The next meeting of the Gloucestershire Hospitals NHS Foundation Trust Main Board will be held on **Thursday 10 October 2019** in the **Cabinet Suite, Shire Hall** commencing at 12:30

(PLEASE NOTE DATE AND VENUE FOR THIS MEETING)

Peter Lachecki
Chair

October 2019

AGENDA

	Item	Paper	Purpose	Time
1.	Welcome and Apologies			**12:30**
2.	Declarations of Interest			**12:32**
3.	Patient Story			**12:33**
4.	Minutes of the meeting held on 12 September 2019	**PAPER**	**For approval**	**13:00**
5.	Matters Arising	**PAPER**		**13:02**
6.	Chief Executive's Report	**PAPER (Deborah Lee)**	**For assurance**	**13:05**
7.	Trust Risk Register	**PAPER (Emma Wood)**	**For assurance**	**13:15**
8.	Learning from Deaths	**PAPER (Mark Pietroni)**	**For assurance**	**13:20**
9.	**Quality & Performance:**			
	▪ Assurance Report of the Chair of the Quality & Performance Committee held on 25 September 2019	**PAPER (Alison Moon)**	**For assurance**	**13:30**
	▪ Quality & Performance Report	**PAPER (Steve Hams Rachael de Caux Mark Pietroni)**	**For assurance**	
10.	**Finance & Digital:**			
	▪ Assurance Report of the Chair of the Finance & Digital Committee held on 26 September 2019	**PAPER (Rob Graves)**	**For assurance**	**13:45**
	▪ Financial Performance Report	**PAPER (Sarah Stansfield)**	**For assurance**	
11.	People & Organisational Development:			

	▪ Research Strategy	**PAPER** (Simon Lanceley)	For information	**14:00**
12.	Audit & Assurance: ▪ Assurance Report of the Chair of the Audit & Assurance Committee held on 17 September 2019	**PAPER** (Claire Feehily)	For assurance	**14:10**
13.	Brexit Briefing	**PAPER** (Sarah Stansfield)	For assurance	**14:15**
GOVERNOR QUESTIONS				
14.	A period of 10 minutes will be permitted for Governors to ask questions.			**14:25**
STAFF QUESTIONS				
15.	A period of 10 minutes will be permitted for Governors to ask questions.			**14:35**
PUBLIC QUESTIONS				
16.	A period of 10 minutes will be permitted for members of the public to ask questions submitted in accordance with the Board's procedure.			**14:45**
17.	New Risks Identified	**VERBAL** (All)		**14:55**
18.	Items for the Next Meeting	**VERBAL** (All)		**15:10**
19.	Any Other Business			**15:15**
	CLOSE			**15:20**

COMPLETED PAPERS FOR THE BOARD ARE TO BE SENT TO THE CORPORATE GOVERNANCE TEAM NO LATER THAN 17:00 ON TUESDAY 01 OCTOBER 2019

Date of the next meeting: The next meeting of the Main Board will take place on
Thursday 14 November 2019 in the **Lecture Hall, Redwood Education Centre, Gloucester Royal Hospital** at **12:30pm**

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

Board Members

Peter Lachecki, Chair

Non-Executive Directors	**Executive Directors**
Claire Feehily	Deborah Lee, Chief Executive
Balvinder Heran	Emma Wood, Director of People and Deputy Chief Executive
Alison Moon	Rachael de Caux, Chief Operating Officer
Mike Napier	Steve Hams, Director of Quality and Chief Nurse
Rob Graves	Mark Hutchinson, Chief Digital and Information
Elaine Warwicker	Simon Lanceley, Director of Strategy & Transformation
	Mark Pietroni, Director of Safety and Medical Director
	Sarah Stansfield, Director of Finance

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE TRUST BOARD
HELD IN THE LECTURE HALL, SANDFORD EDUCATION CENTRE,
CHELTENHAM GENERAL HOSPITAL ON THURSDAY 12 SEPTEMBER 2019 AT 12:30

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

PRESENT	Peter Lachecki	PL	Chair
	Deborah Lee	DL	Chief Executive Officer
	Emma Wood	EW	Director of People & Organisational Development and Deputy Chief Executive Officer
	Rachael De Caux	RdC	Chief Operating Officer
	Steve Hams	SH	Director of Quality and Chief Nurse
	Mark Hutchinson	MH	Chief Digital and Information Officer
	Simon Lanceley	SL	Director of Strategy & Transformation
	Mark Pietroni	MP	Director of Safety and Medical Director
	Sarah Stansfield	SS	Director of Finance
	Claire Feehily	CF	Non-Executive Director
	Rob Graves	RG	Non-Executive Director
	Alison Moon	AM	Non-Executive Director
	Elaine Warwicker	EW	Non-Executive Director
IN ATTENDANCE	Anne Davies	AD	Public Governor, Cotswold
	Alan Thomas	AT	Lead Governor, Cheltenham
	Bilal Lala	BL	Associate Non-Executive Director
	Craig MacFarlane	CMcF	Head of Communications and Marketing
	Haroon Kadodia	HK	Patient's relative
	Katie Parker	KP	Head of Quality
	Carolyne Claydon	CC	Corporate Governance
APOLOGIES	Mike Napier	MN	Non-Executive Director
	Marie Annick-Gournet	MAG	Associate Non-Executive Director
	Balvinder Heran	BH	Non-Executive Director

181/19 WELCOME AND APOLOGIES **ACTIONS**

PL welcomed everyone in particular Elaine Warwicker who has joined the Trust as a new Non-Executive Director.

Apologies were noted.

182/19 DECLARATIONS OF INTEREST

There were none.

183/19 PATIENT STORY

Mr Kadodia attended today's meeting with KP and presented some slides on the experiences of his parents during a recent stay at Gloucestershire Royal Hospital and is attached as an appendix to these Minutes.

The key points of Mr Kadodia's presentation were:

- There were problems with communication with his parents not understanding everything that was said to them;
- Diversity leaflets would have been helpful;
- He would have liked to have seen staff being more proactive in making his parents more comfortable;
- It would have been welcomed for staff to ask what ethnic religion his

parents belonged to;
- People should not be afraid to ask questions and Mr Kadodia has conducted workshops on this;
- Mr Kadodia is to become part of the team to work with communities to find out what really matters to them when they come in to hospital;
- The recommissioning of translation services is being considered;
- How is it possible to measure whether the BAME voice has been captured?

In response:

- PL thanked Mr Kadodia for his presentation.
- Addressing Mr Kadodia's question, DL acknowledged that historically the BAME voice has not been heard well enough but significant steps had been taken to address this, including the recent recruitment of three BAME Board members to ensure the Board is more representative of the communities we serve and the staff we employ. DL explained that 10% of the workforce comes from the BAME community, and this rises to 30% in the medical staff group. She added, in common with other Trusts, representation BAME staff in senior management roles is poor and we are taking steps to address this including the inclusion of a BAME panel member on all senior manager interviews and sponsorship of BMAE staff on the national Stepping Up Programme which is aimed at the development of BAME staff and support into senior roles. KP has brought significant knowledge and contacts with her since joining the Trust and DL is grateful to Mr Kadodia for supporting us on this journey.
- AM asked how the Trust can give the staff confidence to tackle sensitive issues which they might not have encountered or felt able to address, previously? Mr Kadodia responded that in his view this relates to personalisation: if we understand that patients are individuals, then the other things should follow including sensitivity to race and religion.
- AM asked SH where the Trust is with the systematic approach to personalisation? SH responded that this will be part of the widespread programme, Pathway to Excellence. SH added that he was saddened to hear about the lack of awareness of daily prayer routines as this is an important part of person-centred care.
- EW stated that they enjoyed the presentation and that the issues raised by Mr Kadodia were linking to the cultural work currently being undertaken with staff and EW very much welcomed Mr Kadodia's involvement.
- MH commented that he and CF have been engaging on how we provide a connection for patients if they want to connect with a religious group? He found the statement from Mr Kadodia's presentation that it is not just the half hour that a chaplain can attend, but how can we make this part of the patient's identity to support them through the rest of their stay very helpful. Mr Kadodia added that the basic understanding of different beliefs is important.
- PL commented that he was delighted to hear the comments about the chaplain and the validation of the value this adds.
- PL enquired about cultural awareness training and whether the organisation had tried to understand why staff are not asking these questions; is it a time issue, or that they do not care, or that they are

afraid of causing offence? Mr Kadodia responded that sometimes he feels that the professionals think it is someone else's responsibility. DL said she felt it linked to staff confidence and a fear of saying the wrong thing and causing offence.

- MP commented that whilst it is great to hear what unites us, if 30% of medical staff are from a BAME background, why do they not feel confident enough to ask the questions on ward rounds? Why is it that we cannot turn this in to an opportunity to have these conversations? Mr Kadodia responded that he does not understand this either as it is a mandatory etiquette that those from the BAME community look out for each other in the street.
- CF added that she finds that there are risks of approaching this through the religious lens and it is the personalisation on which we need to focus, together with the conversations around those important things at their time of crisis, irrespective of culture. This is part of the communication spectrum that is found to be more challenging, and a way needs to be found of doing this more culturally and naturally.
- DL added that if inpatient surveys are looked at over the last two years, the theme which comes out repeatedly is a failure of staff to proactively ask patients if they are happy with the nature and quality of the care they are receiving. The Electronic Patient Record (EPR) programme is anticipated to release up to 24% of staff time for care and she asked SH and MH to consider how we can ensure that both the EPR and this released time is targeted at moving forward the agenda of truly personalised care

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PL thanked Mr Kadodia again and everyone for the contribution made.

184/19 MINUTES OF THE MEETING HELD ON 11 JULY 2019

RESOLVED: That the minutes of the Board meeting held on 11 July 2019 be agreed as a correct record and signed by the Chair.

185/19 MATTERS ARISING

PL commented that there were no challenges or updates needed on the Matters Arising, and expressed thanks to the Corporate Governance team for ensuring that a contemporary set of updates was provided.

186/19 CHIEF EXECUTIVE'S REPORT

DL presented the Chief Executive's Report, the key points of which were:

- Our Trust has been acknowledged as the best performing system nationally for the month of June, for A&E performance.
- In relation to the Pathway to Excellence, this is a huge opportunity for the organisation.
- Regarding outpatient letters, although this has been in a poor place for a long time, a revised letter template has been produced and DL would like to acknowledge the good feedback from the specialities and thanked governors for their input.
- DL is delighted that SH has taken up the mantel of "Green Champion" in terms of sustainability as this gives us the opportunity to engage those

who would not normally do so.

- Regarding EPR, there has been great engagement with this programme and it is great to see the amount of positive feedback given previous experience.
- Fit for the Future is a hugely exciting vision which DL will talk more about this evening at the Annual Members' Meeting. Some exciting progress is being made regarding getting the messages out and what opportunities we could seize whilst trying to be a truly outstanding Trust. She noted that much of the misinformation that had been circulated, appeared to have now been "re-set".

In response:

- CF enquired about paragraph 1.2 of the report regarding the Emergency Department. CF stated that it was good to see the performance report but also as important is that performance evidence is starting to be supported by data and other sources, e.g. the NASS score has turned green, and that one or two narrow metrics are not being relied on to tell the story.
- DL added that balancing measures are in place but that this is testament to the committees that sit underneath this Board which have brought a more balanced view.
- CF continued that the EPR programme feels vibrant with lots of energy. Reflecting on the Trak experience, CF asked whether there is more confidence that that the operational concerns are known and is the organisation brave enough to tell its leadership that something is wrong or that it is going too fast? Also, will there be parts of the organisation with the new system and parts without, and how does the organisation know what the risks are of this?
- DL invited RdC to talk about the operational readiness to which RdC explained that the team have been very proactive when engaging with operational colleagues from the grass roots upwards and they are closely involved with the project. She is confident that the staff will air their concerns and to support this, there are regular weekly senior operational meetings in place. There are also a number of gateways that need to be cleared before the operational team can say that it is ready as an organisation to go forward.
- MP added that there is huge enthusiasm in the consultant body for this system and that he has been asked to engage staff with the process.
- MH added that there has been a cultural change and during the recent Trak upgrade, where Trak was taken offline overnight, there were a lot of comms with the clinical teams so that they were aware of what was happening, which would not have happened when Trak was initially installed.
- Regarding working in a mixed environment, this will only be for a limited time in anticipation of proceeding to a full roll out. The organisation will have the opportunity over a two week period of learning from operating in a small environment and addressing any issues before wide-scale rollout. MH has tried to ensure that the continuity of care travels from ward to ward. Nursing documents will be printed off and put in the folder at the end of the bed, ahead of a patient being moved to an EPR

ward, and vice versa. This will ensure that the data capture is correct.

- SH added that there is a really refreshing sense to the conversations taking place and that his colleagues have raised a number of issues both positive and not so positive. All the issues have been worked through and concerns are being listened to, the biggest one which is Acute Medical Unit (AMU) due to the nature of the unit and nurse staffing challenges; he stressed that AMU was being given significant attention as part of the preparation for rollout.
- PL posed a question regarding values. Having done the survey, he was delighted to look at the behavioural nature of the questions as they were thought-provoking. What is the plan once the survey responses have been received? EW responded that more triangulation will be carried out with the data received from the engagement sessions, then her team will present back to the Trust Leadership teams, the People & OD Delivery Group, and finally to Board in the seminar sessions in November.
- AM stated that the Pathway to Excellence, and being one of just 14 Trusts recognised nationally, is really good news and thanked Steve Hams and his team for securing this achievement. She requested that in due course, it would be helpful to hear more about the outcomes for patients and colleagues.
- PL commented that this was a helpful point and that this will come back through Quality & Performance Committee in the future.

RESOLVED: That the Board noted the report.

187/19 BOARD ASSURANCE FRAMEWORK

EW presented the Board Assurance Framework (BAF), the key points of which were:

- This is the first reiteration of the new BAF based on ten new strategic objectives.
- The Board looked at the strategic objectives, agreed the principle risks and aligned them to a number of committees, ensuring that assurance and mitigations were in place to achieve these objectives or to deal with any obstacles.
- Each committee has looked at their own BAF and has agreed the risks and ratings which relate to the current risk register entries whether it be the Board, Programme or Trust Risk Register.
- One risk that has not been included is BAF – 5.3.
- A reflection on this BAF is that it is too long so whilst this is the first summarised version of all the committees, consisting of 75 pages, future iterations should be shorter.
- CF commented that she felt it valuable to see the BAF in its entirety and to work through it systematically. She continued that we have captured everything that we need to capture but that we need to move through to a more elegant and agile way of sense checking in the future, by focussing on the gaps, e.g. the engagement risk.
- DL added that the BAF is intended to be an “at a glance” sense of assurance. It is recognised that there are many duplications which can be condensed whilst still seeing some of the detail around the risks and

assurances at Committee level where the detailed scrutiny should take place.

- AM stated that Quality and Performance Committee looked at objectives 1 and 3 in more detail, which does not reflect those changes discussed. Indeed, there are more quite significant assurances on the controls which are not listed. It is a good use of sub-committee time to review this.
- RG added that he appreciated the evolution of the BAF and knows how much work has gone on behind the scenes, and is happy to help move this forward.

RESOLVED: That the Board noted the BAF and is supportive of the next steps as outlined on page 4 of the document.

188/19 TRUST RISK REGISTER

EW presented the Trust Risk Register (TRR), they key point of which was:

- Since the last Board meeting, one additional risk has been escalated to the register regarding the risk of harm to due to a failure to recognise and/or respond to a deteriorating patient. SH added that Quality and Performance Committee has looked at the risk in more detail.
- MP advised that work to conclude and evidence the risks relating to emergency was on-going and he anticipated sign off at October's Trust Leadership Team for subsequent Board review if added to the TRR.

RESOLVED: That the Board noted the Trust Risk Register.

189/19 QUALITY AND PERFORMANCE:

ASSURANCE REPORT OF THE CHAIR OF THE QUALITY AND PERFORMANCE COMMITTEE – MEEINGS HELD ON 31 JULY 2019 AND 28 AUGUST 2019

AM presented the Chair's Reports for the Quality & Performance Committee, the key points of which were:

- AM reported jointly on the outcome of both the committees on 31 July and 28 August 2019.
- The key risks are discussed at Quality & Performance Committee including the one presented to Board today.
- The orthopaedic drills issue was discussed at the July meeting where good assurance was given that the one issue which had emerged had been addressed. However, it can be seen in the August paper that we were more challenging on the fact that there had been several low level incidents reported around Stryker drills.
- There was concern with the Executives and the Non-Executive Directors around falls, particularly including the harm resulting from falls. It had been agreed by the Executives to investigate this through a Quality Summit approach consisting of three to four meetings to look at what we can do as an organisation, and then to form plans from this.
- SH described the Quality Summit as an important and collaborative way of approaching outstanding issues.
- There are 12 "must dos" on the CQC action plan: three were green, nine

were amber and none were red. (Amber means "being progressed"). There is still momentum to close down the action plan.

- Regarding cancer standards, there has been a huge focus in operational business. In the Q&P Committee, there have been some good discussions on understanding the two to three big hitting things which need to be in the targets, e.g. histopathology and radiology. The Committee felt that there is a good grip on this and the proposed solutions.
- SI reporting –the last committee saw the first new template on which the root causes can be seen as well as the wider learning themes.
- Emergency Care Reporting illustrates that performance is good. The 15 minute triage has a deteriorating trend over a period of time and there was a helpful discussion led by MP about what can be done as an organisation to make this better for patients.
- It was suggested that a deep dive on VTE and Dementia would be useful in the future. SH and MP responded saying given the data issue in dementia recording that this should be deferred.
- Regarding the draft Winter Plan, there has been much assurance that there was a lot of learning from last year but significant concerns remained regarding bed capacity.

In response:

- DL stated that it was subsequently picked up through TLT that there was not sufficient assurance on the system elements of the Winter Plan, e.g. delayed discharge from hospital. There has been a conversation with system partners as to how we ensure ourselves that the plan is robust and she had written to ICS partners expressing her concerns about aspects of the plan, including bed capacity.
- MP commented on the 15 minute triage issue by stating that 15 minute triage rates have been retained at over 90% for a period of time but that this has meant a rapid triage assessment. There is debate as to whether time is put in the up-front triage which would produce a downturn in triage numbers, although the hope would be to reinvest the time at the back end of the stay. The median time to triage is still within 15 minutes.

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

QUALITY AND PERFORMANCE REPORT

RdC presented the Quality and Performance Report, the key points of which were:

- The cancer two week wait position has been recovered although will remain fragile in the face of increasing activity.
- Although the 62 day performance is still not where the organisation would like it to be, there are several departments performing better than has been seen for a few months.
- Planned Care – a stable position has been maintained. Referral To Treatment and the 52 week position are both better than plan.
- Clinic utilisation at the GHT sites is at 84% which is the best it has been for three years.

- Emergency care pathway – quality standards are being focussed on rather than just performance standards, with quality metrics at the forefront of people's minds.
- SH stated that we have been unhappy for a while with falls and pressure ulcers, and the number of people who have fallen with increased harm is increasing hence the Summit.
- C. diff patients – there was a higher number of patients seen in June and July. A review and update is going in to the Quality and Performance Committee in September.

In response:

- CF commented on the planned care dimension to the Winter Plan and asked what the sense is of how far the Winter Plan will enable us to protect from cancellations etc. RdC responded that ED's patients are no more or less important than those on our elective and cancer pathways and that, apart from a planned period over Christmas and the New Year, it is not planned to reduce on elective lists but this would be assessed in real-time and decisions made on te4h grounds of safety.
- RG commented on the Demand and Activity table where he noted that GP attendances are down whereas ED attendances are up and asked whether this is because those who would have been going to the GP are attending at GHT instead? MP responded that GPs send in patients by referral whereas those presenting at ED will have come in largely by themselves with small or minor illnesses. DL added that we need a consistent, clearly communicated community offer that everyone understands and therefore patients are not more attracted to ED care which is better understood; this is very much at the heart of the thinking around Fit for the Future.
- AM added that Primary Care Networks (PCNs) are supposedly the answer and there is a lot of money going in nationally to these new Networks.
- DL said that the PCNs are going to be vital partners but in relation to RG's question, this pattern of behaviour is not connected so much to primary care but more around patient behaviour. PL agreed that more work is needed on understanding the motivation behind the behaviours and has raised this several times at ICS Board.
- MP continued that there is strong evidence that primary care has created additional appointments, particularly emergency ones and that there is a real danger of supply led demand, to which DL emphasised that clear communication is vital.

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

GUARDIAN REPORT ON SAFE WORKING HOURS FOR DOCTORS AND DENTISTS IN TRAINING

MP presented the Guardian Report on Safe Working Hours for Doctors and Dentists in Training, the key points of which were:

- The number of exception reports has reduced and there were not any

safety issues reported which could not be resolved.
- There is a new Junior Doctor contract regarding night shifts which stipulates the number of days to be taken off particularly following a night shift. As a result, new rota changes are being implemented from February 2020 which may lead to some exception reports being raised.

In response:

- DL commented on the recent Deanery visit when the exception reports in neurology were still reported as an issue. She asked how we ensure that changes are effected, as a result of exception reports being submitted? MP confirmed that he has met with neurology and has flagged this as an issue, and he is confident that relatively minor changes in workflow and work plans lead to compliance. He has spoken to the Ophthalmology teams to discuss how to become compliant and it was agreed that if workload or work patterns are causing the Junior Doctor to work consistently late, then this is when they should raise an exception report. MP feels that there is gap in assurance at present as we rely solely on the reduction in numbers of exception reports coming through, but it might be clearer to have oversight of action required and taken by way of a report in to a different forum, e.g. the People & OD Committee. MP is checking the rules around this to ensure it is feasible that this report goes into the People & OD Committee before going to Main Board. **Action: MP to clarify national reporting requirements.** **MP**
- AM queried issue 7 on the report regarding immediate safety concerns and asked whether there is a closing of the loop with the individuals concerned regarding language and terminology? MP responded that anyone who raises a safety concern through an exception report will be contacted by the Guardian who will then follow up. "Immediate safety concern" is a term used to flag that attention is needed, and might relate to a member of staff feeling overwhelmed which, in turn, could lead to safety concerns. AM asked whether this could be explained in future reports.

