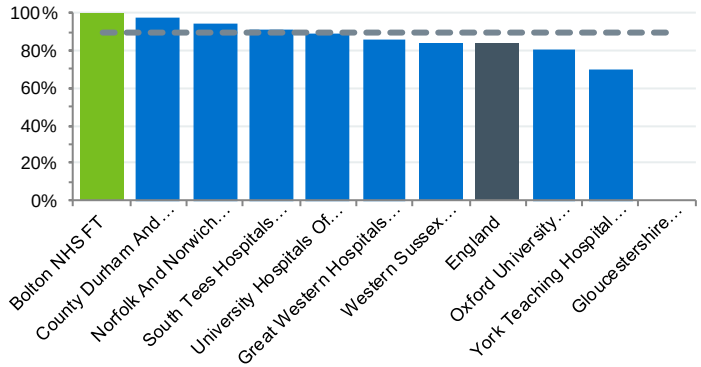
Metric Name & Standard	Trend Chart	Exception Notes	Owner
Care hours per patient day RN **Standard: >=5**		The Lead Nurse for Retention, Recruitment and Attraction is developing retention strategy, has reviewed student nurse recruitment and supporting all recruitment events.	**Director of Nursing and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

Benchmarking (1)

Gloucestershire Hospitals NHS Foundation Trust

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

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

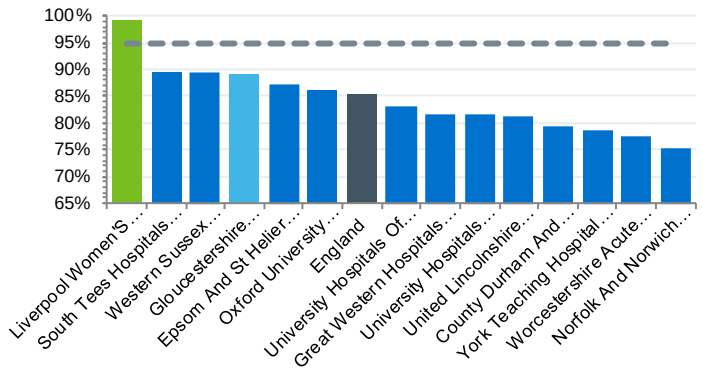
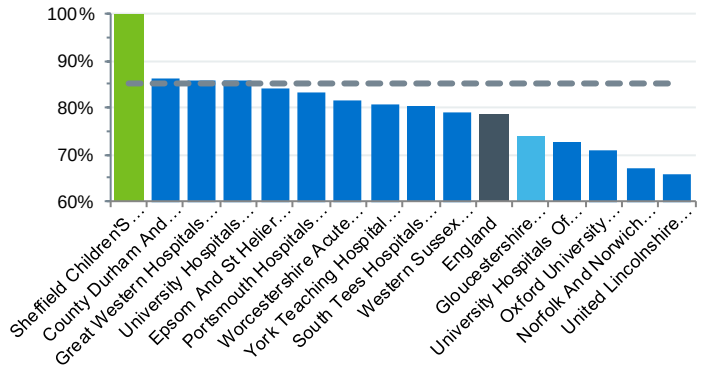
Metric	Period	Peer Group	Rank	Quartile
Diagnostics	August-19		52 / 169	2nd
Dementia	July-19		84 / 84	4th

Benchmarking (2)

Gloucestershire Hospitals NHS Foundation Trust

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

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

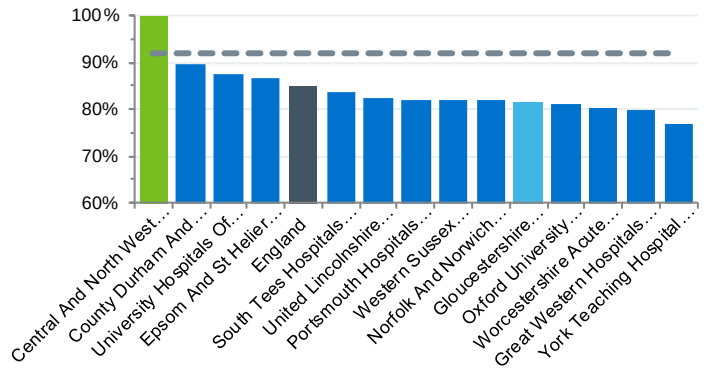
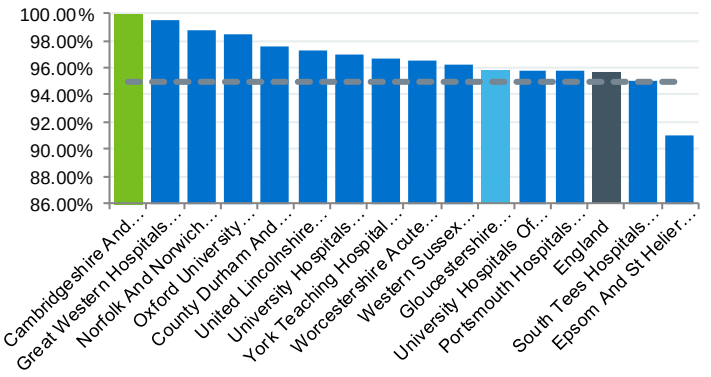
Metric	Period	Peer Group	Rank	Quartile
ED 4 Hour (Type 1 & Type 3)	September-19		29 / 120	1st
Cancer 62 Days GP Referrals	August-19		111 / 143	4th