RESOLVED: That the report be received as assurance that the Trust's oversight of junior doctor working practices and the Guardian role is robust.
[Break at 2.00pm]

190/19 FINANCIAL AND DIGITAL:

ASSURANCE REPORT OF THE CHAIR OF THE FINANCE AND DIGITAL COMMITTEE – MEETINGS HELD ON 25 JULY AND 29 AUGUST 2019
RG presented the Assurance Report of the Finance and Digital Committee for the committees held on 25 July and 29 August 2019, they key points of which were:

Finance Committee:
- At the end of month 4 there is a small favourable Income & Expenditure variance.
- The challenge accelerates as the year progresses due to the level of cost improvement required in Quarters 2 and 3.

- Cash balances are high but the reasons understood and relate to timing of funds held for others.
- Regarding costing, NHS organisations are required to formally submit their returns regarding costing activity which is compiled in to a national database. There is considerable work to be done in this area but this is dependent on a critical appointment which is currently being pursued.
- Regarding clinical productivity, this is discussed in both Finance & Digital Committee as well as People & Organisational Development Committee, and good work has been taken under the leadership of the Medical Director and Deputy Medical Director, through which an understanding of the benefits is being gained. The next Clinical Productivity report is due in October.

Digital Committee:

- The Digital agenda is currently being streamlined and a different approach is being considered regarding the key projects coming in to the committee.
- The most encouraging report is the one in terms of the dialogue and interface of prospective users of this system. This is a project that we will look at on a monthly basis.
- Regarding ChemoCare and the system switch, RG is assured through Digital Committee that MH and his team are actively managing the risks associated with this deployment and as a result the risks to a delayed go-live are reducing.

FINANCIAL PERFORMANCE REPORT:
SS presented the Month 4 report, the key points of which were:

- In June, the Group's consolidated position shows a year to date deficit of £8M.
- This is £0.5M favourable against plan.
- The position includes an impairment of £4.9M for the writing down of TrakCare capital expenditure incurred in previous financial years, which has no impact on the control total position.
- The Group's forecast year end position remains a deficit of £1.5M but with a number of risks. A downside forecast was being prepared.
- At month 4, the Trust has delivered £4.9M of CIP against the year to date target of £3.25M.
- Regarding the cash position, this is currently unusually high with just under £20M in the bank at the end of July. This is as a result of timing differences in terms of outflow and ring-fenced capital.
- The capital plan YTD is £6.5M with a spend of £5.3M due to some project slippage but this is being tightly managed.
- It is hoped that there will be a decision regarding the £5M capital loan next month.

In response:

- PL asked about the 20% capital that was not to be spent and which has been reserved by decree, and how this relates to the £5M? SS

responded that there is a conversation ongoing between herself and NHSI on whether we could reinstate the 20% without borrowing any more as we have not yet allocated the additional £3.3M PSF and if this is the case, would NHSI be happy for us to put back the 20% into the cash position? This is going through NHSI to the Secretary of State for final approval in October.

- CF enquired whether there was anything emerging in terms of the EU exit, relating to cost pressures or an assumed income position? SS responded that there are a number of potential risks around the EU exit, e.g. income around overseas visitors, the supply chain but that it is difficult to assess due to the political and timeline uncertainty. We have been asked by NHSI to record any costs associated with the EU exit but there have been no messages to suggest such spend would be reimbursed to Trusts from central government. **Action**: SS to start to flag this through the Trust Risk Register from next week with as much clarity as possible going through the Financial & Digital Committee. **SS**
- AM enquired about the cost improvement programme and asked whether the consultants were expected to help? SS responded that all staff are expected to be actively engaged in CIP delivery and resource is largely being targeted at that which supports the delivery. We have seen an upswing in the identified CIP of circa £1M between month 3 and month 5. Some strong interaction with the Divisions has been seen, with particularly useful progress in the position of Medical Division.
- RdC made reference to additional capacity in the CIP Team who has added huge value to what we are trying to achieve.

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

191/19 PEOPLE AND ORGANISATIONAL DEVELOPMENT:

ASSURANCE REPORT OF THE CHAIR OF THE PEOPLE AND ORGANISATION DEVELOPMENT COMMITTEE – MEETING HELD ON 19 AUGUST 2019

EW presented the Assurance Report of the People & Organisational Development Committee held on 19 August 2019, the key points of which were:

- There was a debate on the staff annual turnover rate of 11.62% which is stable and shows a slight decrease, and which is good for an acute Trust but above our target.
- The work that SH is involved regarding recruitment and retention benchmarks well to NHSI best practice recruit people but we continued to think innovatively about how to reduce turnover further in nursing where the problem is most acute.
- Medical retention is 16% which is an outlier and there will be a deep dive on this in the next report.

PEOPLE AND ORGANISATIONAL DEVELOPMENT REPORT

EW presented the People & Organisational Development Report, the key points of which were:

- Staff numbers have increased by 140 across bands 2, 3 and 8 and above.
- Appraisal compliance has risen to 81%.
- Mandatory training compliance is at 91%.
- The sickness rate is holding and is good at an annual rate of 3.35%, with 50% of this relating to long term sick leave.
- The new Staff Hub is trying to prevent staff moving in to long term sickness.
- A different strategy is being put together around staff experience, bullying, harassment and diversity, and this will be added in to the new dashboard which will come to the next Board in November.
- A new workforce information pack is being developed which will go in to the Executive Reviews to support accountability for delivery in these areas.

In response:

- Regarding appraisals, PL commented that it is good that there is an improvement but that the Trust is well away from the 90% target. Are long terms solutions being looked at and whether the 90% target can ever be reached? Or should the 90% target be considered as correct? EW responded that it has been considered whether extending the data capture period from 12 to 15 months would be beneficial but in reality she does not think it will make much difference. However, she felt that 90% was realistic and should be strived for given the importance of the appraisal in ensuring staff felt supported, received feedback on their performance, had career conversations and understood their goals and priorities.

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

192/19 AUDIT AND ASSURANCE:

ASSURANCE REPORT OF THE CHAIR OF THE AUDIT AND ASSURANCE COMMITTEE – MEETING HELD ON 2 JULY 2019

CF presented the Assurance Report of the Audit and Assurance Committee held on 2 July 2019, the key points of which were:

- The internal auditors presented two interesting reports that spoke very much to the quality and performance agendas being discussed at today's Main Board meeting.
- A useful piece of work has been carried out on RTT clock stops; the second internal audit report was around divisional governance.
- There had been a delay to the production of the year end external audit and we are still in discussion with the firm concerning their performance and next steps.
- Regarding the national costing audit report, this is an important baseline review for us which confirms that we are not where we want to be in terms of the costing area. Remedial action is in hand.
- Understanding the task and assurance from the team that we are doing what we need to do, underpins what we need to do around CIP and

activity planning.

In response:

- SS clarified regarding the costing piece that the national costing audit report was a report on the 17/18 audit costing process. The one in RG's report is based on the 18/19 process. The action plan from this report has either been addressed in the 18/19 report or has ongoing actions.

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

193/19 ASSURANCE REPORT FO THE CHAIR OF THE ESTATES AND FACILITIES COMMITTEE – MEETINGS HELD ON 8 JULY 2019 AND 3 SEPTEMBER 2019

RG presented the Assurance Reports of the Estates & Facilities Committee held on 8 July and 3 September 2019, the key points of which were:

- The Committee now looks at two categories of topic:
  1. Oversight of Gloucestershire Managed Services (GMS)
  2. The broad Estates strategy
- Oversight of GMS
  - The introduction of the Contract Management Board was bringing huge benefits. Concerns did remain in a number of areas but both parties were working well together.
  - A new Associate Director of Estates & Facilities starts shortly with a remit for managing the contract and relationship with GMS.
  - Interviews for a Substantive Managing Director had taken place with announcements pending.
- Estates Strategy –
  - In the July meeting, there was discussion on the broader ICS strategy. Questions were being asked regarding the process to be undertaken over the next couple of months whilst the strategy is fleshed up and worked out.
  - A good level of assurance was received.

In response:

- PL commented that he and the other Non-Executive Directors are pleased at how this committee is developing.

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

194/19 ANNUAL SAFEGUARDING REPORTS
- SAFEGUARDING ADULTS AND SAFEGUARDING CHILDREN

SH presented the Annual Safeguarding Reports for Adults and Children, the key points of which were:

- Against a backdrop of increased activity over the past year, SH thanked CW for the progress made and her personal leadership, on his behalf.
- Both reports highlight multi-disciplinary and multi-agency reports across Gloucestershire.
- There has been much work on the CQC improvement plan, particularly

around section 13 regarding the Mental Health Act.

- Regarding children, the Trust has been working with our partners on the serious non-accident injury for babies under 12 months and also for teens that have self-harmed.
- There has been increased focus on Adverse Childhood Experiences (ACEs) and how they affect life chances for children.
- We have participated in a number of case reviews over the last 12 months.
- The key focus over the next 12 months will be on liberty protection safeguards which are expected to increase this coming year.
- Both reports have been through Quality & Performance Committee.

In response:

- PL commented regarding the ACEs by stating that this is an area that is high profile in the county and comes through strongly to the Health & Wellbeing Board where our contribution has been recognised.
- AT is keen to understand our preparation for replacement for Deprivation of Liberty Safeguards (DoLS) to which PL added that he is pleased to see that this is being thought about but requested to have a clear plan which should go through Quality & Performance Committee.
- SH continued that, in terms of Liberty Protection Safeguards Legislation (LPSL), the system is trying to mobilise. There is a slight concern that DoLS and LPSL will run side by side for 12 months which could be problematic. The LPSL national guidance has not yet been published.
- AM commented that she has attended a couple of the safeguarding groups and that SH's leadership was very positive and had impacted significantly. In addition, allocating CW to take this on has been good and that it feels in a very different place to where it was a couple of years ago.

RESOLVED: That the Board note the report.

195/19 INFECTION CONTROL ANNUAL REPORT

SH presented the Infection Control Annual Report, the key points of which were:

- The oversight and membership of the team has been strengthened with good leadership being noted.
- There has been a steady fall of MRSA which has been helped by working with our public health colleagues on supporting safe substance misuse.
- There has been a 22% reduction in C. diff cases from the previous year with 36 cases being reported.
- There is now an antimicrobial nurse prescriber in the team.
- Last winter, Flu A was the predominant strain.
- 72.9% of staff took up the flu jab last year.
- Reporting was suspended for a short time last year while we worked on the methodology of active surveillance.
- SH commended this report to the Board.

In response:

- CF commented on page 22 of the report regarding suspending reporting in order to understand the data better and that we were reporting correctly. CF enquired as to the next steps to which SH responded that reporting is now correct although the first set of data has not yet come through. As soon as this is received, it will be reported through Quality & Performance Committee.
- RG asked whether, with the increasing prevalence of infection, is SH satisfied that we are as well informed and resourced as we should be? SH responded that he believes the Trust is very well equipped regarding the reduction of antimicrobials. MP added that there is good consultant engagement. There is one prescribing issue to be addressed where local practice differs and this is being addressed.
- Regarding prescribing practices, PL asked whether there are engrained practices with senior people across the organisation with whom the junior staff are uncomfortable to raise questions, to which MP responded that he does not believe this to be a problem.
- DL added it is impressive that the team achieving and making such strong progress through positive engagement and enthusiasm, rather than policies and dictates.
- PL commented that there had been a great presentation to one of the Governor groups regarding some of the more interesting parts of this topic.

RESOLVED: That the Board noted the report.

196/19 MINUTES OF THE MEETING OF THE COUNCIL OF GOVERNORS HELD ON 19 JUNE 2019

RESOLVED: That the Minutes were accepted.

197/19 GOVERNOR QUESTIONS

The Governors asked the following questions:

- AD enquired regarding C. diff and whether we have any understanding as to why there was a surge of cases on the ward? SH responded that he believes it is multi-factorial and was a combination of prescribing issues, cleaning and ward layout; all of which are being addressed. The ward is now open following an extensive clean and redecoration.
- AD commented regarding ACEs and stated that it is important that this is addressed in puberty as it can affect development. AD thanked DL for getting a youth group going to which PL in turn thanked AD for her passion and drive.
- AT stated that he felt it was a good patient story. The personalised care that Mr Kadodia referred to is applicable to everyone.
- Regarding quality and performance, he is concerned about the performance in dementia which is something that has to be right. AT is also concerned regarding the number of mixed sex breaches.
- AT continued that he was surprised that the caring metric was veering towards red and asked whether this was a measurement issue.
- AT liked the detailed BAF. However, where he sees there are no gaps

in assurance, how is assurance obtained that this is correct?
- Regarding engagement, AT attended a Digital Patient Engagement Workshop in Leeds where it was discussed why there are not standards of engagement against which Trusts are measured. AT asked whether the CQC could come in to tell us what we are not doing in terms of engagement?
- Regarding safeguarding, AT was pleased to see the reference to the Mental Health initiatives being set up and he will follow this.
- Regarding the external audits, AT commented that he looked forward to an update on the delay at the next Council of Governors.

In response:

- SH responded regarding mixed sex breaches in that this related to Critical Care and the time it takes to move people off the unit. It should take two to three hours but can take longer if ward beds are not available. Once a patient becomes ready for discharge, they become a mixed sex breach if they remain more than four hours.
- Regarding dementia, SH responded that in six months' time, this should be resolved: it is a recording issue and practice is much better which will be evidenced by paper based audits are now underway. SH is delighted to be working with Dementia UK on a Lead Nurse post.
- Regarding Friends & Family, SH responded that the team working on this in the Quality Summits has a good understanding of what needs to be achieved. This Trust is not yet the best in class but this is where it needs to get to.
- DL asked whether there is a sense of what is driving the low FFT ranking in Maternity Services, to which SH responded that he is not sure at present but that this will go through Quality & Performance Committee.
- SH responded that patient engagement in planning and evaluation of care needs attention and that SL is leading on this by producing the measurements which sit underneath. There are also standards set out on the CQC well led domain. AT added that he attended a workshop which gave some information on this which he will share. **Action**: Add measurements for engagement standards to the agenda for the next Governors' Strategy & Engagement Session. **CC (work plan)**

198/19 STAFF QUESTIONS

There were none.

199/19 PUBLIC QUESTIONS

There were none.

200/19 NEW RISKS IDENTIFIED

- No new risks were identified.
- DL requested that the issue of capacity is captured in the risk process around safeguarding.

200/19 ITEMS FOR THE NEXT MEETING

There were none.

201/19 ANY OTHER BUSINESS

PL congratulated AT on his re-election as a Governor for the next three years. PL continued that AT's contribution has been phenomenal and that he is now eligible to participate in the Lead Governor elections to stand for re-election.

[Meeting closed at 15:12]

DATE OF NEXT MEETING

The next **Public** meeting of the **Trust Board** will take place at 12:30 on **Thursday 10 October 2019** in the **Cabinet Suite, Shire Hall, Gloucester County Council, Gloucester.**

Chair
10 October 2019

TRUST BOARD – SEPTEMBER 2019

MATTERS ARISING

CURRENT TARGETS

Target Date	Month/Minute/Item	Action with	Issue	Action	Update
October 2019	September 2019 – 189/19 – Quality & Performance – Guardian Report on Safe Working Hours for Doctors and Dentists in Training	**MP**	Regarding the feasibility of this reporting being taken to People & OD Committee before Main Board.	**Action:** MP to clarify national reporting requirements.	Closed: Reporting to Board or Board Committee is acceptable.
October 2019	September 2019 – 190/19 Financial Performance Report	**SS**	CF enquired whether there was anything emerging in terms of the EU exit, relating to cost pressures or an assumed income position? SS responded that there are a number of potential risks around the EU exit.	**Action**: SS to start to flag this through the Trust Risk Register from next week with as much clarity as possible going through the Financial & Digital Committee.	Closed: Covered on the agenda.
October 2019	September 2019 – 197/19 Governor Questions	**SL**	DL enquired about engagement standards and whether there is a subjective measure and whether we need to think about what "good" looks like. SH responded that this needs attention and that SL is leading on this by producing the measurements which sit underneath.	**Action:** Measurements for the engagement standards to be added to the agenda for the next Governors' Strategy & Engagement meeting.	Closed: Added to work plan for the next Governors' Strategy & Engagement session on 5 December 2019. Metrics (what good looks like) will be included in new Engagement Strategy.

TRUST BOARD – OCTOBER 2019

REPORT OF THE CHIEF EXECUTIVE

1. Our Trust

1.1 Operationally, again we end the quarter with a number of positive achievements despite the number of patients attending our hospital A&E departments increasing and referrals to our specialist teams rising. As a system, again we exceeded the 90% trajectory for the 4 hour A&E waiting standard for quarter two and despite some very challenged days, and associated poor performance, we remain in the upper quartile of Trust's on the majority of weeks. Of particular note, however, is the return to delivery of the Two Week Wait Cancer Standard which has not been achieved since March 2019 and even more impressively to a level which reflects the strongest performance since recording began in 2013 at 96.5% against the 93% standard; this performance is in contrast to national and regional performance of 90.9% and 87.2% respectively. Given 90% of patients who are assessed at this two week appointment will go on to be advised that they do NOT have cancer, this has a huge impact on positive patient experience.

1.2 Last month in my report I heralded the start of our *Big Green Conversation* and I am delighted to be able to provide an update following our inaugural event. One staff member's Tweet probably summed up the event when he said "in over 6 years at this Trust, this has to be one of the most passionate and compelling mornings I've seen and been part of". The session, which could easily have filled the whole day, drew out colleagues from every discipline and department, all with the common characteristic of being passionate about sustainability and what the Trust can do to raise awareness and most importantly, what we can do to reduce our own carbon footprint. We had speakers from the National Sustainability Unit and Newcastle NHS Foundation Trust - the first NHS Trust to declare a "climate emergency" - join us (via technology) to share what they have been doing. Gloucestershire County Council joined the session and shared what they have done in order to massively exceed their own carbon emissions reduction target of 60% by 2020 having already achieved 70%; they are now well on the way to exceeding their 2030 target of a 80% reduction. We also heard from Jan Cleary, GMS lead for sustainability who described a phenomenal range of initiatives that we have already implemented or have in hand – a truly impressive array. Such was the passion in the room, and the very clear evidence from elsewhere that change in this area has to start from the very top, the room passed a motion which it will put to the Trust's Board in November stating that "*the signatories below would like the Gloucestershire Hospitals' Trust Board to declare a 'climate emergency', reflecting the evidence that climate change is the biggest global health threat of the 21st century*" - 95% of those present signed the motion.

1.3 This month, the Trust has been widely commended for the work it has recently undertaken with NHS Employers on reducing the stigma associated with disability and mental health. Three members of the Executive Team, alongside Abby Hopewell, the Trust's lead for equality and diversity, produced a Podcast and video talking about their experiences of mental health, disability and employment within our Trust. The response from people, inside and outside the organisation, has been phenomenal and represents a hugely positive step forward in respect of recognition for the Trust's approach and our evolving culture.

1.4 The Trust is now making considerable, very positive progress with the deployment of our Electronic Patient Record. The first phase of roll out commences next month and will enable a number of very important safety features to be deployed throughout our wards in Gloucestershire Royal ahead of Winter, followed by rapid deployment to Cheltenham General Hospital in the New Year. The Trust also successfully deployed a

new chemotherapy prescribing system in the first week of the month which, despite the complexity, went very well.

1.5 Progress continues on development of the business case for the Strategic Site Development and the team is on track to present the Outline Business Case to the December Board. Positively, since the last meeting of the Board, NHSI has confirmed their approval of the Strategic Outline Case (SOC).

1.6 Suzie Cro, Freedom To Speak Up Guardian (FSUG) and her team are busily promoting their role and the value that comes from an organisation where speaking up is a welcome and safe thing to do. We are using the framework that is enshrined in the *Civility Saves Lives* initiative and will be using this as the focus of our forthcoming 100 Leaders event, later this month. Following on from the establishment of the role, we now have four Guardians in the organisations including formalising the role of Dr Simon Pirie, Guardian of Safe Working for Junior Doctor's as a FSUG.

1.7 I had the privilege of joining 24 colleagues, including non-executive director Mike Napier, whilst they competed against 17 other NHS Trusts from the South West Region in this year's NHS Military Challenge. The team representing Cheltenham General are absolutely thrilled to have brought home the bronze medal, with colleagues from Gloucestershire Royal Hospital achieving a very decent 8th place. The personal journey that participants make over the weekend is a pleasure to watch, with many moving out of their traditional comfort zones in pursuit of team goals. As a result two new teams and multiple friendships have been created which will benefit many of them both personally and professionally. A fabulous example of staff engagement at its best.

1.8 Judging for this year's Staff Award finalists is now complete and has been published to the organisation. More than 500 nominations were received, including over a 100 from patients hoping to secure a place for the staff member that made a huge difference to their or their family members' care. If the social media response is anything to go by, the judges did well with some hugely popular finalists having been selected. The Awards will take place at Hatherley Manor on 27th November and this year, for the first time, will include a live webcast of the event so many more staff can share in these feel good moments!

1.9 A number of staff from oncology services came together, in partnership with Trust charity FOCUS and the John Lewis Partnership to put on an extravaganza of an evening; staff who strutted their stuff in high fashion raised just over £16,000 for the charity.

2 Our System and Community

2.1 In Gloucestershire we are aiming high and want everyone to have access to the very best healthcare, and to be best placed to manage their own health in partnership with clinicians and other health care professionals. With this exciting aim, our public engagement activities under the banner of *Fit For the Future (FFTF)* continue and are going well. Since my last update, we have run a number of topic based sessions which have been well attended and positively received by staff, patients and members of the public. These events have explored topics including general surgery services, image guided surgery and most recently acute and emergency care. On the 8th October we commence eight locality events which run throughout the first half of October, again to share the challenges and opportunities facing local communities and hear views on how we might respond to these.

2.2 We are also now preparing for the next phase of engagement activities which includes the Citizen's Jury and an Engagement Hearing. The latter will take place on the 24th October and a number of organisations or individuals have booked an opportunity to present their ideas to the Hearing. Recruitment for December's Citizen Jury is also

underway and places for members of the public to observe the Jury in action are still available and can be booked through the *One Gloucestershire* website.

2.3 Since the last meeting, the Trust and its partners in *Research4Gloucestershire* held the inaugural event to which more than a 100 colleagues from across health, education and social care came together. The leadership team for R4G presented an exciting and ambitious vision for research cross health and social care which was well received by all present. In the same week, the Trust hosted its first ever Festival of Quality Improvement, Research and Innovation which showcased the fabulous achievements of staff who have worked with the Gloucestershire Safety and Quality Improvement Academy to improve patient or staff experience. This week saw the Academy's 14th Silver Graduation Event with another eight teams or individuals driving up the safety and quality of care in their area. This month's overall winner was junior doctor Claire Cushley who won the award for her work on improving compliance with the World Health Organisation's (WHO) theatre safety checklist; dieticians Michelle Barry and Lyndsey Tomlinson won the prize for best poster for their work on reducing errors in the administration of enteral feeds for patients in care homes.

3 National and Regional

3.1 Brexit preparations for a 'no-deal' scenario remain high up the agenda with the National Strategic Commander, Keith Willetts continuing to leading preparations. The risks remain largely as perceived earlier in the year and the Trust's Executive Lead remains Sarah Stansfield, Director of Finance although given Sarah's planned departure at the end of October, this is now a shared responsibility with Rachael De Caux, Chief Operating Officer. Safeguards in respect of the supply chain for essential goods, including medicines remains nationally managed and to date there are no local issues that are not mirrored nationally. Regional co-ordination remains the modus operandi with a workshop planned for early September. More detail will provided under the relevant Board agenda.

3.2 NHS England and NHS Improvement's proposals for legislative change were published this week. The proposed changes, which are targeted at change to support delivery of the NHS Long Term Plan, are set out in the document entitled *Implementing the NHS long term plan: proposals for possible changes to legislation*. The changes are potentially wide reaching if supported; during the engagement phase, the proposals were heavily influenced by provider Trust representative body, NHS Providers who expressed concern about the potential cumulative effect of the proposals to be one that, despite the Long Term plan rhetoric about localisation, integration and devolved autonomy, would result in more centralised decision making and power shifting to arms-length bodies. NHS Providers have produced their own response to the proposals which can be accessed via their website or here briefing.

Deborah Lee
Chief Executive Officer

3rd October 2019

TRUST BOARD – OCTOBER 2019
Cabinet Suite, Shire Hall commencing at 12:30

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

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

Key issues to note

- The Trust Risk Register enables the Board to have oversight, and be assured of the active management, of the key risks within the organisation which have the potential to affect patient safety, care quality, workforce, finance, business, reputation or statutory matters.
- Divisions are required on a monthly basis to submit reports indicating any changes to existing high risks and any new 12+ for safety and 15+ other domains to the Trust Leadership Team (TLT) for consideration of inclusion on the Trust Risk Register.
- New risks are required to be reviewed and reassessed by the appropriate Executive Director prior to submission to TLT to ensure that the risk does not change when considered in a corporate context.

Changes in the reporting period
The Trust Leadership Team (TLT) met on 2 October 2019 and considered 7 risks.

Risks reviewed by TLT:

C2275 : A risk of sub-optimal surgical staffing caused by a combination of insufficient trainees, senior staff and increased demand resulting in compromised trainee supervision, excessive work patterns and use of agency staff impacting on the ability to run a safe and high quality surgical rotas.
The current risk has been re-phrased and now also includes reference to increase demand

Executive lead – Director for Safety & Medical Director Scoring 4x4-=16 for Workforce.

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

C3034: The risk of patient deterioration, poor patient experience, poor compliance with standard operating procedures (high reliability)and reduce patient flow as a result of high registered nurse vacancies within adult inpatient areas at Gloucestershire Royal Hospital and Cheltenham General Hospital.

Executive lead – Director of Quality & Chief Nurse. Scoring 3x4 =-12 for Safety

S2930: A risk to patient safety caused by insufficient senior surgical cover resulting in delayed senior assessment and delays to urgent treatment for patients.
Executive lead – Director for Safety & Medical Director. Scoring 3x5 =15 for Quality

C3035: A risk to safe service provision caused by an inability to provide an appropriate training environment leading to poor trainee feedback which could result in a reduction in trainee allocation impacting further on workforce and safety of care.
Executive lead; Director for Safety & Medical Director Scoring 5x3 =15 for Workforce

C3036: A risk of sub-optimal care for patients with specialist care and other sub-specialty conditions caused by a lack of ability to create sub-specialty rotas resulting in inequitable care and different clinical outcomes
Executive lead- Director for Safety & Medical Director. Scoring 3x5=15 for Quality

C3038: A risk of sub-optimal care for emergency surgery patients requiring surgical treatment caused by limited day time access to emergency theatres resulting in increased length of stay and poor patient experience
Executive lead – Director for Safety & Medical Director. Scoring 4x4=16 for Quality

C2817COO: Risk of fire in Tower Block ward ducts/vents due to build-up of dust over many years. Wards needs to be empty for 24 hrs to clean ducts
Executive lead- Chief Operating Officer. Scoring 5x1=5 for all domains except Statutory.

No risks on TRR have been upgraded in this period.

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

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

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

Recommendations

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

Impact Upon Strategic Objectives

Supports delivery of a wide range of objectives relating to safe, high quality care and good governance

Impact Upon Corporate Risks

The Trust Risk Register is included in the report.

Regulatory and/or Legal Implications

The risk of regulatory intervention (including fines) and poor patient experience resulting from the non-delivery of appointments within 18 weeks within the NHS Constitutional standards (Risk C2628COO)

Equality & Patient Impact

Potential impact on patient care, as described under individual risks on the register.

Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required

For Decision		For Assurance	√	For Approval		For Information	

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

Audit & Assurance Committee	Finance and digital Committee	GMS Committee	People and OD Committee	Quality & Performance Committee	Remuneration Committee	Trust Leadership Team	Other (specify)
						2 October 2019	

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

TRR at 3/10/19

Ref	Inherent Risk	Controls in place	Action / Mitigation	How would you assess the status of the controls?	Consequence	Likelihood	Risk Rating	Division	Highest Scoring Domain	Executive Lead title	Title of Assurance / Monitoring Committee
F2927	Risk that the Trust does not achieve the required cost improvement resulting in failure to deliver the Financial Recovery Plan for FY20	1. PMO in place to record and monitor the FY20 programme 2. Finance Business Partners to assist budget holders 3. Fortnightly CIP Deep Dives 4. Monthly monitoring and reporting of performance against target 5. Monthly Financial Sustainability Delivery Group 6. Monthly Finance and Digital Committee scrutiny 7. Monthly and Quarterly executive reviews 8. NHSI monitoring through monthly Finance reporting		Partially complete	Catastrophic (5)	Likely - Weekly (4)	20	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Finance	Director of Finance	Finance and Digital Committee
S3038	A risk of sub-optimal care for emergency surgery patients requiring surgical treatment caused by limited day time access to emergency theatres resulting in increased length of stay and poor patient experience.	2 slots are allocated in GRH to the gynaecology emergencies first thing Regularly negotiate with other specialities to prioritise cases according to clinical need The vascular service in CGH reutilises their elective sessions to compensate for the inadequate emergency list provision	Task and Finish group in situ to review all possible mitigations, meeting weekly Fit for the Future engagement process re emergency general surgery	Incomplete	Major (4)	Likely - Weekly (4)	16	Surgical	Quality	Medical Director	
C2895COO	Risk that patients and staff are exposed to poor quality care or service interruptions arising from failure to make required progress on estate maintenance, repair and refurbishment of core equipment and/or buildings, as a consequence of the Trust's inability to generate and borrow capital Risk that the Trust's future capital funding is with the resulting impact on business and service continuity.	1. Board approved, risk assessed capital plan including backlog maintenance 2. MEF and Capital Control Group 3. Capital funding issue and maintenance backlog escalated to NHSI 4. All opportunities to apply for capital made 5. Finance and Digital Committee oversight 6. GMS Committee and Board oversight	1. Prioritisation of capital managed through the intolerable risks process for 2019/20 Ongoing escalation to NHSI and system	Partially complete	Major (4)	Likely - Weekly (4)	16	Corporate	Environmental	Chief Operating officer	Executive Management Team
S2275	A risk of sub-optimal surgical staffing caused by a combination of insufficient trainees, senior staff and increased demand resulting in compromised trainee supervision, excessive work patterns and use of agency staff impacting on the ability to run a safe and high quality surgical rotas. Impact of any changes to non-contractual clinical support to services. Impact of any risk through workload leading to deanery withdrawal of trainees.	1. Guardian of Safe working Hours. 2. Junior doctors support 3. Staff support services available to staff 4. Mental health first aid services available to trainees in ED1. guardian of Safe working Hours. JavaScript:void(showFormPanel('panel-section2'))	Escalation Attempts to recruit 1. Agency/locum cover for on call rota 2. Nursing staff clerking patients 3. Prioritisation of workload 4. exsisiting junior doctors covering gaps where possible 5. consultants acting down 6. Ongoing recruitment for substantive and locum surgeons for rota including international opportunities 7. Health and well being hub will offer greater emotional well being services	Partially complete	Major (4)	Likely - Weekly (4)	16	Surgical	Workforce	Medical Director	People and OD Committee, Trust Leadership Team
F2335	The risk of agency spend in clinical and non-clinical areas exceeding planned levels due to ongoing high vacancy levels, with resulting impact of delivery of FY20 CIP programme	1. Challenge to agency requests via VCP 2. Agency Programme Board receiving detailed plans from nursing medical workforce and operations working groups 3. Finance agency report review on a 6 monthly basis 4. Turnaround Implementation Board 5. Quarterly Executive Reviews	Establish Workforce Committee Complete PIDs for each programme Reconfiguring Structures Agency Programme Board recieving detailed plans from nursing medical workforce and operational working groups 1. Convert locum/agency posts to substantive 2. Promote higher utilisation of internal nurse and medical bank 3. Implementation of healthRoster for roster and Bank management 4. implementation of Master Vendor Agreement for Nursing Agency - improving the control of medical agency spend and authorisation 5. Finalise job planning 6. Ongoing recruitment processes including international recruitment 7. Creation of new medical roles such as Associate specialists 8. Creation of a health and wellbeing hub aimed at reducing absence and reliance on costly temporary solutions	Partially complete	Major (4)	Likely - Weekly (4)	16	Corporate, Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Finance	Chief Nurse	Finance and Digital Committee, People and OD Committee
C2628COO	The risk of regulatory intervention (including fines) and poor patient experience resulting from the non-delivery of appointments within 18 weeks within the NHS Constitutional standards.	The standard is not being met and reporting is planned for March 2019 (February data). This risk is aligned with the recovery of Trak. Controls in place from an operational perspective are: 1.The daily review of existing patient tracking list 2. Additional resource to support central and divisional validation of the patient tracking list. 3.Review of all patients at 45 weeks for action e.g. removal from list (DNA / Duplicates) or 1st OPA, investigations or TCI. 4. A delivery plan for the delivery to standard across specialities is in place 5. Additional non-recurrent funding (between cancer/ diagnostics and follow ups) to support the reduction in long waiting	1.RTT and TrakCare plans monitored through the delivery and assurance structures	Partially complete	Major (4)	Likely - Weekly (4)	16	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Statutory	Chief Operating Officer	Quality and Performance Committee
C1798COO	The risk of delayed follow up care due outpatient capacity constraints all specialities. (Orthodontics; ENT; Urology; Oral Surgery; Diabetic Medicine; Paediatric Urology; Endocrinology; Cardiology; Paediatric Surgery; Neurology; Colorectal and GI Surgery) Risk to both quality of care through patient experience impact(15)and safety risk associated with delays to treatment(4).	1. Speciality specific review administratively of patients (i.e. clearance of duplicates) (administrative validation) 2. Speciality specific clinical review of patients 3. Utilisation of existing capacity to support long waiting follow up patients 4.Weekly review at Check and Challenge meeting with each service line 5.Do Not Breach DNB (or DNC)functionality within the report for clinical colleagues to use with 'urgent' patients. 6. Use of telephone follow up for patients - where clinically appropriate 7. Additional capacity (non recurrent) for Ophthalmology and ENT specialities to support follow up capacity 8. Review of good practice across Divisions to feed through to corporate approach	1. Revise systems for reviewing patients waiting over time 2. Assurance from specialities through the delivery and assurance structures to complete the follow-up plan 3. Additional provision for capacity in key specialiities to support f/u clearance of backlog	Partially complete	Moderate (3)	Almost certain - Daily (5)	15	Medical, Surgical	Quality	Chief Operating Officer	Quality and Performance Committee
S3035	A risk to safe service provision caused by an inability to provide an appropriate training environment leading to poor trainee feedback which could result in a reduction in trainee allocation impacting further on workforce and safety of care	Current service configuration does not lend itself to creating an environment for improved training and therefore the risk of poor feedback and the associated implications are not mitigated.	Fit for the Future engagement process re emergency general surgery Task and Finish group in situ to review all possible mitigations, meeting weekly	Incomplete	Catastrophic (5)	Possible - Monthly (3)	15	Surgical	Workforce	Medical Director	Divisional Board
S3036	A risk of sub-optimal care for patients with specialist care and other sub-specialty conditions caused by a lack of ability to create sub-specialty rotas resulting in inequitable care and different clinical outcomes	An upper GI surgeon is the on call surgeon approximately 50% of the time so patients admitted with gallbladder disease when this is the case do get this optimal treatment. In the event of UGI elective theatre cases being cancelled or DNA emergency gallbladder disease cases may be operated on due to unexpected surgeon availability.		Incomplete	Moderate (3)	Almost certain - Daily (5)	15	Surgical	Quality	Medical Director	Divisional Board
M2473Emer	The risk of poor quality patient experience during periods of overcrowding in the Emergency Department	Identified corridor nurse at GRH for all shifts; ED escalation policy in place to ensure timely escalation internally; Cubicle kept empty to allow patients to have ECG / investigations (GRH); Pre-emptive transfer policy patient safety checklist up to 12 hours Monitoring Privacy & Dignity by Senior nurses	CQC action plan for ED Development of and compliance with 90% recovery plan	Incomplete	Moderate (3)	Almost certain - Daily (5)	15	Medical	Quality	Director of Quality / Chief Nurse	Divisional Board, Quality and Performance Committee, Trust Leadership Team
		Criteria of patients suitable for transfer to	Transformation Delivery Group								

S2930	A risk to patient safety caused by insufficient senior surgical cover resulting in delayed senior assessment and delays to urgent treatment for patients.	SAU is in place (e.g. NEWS < 2 and specific conditions described in SOP that are suitable for SAU) Limited (one wte) ANP cover for SAU with a plan in place for training of additional ANPs. Current cover (1) Medical: team cover admissions and operating theatre (reducing availability of senior decision makers when they are operating). Consultant 24/7, Specialty trainee (registrar) 24/7, CT (sho) 08:00-00:00, F1 24/7 (2) ANP: 1 wte 37.5 hours/week (3) Nursing: SAU coordinator (band 5/6) 3 trained and 3 HCA (3/2 overnight). Minimum of 1 trained and 1 HCA cover SAU chair area (Bay C) Discretionary informal mitigations by our medical staff include reviewing and operating on emergency patients in the evening, taking emergency patients to elective lists in the event of elective cancellations / DNA's / under-running lists, second Saturday ward round which is unfunded and not job planned, flexibility from juniors in the event of rota gaps	Risk to be discussed at Surgical Board Fit for the Future engagement process re emergency general surgery Task and Finish group in situ to review all possible mitigations, meeting weekly	Incomplete	Moderate (3)	Almost certain - Daily (5)	15	Surgical	Quality	Director of Safety and Medical Director	Trust Leadership Team
C3034N	The risk of patient deterioration, poor patient experience, poor compliance with standard operating procedures (high reliability)and reduce patient flow as a result of high registered nurse vacancies within adult inpatient areas at Gloucestershire Royal Hospital and Cheltenham General Hospital.	1. Temporary Staffing Service on site 7 days per week. 2. Twice daily staffing calls to identify shortfalls at 9am and 3pm between Divisional Matron and Temporary Staffing team. 3. Out of hours senior nurse covers Director of Nursing on call for support to all wards and departments and approval of agency staffing shifts. 4. Band 7 cover across both sites on Saturday and Sunday to manage staffing and escalate concerns. 5. Safe care live completed across wards 3 times daily shift by shift of ward acuity and dependency, reviewed shift by shift by divisional senior nurses. 6. Master Vendor Agreement for Agency Nurses with agreed KPI's relating to quality standards. 7. Facilitated approach to identifying poor performance of Bank and Agency workers as detailed in Temporary Staffing Procedure. 8. Long lines of agency approved for areas with known long term vacancies to provide consistency, continuity in workers supplied. 9. Robust approach to induction of temporary staffing with all Bank and Agency nurses required to complete a Trust local Induction within first 2 shifts worked. 10. Regular Monitoring of Nursing Metrics to identify any areas of concern.	To review and update relevant retention policies Set up career guidance clinics for nursing staff Review and update GHT job opportunities website Support staff wellbing and staff engagment Assist with implementing RePAIR priorities for GHFT and the wider ICS Devise an action plan for NHSI Retention programme - cohort 5 Trustwide support and Implementation of BAME agenda Devise a strategy for international recruitment	Incomplete	Moderate (3)	Likely - Weekly (4)	12	Medical, Surgical	Safety	Director of Quality and Chief Nurse	Quality and Performance Committee
C2669N	The risk of harm to patients as a result of falls	1. Patient Falls Policy 2. Falls Care Plan 3. Post falls protocol 4. Equipment to support falls prevention and post falls management 5. Acute Specialist Falls Nurse in post 6.Falls link persons on wards 7. Falls monitored and reported at the Health and Safety Committee and the Quality and Performance Committee	4. Discussion with Matrons on 2 ward to trial process 1. Falls training 2. HCA specialist training 3. #Litle things matter campaign 4. Discussion with matrons on 2 wards to trial process	Partially complete	Major (4)	Possible - Monthly (3)	12	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Chief Nurse/ Quality Lead	Quality and Performance Committee, Trust Leadership Team
C2819N	The risk of serious harm to the deteriorating patient as a consequence of inconsistent use of NEWS2 which may result in the risk of failure to recognise, plan and deliver appropriate urgent care needs	Ongoing education on NEWS2 to nursing, medical staff, AHPs etc o E-learning package o Mandatory training o Induction training o Targeted training to specific staff groups, Band 2, Preceptorship and Resuscitation Study Days o Ward Based Simulation o Acute Care Response Team Feedback to Ward teams o Following up DCC discharges on wards • Use of 2222 calls – these calls are now primarily for deteriorating patients rather than for cardiac arrest patients • Any staff member can refer patients to ACRT 24/7 regardless of the NEWS2 score for that patient • ACRT are able to escalate to any department / specialist clinical team directly • ACRT (depending on seniority and experience) are able to respond and carry out many tasks traditionally undertaken by doctors o ACRT can identify when patient management has apparently been suboptimal and feedback directly to senior clinicians	Monthly Audits of NEWS2. Assessing completeness, accuracy and evidence of escalation. Feeding back to ward teams Development of an Improvement Programme	Complete	Major (4)	Possible - Monthly (3)	12	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Director of Quality and Chief Nurse	Quality and Performance Committee
M2268Emer	The risk of patient deterioration (Safety) due to lack of capacity leading to ED overcrowding with patients in the corridor	RGN and HCA now identified on every shift to have responsibility for patients in the ambulance assessment corridor. Where possible room 24 to be kept available to rotate patients 9(or identified alternative where 24 occupied) (GRH) 8am - 12mn consultant cover 7/7 (GRH) reviewed by fire officers safety checklist; Escalation to silver/gold on call for extra help should the department require to overflow into the third (radiology) corridor. Silver QI project undertaken to attempt to improve quality of care delivered in corridor inc. fleeced single use blankets and introduction of patient leaflet to allow for patients to access PALS. 90% recovery plan May 2019.	Complete CQC action plan Compliance with 90% recovery plan	Incomplete	Moderate (3)	Likely - Weekly (4)	12	Medical	Safety	Director of Quality and Chief Nurse	Divisional Board, Trust Leadership Team
C2667NIC	The risk to patient safety and quality of care and/or outcomes as a result of hospital acquired C .difficile infection.	1. Strengthened infection control team. 2. Deputy Director of Infection control in post 3. New cleaning regime introduced	1. Delivery of the detailed action plan, developed and reviewed by the Infection Control Committee. The plan focusses on reducing potential contamination, improving management of patients with C.Diff, staff education and awareness, buildings and the envi	Partially complete	Major (4)	Possible - Monthly (3)	12	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Director of Quality and Chief Nurse	Infection Control Committee, Quality and Performance Committee
C1945NTVN	The risk of moderate to severe harm due to insufficient pressure ulcer prevention controls	1. Evidence based working practices including, but not limited to; Nursing pathway, documentation and training including assessment of MUST score, Waterlow (risk) score, Anderson score (in ED), SSKIN bundle (assessment of at risk patients and prevention management), care rounding and first hour priorities. 2. Tissue Viability Nurse team cover both sites in Mon-Fri providing advice and training. 3. Nutritional assistants on several wards where patients are at higher risk (COTE and T&O) and dietician review available for all at risk of poor nutrition. 4. Pressure relieving equipment in place Trust wide throughout the patients journey from ED to DWA once assessment suggests patient's skin may be at risk. 5. Trustwide rapid learning from the most serious pressure ulcers, RCAs completed within 72 hours and reviewed at the weekly Preventing Harm Improvement Hub.	1. To create a rolling action plan to reduce pressure ulcers 2. Amend RCSA for presure ulcers to obtain learning and facilitate sharing across divisions 3. Sharing of learning from incidents via matrons meetings, governance and quality meetings, Trust wide pressure ulcer group, ward dashboards and metric reporting. 4. NHS collabborative work in 2018 to support evidence based care provision and idea sharing Discuss DoC letter with Head of patient investigations Advise purchase of mirrors within Division to aid visibility of pressure ulcers update TVN link nurse list and clarify roles and responsibilities implement rolling programme of lunchtime teaching sessions on core topics	Incomplete	Moderate (3)	Likely - Weekly (4)	12	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Director of Quality and Chief Nurse	Quality and Performance Committee
	Risk of fire in Tower Block ward ducts/vents	Fire dampers are installed and tested annually by GMS. Ward 9A cleaning complete. Tender for remedial works complete and available to call off.	Duct cleaning only possible when ward is fully decanted. Implement ward closure programe to provide access to undertake the works.								Divisional Board, Executive