Benchmarking (3)

Gloucestershire Hospitals NHS Foundation Trust

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

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

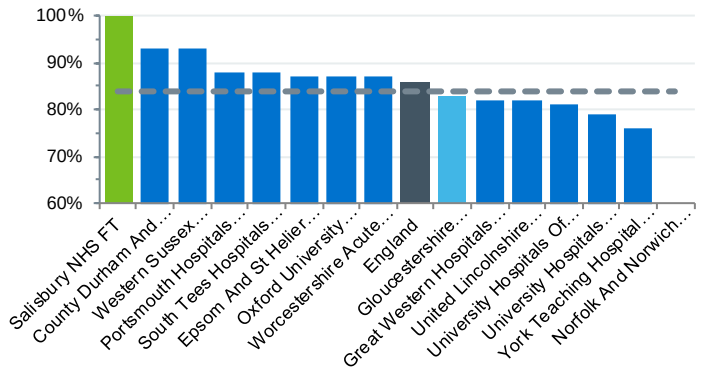
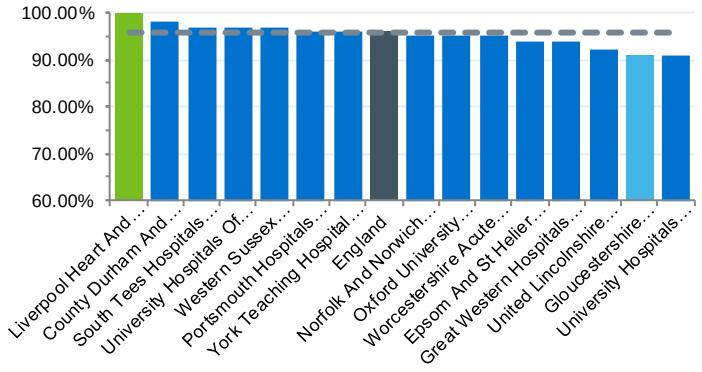
Metric	Period	Peer Group	Rank	Quartile
RTT	August-19		133 / 166	4th
VTE (published quarterly)	June-19		80 / 146	3rd

Benchmarking (4)

Gloucestershire Hospitals NHS Foundation Trust

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

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

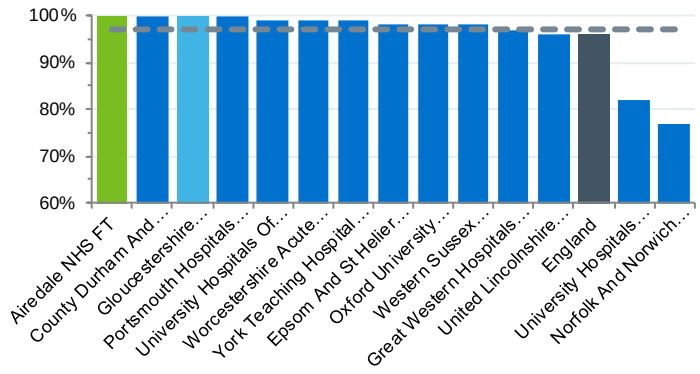
Metric	Period	Peer Group	Rank	Quartile
FFT - ED (percentage recommended)	August-19		94 / 131	3rd
FFT - Inpatient (percentage recommended)	August-19		133 / 145	4th

Benchmarking (5)

Gloucestershire Hospitals NHS Foundation Trust

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

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

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

COUNCIL OF GOVERNORS – 18 DECEMBER 2019
Redwood Education Centre, Gloucestershire Royal Hospital commencing at 17:30

Report Title

Financial Performance Report – Month 6 2019/20

Sponsor and Author(s)

Author: Tony Brown, Senior Finance Advisor
Sponsor: Jonathan Shuter, Acting Director of Finance

Executive Summary

Purpose

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

Key issues to note

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

Conclusions

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

Implications and Future Action Required

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

Recommendations

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

Impact Upon Strategic Objectives

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

Impact Upon Corporate Risks

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

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

Regulatory and/or Legal Implications

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

Equality & Patient Impact

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

Resource Implications

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

Action/Decision Required

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

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

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

Outcome of discussion when presented to previous Committees/TLT

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

Gloucestershire Hospitals NHS
NHS Foundation Trust

Report to the Trust Board

Financial Performance Report
Month Ended 30th September 2019

Introduction and Overview

Gloucestershire Hospitals NHS
NHS Foundation Trust

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

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

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

Statement of Comprehensive Income (Trust and GMS)