C2817COO	due to build up of dust over many years. Wards needs to be empty for 24 hrs to clean ducts	GMS minimise risk of spark or electrical failure within ductwork through control of works and lack of electrical installations in ductwork. Kit being ordered	Ward 3B being assessed for ability to undertake works this Summer	Incomplete	Catastrophic (5)	Rare - Less than annually (1)	5	Corporate	Safety	Chief Operating officer	Divisional Board, Executive Management Team
S2568Anaes	The risk to patient safety of failure of anaesthetic equipment during an operation with currently very few spares to provide a reliable back up.	1. Prioritisation of operations 2. Maintenance by own medical engineering service	Request for 5 x Induction machines and 5 x anaesthetic machines Ensure risk raised to all surgical board meetings To request further equipment replacement before end of September 2017 to ensure all oldest machines are replaced. List of machine to be replaced on that action to be drawn up. E-mail to medical engineering to obtain that list. Review required 1. Application to MEF 2.. Loan request	Partially complete	Catastrophic (5)	Rare - Less than annually (1)	5	Surgical	Safety	Medical Director	Divisional Board, Medical Devices Committee, Quality and Performance Committee
S2775CC	The risk to patient safety of respiratory or/and cardiovascular instability and even death in the event of either an electrical or mechanical failure or as a result of needing to change over to a different mechanical ventilator.	1. Alarmed ventilators 2. All staff trained to hand-ventilate and portable ventilators available on both sites and in theatres Standard Servo will be delivered by the end of June 2019, MRI compatible will be delivered mid July. Old ventilator can be used as a backup until the other 2 have arrived	order Critical care ventilators ordered	Incomplete	Catastrophic (5)	Rare - Less than annually (1)	5	Surgical	Safety	Medical Director	Divisional Board, Quality and Performance Committee

Main Board – October 2019
Shire Hall, Gloucester

Report Title

Learning from Deaths Quarterly Report

Sponsor and Author(s)

Author: Andrew Seaton, Quality Improvement & Safety Director
Sponsor: Prof Mark Pietroni, Director for Safety & Medical Director

Executive Summary

Purpose
To provide assurance of the governance systems in place for reviewing deaths and in addition demonstrate compliance with the National Guidance on Learning from Deaths.

Key issues to note

- All deaths in the Trust have a high level review by the Trust Bereavement Team and the Trust Medical Examiners.
- All families meet with the bereavement team and have the opportunity to feedback any comments on the quality of care.
- The main learning from structure reviews is through the feedback, reflection and discussion in local clinical meetings at Specialty level. Currently 52% of triggered SJRs are completed within 3 months
- All serious incidents have action plans based on the identified learning which are monitored to completion. High level learning themes identified will feature in the new Learning from Concerns report in October 2019.
- HSMR for the period April 2018 to March 2019 remains within the expected range and SMR is now statistically significantly lower than expected.
- Actions from a recent internal audit will be reflected in the next report

Conclusions
- All deaths are reviewed in the Trust through the Medical Examiner, structured judgement reviews drives local learning and feedback.

Implications and Future Action Required

To ensure actions have desired impact and embed learning from good care into driving change.

Recommendations

Main Board is asked to note the Learning from Deaths Quarterly Report.

Impact Upon Strategic Objectives

This work links directly to our Trust objectives to achieve outstanding care and continuous quality improvement.

Impact Upon Corporate Risks							
Understanding the themes from mortality reviews will inform Trust risks							
Regulatory and/or Legal Implications							
National requirement to report to Trust Board.							
Equality & Patient Impact							
None							
Resource Implications							
Finance				Information Management & Technology			
Human Resources				Buildings			
Action/Decision Required							
For Decision		For Assurance	✓	For Approval		For Information	✓

Date the paper was presented to previous Committees						
Quality & Performance Committee	**Finance Committee**	**Audit & Assurance Committee**	**Workforce Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
25th September						
Outcome of discussion when presented to previous Committees						
The paper was noted with a request to improve the monitoring section for completion of SJRs						

Quality & Performance Committee – September 2019

LEARNING FROM DEATHS QUARTERLY REPORT

1. Aim

1.1 To provide assurance of the governance systems in place for reviewing deaths and in addition demonstrate compliance with the National Guidance on Learning from Deaths.

1.2 The period covered is Apr-Jun 2018/19.

2. Executive Summary

2.1 The main processes to review and learn from deaths are:

a. Review by the Medical Examiners and family feedback collected by the bereavement team on all deaths and provided to wards.

b. Structured judgment reviews (SJR) for deaths that meet identified triggers completed by clinical teams, providing learning through presentation and discussion within specialties.

c. Serious incident review and implementation of action plans

d. National reviews including Learning Disability Reviews, Child Death Reviews, Perinatal Deaths and associated learning reports

2.2 100% of deaths in the Trust have a high level review by the Trust Bereavement Team and the Trust Medical Examiners. These deaths are entered on to the Datix system to support the SJR process.

2.3 All families meet with the bereavement team and have the opportunity to feedback any comments on the quality of care. An analysis of these comments is included within this paper (Appendix VI). The feedback is overwhelmingly positive and is routinely shared with the relevant ward area.

2.4 The main learning from structure reviews is through the feedback, reflection and discussion in local clinical meetings at Specialty level. Currently 52% of triggered SJRs are completed within 3 months, a more timely response would benefit the learning and referral if required to SI status.

2.5 All serious incidents have action plans based on the identified learning which are monitored to completion. High level learning themes identified will feature in the new Learning from Concerns report in October 2019.

2.6 Learning reports from national mortality audits are presented to the relevant specialty and\or to the Quality Delivery Group. The process for reporting and learning from these national systems is under review.

2.7 HSMR for the period April 2018 to March 2019 remains within the expected range and SMR is now statistically significantly lower than expected.
HSMR is now 94.5 and SMR is 94.5

3. Mortality Review Process

3.1 The input of the Bereavement Team continues to add huge value to our process. It is the model on which other Trusts will be expected to base their service. They have now managed to ensure all deaths are recorded in real time.

3.2 The SJR approach continues to embed within all divisions. Feedback on progress is provided to the Hospital Mortality Group. The table below illustrates the general performance. Improvement is required in the timeliness of the review to improve local learning and escalation to SI status. Any delay to escalation to SI means we have to contact families under Duty of Candour some considerable time after the death.

NB these data are - Jan – March 2019

Division	Triggering deaths (healthcare staff or family concerns)	Triggering deaths (other triggers)	compliance with 1 month deadline (healthcare staff or family concerns)	compliance with 3 month deadline (other triggers)
Surgery	6	12	1 (17%)	9 (75%)
Medicine	12	13	1 (8%)	4 (31%)
D&S	5	4	1 (20%)	2 (50%)
W&C	0	0	0	0
Total	23	29	3 (13%)	15 (52%)

4. Family Involvement

4.1 Our aim is to comply with the letter and spirit of close family involvement in our mortality review process, This is achieved through the family contact with the Bereavement team and through the family involvement with serious incident investigation.

4.2 The publication of the national guidance in this respect has been helpful to focus towards a standard approach. The most significant gap is the integration of families in the training of staff on death reviews.

4.3 Establishing a quick feedback loop to staff on performance from families is an excellent method to reflect and learn for staff.

5. Learning from Deaths

5.1 All mortality reviews are reported through Speciality mortality and morbidity (M&M) meetings. Actions are developed within the speciality and monitored through the speciality and divisional processes, this approach although improving is still inconsistent.

5.2 The main learning from structure reviews is through the feedback and discussion in local clinical meetings at Specialty level. Some common themes continue to be identified which are in common with known areas of quality in

particular the complex management of the deteriorating patient and end of life planning particularly in the first stages of admission. High level themes identified will feature in the new Learning from Concerns report in October 2019.

5.3 There is an inconsistent approach to monitoring and learning from the national mortality reporting process, the system is under review with the expectation that better compliance is achieved by the end of march 2020.

6. Learning with Partners

6.1 We continue to work with colleagues in the South West through the Academic Health Science Network giving us the opportunity to ensure that our approach mirrors that in other Trusts in the South West.

6.2 We are active members of the Countywide Mortality Group and have undertaken two joint death reviews with partners. In addition we review our mortality data with colleagues in the CCG at the Quality Contract Review Group.

7. Dr Foster alert report

7.1 HSMR for the period April 2018 to March 2019 remains within the expected range and SMR is now statistically significantly lower than expected.
HSMR is now 94.5 and SMR is 94.5

7.2 Both weekend and weekday mortality for emergency admissions are within the expected range.

7.3 Summary Hospital Mortality Indicator is 1.045 and continues to be within the expected range.

7.4 There is no new Relative Risk alert and one cumsum alert for the group of "Other acquired deformities" which relates to very small actual numbers so will continue to be monitored. (All alerts are monitored at the Hospital Mortality Group)

7. Mortality Dashboard (Appendices)

7.1 The Trust reporting requirements can be found below:

Appendix 1
a) The total number of deaths in the quarter
b) The number of deaths having a high level review
c) The number of deaths where problems in care more likely than not contribute significantly (a score of < 3 in SJR)
d) Deaths reviewed in other processes

Appendix 2
a) Mortality indicators – Dr Foster report

Appendix 3
a) Divisional performance
Appendix 4

a) Family feedback report

Appendix 5
a) Summary statistics

8. Conclusions

8.1 All deaths are reviewed within the Trust via the bereavement and the Medical Examiner approach.

8.2 There is good progress on local learning from problems in care and ensuring these are being reflected on within specialties. Identified themes will feed in to the Learning from Concerns report.

8.3 Timeliness and completion rate needs to be continually improved for SJRs and further action to improve consistency of approach across the Trust is required.

9. Recommendations

9.1 The Quality & Performance Committee is asked to note the Learning from Deaths Quarterly Report and approve in advance of it going to the Trust Main Board.

Prof Mark Pietroni, Director for Safety & Medical Director
September 2019

APPENDIX I

Learning from Deaths – Mandatory reporting data

Structured Judgment Mortality Reviews

Division	Deaths	SJRs completed (or national)	Rating of poor or very poor care	DoC or SI reviews of deaths	Rating of excellent care
Surgery	96	20	2	1	7
Medicine	405	48	2	5	8
D&S	21	11	0	0	0
W&C	1	0	0	0	0
Total (%)	**523**	**79**	**4**	**6**	**15**

Other Mortality Review systems

Deaths by Special Type – Apr-Jun		
Type	*Number*	
Maternal Deaths (MBRRACE)	0	
Coroner Inquests with SI	12	
Serious Incident Deaths	6	
Learning Difficulties Mortality Review	8	
Perinatal Mortality	Neonatal <8 days	3
	Still births	2

Appendix 2

Dr Foster Summary Report

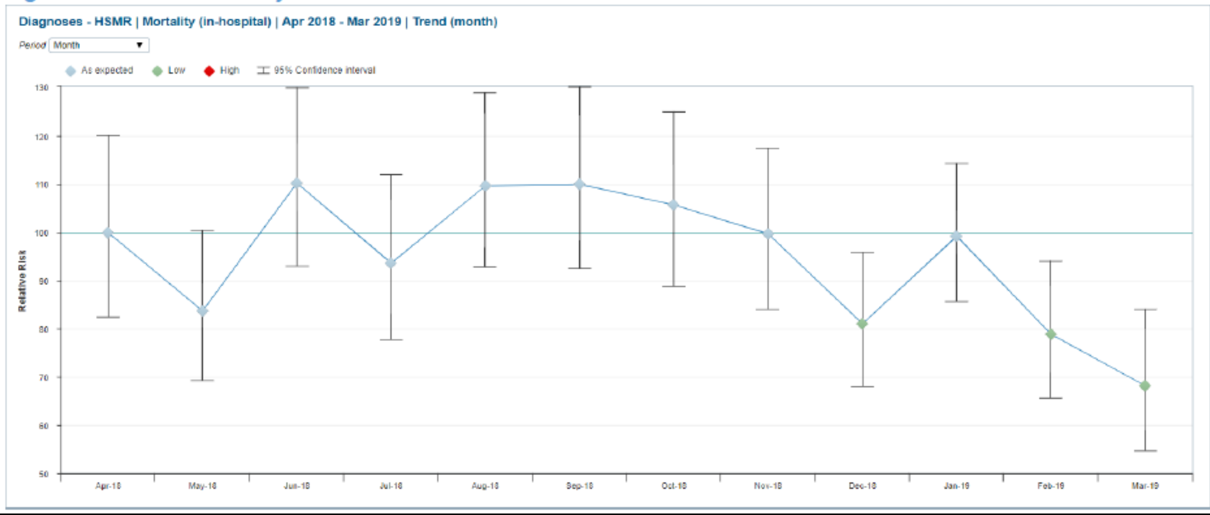
Results Summary

Metric	Result (arrows in brackets indicate change vs. previous reported time period)
HSMR	Trust – 94.5, statistically significantly lower than expected (↓) Cheltenham General – 86.6, statistically significantly lower than expected (↓) Gloucestershire Royal – 99.3, within the expected range (↓)
Emergency Weekend/Weekday HSMR	Trust: Weekday – 93.4, statistically significantly lower than expected (↓) Weekend – 96.8, within the expected range (↓)
Trends in Coding for HSMR Basket (18/19 FY)	Palliative Care Coding Rate (non-elective spells): 4.60% (↑), national rate is 4.11% Charlson Comorbidity Upper Quartile Rate: 25.6% (↓), this is 103 as an index of national
SMR	Trust – 94.5, statistically significantly lower than expected (↓) Cheltenham General – 86.1, statistically significantly lower than expected (↓) Gloucestershire Royal – 99.4, within the expected range (↓)
New Relative Risk Alerts	None
New CUSUM Alerts	Other acquired deformities
Mortality Patient Safety Indicators	Deaths in low risk diagnosis groups has a relative risk that is within the expected range. Deaths after surgery has a relative risk that is statistically significantly lower than expected
SHMI (February 2018 to January 2019)	104.57, within the expected range using NHS Digital's 95% control limits adjusted for over dispersion (↑)
New Early Warning Mortality Relative Risk Alerts	No new data received

Trend

The Trust's HSMR is 94.5 (90.0 – 99.3), this is statistically significantly lower than expected compared to hospital trusts nationally. There were 1,603 deaths compared to an expected figure of 1695.8. The crude mortality rate for the HSMR basket was 2.5%.

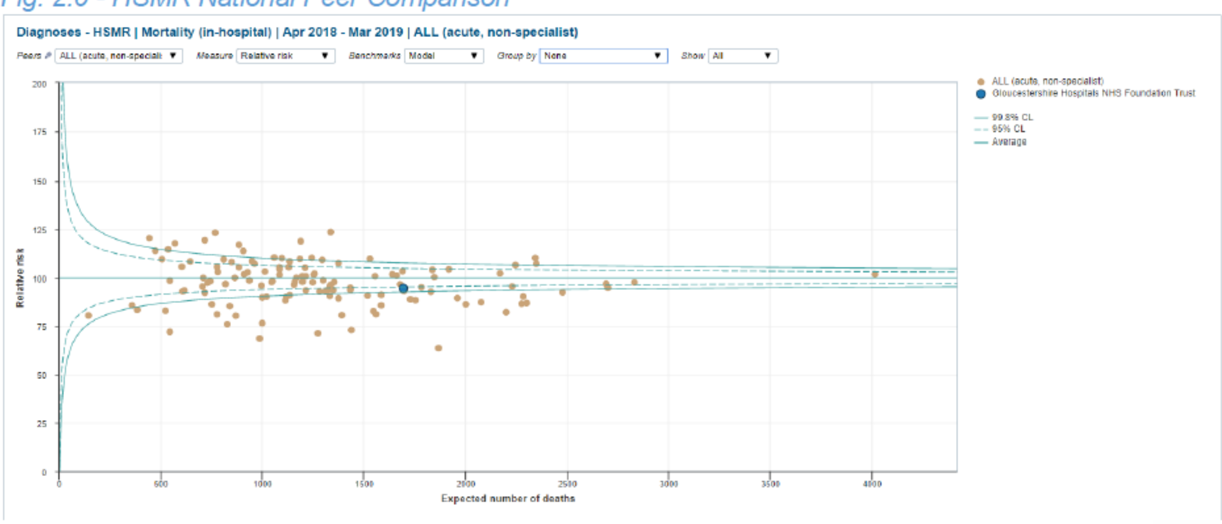
Fig. 1.0 - HSMR Monthly Trend



Peer Comparison

The HSMR for the Trust is within the expected range using 99.8% control limits.

Fig. 2.0 - HSMR National Peer Comparison



APPENDIX 3

DIVISIONAL DETAIL

Learning from Deaths

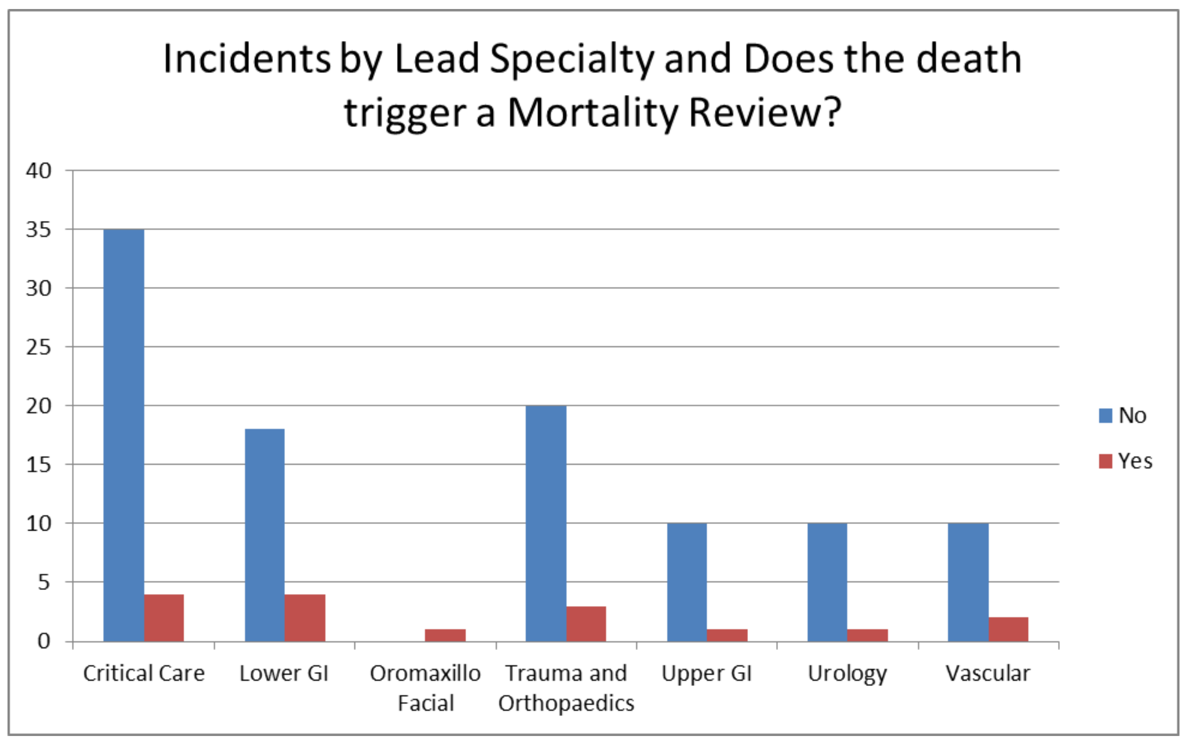
Quarter 4 (January, February, March 2019)

Surgical Division

Total number of deaths = 139
Number of completed SJRs = 16
Number of SJRs indicating sub-optimal care = 1
Number of SJRs indicating excellent care = 4

Number of deaths by lead Speciality

Lead specialty at death	Specialty at death	Q3 total	Jan	Feb	Mar	Q4 total
Surgical	Colorectal surgery	10	5	11	6	**22**
	Critical care medicine	24□	12	8	19	**39**
	ENT	1□	0	0	0	**0**
	Trauma and Orthopaedics	15□	11	8	4	**23**
	Upper gastrointestinal surgery	18	4	1	6	**11**
	Urology	4	7	3	1	**11**
	Vascular surgery	7□	6	4	2	**12**
	Division total	79□				



Number of SJRs by Speciality

Speciality	*No. of SJRs conducted*	*No. of SJRs indicating sub-optimal care*	*No. of SJRs indicating excellent care*
Critical Care	5	1	3
Lower GI	2	0	0
T&O	2	0	0
Upper GI	1	0	1
Vascular	3	0	0
OMF	1	0	0
Urology	2	0	0