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

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

Group Statement of Comprehensive Income

Gloucestershire Hospitals NHS
NHS Foundation Trust

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

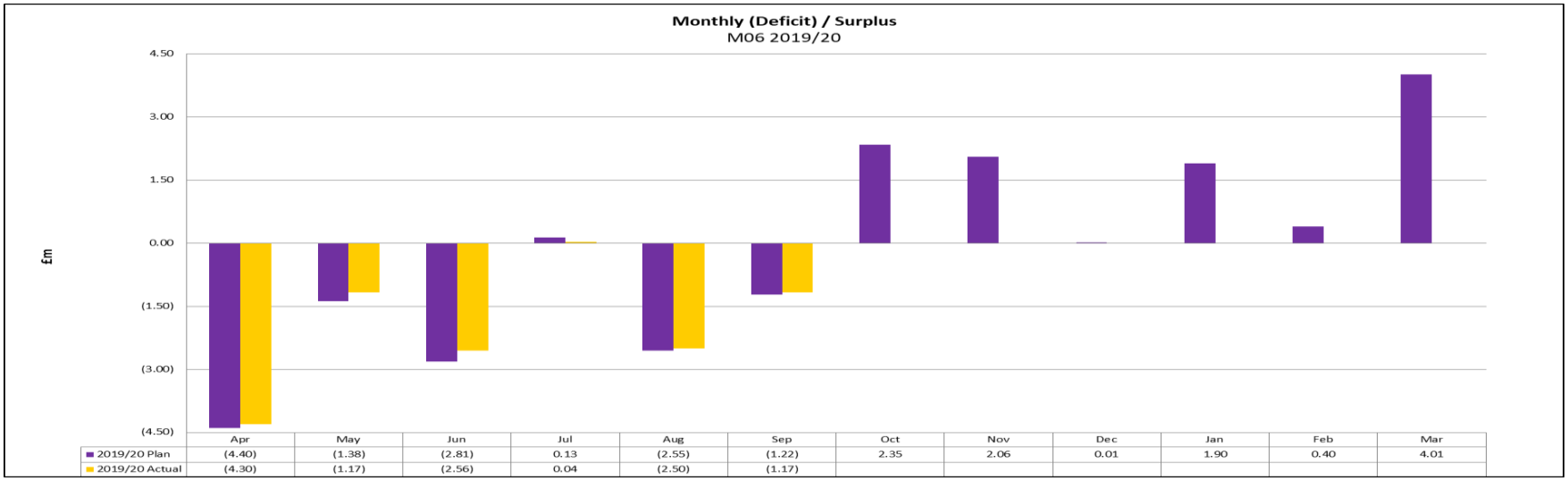
In September the Group's consolidated position shows an in month deficit of £1.2m on a control total basis, a favourable variance to plan of £53k.

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

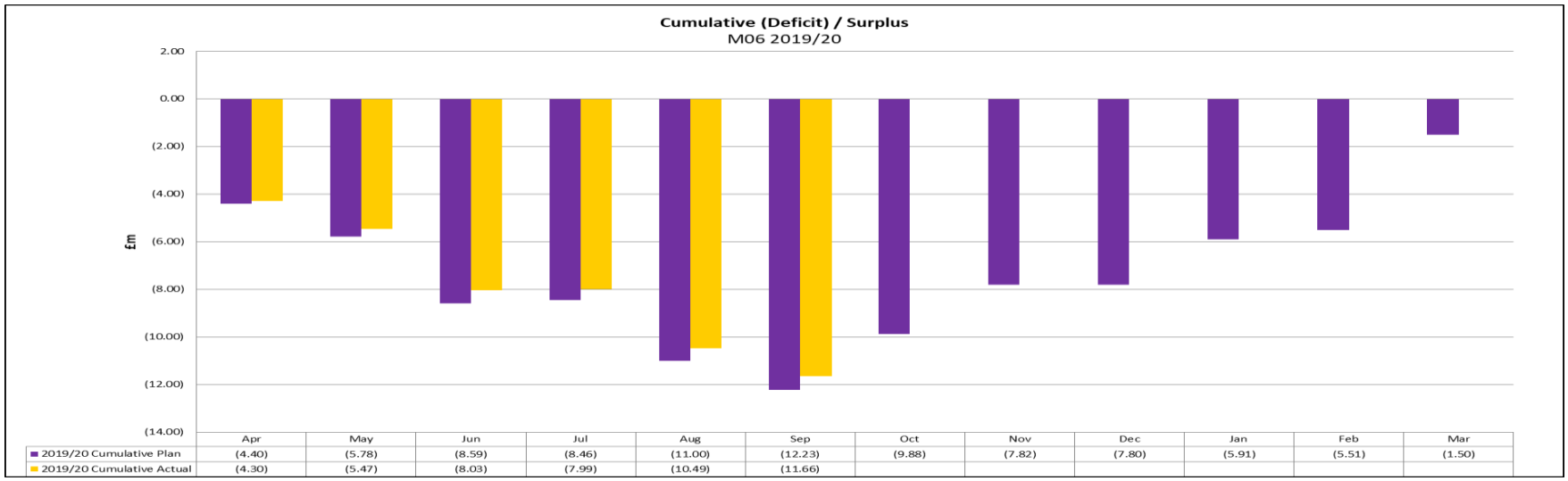
2019/20 Position Trend

Gloucestershire Hospitals NHS
NHS Foundation Trust

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



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



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

Detailed Income & Expenditure

Gloucestershire Hospitals NHS
NHS Foundation Trust

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

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

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

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

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

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

Cost Improvement Programme

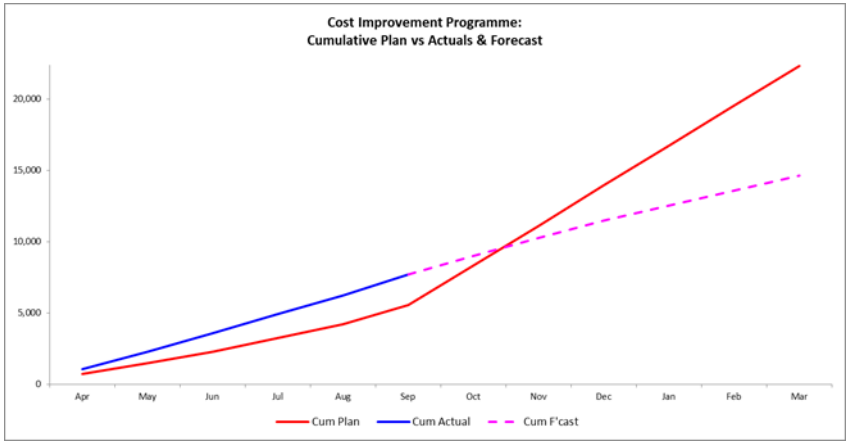
Gloucestershire Hospitals NHS
NHS Foundation Trust

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

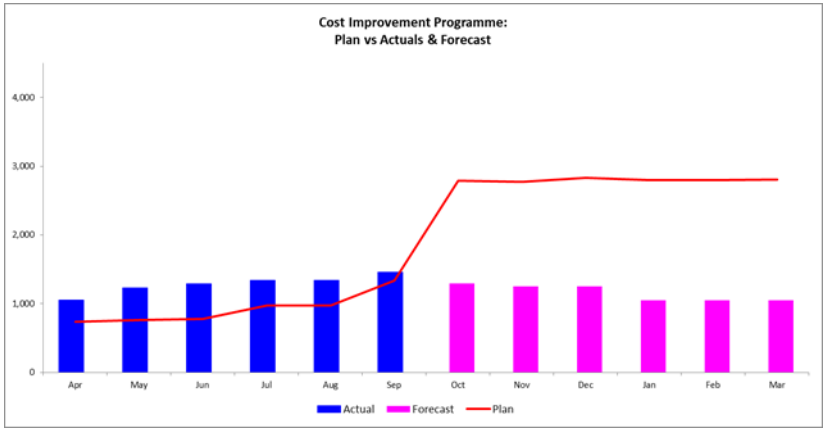
2. At Month 6, the Divisional year end forecast figures indicate delivery of £14.7m against the Trust's target of £22.4m. This has stayed relatively steady with a decrease of £0.1m since month 5 which leaves an under performance against target of £7.7m.

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

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



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



Balance Sheet (1)

Gloucestershire Hospitals NHS
NHS Foundation Trust

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

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

Balance Sheet (2)

Gloucestershire Hospitals NHS
NHS Foundation Trust

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

Current Assets

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

Non-Current Liabilities

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

Retained Earnings

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

Better Payment Practice Code (BPPC)

Gloucestershire Hospitals NHS
NHS Foundation Trust

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

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

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

Liabilities – Borrowings

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

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

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

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

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

Cashflow : September

Gloucestershire Hospitals NHS
NHS Foundation Trust

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

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

Cashflow Key movements:

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

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

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

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

Year End Income and Expenditure Forecast

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

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

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

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

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

Closing The Year End Income and Expenditure Gap

Gloucestershire Hospitals NHS
NHS Foundation Trust

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

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

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

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

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

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

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

Capital Programme

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

Capital Programme Expenditure Summary position at 30th September 2019

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

Points to note:

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

Recommendations

Gloucestershire Hospitals NHS
NHS Foundation Trust

The Board is asked to note:

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

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

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

REPORT TO COUNCIL OF GOVERNORS – December 2019

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

This report describes the business conducted at the Estates and Facilities Committee held 11 November 2019, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
GMS Chair's Report	Staff Forum continues to go from strength to strength. Cleaning performance is being closely monitored in GMS Board	Are there plans for a staff survey? What is the sense of urgency at GMS Board on such a matter, which is causing considerable unease within the Trust?	GMS are developing their own staff survey, planned for February 2020. Performance is reviewed each month, with remedial plans tracked by the Board and holding the Managing Director to account.	

Contract Management Group (CMG) Report	The COO reported that GMS had not submitted a KPI report for the October CMG meeting and so could not provide assurance to Committee. Key issues to arise: (a) Estates Urgent and Routine Faults performance had deteriorated. (b) GMS forecasting an overspend of c. £310k. (c) Vent cleaning on rolling basis now underway. (d) Parking being reviewed, especially permits, due to report in Spring 2020.	Cleaning KPIs were questioned in relation to standards required by the Trust. Is the Trust satisfied that the risk assessment on vent cleaning allows for phased cleaning, or should it be accelerated?	The GMS KPI Report was subsequently circulated. Trust confirms that this is being reviewed as part of next year's planning.	Committee expects to see confirmation that the CMG receives the KPI Report in good time and is reported to Committee on an exception basis, as previously agreed. Trust and GMS need to continue discussions on cleaning standards and the revert to Committee on this.
National Cleaning Standards	Paper presented by Director of Quality and Chief Nurse. The paper was in the context of the recent C.Diff outbreak and he reported significant concerns around the current standard of cleaning.	This topic has been the subject of much discussion at this Committee and also the Quality and Performance Committee. It would appear that the standards to which cleaning should be performed, the actual standard of cleaning carried out and how performance is audited/monitored all remain outstanding issues.	Chief Nurse confirmed that an action plan is in place and is being monitored by the Infection Control Committee, which is also attended by GMS colleagues. While there are procedures for escalation, these do not appear to be effective.	An action plan has been agreed post meeting for GMS to assess cost of achieving contractual standards and also national standards so that any investment can be included in this year's planning round. In the meantime, Trust and GMS will monitor progress and will report back to Committee via the CMG report, with a dedicated report from the Chief Nurse requested in six months.