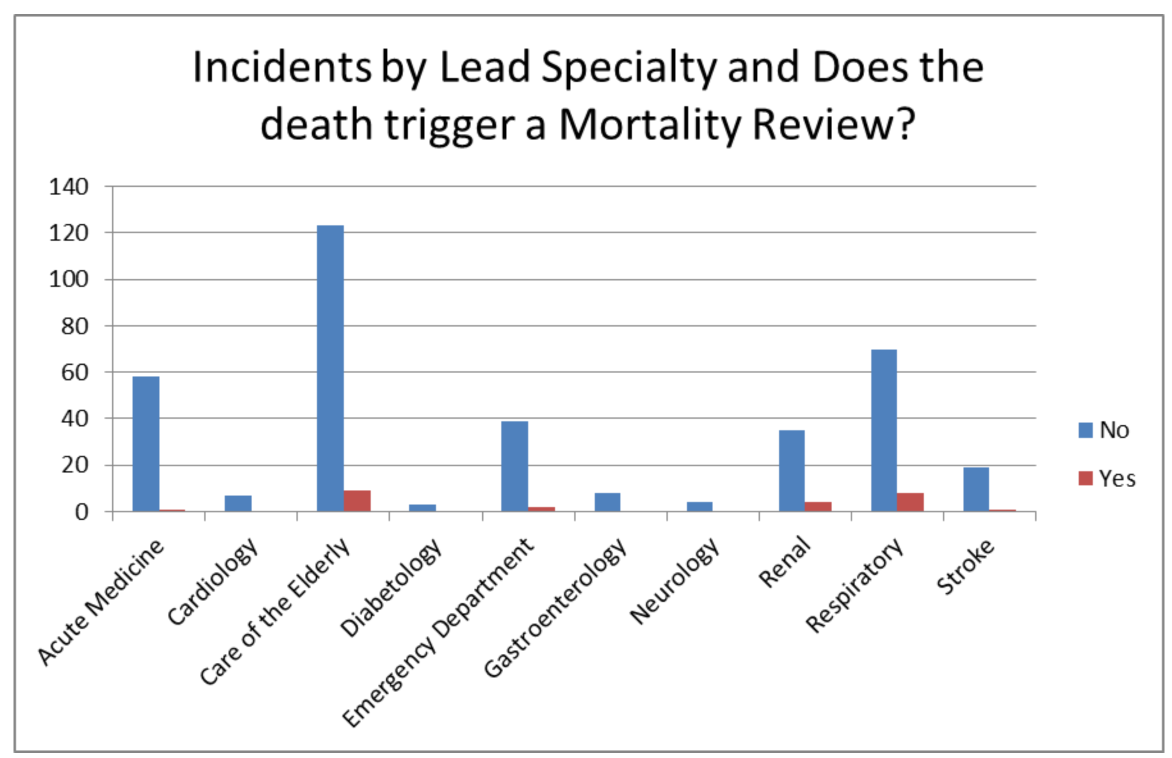
TOTAL = 16

Medical Division

Total number of deaths = 373
Number of completed SJRs = 78
Number of SJRs indicating sub-optimal care = 3
Number of SJRs indicating excellent care = 27

Number of deaths by Speciality

division at death	Specialty at death	Q3	Jan	Feb	Mar	Q4 total
Medical	Accident and Emergency	33	21	11	9	41
	Cardiology	20	4	0	3	7
	Diabetic medicine	1	1	2	0	3
	Emergency Medicine	50	26	18	16	60
	Stroke	28	10	4	6	20
	Gastroenterology	24	1	4	3	8
	Care of the elderly	105	44	43	45	132
	Renal	20	17	9	13	39
	Neurology	15	1	1	2	4
	Respiratory medicine	71	37	12	29	78
	Division total	367	162	104	126	392



Number of SJRs by Speciality

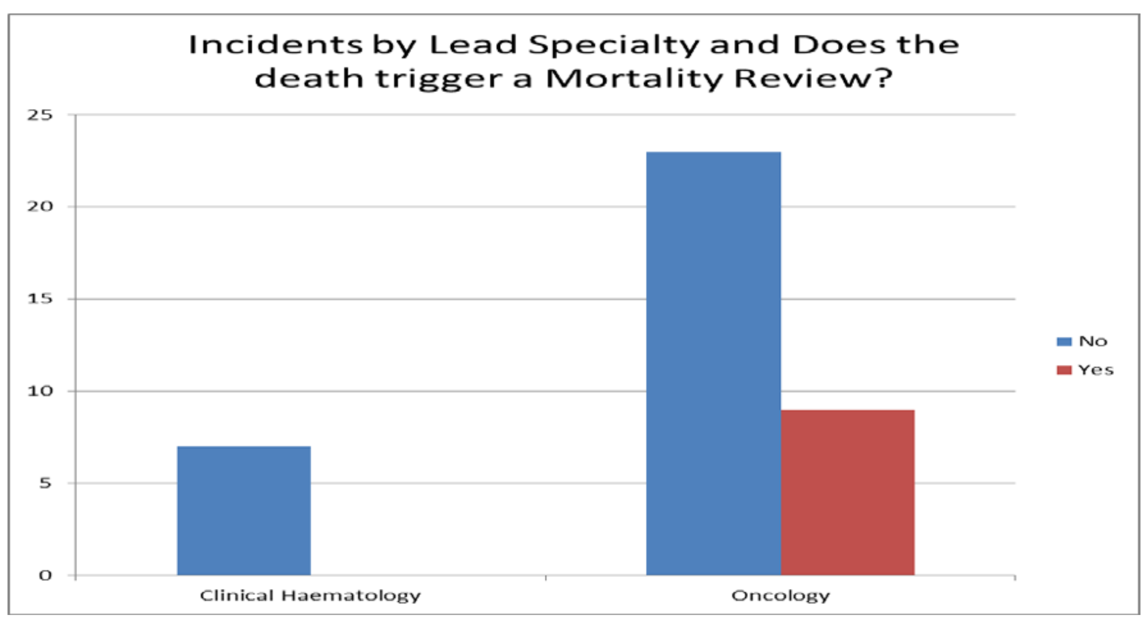
Speciality	*No. of SJRs conducted*	*No. of SJRs indicating sub-optimal care*	*No. of SJRs indicating excellent care*
Acute Medicine	**3**	**1**	**0**
Care of the Elderly	**6**	**1**	**0**
Emergency	**49**	**1**	**25**
Respiratory	**5**	**0**	**0**
Stroke	**7**	**0**	**2**
Renal	**1**	**0**	**0**
Cardiology	**2**	**0**	**0**
Gastroenterology	**3**	**0**	**0**
Neurology	**2**	**0**	**0**

TOTAL = 78

D&S Division

Total number of deaths = 40
Total number of completed SJRs = 8
Number of SJRs indicating sub-optimal care = 0
Number of SJRs indicating excellent care = 0

Division at death	Specialty at death	Q3 total	Oct	Nov	Dec	Q4 total
Diagnostic & Specialist	Clinical haematology	7	4	1	2	**7**
	Medical oncology	25	12	9	11	**32**
	Division total	32	16	10	13	39



Number of SJRs by Speciality

Speciality	*No. of SJRs conducted*	*No. of SJRs indicating sub-optimal care*	*No. of SJRs indicating excellent care*
Oncology	8	0	1
Clinical Haematology	0	0	0

TOTAL = 8

Learning from Deaths

Quarter 4 (January, March, April 2019)

W&C Division

Total number of deaths = 3
Total number of completed SJRs = 0
Number of SJRs indicating sub-optimal care =0
Number of SJRs indicating excellent care = 0

Division at death	Specialty at death	Q3 total	Jan	Feb	Mar	Q4 total
Women & Children	Gynaecological oncology	**0**	0	0	0	**0**
	Gynaecology	**0**	1	1	0	**2**
	Neonatology	**0**	0	0	0	**0**
	Obstetrics	**0**	0	0	0	**0**
	Paediatrics	**1**	0	0	0	**0**
	Well babies	**0**	0	0	0	**0**
	Division total	**1**	**0**	**0**	**0**	**2**

Appendix 4

Feedback report from bereaved families:April-June 2019

1.0 Background

With the development of the Datix mortality system all feedback from relatives is now entered on the system for completeness e.g it sits with the individual deceased patient details/cause of death given, people involved and any SJR recordings. The benefits of using Datix are that the comments can be linked to incident reports and complaints pertaining to the deceased and comments are visible to senior ward and departmental staff and can be included in reporting structures.

2.0 Methodology

2.1 All families are asked in person/real time:

> ***"is there anything about the care your .... received in the hospital you would like to feedback to us?"***

This ensures that the question is not leading and is simple to understand and respond to. The benefits of this approach include:

- It is asked in real time when the experiences of care are fresh in the relatives' minds.
- The Bereavement/Medical Examiner (ME) service and its staff are independent of the care and normally gain the trust of the relatives during the time they are involved with them after the death.
- Raising concerns with safety and transparency are the key to the remit of the

The limitations of this method are that:

- It does not necessarily reflect the full experience of the deceased person.
- Relatives may have differing perspectives so the review is limited to the person collecting the MCCD and
- Relatives with further time to dwell on experiences can change their minds.

2.2 The results have been filtered by area linked to the feedback and have been divided into positive negative and mixed comments. The comments have then been analysed for key words and themes.

3.0 Results

Loc	Pos	Neg	Mix
2a Trauma	1 (100%)	0	0
2b Head and Neck	2(66%)	1 (33%)	0
3a Trauma	3 (100%)	0	0
3b Trauma	4(80%)	0	1 (20%)
4a COTE	5 (50%)	2 (20%)	3 (30%)
4b COTE	13 (81%)	2 (12.5%)	1 (6.5%)
5a / SAU	1 (100%)	0	0
5b Upper & Lower GI	3 (75%)	0	1 (25%)
6a Stroke	5 (100%)	0	0
6b stroke	15 (75%)	4 (20%)	1 (5%)
7a Renal	6 (86%)	1 (14%)	0
7b Renal	7 (78%)	1 (11%)	1 (11%)
8a Neuro	4 (100%)	0	0
8b Respiratory	13 (68%)	2 (11%)	3 (21%)
9a Gynae	0	0	0
9b Acute Medicine	5 (62.5%)	2 (25%)	1 (12.5%)
ACUA / AMU	17 (77%)	4 (18%)	1 (5%)
ACUC	10 (91%)	0	1 (9%)
Avening Respiratory	23 (82%)	1 (4%)	4 (14%)
Bibury	4 (100%)	0	0
Cardiac Cardiology, CGH	2 (66%)	0	1 (34%)
Cardiology Ward, GRH	1 (100%)	0	0
Critical Care CGH	7 (87.5%)	1 (12.5%)	0
Critical Care GRH	11 (100%)	0	0
Emergency Department	8 (89%)	1 (11%)	0
Gallery Ward (MSFD), GRH	3 (60%)	1 (20%)	1 (20%)
Guiting Vascular	7 (78%)	0	2 (22%)
Hartpury	1 (100%)	0	0
Knightsbridge Respiratory	3 (75%)	0	1 (25%)
Lilleybrook Oncology	6 (86%)	0	1 (14%)
Rendcomb Oncology	8 (80%)	1 (10%)	1 (10%)
Ryeworth Ward	17 (81%)	1 (5%)	3 (14%)
Woodmancote COTE	16 (80%)	1 (5%)	3 (15%)
Prescott Ward (Urology & Breast)	2 (66%)	1 (34%)	0
Snowshill Ward (Gastro)	5 (83%)	1 (17%)	0
Specialist investigations	1 (100%)	0	0
TOTAL	239 (81%)	25 (9%)	31 (10%)

2.3 Positive comments

The most common positive words used to describe the staff and the care received were:

Wonderful (43 times)
Good (36)
Faultless/ could not fault (35 times)
Excellent (34)
Lovely (28)
Kind (28)
Brilliant (25)
Fantastic (24)
Caring (20)
Amazing (14)
Compassionate (5)

Communication was mentioned positively 16 times. Families valued honesty and time spent explaining things. One specific comment commended the staff member on their ability to communicate to all age ranges within the family.

Support of the family members was mentioned positively 5 times. These families felt looked after and welcomed.

4 families were thankful for access to overnight accommodation/ facilities.

1 family were very pleased that a member of staff sat with their mum when she was dying as they knew she didn't want to die alone.

Most comments refer to staff or teams in general however 22 comments specifically refer to the nursing staff, 26 to doctors, 9 to the palliative care team and 3 to the bereavement team. Mentions were made of tea servers, student nurses, the chapel and cleaners. 115 staff were specifically named by the relatives for the care they provided.

2.4 Negative comments

Communication was mentioned negatively 20 times. One theme included inconsistent/ wrong information. One family reported several instances of conflicting communications between the specialties which left the family bewildered and confused at times

3 comments related to the breaking of news of death:

Family disappointed with contact from ward when he passed away they just said "Hes gone " and gave no further instructions regarding next procedure

Staff nurse broke news badly - "went for my break and when I got back he didn't have a pulse"

When family came in on the evening he died the daughter was just told to walk down ward and he's behind the curtain.The family were shocked to see he was dead, they didn't know he had already died. Wife very tearful and emotional.Family feel

communication should have been better to ensure family knew he had died before seeing him.

3 comments related to the timeliness of informing relatives about the death affecting their ability to be present at the time:

heartbroken they had not been called and also queried time of death as didn't tally with their understanding of events

unhappy he is about not being contacted by the ward to come in when his Dad died. He only lives 5 mins away and is devastated not to have been with his Dad at the end.

Informed of death on 'phone - patient had been dead 2 hours when call came through

2 comments related to the timeliness answering call bells

2 comments related to poor pain management

3 comments related to the lack of availability of a side room at the time of death- Emergency

6 comments related to lack of staffing

2 comments related to concerns over cleanliness

2 comments related to the standard of food – cold, not nutritious and below par

3.0 Conclusion

81% of comments were positive with 10 areas having 100% positive comments. Wards are asked to review their comments and provide feedback to staff especially where they have been specifically named.

Appendix 5

ADDITIONAL DETAIL

Quarter One (April, May, June 2019)

Categories of Care which Trigged a Structured Judgement Review

TRIGGER	No.	%
Concern raised by family	8	16%
Concern raised by healthcare staff	2	4%
Deaths following readmission (within 72hrs)	11	22%
Death of patient with C Difficile	2	4%
Deaths following elective admission	7	14%
Deaths taking place during or shortly after a procedure	2	4%
Patients with a Learning Disability	4	8%
Safeguarding concerns	2	4%
Systemic Anti-Cancer Treatment (SACT) in last 30 day - (Specialty Trigger)	7	14%
DCC Specialty Trigger	6	12%

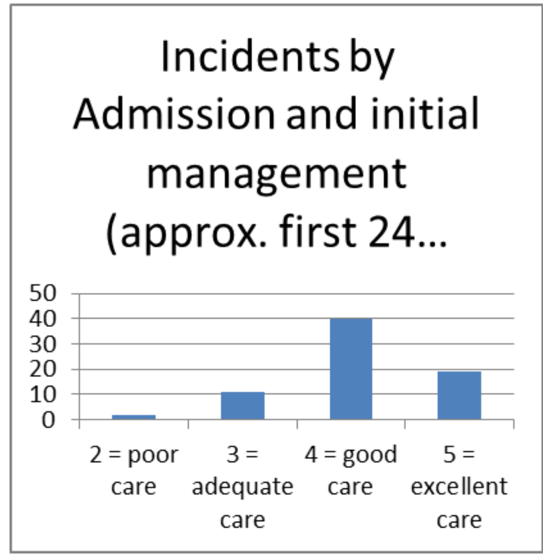
Learning from Deaths

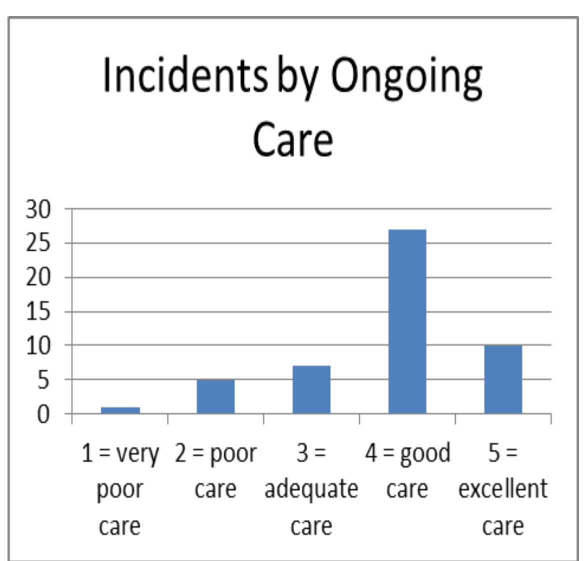
Quarter One (April, May, June 2019)

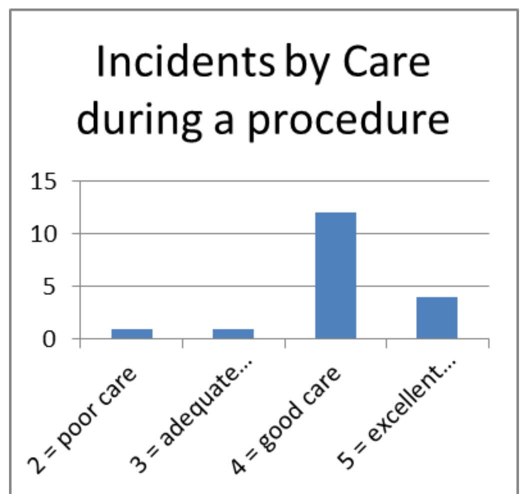
Location at Time of Death

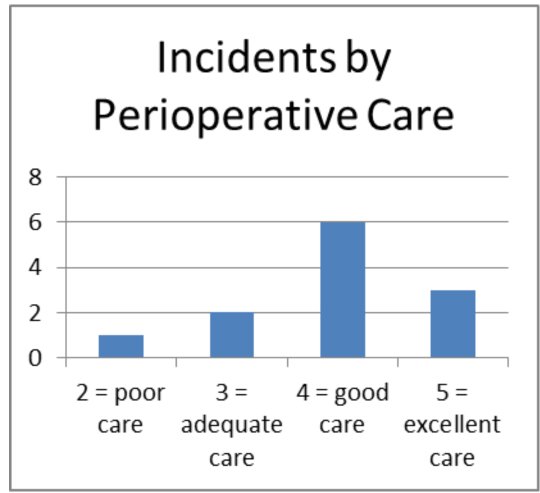
LOCATION	No.
ACUA / AMU	46
8b Respiratory	37
Avening Respiratory	34
4b COTE	31
6b stroke	31
Emergency Department	29
Ryeworth Ward	29
4a COTE	27
Woodmancote COTE	24
7b Renal	22
7a Renal	19
Critical Care GRH	19
9b Acute Medicine	16
3a Trauma	15
Rendcomb Oncology	13
Critical Care CGH	12
3b Trauma	11
6a Stroke	11
8a Neuro	11
Guiting Vascular	11
Gallery Ward (MSFD), GRH	10
ACUC	9
5b Upper & Lower GI	8
Lilleybrook Oncology	8
Knightsbridge Respiratory	7
Snowshill Ward (Gastro)	7
Prescott Ward (Urology & Breast)	6
5a / SAU	5
Bibury Ward (Lower GI & Gen Surgery)	4
2a Trauma	3
2b Head and Neck	3
Cardiac Cardiology, CGH	3
9a Gynae	1
Cardiology Ward, GRH	1