Strategic Site Development Programme	Preferred option and business case was presented to Committee ahead of presentation to the Trust Board.	Is there any potential conflict with the proposed Cancer Institute? Do these plans compromise the Fit for the Future consultation process?	There are no conflicts – the two schemes are independent. The strategic site development is not dependent on the Fit for the Future outcomes – it is future-proofing the Estate and will accommodate whatever the outcome of FFTF.	
Trust Estates Strategy	The Trust's Estate Strategy was presented to Committee for approval on behalf of the Board.	This has been reviewed and challenged at previous Committee meetings.	The Strategy was approved by Committee.	Future versions, following the outcome of the Fit for the Future plans and ICS developments, would be subsequently submitted.
Estates and Facilities Risk Register	This was presented by the COO with changes highlighted.	The risk of whether the Trust has sufficient medical devices was questioned – how can these be tracked?	The Medical Devices Group has been re-formed to address this.	A tracking system is required, not least linked to the Trust's capital register.

Mike Napier
Chair of Gloucestershire Managed Services Committee
11 November 2019

REPORT TO COUNCIL OF GOVERNORS – December 2019

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

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

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

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

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

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

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

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

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

Board note/matter for escalation

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

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

COUNCIL OF GOVERNORS – DECEMBER 2019
THE LECTURE HALL, REDWOOD EDUCATION CENTRE, GRH
commencing at 5.30pm

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

Purpose

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

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

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

Key issues to note

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

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

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

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

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

Recommendations

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

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

Impact Upon Strategic Objectives

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

Impact Upon Corporate Risks

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

Regulatory and/or Legal Implications

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

Equality & Patient Impact

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

Resource Implications

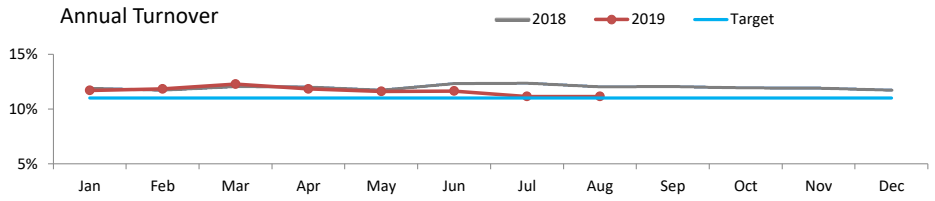
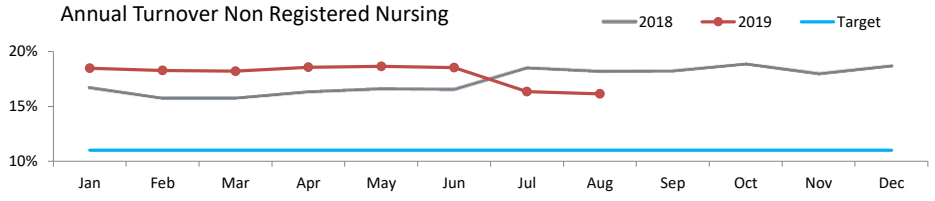
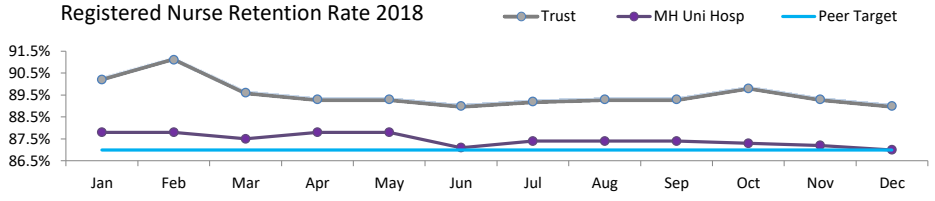
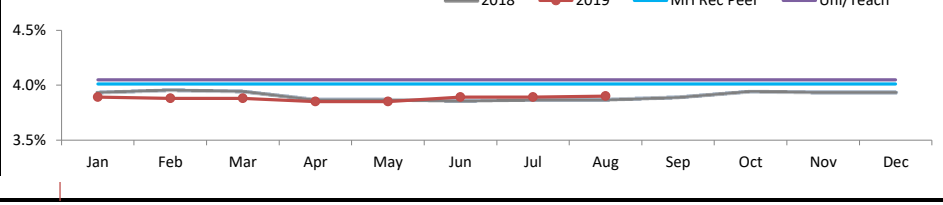
Finance	✓	Information Management & Technology	
Human Resources	✓	Buildings	

Action/Decision Required

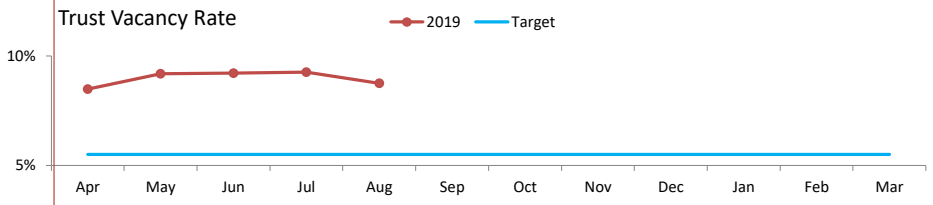
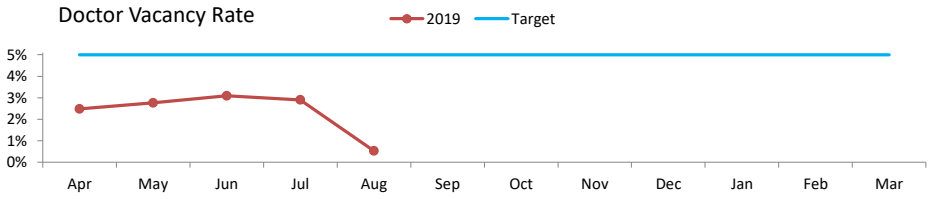
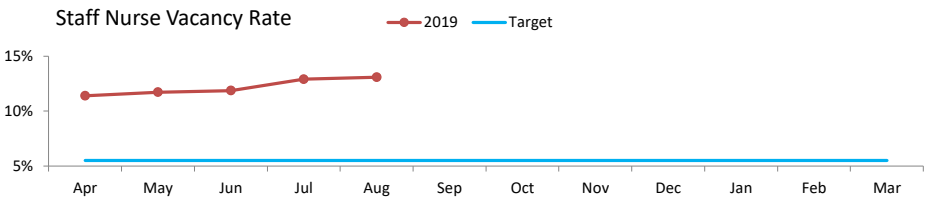
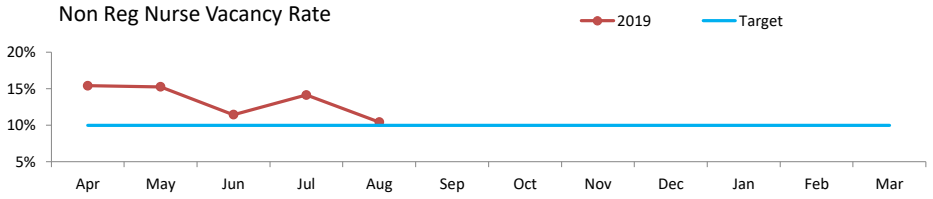
For Decision		For Assurance	✓	For Approval		For Information	✓

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

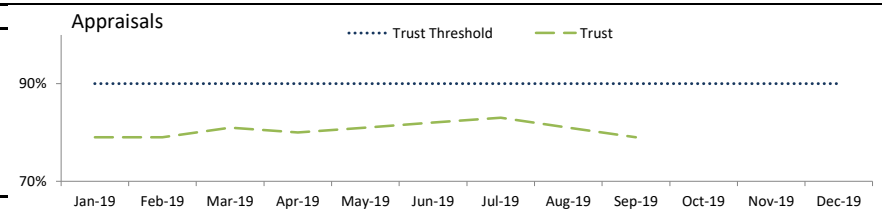
Gloucestershire Hospitals NHS Foundation Trust - P&OD DASHBOARD , Oct 2019

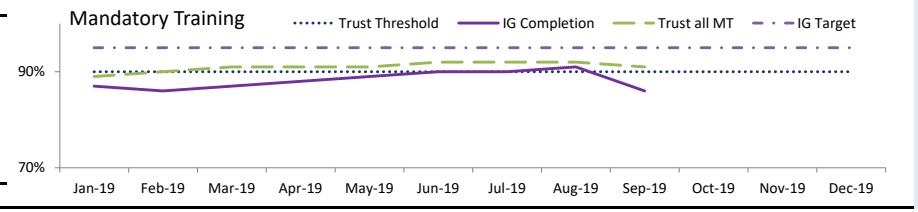
Measure	Description	Aug-18	Aug-19	Trend	Variation
12 Month Rolling Turnover	Turnover is the no of leavers (in fte) expressed as a % of the ave numbers (fte)over the period. It is based on permanent contracts only.Trust target 11% Model Hospital only reports monthly figures. Latest avail Mar 19 - Trust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

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

Measure	Description	Apr-19	Aug-19	Trend	Variation
Trust Vacancy Rate	The difference between the establishment and the staff in post as a percentage of establishment. Target revised to ...	8.48%	8.75%		August's vacancy rate at 8.75% has decreased by 0.5% since July and remains within trend for the year to date.
Doctor Vacancy Rate	The difference between the establishment and the staff in post as a percentage of establishment.	2.48%	0.53%		August's vacancy rate at 0.53% has decreased dramatically since July with recruitment to key posts. The team are proactively working to target trainees due to qualify as consultants in 2020 and have issued conditional offers for key posts (subject to qualification and successful selection exercises). The Associate Specialist role was launched in October 2019 to support alternative skill mix solutions where vacancies remain hard to fill.
Staff Nurse Vacancy Rate	The difference between the establishment and the staff in post as a percentage of establishment.	11.39%	13.08%		August's vacancy rate at 13.08% has increased by 0.17% since July. Staff Nurse vacancies continue to be of concern at 13.08%, reflecting the national picture relating to staff nurse recruitment. Efforts continue to find innovative ways to attract and recruit Nursing staff from both domestic and international pipelines
HCA Vacancy Rate	The difference between the establishment and the staff in post as a percentage of establishment. Target revised to ...	15.40%	10.42%		August's vacancy rate at 10.42% has decreased by 3.71% since July and continues the general downward trend for the year to date.

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

Measure	Description	Sep-18	Sep-19	Trend	Variation
Appraisals	% of Appraisals completed in previous 12 months. Excludes: Bank, staff joining Trust in the last 10 months (12 months for Medical staff) , staff on Maternity & adoption leave, suspended, external secondment, career break, Junior medical staff.	79.00%	79.00%		Lowest Divisional Appraisal rate is Corporate with 70% completion. No Division has reached target, Surgery is closest with 82%. Divisions are challenged via the executive review process to report on specific action plans to improve compliance and their progress.