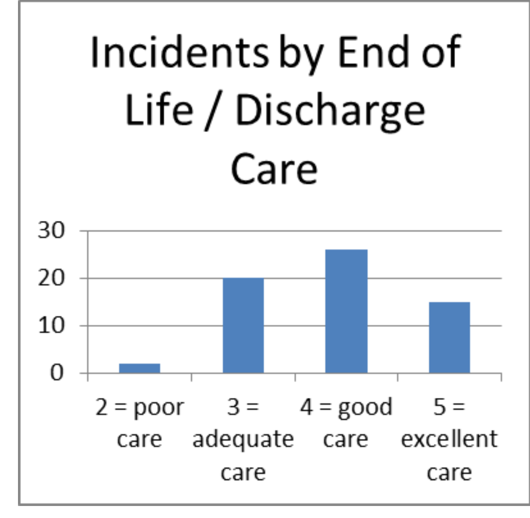
Ratings by Stage of Care

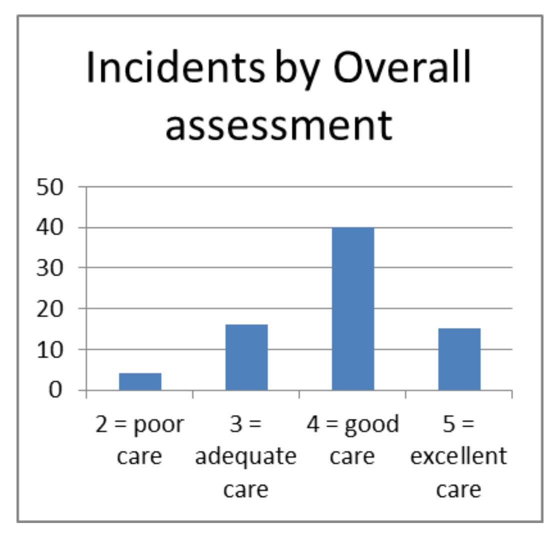




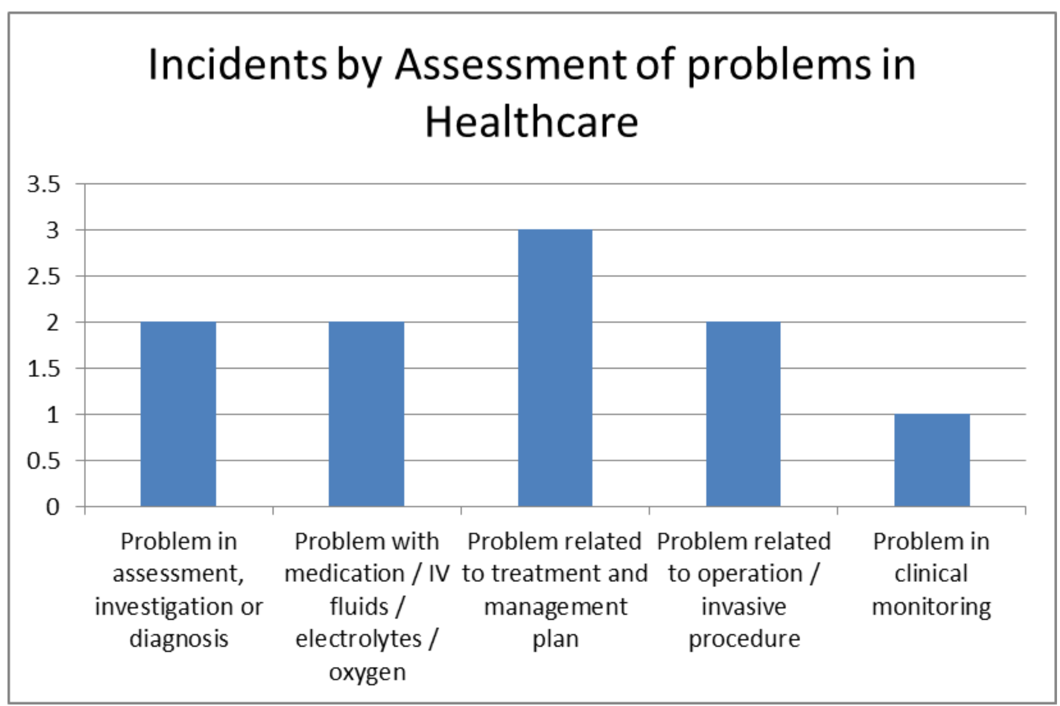








Problems of healthcare



REPORT TO MAIN BOARD – October 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 25th September 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
Electronic Patient Record update	Update on EPR progress Strong clinician involvement, developing single point of access Staged roll out, adult inpatient wards at Gloucestershire Royal Hospital November 2019.	How do we recognise areas/wards with greatest risk in rollout and how supported? What are the balancing measures being used to ensure implementation positively impacts on patient outcomes. How does this support people who are not confident in IT? We have seen clinical incidents where the introduction of EPR would improve safety, can the implementation be flexible When will it be done and will it cover everyone?	Use of support/ bank staff, floor walkers. Clear clinical leadership. Ward based risk assessments, specifically in high intensity areas such as acute assessment areas. Balancing measures dashboard to be monitored as implementation progresses. Working with areas, providing tailored support Several examples of executive level clinical check and challenge and re prioritising of implementation System will always need refining with focus kept on aspects which give greatest benefit	Plans in place, needs further working through practical support for areas/wards specific issues and needs.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
C.difficile report	Brief on outbreak, six patients involved. Ward closed for a total of 15 days Control measures introduced, no further cases to date.	Some of the recommendations specific to that ward, some generic, what else needs to be done more widely in relation to learning? How can we respond to 'small' things which need attending, which if left can contribute to bigger issues? How do we know that escalating concerns works? What is the confidence with antimicrobial prescribing and practice?	Importance of focus on local leadership as well as reliance on Gloucestershire Managed Services standards of responsiveness. Medical Director meeting with Consultants imminently to discuss and clarify	Excellent example of whole Trust learning, so to take to DOG (Directors Operational Group) specifically re escalation processes in place. Brief going to Gloucestershire Managed Services Contract Management Board. Further review of C.diff action plan. Review of C.diff risk profile on risk register
Corporate Risk Register	New risk noted of risk of serious harm to deteriorating patient as a consequence of inconsistent use of NEWS2. A new risk being considered regarding ionizing radiation reflecting concerns of CQC during recent visit No assurance on Stryker drills 7 and 8		Through exception reporting from Quality Delivery Group. Now going out to procurement for drills. No issues noted with Stryker 6 drill.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Serious Incident Report	No new never events during reporting period. Three new serious incidents. Case referred to HSIB One serious incident closed using new template	Vacancy rate noted in an area, what is the risk? Noted this external review could take several months, what can and should we be doing internally to give assurance on learning?	Known area of focus, additional leadership in place, winter workforce plan, additional roles agreed and establishment needing review Template working well. .	Noted that this should be reviewed in detail at People and Organisational Development Committee, need to avoid duplication of scrutiny. Review of any wider learning which can be implemented locally Consider what we can do locally and report back
Quality and Performance Report	**Emergency delivery group** Activity up from same reporting period 2018 Performance generally good, Time for patient to be reviewed by a doctor improved despite new intake of junior doctors. 15 minute to triage also improved. Greater working with community partners. Trust performance still in upper quartile nationally. All provider winter plans received by Gloucestershire Clinical Commissioning Group.	Is our performance sufficient to support us for winter months, traditionally more challenging? What confidence is there in the support from the partners in the system?	Specific and considerable challenges with social care capacity. Trust knows figures needed to keep hospital flow. Introduction of SHREWD should be very helpful. System meeting on 10th October to share all winter plans in detail, assess if any gaps and what actions needed if present.	Hard Launch 1st October, soft launch successful 1st September Risks in the system sit with A&E Delivery Board Further updates for Quality and Performance Committee and Board post system meeting.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	Planned care delivery group RTT on trajectory at 81.4% High levels of validation, visibility and accuracy. Recovery plan in place for over 52 week waiters and RTT performance	How do we know that the % performance for RTT is accurate? Are there any risks in missing the ‘outcomes’? Have we trajectories for 40 weeks?	Specific tailored GHT validation tool in play. Exec confident with validation specifically for RTT. Internal Audit gave moderate assurance There are processes in place to catch that.	More information to be provided on missing outcomes and audits in future report Trajectory to be considered through Planned Care Delivery Group.
	Cancer delivery group August 62 day performance 72.9% (unvalidated) Urology performance continues to impact on Trust ability to deliver 62 day standard 2 Week Wait demand giving pressure. Diagnostic and histopathology capacity issues. Dermatology above upper control total by 25% and significantly increased from last year.	Will the dermatology plan work?	Refocus on MDT support to cancer huddles. Capacity review Pathway reviews supported by NHSI/E, Peer Visit by Epsom and St Helier (best performing) Histopathology reporting backlog resolved (outsourced) Confidence in plan being able to deliver	Consideration of assurance on what

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
		In e.g. Head and Neck surgery, what is breakdown of breaches over 62 days?	No 104 day breaches in H and N, every patient known to teams.	patient understands about time intervals and next steps.
	Quality Delivery Group Quality Summit process embedded. 2 x quality summits closed, adult inpatient survey and deteriorating patient, both will be monitored through Quality Delivery Group and escalated to Quality and Performance Committee if necessary. Summit in process for reduction of pressure ulcers and falls. NAAS 2 complete with focus on outstanding practice Quality Strategy deferred to October 2019 meeting. Divisional areas enhanced surveillance set out.	What will the coverage of real time feedback includes and what confidence that the system to support areas is robust? What is the role of Quality Delivery Group to ensure the Divisions quality governance system and meetings are functioning? What confidence that we won't get into the same position again re backlog?	Real time feedback a key principle in the quality strategy, need for review with changing national FFT approach Not QDG role, included in the new Executive Review Process being led by the Chief Operating Officer. Backlog due to be cleared. System in place which provides clarity of responsibility and accountability. Oversight of	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	Policy update, now 83 outstanding, noting significant progress with a view to all policies to be reviewed by end of September 2019.		policies will be part of the performance regime.	
Learning from Deaths report	All deaths have high level review by bereavement team and medical examiners All families meet with bereavement team and have opportunity to provide comments 52% of triggered structured judgement reviews are completed within 3 months HSMR remains within expected range. SMR statistically lower than expected. Actions from recent Internal Audit report will be featured in next report.	How can the % of triggered reviews completed within 3 months be improved? How many LeDeR reviews have we taken part in and what is our learning?	Clarity of expectations for Divisions and reviewed monitored through the exec review process. Aware of importance of learning from LeDeR, not set out in this report.	Future reports to include Trust involvement and learning from LeDeR reviews

Board to note,
ICS update. £500k successfully awarded in response to our bid for UEC Capital from NHSI / E. Liaising with System partners for a 'Reset' week ahead of Winter 4th November with support from ECIST colleagues,.

Clinical Comissioning Group update, no Clinical Quality Review Group held, next will be November, no outstanding significant issues with the Trust in lieu of meeting. Trust will receive regular feebdack through Clinical Comissioning Group quality portal. Clinical Comissioning Group attendees to have admin control access for ease.

Feedback from Audit and Assurance Committee, focus on risk management arrangements. Internal Audit from Gloucestershire Managed Service on cleaning noted.

Alison Moon
Chair of Quality and Performance Committee

MAIN BOARD - OCTOBER 2019
SHIRE HALL, GLOUCESTER COUNTY COUNCIL

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

Purpose

This report summarises the key highlights and exceptions in Trust performance for the August 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.

QDG Red Rag Rated Indicators and improvement plans
Quality Summits

1. Preventing Harm - Hospital Acquired Pressure Ulcers
   Insight - this indicator is in the Quality Summit process and there is an improvement ("white space") meeting planned for end of September.
   Data during August 2019 there were
   - 36 hospital acquired category 2 pressure ulcers sustained in patients across 22 wards. High incidence was recorded on 4b, 8b and AMU.
   - 6 hospital category 3 pressure ulcers sustained in patients across 5 wards, with 2 on Ryeworth
   - 9 hospital acquired unstageable pressure ulcers sustained in patients across 7 wards, with more than on 4b.
   - 7 hospital acquired deep tissue injuries sustained with more than one on 2a and AMU.

Themes and trends from harm reviews

- Issues raised at the Hub include missed opportunities to complete risk assessment documentation, timely provision of equipment and robustness of pressure relieving measures.

Involvement – in our quality summit event we are involving clinicians, ward teams and specialists in reviewing the data and planning our change ideas and improvements.
Actions for improvement

- All hospital acquired pressure ulcers are reviewed by ward teams to identify learning.
- The Trust is involved in an NHS Improvement collaborative to reduce the incidence of category 2 pressure sores in AMU.

- Medicine and Surgery have plans to respond and reduce pressure ulcers.
- 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.

2. Sepsis metrics

- Sepsis and the deteriorating patient continue to be in the quality summit process. A draft improvement plan has been developed and was shared with QDG. Once the plan has been approved the responsibility for monitoring the delivering the actions will be monitored through the Deteriorating Patient and Resuscitation Committee.

3. Patient Experience Indicators (red FFT <93%)

Inpatient FFT

Inpatient FFT rate has remained static for a number of months. New platform is being commissioned for FFT and Real-time surveys, and national guidance has been published about changes to FFT from April 2020, which will allow more flexibility in when we ask patients for their feedback, and other freetext options that will give us more useful insight.

Real-time Survey

This has shown an improvement against Q1 data of 76.91%, and a continued improvement from July's responses of 79%. This will be a continued area of focus, with a number of projects as part of Best Care For Everyone looking at communication and how we can keep patients and relatives more informed and involved

Enhanced Surveillance Metrics

Bed days lost (red >30 days)

Bed days lost during August were due to an outbreak of CDI on Snowshill ward. The ward was closed to bring about outbreak control.

VTE assessments (red <97%)

Improvement work continues and the new electronic inpatient record will help identify the ward areas where support is required.

Dementia indicator

Manual collection of dementia metrics is continuing until Electronic Patient Record (EPR) is in place which will be by December. Recent data collection trial had insufficient cases to provide assurance (3 of 20), particularly for performance in latter stages of dementia pathway where the cohort total reduces down further. Contemporaneous audit continues for monitoring.

Vacancy rate (red >5.5%)

Medical staff

- Significant gaps continue to exist within the Doctors in Training Rota. To mitigate risk associated with this we continue to use agency locums where appropriate and alternative roles such as: Physicians Associates and Advanced Clinical Practitioners.
- The ACP business case is due for further review by Medical Director and Chief Nurse at the end of September 2019 with a view to progress the business case through internal delivery groups and to TLT by November 2019.
- 5 year workforce plans are being finalised over September and October 2019 and will include consideration of alternative roles where ongoing hard to fill vacancies exist.
- The re-opening of the Associate Specialist Grade is now being considered, with hard to fill specialities being identified as potential implementation opportunities.

Nurses

- The Trust welcomed 14 Nurses from the Philippines in late August.
- A successful Newly Qualified Open Day was held (14.9.19) with extremely positive interest and a number of recruitment offers were made and accepted.
- We continue to perform a a daily, dynamic risk assessment of safe staffing numbers using

Bank and Agency to fill gaps as appropriate.
- The Trust has now joined cohort 5 of the NHSI Retention Direct Support Programme

Performance

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

In August 2019, the trust performance against the 4hr A&E standard was 88.16%, including system performance was 92.01%. 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.

In respect of RTT, we are reporting 81.41% for August 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 86.0%, (un-validated) compliance is expected from September onwards, subject to fluctuations in referral rates.

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. The Trust have secured support from NHS I to review tumour site pathways.

Cancer 62 day Referral to Treatment (GP referral) performance for July was 71.7% (un-validated). Diagnostic pressures impact delivery of the 62 day pathway.

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.

Conclusions

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.

Equality & Patient Impact

Failure to meet national access standards impacts on the quality of care experienced by patients. There is no evidence this impacts differentially on particular groups of patients.

Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	
No change.			

Action/Decision Required

For Decision		For Assurance	✓	For Approval		For Information	✓

Date the paper was presented to previous Committees

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

Outcome of discussion when presented to previous Committees

Quality and Performance Report

Reporting period August 2019

to be presented at September 2019 Trust Board

Contents

Contents	2
Executive Summary	3
Performance Against STP Trajectories	4
Summary Scorecard	5
Demand and Activity	6
Trust Scorecard – Safe	7
Trust Scorecard – Effective	9
Trust Scorecard – Caring	11
Trust Scorecard – Responsive	12
Trust Scorecard – Well Led	15
Exception Reports – Safe	16
Exception Reports – Effective	19
Exception Reports – Caring	22
Exception Reports – Responsive	23
Exception Reports – Well Led	29
Benchmarking	31

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Executive Summary

Delivery of agreed action plans remains critical to restore operational performance to the expected levels. During August 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 August was 88.16% against the STP trajectory at 85.22% against a backdrop of significant attendances. The system met the delivery of 90% for the system in August.

The Trust has met the diagnostics standard for August at 0.84%.

The Trust has not met the standard for 2 week wait cancer at 86.0% in August, 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.

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Performance Against STP Trajectories

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							
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							
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%							
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%							
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%							
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							
% 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%							
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%							
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%							
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%							
Cancer – 31 day diagnosis to treatment (subsequent – drug)	Trajectory	98.10%	98.30%	98.20%	98.90%	98.1%	98.0%	99.0%	98.0%	98.9%	98.0%	98.0%	98.0%
	Actual	100.00%	96.20%	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%	95.1%	95.1%	95.1%	95.1%	95.1%	95.1%	95.1%
	Actual	96.40%	97.50%	96.30%	100.00%	83.70%							
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	Trajectory	94.00%	95.50%	95.30%	94.80%	94.4%	95.1%	95.5%	95.4%	95.6%	94.8%	94.8%	94.8%
	Actual	94.00%	95.10%	100.00%	89.60%	89.40%							
Cancer 62 day referral to treatment (screenings)	Trajectory	90.30%	90.90%	91.70%	90.90%	91.4%	91.7%	91.4%	91.4%	92.3%	90.6%	90.6%	90.6%
	Actual	100.00%	96.60%	85.20%	84.60%	100.00%							
Cancer 62 day referral to treatment (upgrades)	Trajectory	100.00%	100.00%	100.00%	100.00%	100%	100%	100%	100%	100%	100%	100%	100%
	Actual	44.40%	57.10%	70.60%	100.00%	83.30%							
Cancer 62 day referral to treatment (urgent GP referral)	Trajectory	81.80%	82.30%	82.40%	82.60%	84.3%	85.0%	85.2%	85.0%	85.0%	85.1%	85.0%	85.0%
	Actual	79.70%	70.70%	66.50%	71.70%	72.90%							

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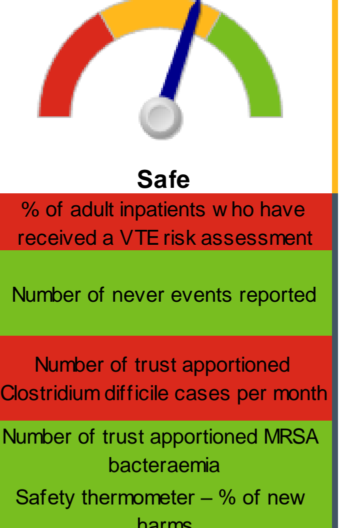
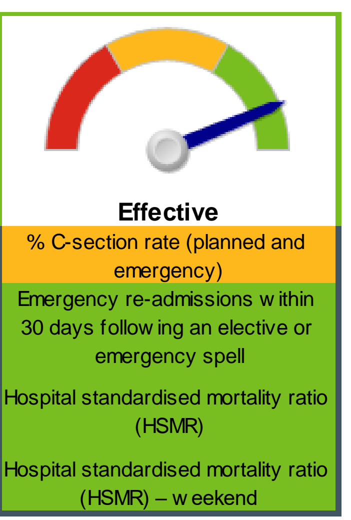
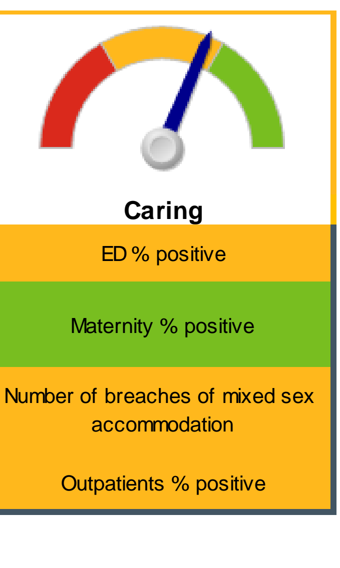
Summary Scorecard

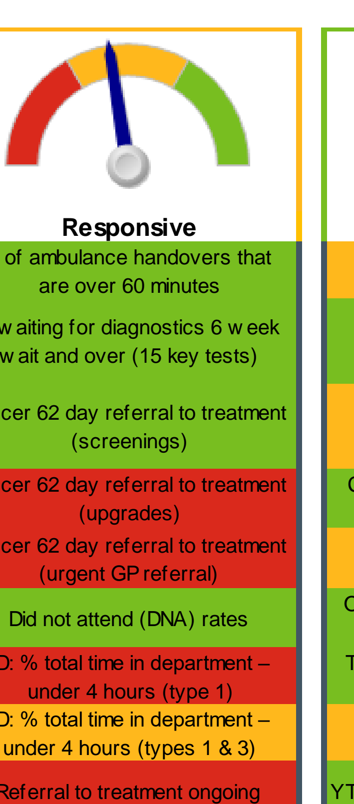
The following table shows the Trust's current monthly performance against the chosen lead indicators within the Trust Scorecard.

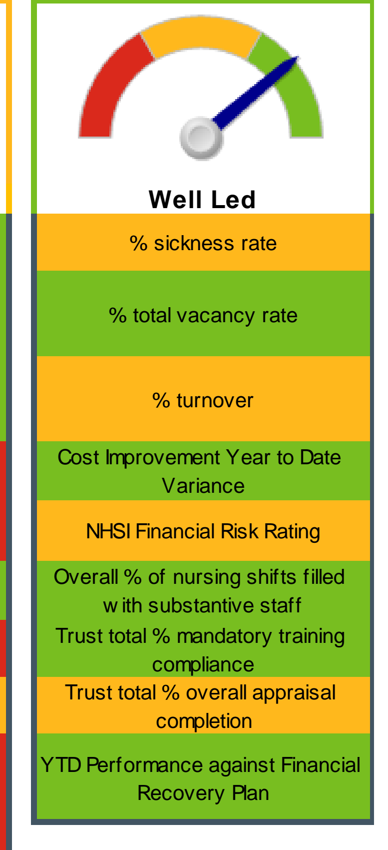
RAG Rating: Overall RAG rating for a domain is an average performance of lead indicators against national standards. Where data is not available the lead indicator is treated as red.