Measure	Description	Aug-18	Aug-19	Trend	Variation
Mandatory Training	Compliance rate is expressed as a percentage of number of completions meeting requirement /number of completions required. NHS Digital have set a national requirement to achieve a compliance target of 95% for Information Governance Training.	88.00%	92.00%		Only Medicine Division is below target at 89%. By Staff Group, Additional Clinical Services and SAS Doctors are at 86%, Training Grade Medical staff are at 70%. All other groups are over target. Information Governance training is highlighted as an exception due to the decline in compliance. It is recognised that the anniversary of this training requirement means some slippage may occur however Divisions will now be challenged to focus on local improvement plans to improve and meet the required 95% target.

Enabling Pillar: Workforce Sustainability

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

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

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

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

Enabling Pillar: Colleague Experience

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

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

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

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

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

COUNCIL OF GOVERNORS – DECEMBER 2019
LECTURE HALL, REDWOOD EDUCATION CENTRE, GRH
commencing at 5.30pm

Report Title
Governors' Log Report
Sponsor and Author(s)
Author: Carolyne Claydon, Corporate Governance Sponsor: Sim Foreman, Trust Secretary
Executive Summary
Purpose To update the Council of Governors on the themes raised via the Governors' Log since the last Council of Governors meeting on 16 October 2019. Key issues to note Questions have been raised on four themes: 1. Transgender Patients 2. Inconsistency of appointments 3. Controls around transferring patient data to an outside company 4. Provision of cervical screening (update by the Chief Executive following release of a recent media article) Three of the four issues have been "closed", with 3) above awaiting confirmation from the Governor concerned that the responses provided satisfy the question.
Recommendations
N/A
Impact Upon Strategic Objectives
N/A
Impact Upon Corporate Risks
N/A
Regulatory and/or Legal Implications
N/A

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

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

COUNCIL OF GOVERNORS – DECEMBER 2019

GOVERNORS' LOG

Included below are submissions received via the Governor's Log for the period since the Council of Governors meeting on 16 October 2019.

Documents explaining the Governor's Log as well as the standard operating procedure are included as Appendices 1 and 2 to this report.

Ref: 14/19	**Governor:** Alan Thomas	**Lead:** Steve Hams (responded by Suzie Cro)
Submitted: 14/10/2019	**Deadline: 25/10/2019**	**Responded: 15/10/2019**
Theme: Transgender Patients		**Status:** Closed

Question:

A recent report in 'The Telegraph' reports that transgender patients can choose whether they want to be treated on male or female wards, according to new NHS guidance. NHS England says patients should be accommodated 'according to their presentation', noting the 'way they dress, and the name and pronouns they currently use'.

What is the Trust's approach to this new guidance?

Answer:

Our approach is the same as the national guidance and is within the GHT Same Sex Accommodation Policy dated for review Sept 2020.

In addition we have organised an engagement session with members of the Trans community in the New Year and in this space we will be talking about how we can improve care for them.

I have lifted the section in our policy and have attached it below for reference.

TRANSGENDER PATIENTS

Transsexual people, that is, individuals who have proposed, commenced or completed reassignment of gender, enjoy legal protection against discrimination. In addition, good practice requires that clinical responses be patient-centred, respectful and flexible towards all transgender people who do not meet these criteria but who live **continuously or temporarily** in the gender role that is opposite to their natal sex. The key points are:
• Trans people should be accommodated according to their presentation: the way they dress, and the name and pronouns that they currently use;
• This may not always accord with the physical sex appearance of the chest or genitalia;
• It does not depend upon their having a gender recognition certificate (GRC) or legal name change;
• It applies to toilet and bathing facilities (except, for instance, that pre-operative trans people should not share open shower facilities);
• Views of family members may not accord with the trans person's wishes, in which case, the trans person's view takes priority.

Those who have undergone full-time transition should **always** be accommodated according to their gender presentation. Different genital or breast sex appearance is **not** a bar to this, since sufficient privacy can usually be ensured through the use of curtains or by accommodation in a single side room adjacent to a gender appropriate ward. This approach may only be varied under

special circumstances where, for instance, the treatment is sex-specific and necessitates a trans person being placed in an otherwise opposite gender ward.

Where admission/triage staff are unsure of a person's gender, they should, where possible, ask **discreetly** where the person would be most comfortably accommodated. They should then comply with the patient's preference immediately, or as soon as practicable. If patients are transferred to a ward, this should also be in accordance with their **continuous** gender presentation (unless the patient requests otherwise).

Ref: 15/19	**Governor:** Alan Thomas	**Lead:** Rachael de Caux / Mark Pietroni
Submitted: 13/11/2019 **Submitted**: 02/12/2019	**Deadline: 27/11/2019** **Deadline: 16/12/2019**	**Responded: 18/11/2019** **Responded: 02/12/2019**
Theme: Inconsistency of appointments		**Status:** Open [Awaiting AT's response that he is happy with the second response)

Question:
I hesitate to put forward personal experience as the reason for a log question, but I think the issue is a generic one that applies to every single patient of this Trust. As some will know, I am a regular mystery shopper of various specialities within the Trust. It gives me a great opportunity to compare methodologies between departments, especially the patient facing ones.

So what I would like to understand please is why there is so much inconsistency between departments in the way appointments are made.

1. I had a cardiology appointment in March 2019; I do not yet have my next appointment, though I had been led to believe it would be in September 2019.