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Demand and Activity

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

													% change from previous year	
Measure	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Monthly (Aug)	YTD
GP referrals	13,332	12,842	15,690	14,814	11,965	14,521	13,202	14,044	13,094	13,415	12,709	12,061	10,302	-22.73%	-10.36%
OP attendances	12,721	12,318	14,284	14,707	11,084	14,083	12,474	13,525	12,663	13,025	13,063	13,856	11,850	-6.85%	-3.27%
Day cases	6,127	5,793	6,828	6,766	5,833	6,167	5,995	6,318	5,815	6,520	6,198	6,955	6,348	3.61%	8.85%
All electives	7,125	6,831	7,901	7,877	6,837	7,124	6,955	7,465	7,255	7,556	7,213	8,096	7,378	3.55%	7.92%
ED attendances	12,200	12,488	12,610	12,230	12,639	12,962	11,701	13,245	12,949	13,618	13,072	14,066	13,267	8.75%	6.62%
Non electives	4,602	4,668	4,878	5,088	5,081	5,132	3,085	4,900	4,696	4,861	4,586	4,802	4,698	2.09%	0.46%

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Trust Scorecard – Safe (1)

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

	18/19	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	19/20 Q1	19/20	Standard	Threshold
Infection Control																		
Number of trust apportioned MRSA bacteraemia	1	1	2	0	0	0	0	0	1	0	1	0	0	0	1	1	Zero	
MRSA bacteraemia – infection rate per 100,000 bed days										0	3.5	0	0	0	1.2	0.7	Zero	
Number of trust apportioned Clostridium difficile cases per month	56	6	3	4	4	1	6	5	4	7	6	7	10	10	20	40	2019/20: 114	
Number of hospital-onset healthcare-associated Clostridioides difficile cases per month													7	6		22	<=5	
Number of community-onset healthcare-associated Clostridioides difficile cases per month													3	4		18	<=5	
Clostridium difficile – infection rate per 100,000 bed days										24.7	20.8	25.5	35.7	25.3	23.6	25.7	<30.2	
Number of MSSA bacteraemia cases	164	8	14	9	4	2	25	30	31	0	1	1	4	1	2	7	<=8	
MSSA – infection rate per 100,000 bed days									31	0	3.5	3.6	14.3	3.6	2.4	5	<=12.7	
Number of ecoli cases	295	28	32	25	4	3	39	41	44	5	4	5	1	4	14	19	No target	
Number of pseudomona cases	59	3	3	3	1	0	11	12	12	1	0	0	2	1	1	4	No target	
Number of klebsiella cases	135	7	10	7	3	2	25	28	31	1	3	1	1	3	5	9	No target	
Number of bed days lost due to infection control outbreaks										40	66	83	70	136	186	395	<10	>30
Patient Safety Incidents																		
Number of patient safety alerts outstanding	5									5	1	0	0	0	0	5	Zero	
Number of falls per 1,000 bed days		6.3	7.5	7.3	6.8	7.2	6.8	7.1	6	6.6	6	5.3	6.6	5.5			<=6	
Number of falls resulting in harm (moderate/severe)	8	6	9	8	6	8	8	2	7	3	4	2	7	1			<=3	
Number of patient safety incidents – severe harm (major/death)	1	1	2	1	0	1	0	3	7	13	7	9	4	12			No target	
Medication error resulting in severe harm									0	0	0	0	0	0			No target	
Medication error resulting in moderate harm									1	1	3	0	2	3			No target	
Medication error resulting in low harm									12	10	15	10	11	11			No target	
Number of category 2 pressure ulcers acquired as in-patient		31								43	36	28	38	36			<=30	
Number of category 3 pressure ulcers acquired as in-patient		7								10	7	7	6	6			<=5	

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Trust Scorecard – Safe (2)

	18/19	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	19/20 Q1	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			<=3	
Number of deep tissue injury pressure ulcers acquired as in-patient									6	10	14	2	8	7			<=5	
RIDDOR																		
Number of RIDDOR		2	5	4	1	4	1	3	3	2	2	1	3	2	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		97.70%	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%	<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%			64.00%		>=90%	<50%
Serious Incidents																		
Number of never events reported	1	0	0	0	0	0	0	0	1	1	0	0	1	0			Zero	
Number of serious incidents reported		4	4	2	1	1	3	0	3	2	3	4	2	1			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%	94.60%	93.80%	94.80%	95.40%	90.70%	96.60%	94.20%	94.80%	95.40%	88.60%	95.80%	96.70%	92.90%	93.20%	93.40%	>95%	

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Trust Scorecard – Effective (1)

	18/19	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	19/20 Q1	19/20	Standard	Threshold
Dementia Screening																		
% of patients who have been screened for dementia (within 72 hours)	1.90%	3.50%	2.30%	1.80%	2.60%	3.30%	1.90%	0.80%	0.60%	0.40%	0.30%	67.00%	66.00%				>=90%	<70%
% of patients who have scored positively on dementia screening tool that then received a dementia diagnostic assessment (within 72 hours)	27.90%	41.20%	18.20%	33.30%	22.20%	26.30%	40.00%	0.00%	33.30%	100%	50.00%	0.00%	0.00%				>=90%	<70%
% of patients who have received a dementia diagnostic assessment with positive or inconclusive results that were then referred for further diagnostic advice/FU (within 72 hours)	2.80%	12.50%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%						>=90%	<70%
Maternity																		
% C-section rate (planned and emergency)	26.78%								29.71%	28.93%	30.20%	29.19%	32.49%	25.61%	29.76%	29.32%	<=25%	>=27%
% emergency C-section rate	14.13%								16.11%	16.31%	16.73%	15.78%	17.42%	14.02%	15.97%	16.14%	No target	
% of women booked by 12 weeks gestation	89.80%	86.60%	90.20%	89.40%	90.90%	89.60%	89.80%	90.50%	91.50%	89.70%	88.00%	87.90%	89.00%	85.30%	89.30%	88.20%	>90%	
% of women that have an induced labour	29.19%								31.17%	29.13%	27.96%	28.99%	28.38%	26.83%	28.75%	28.26%	<=20%	>25%
% of women smoking at delivery	11.21%	11.97%	9.76%	12.43%	12.18%	12.28%	7.79%	13.05%	10.46%	12.06%	11.22%	11.83%	9.78%	10.16%	11.71%	11.01%	<=14.5%	
% stillbirths as percentage of all pregnancies > 24 weeks	0.26%								0.21%	0.39%	0.00%	0.00%	0.38%	0.20%	0.10%	0.20%	<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	98.1	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	96.6	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	490	739	No target	
Number of deaths of patients with a learning disability									2	4	1	1	2	2	6	10	No target	
Readmissions																		
Emergency re-admissions within 30 days following an elective or emergency spell	6.90%	7.20%	6.80%	7.10%	6.10%	7.10%	6.70%	6.90%	6.30%	7.40%	7.10%	6.40%	6.30%		7.00%	6.80%	<8.25%	>8.75%
Research																		
Research accruals	1,621	147	121	199	96	84	71	81	91	115	119	134	123	103	435		No target	

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Trust Scorecard – Effective (2)

	18/19	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	19/20 Q1	19/20	Standard	Threshold
Stroke Care																		
Stroke care: percentage of patients receiving brain imaging within 1 hour	36.90%	47.00%	41.50%	34.30%	26.60%	31.90%	37.10%	32.70%	22.40%	52.10%	55.30%	43.80%	53.50%	50.60%	50.20%	51.00%	>=50%	<45%
Stroke care: percentage of patients spending 90%+ time on stroke unit	90.80%	97.20%	93.40%	80.70%	87.70%	91.90%	88.70%	84.10%	87.70%	85.70%	96.30%	87.10%	80.90%		89.70%	87.20%	>=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%	64.10%	65.80%	>=80%	<72%
% patients receiving a swallow screen within 4 hours of arrival									70.70%	52.10%	59.20%	63.80%	66.30%	64.90%	58.60%	61.50%	>=90%	<80%
Trauma & Orthopaedics																		
% of fracture neck of femur patients treated within 36 hours	76.00%	88.70%	85.50%	67.70%	70.10%	75.00%	83.90%	85.60%	77.80%	77.00%	81.80%	82.20%	67.10%	46.60%	80.00%	76.50%	>=90%	<80%
% fractured neck of femur patients meeting best practice criteria									77.78%	77.78%	81.82%	80.49%	65.70%	45.21%	78.92%	75.29%	>=65%	<55%

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Trust Scorecard – Caring

	18/19	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	19/20 Q1	19/20	Standard	Threshold
Friends & Family Test																		
Inpatients % positive	91.20%	90.70%	91.90%	92.20%	90.90%	91.50%	91.90%	89.20%	91.50%	89.10%	90.80%	91.60%	90.70%	91.10%	90.50%	90.70%	>=96%	<93%
ED % positive	83.10%	82.00%	85.90%	82.70%	82.70%	81.00%	82.70%	82.80%	82.70%	82.70%	81.90%	85.30%	79.80%	83.30%	83.20%	82.60%	>=84%	<81%
Maternity % positive	96.70%	94.70%	0.00%	100%	98.20%	100%	100%	93.50%	97.50%	96.60%	97.00%	87.10%	96.20%	100%	93.50%	95.50%	>=97%	<94%
Outpatients % positive	92.60%	91.90%	92.30%	93.00%	92.50%	92.90%	93.40%	92.50%	93.10%	92.80%	93.20%	92.50%	92.80%	93.20%	92.80%	92.90%	>=94%	<91%
Total % positive	91.20%	90.30%	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%	>=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%	76.91%	76.91%	>=90%	
Are you involved as much as you want to be in decisions about your care and treatment?										94.06%	89.44%	89.65%	90.61%	95.03%	90.55%	90.55%	>=90%	
Do you feel that you are treated with respect and dignity?										93.07%	97.16%	94.26%	96.09%	98.58%	95.12%	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%	96.65%	96.65%	>=90%	
Do you get enough help from staff to eat your meals?										95.96%	98.86%	95.93%	97.20%	97.17%	97.08%	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%	96.09%	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%	96.63%	96.63%	>=90%	
MSA																		
Number of breaches of mixed sex accommodation	68	6	0	7	2	6	2	1	3	4	11	18	16	11	33	60	<=10	>=20

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Trust Scorecard – Responsive (1)

	18/19	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	19/20 Q1	19/20	Standard	Threshold
Cancer																		
Cancer – urgent referrals seen in under 2 weeks from GP	90.00%	88.90%	82.80%	91.70%	90.40%	94.30%	92.00%	93.90%	95.20%	87.90%	86.50%	89.40%	92.70%	86.00%	87.80%	87.80%	>=93%	<90%
2 week wait breast symptomatic referrals	95.80%	97.80%	98.90%	99.20%	94.60%	97.70%	95.50%	97.00%	95.60%	96.90%	97.30%	99.00%	96.30%	98.40%	97.70%	97.70%	>=93%	<90%
Cancer – 31 day diagnosis to treatment (first treatments)	94.60%	96.90%	93.50%	93.30%	93.20%	94.20%	92.90%	91.60%	92.10%	92.00%	92.90%	93.50%	92.60%	92.40%	92.90%	92.60%	>=96%	<94%
Cancer – 31 day diagnosis to treatment (subsequent – drug)	99.90%	100%	98.80%	100%	100%	100%	100%	100%	100%	100%	96.20%	100%	100%	100%	98.60%	99.20%	>=98%	<96%
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	95.30%	95.70%	94.30%	98.30%	96.80%	92.90%	93.20%	96.60%	96.60%	94.00%	95.10%	100%	89.60%	89.40%	93.90%	91.60%	>=94%	<92%
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	99.30%	100%	100%	98.60%	98.70%	98.60%	100%	98.90%	98.70%	96.40%	97.50%	96.30%	100%	83.70%	97.50%	94.40%	>=94%	<92%
Cancer 62 day referral to treatment (urgent GP referral)	74.80%	76.30%	69.00%	69.40%	78.70%	74.90%	76.80%	66.20%	77.40%	79.70%	70.70%	66.50%	71.70%	72.90%	73.40%	73.20%	>=85%	<80%
Cancer 62 day referral to treatment (screenings)	96.50%	100%	85.50%	93.50%	93.80%	100%	94.10%	96.40%	100%	100%	96.60%	85.20%	84.60%	100%	93.60%	93.70%	>=90%	<85%
Cancer 62 day referral to treatment (upgrades)	68.90%	100%	75.00%	73.30%	58.80%	70.00%	71.40%	60.00%	77.30%	44.40%	57.10%	70.60%	100%	83.30%	54.50%	61.40%	>=90%	<85%
Number of patients waiting over 104 days with a TCI date	141	22	26	7	13	8	8	8	14	20	15	20	18	13	55	86	Zero	
Number of patients waiting over 104 days without a TCI date	347	24	30	39	37	27	42	37	25	19	30	21	37	32	70	139	<=24	
Diagnostics																		
% waiting for diagnostics 6 week wait and over (15 key tests)	0.45%	1.27%	0.63%	0.03%	0.35%	0.20%	0.67%	0.21%	0.45%	0.54%	0.67%	1.08%	0.76%	0.84%	1.08%	0.84%	<=1%	>2%
The number of planned / surveillance endoscopy patients waiting at month end	726	407	576	630	680	686	639	600	726	835	872	966	770	714	966	714	<=600	
Discharge																		
Number of patients delayed at the end of each month	37	44	41	44	40	34	29	24	43	45	39	18	43	41	18	41	<=38	
Patient discharge summaries sent to GP within 24 hours	50.50%	49.60%	51.80%	51.60%	49.10%	47.20%	51.90%	49.60%	51.00%	56.60%	54.60%	53.30%	57.90%		54.80%	55.60%	>=88%	<75%

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Trust Scorecard – Responsive (2)

	18/19	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	19/20 Q1	19/20	Standard	Threshold
Emergency Department																		
ED: % total time in department – under 4 hours (type 1)	89.60%	90.26%	89.01%	90.54%	91.59%	87.55%	84.46%	86.08%	87.13%	86.01%	87.99%	86.80%	88.53%	88.16%	86.95%	87.46%	>=95%	<90%
ED: % total time in department – under 4 hours (types 1 & 3)	92.78%	93.45%	92.47%	93.60%	93.98%	91.29%	89.02%	90.21%	91.00%	90.39%	91.70%	91.05%	92.20%	92.01%	91.06%	91.41%	>=95%	<90%
ED: % total time in department – under 4 hours CGH	96.40%	96.00%	96.40%	96.90%	96.94%	95.47%	93.70%	95.50%	96.10%	94.66%	96.04%	96.40%	95.44%	96.20%	95.37%	95.33%	>=95%	<90%
ED: % total time in department – under 4 hours GRH	86.20%	87.40%	85.20%	87.30%	89.06%	83.82%	80.10%	81.60%	82.80%	81.89%	84.16%	82.77%	85.09%	84.25%	82.95%	83.67%	>=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%	90.70%	87.30%	88.80%	89.60%	85.40%	85.20%	83.60%	78.40%	75.80%	78.30%	77.30%	71.30%	75.70%	77.20%	75.60%	>=95%	<92%
ED: % of time to start of treatment – under 60 minutes	33.50%	34.30%	29.00%	36.70%	34.50%	32.10%	34.90%	32.40%	32.60%	32.00%	35.90%	37.20%	30.30%	31.20%	35.00%	33.80%	>=90%	<87%
% of ambulance handovers that are over 30 minutes									7.90%	1.66%	1.28%	1.01%	1.25%	1.93%	1.25%	1.37%	<=2.96%	
% of ambulance handovers that are over 60 minutes									0.10%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	<=1%	>2%
Operational Efficiency																		
Number of patients stable for discharge	73	75	80	75	76	69	74	72	77	86	77	63	79	88	75	79	<=70	
% of bed days lost due to delays										4.74%	3.78%	2.24%	3.42%	4.26%	2.24%	4.26%	<=3.5%	>4%
Number of stranded patients with a length of stay of greater than 7 days	384	382	376	374	382	374	399	412	397	389	391	370	371	360	383	376	<=380	
Average length of stay (spell)	5.05	5.11	5	5.05	5.14	4.83	5.14	5.35	4.98	5.03	5.35	4.85	4.87	4.8	5.08	4.98	<=5.06	
Length of stay for general and acute non-elective (occupied bed days) spells	5.66	5.62	5.58	5.72	5.77	5.29	5.7	6.07	5.67	5.53	5.99	5.42	5.5	5.3	5.65	5.55	<=5.65	
Length of stay for general and acute elective spells (occupied bed days)	2.71	3	2.75	2.47	2.84	2.89	2.59	2.67	2.55	2.78	2.68	2.55	2.56	2.71	2.67	2.65	<=3.4	>4.5
% day cases of all electives									84.60%	80.00%	86.28%	85.92%	85.91%	86.04%	84.15%	84.87%	>80%	<70%
Intra-session theatre utilisation rate									84.70%	87.80%	88.49%	85.50%	87.30%	87.50%	85.00%	87.20%	>85%	<70%
Outpatient																		
Outpatient new to follow up ratio's									1.93	1.92	1.91	1.9	1.87	1.9	1.91	1.9	<=1.9	
Did not attend (DNA) rates									6.40%	6.80%	6.80%	6.80%	7.00%	7.00%	6.80%	6.90%	<=7.6%	>10%

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Trust Scorecard – Responsive (3)

	18/19	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	19/20 Q1	19/20	Standard Threshold
RTT																	
Referral to treatment ongoing pathways under 18 weeks (%)	79.75%								79.75%	79.46%	80.63%	81.11%	81.80%	81.41%	81.11%	81.41%	>=92%
Referral to treatment ongoing pathways 35+ Weeks (number)	2,352								2,352	2,163	2,149	1,953	1,772	1,703	1,953	1,703	No target
Referral to treatment ongoing pathways 40+ Weeks (number)	1,860								1,860	1,699	1,748	1,626	1,437	1,378	1,626	1,378	No target
Referral to treatment ongoing pathways over 52 weeks (number)	95	125	105	103	105	97	89	97	95	93	91	90	78	77	90	77	Zero
SUS																	
Percentage of records submitted nationally with valid GP code	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	99.90%	100%	100%		99.90%	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%	99.80%	99.90%	99.40%	99.80%	99.80%		99.50%	99.70%	>=99%

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Trust Scorecard – Well Led

	18/19	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	19/20 Q1	19/20	Standard	Threshold
Appraisal and Mandatory Training																		
Trust total % overall appraisal completion	79%	75%	79%	80%	79%	79%	79%	79%	81%	80%	81%	82%	83%	81%		81%	>=90%	<70%
Trust total % mandatory training compliance	89%	88%	90%	91%	91%	91%	89%	89%	91%	91%	91%	92%	92%	92%		92%	>=90%	<70%
Finance																		
Total PayBill Spend		30.5	27.5	29.5	29.03	29.7	29.4	29.9	33.3	31.8	30.8	30.9	30.7	31.7				
YTD Performance against Financial Recovery Plan		0.2	0.2	0.2	0.4	0.04	-3	-6.6	-14.1	0.2	0.3	0.6	0.5	0.5				
Cost Improvement Year to Date Variance		2,342	2,975	2,994	2,013	1,593	0	-1,784	-3,378	0	1	1	2	2				
NHSI Financial Risk Rating		4	4	4	4	4	3	4	4	4	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		2	3	3	3	3	3	3	3	3	3	4	3	3				
Safe Nurse Staffing																		
Overall % of nursing shifts filled with substantive staff										96.55%	96.40%	95.10%	97.40%	95.40%	96.00%	96.20%	>=75%	<70%
% registered nurse day										97.90%	97.90%	96.60%	98.70%	96.50%	97.50%	97.50%	>=90%	<80%
% unregistered care staff day										97.00%	99.20%	99.40%	101.0%	99.40%	98.50%	99.20%	>=90%	<80%
% registered nurse night										94.10%	93.50%	92.40%	94.80%	93.30%	93.30%	93.60%	>=90%	<80%
% unregistered care staff night										100.3%	99.40%	104.8%	105.7%	105.3%	101.5%	103.1%	>=90%	<80%
Care hours per patient day RN									6.2	4.61	4.6	4.7	4.8	4.7	4.6	4.7	>=5	
Care hours per patient day HCA									3.2	2.8	2.9	3	3	3	2.9	2.9	>=3	
Care hours per patient day total	7.1	7.2	6.8	7.2	7.1	7.3	7.3	7.2	8.1	7.4	7.5	7.7	7.8	7.6	7.5	7.6	>=8	
Vacancy and WTE																		
% total vacancy rate										9.03%	10.02%	9.54%	8.65%	8.60%			<=11.5%	>13%
% vacancy rate for doctors										8.07%	8.86%	8.53%	8.20%	8.20%			<=5%	>5.5%
% vacancy rate for registered nurses										12.09%	9.52%	9.42%	8.65%	8.65%			<=5%	>5.5%
Staff in post FTE										6181.16	6150.11	6148.56	6171.97	6233.23			No target	
Vacancy FTE										610	683	650	652.42	650			No target	
Starters FTE										65.5	52.8	45.2	66.66	60			No target	
Leavers FTE										55.14	37.5	57.4	44.69	45			No target	
Workforce Expenditure and Efficiency																		
% turnover	11.80%	12.00%	12.10%	11.90%	11.60%	11.70%	11.70%	11.90%	12.20%	11.80%	11.60%	11.60%	11.80%	11.90%			<=11%	>15%
% turnover rate for nursing	10.99%									1.09%	10.93%	10.87%	10.99%	11.00%			<=11%	>15%
% sickness rate	3.90%	3.90%	3.90%	3.90%	3.90%	3.90%	3.90%	3.90%	3.90%	3.90%	3.40%	3.80%	3.80%	3.80%			<=3.5%	>4%

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Exception Reports – Safe (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of adult inpatients who have received a VTE risk assessment Standard: >95%		The national target for VTE risk assessment is 95%, over the past 9 months the clinical audit results has demonstrated a consistent system with data ranging from 92-96%. The VTE committee are currently reviewing the policy against the new NICE guidance which will affect future results.	Director of Safety
Number of bed days lost due to infection control outbreaks Standard: <10		Beddays lost during August were due to an outbreak of CDI on Snowshill ward. The ward was closed to bring about outbreak control.	Associate Chief Nurse and Deputy Director of Infection Prevention and Control
Number of category 2 pressure ulcers acquired as in-patient Standard: <=30		During August 2019 there were 36 hospital acquired category 2 pressure ulcers sustained in patients across 22 wards. High incidence was recorded on 4b, 8b and AMU. Hospital acquired category 2 pressure ulcers are reviewed by ward teams to identify learning. The Trust is involved in an NHS Improvement collaborative to reduce the incidence of category 2 pressure sores in AMU. Medicine and Surgery have plans to respond and reduce pressure ulcers. A Preventing Harm Summit is being planned for September to identify key areas of focus and drive rapid improvements across the trust.	Deputy Nursing Director & Divisional Nursing Director - Surgery