2. I had a respiratory appointment in August 2019; I am on a 6 month appointment list so am expecting one in Feb 2020 - along with lung function tests beforehand. I have yet to receive either appointment.

3. I had a renal appointment this week; 2 days later I received a letter with my next appointment - for March 2020.

The practice exhibited in No 3 is much to the preference of all patients in that it allows proper planning and speedy resolution of pre-existing timetable calendar issues. Why can this not be the normal practice?

Response:
We are reviewing our access policy and as such you will be aware that we have recently updated our clinic letters to patients and very recently our approach to text message reminders for our patients. It would be useful to understand if these have made their way to you now and in the future and any feedback you have.

In relation to the points raised, we note the inconsistency that has been applied. We operate though as a provider to provide the appropriate period of notice for appointments and, as such, we do not offer these with 'long' periods of notice. Whilst we appreciate that some patients would prefer this, there are a number of reasons that we would not approach it in this way. For example, clinic availability; clinician availability and changes in timetables would normally mean that a period of 8 weeks is sufficient to ensure that the patient is not unnecessarily changed. We have found that the long waiting appointments create additional work for us and disappointment for

patients if and when we have to reschedule these appointments. The process of cancelling and re-booking, therefore, we seek to avoid at all times. It is a balance between sufficient notice for our patients to attend their appointments and to mitigate the risk of cancellations.

For reassurance, however, we have recently recruited two new Renal consultants who commenced in post in October 2019 and we have, therefore, been able to open additional capacity in order to book patients up to March.

Additional Questions [received 2 December 2019]
1. I can understand the general point you make about crystal ball gazing into the future - in order to avoid cancellations and re-appointments. However, I wonder whether you have any evidence to suggest that this is what the patient would prefer? I don't want this to become a personal question, but a date that is in the diary and then has to be changed, will be changed with consultation. The current system will often lead to unsuitable dates (for the patient) and the need to change the date in any event. I would like to see some work done on patient preferences, if that is possible.

2. Again, I am delighted to see increased staffing in the renal department - but its ability to provide appointments in the way I have described has been going on for some time.

Response: Appreciate your further query. In terms of evidence of direct patient feedback for this process, as described previously, it is a careful balance of ensuring the notice period is sufficient but also that we can mitigate the risk of cancellations. There are some specialties as you identify where there are additional factors to consider and where we would support 'longer appointments'. In the case of renal, the response detailed the additional capacity as a positive benefit, recognising that the service has approached appointments in this way because of the direct linkages to dialysis and transplant pathways.

In terms of direct patient feedback, I am not aware that we have undertaken any patient surveys in this area, however our access policy is similar to other large Trusts such as ourselves. We are continuing to focus on the patient experience element of outpatients, as we described last time to address our mechanisms of information e.g. clearer letters and text reminders

Happy to discuss further.

Ref: 16/19	**Governor:** Alan Thomas	**Lead:** Mark Hutchinson
Submitted: 18/11/2019	**Deadline: 02/12/2019**	**Responded: 02/12/2019**
Theme: Controls around transferring patient data to an outside company		**Status:** Closed

Question:
In the light of recent media discussion of Google, and its ability to examine patient data without recourse to patients (see Project Nightingale), can we be assured that any patient data transferred to an outside company is only done so under very strict conditions, and with patient knowledge?

Answer:
Yes you can be assured. Unlike the US, NHS Trusts within the UK are subject to a Full Data Impact Assessment by law and any data transfer would only be approved under strict conditions such as anonymisation. Further details can be provided if required.

Ref: 17/19	**Governor:**	**Lead:** Deborah Lee
Submitted: 19/11/2019	**Deadline: N/A**	**Responded: 26/11/2019**
Theme: Provision of cervical screening		**Status:** Closed

Question:

It was recently reported in the media that the Trust decided not to bid to be one of nine national centres designated for the provision of cervical screening as part of the national screening programme. Why did the Trust not bid?

Answer:

The rationalisation of cervical screening cytology services is a response to national policy which is reflecting the evidence that larger centres, processing higher volumes of tests, produce better outcomes and save more lives. NHS England led the procurement to commission nine centres nationally. After very careful consideration by the Trust's Leadership Team it was apparent that the Trust could not meet the requirements of the tender without considerable investment in infrastructure – both buildings and equipment. Given the timeline for implementation of the revised arrangements, even if funds could have been secured, the necessary expansion in buildings, equipment and workforce could not have been achieved in the required timeline. Two other considerations were also factors in the decision making 1) two adjacent laboratory services were able to mobilise the new service with immediate effect and had both been national pilot sites which we were not 2) the introduction of the HPV vaccine will result in the service from changing dramatically in the next decade which was considered a considerable risk in the face of the investment required. Importantly, all cervical screening services remain as they were i.e. local in GP practices and sexual health clinics and any woman requiring onward care as a result of an abnormal smear will be treated by our services utilising the retained gynaecology histopathology service expertise, as is the case now.

Sim Foreman
Trust Secretary
December 2019

APPENDIX I

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.

APPENDIX II

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 12

CONFIRMATION OF LEAD GOVERNOR APPOINTMENT PROCESS

VERBAL

Sim Foreman

ITEM 13

RESULT OF THE GOVERNANCE AND NOMINATIONS COMMITTEE ELECTION

VERBAL

Sim Foreman

ITEM 14

ANY OTHER BUSINESS

VERBAL

All