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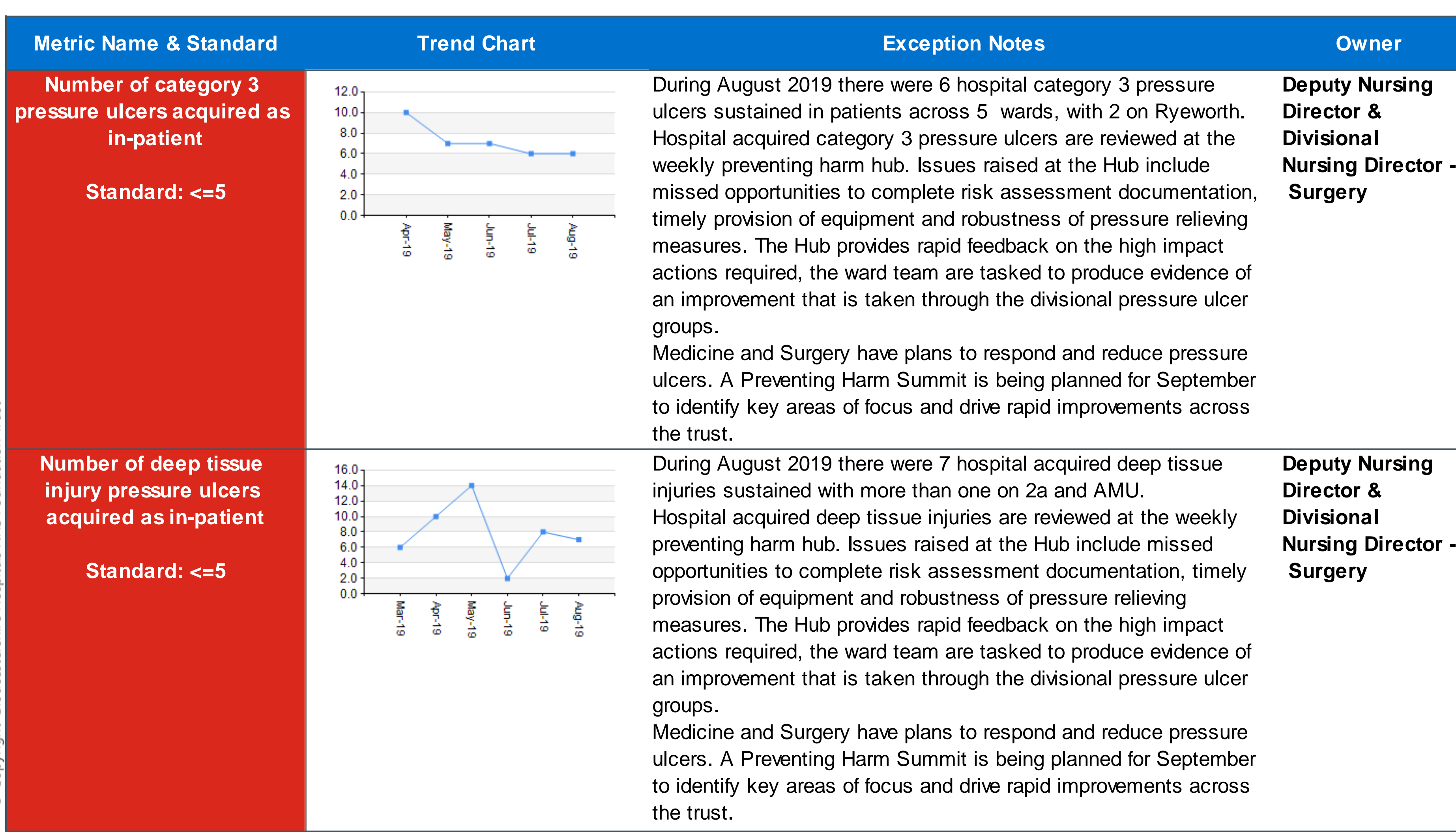
Exception Reports – Safe (2)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of category 3 pressure ulcers acquired as in-patient **Standard: <=5**	12.0, 10.0, 8.0, 6.0, 4.0, 2.0, 0.0 Apr-19, May-19, Jun-19, Jul-19, Aug-19	During August 2019 there were 6 hospital category 3 pressure ulcers sustained in patients across 5 wards, with 2 on Ryeworth. Hospital acquired category 3 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. A Preventing Harm Summit is being planned for September to identify key areas of focus and drive rapid improvements across the trust.	**Deputy Nursing Director & Divisional Nursing Director - Surgery**
Number of deep tissue injury pressure ulcers acquired as in-patient **Standard: <=5**	16.0, 14.0, 12.0, 10.0, 8.0, 6.0, 4.0, 2.0, 0.0 Mar-19, Apr-19, May-19, Jun-19, Jul-19, Aug-19	During August 2019 there were 7 hospital acquired deep tissue injuries sustained with more than one on 2a and AMU. Hospital acquired deep tissue injuries 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. A Preventing Harm Summit is being planned for September to identify key areas of focus and drive rapid improvements across the trust.	**Deputy Nursing Director & Divisional Nursing Director - Surgery**

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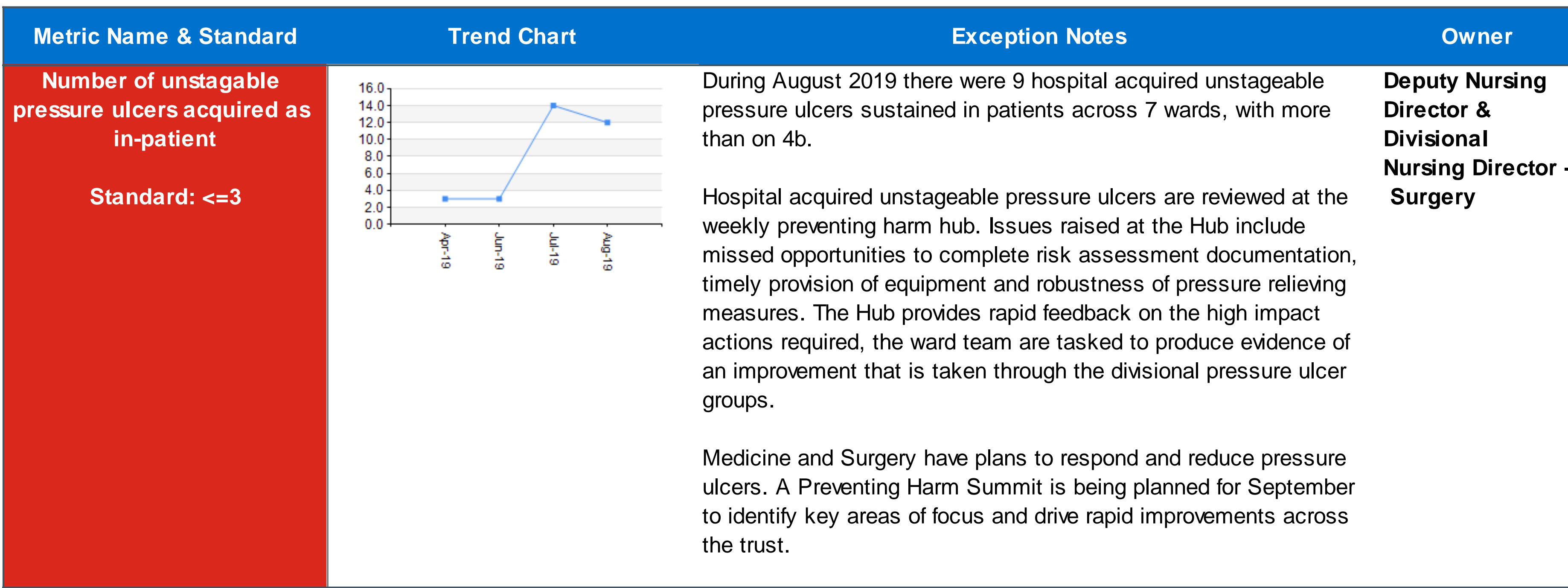
Exception Reports – Safe (3)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of unstagable pressure ulcers acquired as in-patient **Standard: <=3**		During August 2019 there were 9 hospital acquired unstageable pressure ulcers sustained in patients across 7 wards, with more than on 4b. 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. A Preventing Harm Summit is being planned for September to identify key areas of focus and drive rapid improvements across the trust.	**Deputy Nursing Director & Divisional Nursing Director - Surgery**

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Exception Reports – Effective (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% fractured neck of femur patients meeting best practice criteria Standard: >=65%	100.00% 80.00% 60.00% 40.00% 20.00% 0.00% Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19	Significant increases in demand in the last 6 months circa 30% have resulted in pressure on trauma times, an action plan has been requested from the service line for review at Divisional Board on Monday 23/09. Additional trauma lists and potential changes to elective lists to support demand are being arranged. Linked to support for fracture clinic increases, which has been raised with commissioners.	Director of Operations - Surgery
% of fracture neck of femur patients treated within 36 hours Standard: >=90%	100.00% 80.00% 60.00% 40.00% 20.00% 0.00% Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19	Significant increases in demand in the last 6 months circa 30% have resulted in pressure on trauma times, an action plan has been requested from the service line for review at Divisional Board on Monday 23/09. Additional trauma lists and potential changes to elective lists to support demand are being arranged. Linked to support for fracture clinic increases, which has been raised with commissioners.	Director of Operations - Surgery
% of patients admitted directly to the stroke unit in 4 hours Standard: >=80%	80.00% 60.00% 40.00% 20.00% 0.00% Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19	52 patients were admitted onto the Stroke unit within the 4 hour target and 24 patients breached this target. The majority of breaches were due to the same issue - non-stroke patients on the unit meaning the patient had to be held on AMU to wait for a stroke specialist bed to become available. This is symptomatic of wider bed pressures leading to excessive medical patients that needed an inpatient bed.	Director of Unscheduled Care and Deputy Chief Operating Officer

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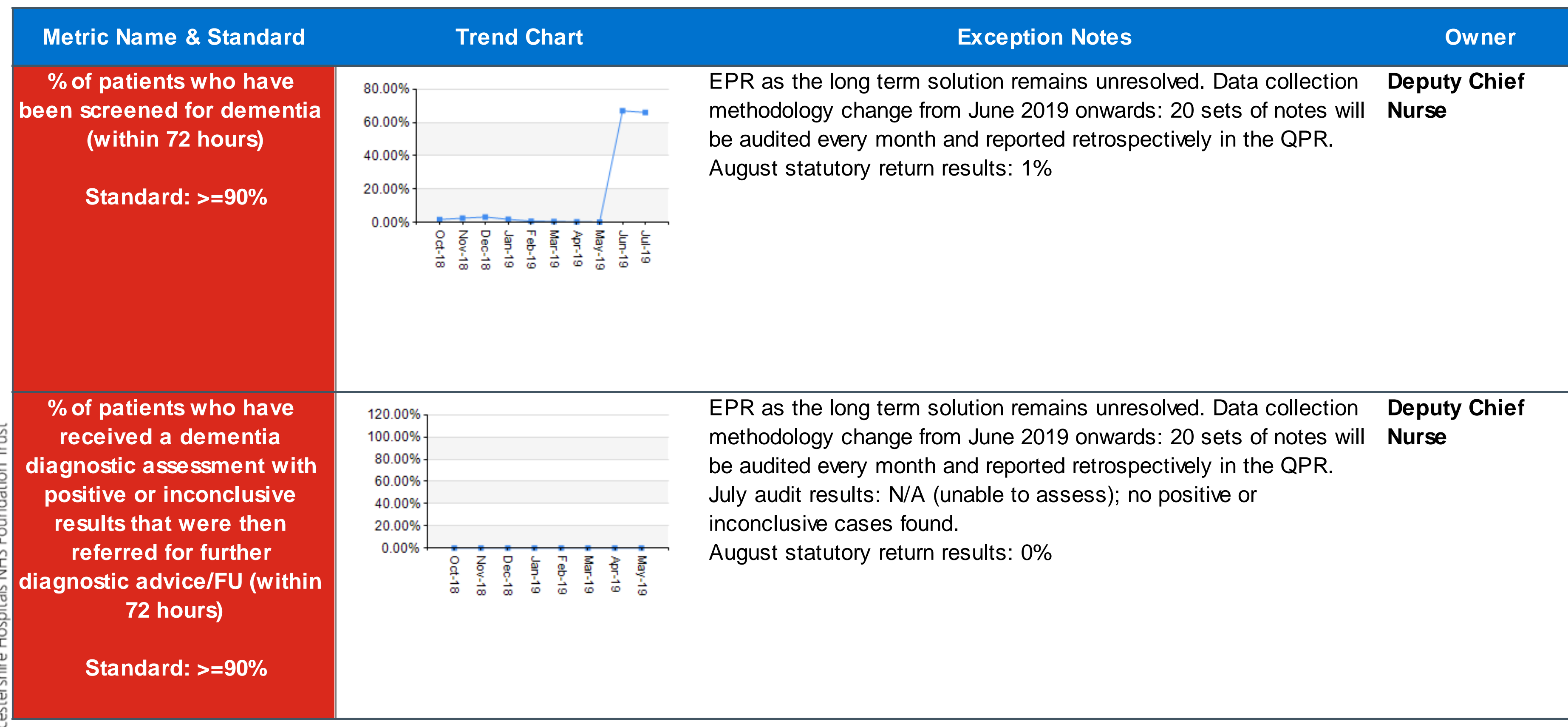
Exception Reports – Effective (2)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of patients who have been screened for dementia (within 72 hours) **Standard: >=90%**		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. August statutory return results: 1%	**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. July audit results: N/A (unable to assess); no positive or inconclusive cases found. August statutory return results: 0%	**Deputy Chief Nurse**

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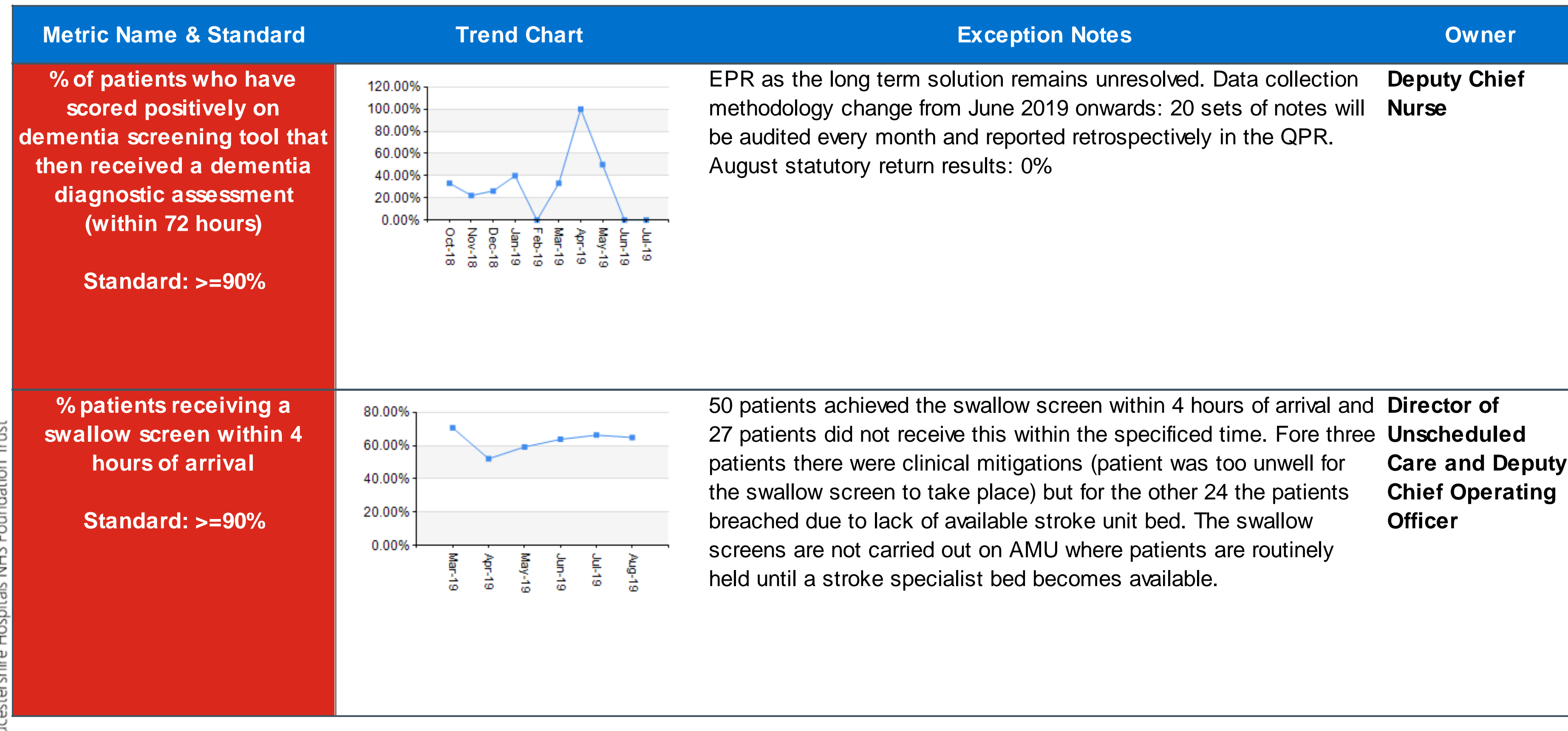
Exception Reports – Effective (3)



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%**	120.00% 100.00% 80.00% 60.00% 40.00% 20.00% 0.00% Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19	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. August statutory return results: 0%	**Deputy Chief Nurse**
% patients receiving a swallow screen within 4 hours of arrival **Standard: >=90%**	80.00% 60.00% 40.00% 20.00% 0.00% Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19	50 patients achieved the swallow screen within 4 hours of arrival and 27 patients did not receive this within the specificed time. Fore three patients there were clinical mitigations (patient was too unwell for the swallow screen to take place) but for the other 24 the patients breached due to lack of available stroke unit bed. The swallow screens are not carried out on AMU where patients are routinely held until a stroke specialist bed becomes available.	**Director of Unscheduled Care and Deputy Chief Operating Officer**

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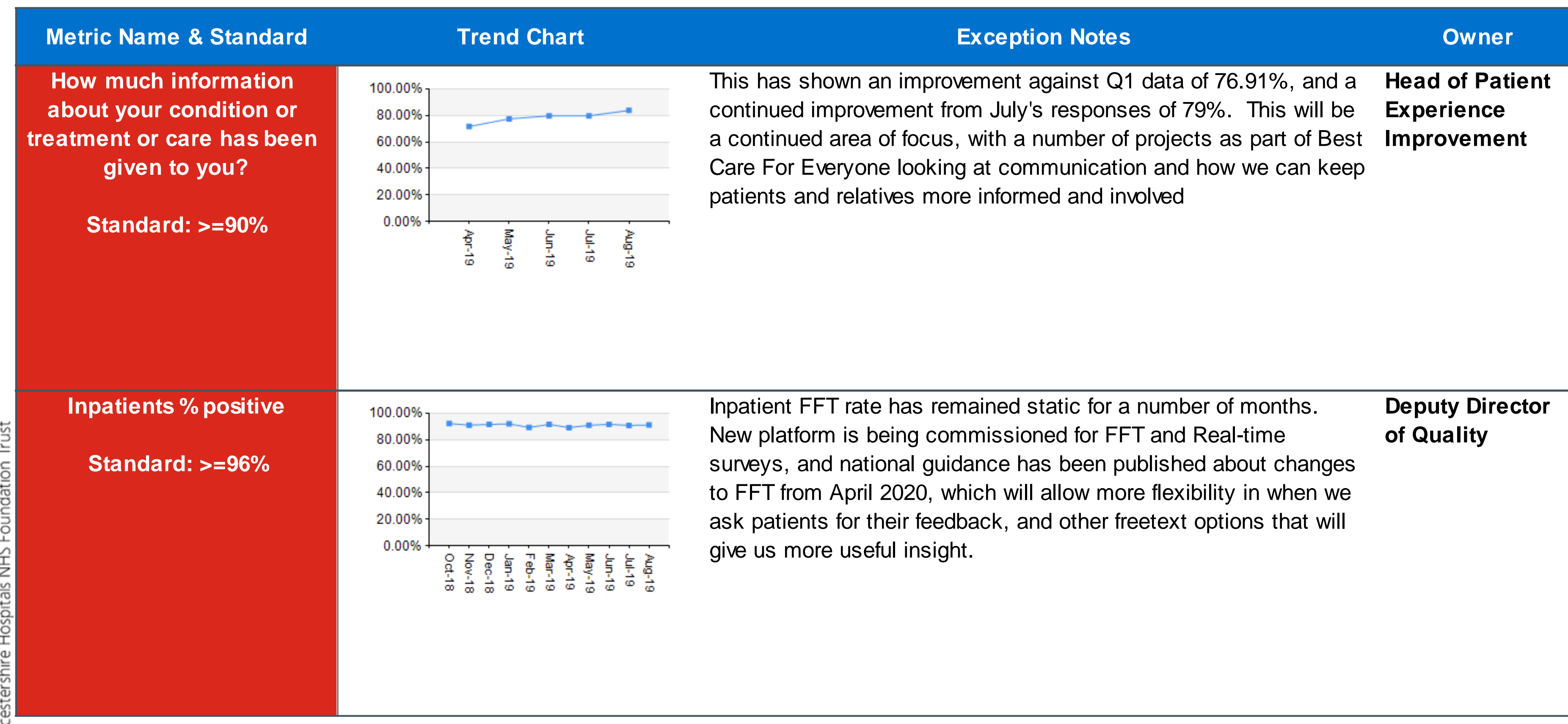
Exception Reports – Caring (1)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
How much information about your condition or treatment or care has been given to you? Standard: >=90%		This has shown an improvement against Q1 data of 76.91%, and a continued improvement from July's responses of 79%. This will be a continued area of focus, with a number of projects as part of Best Care For Everyone looking at communication and how we can keep patients and relatives more informed and involved	**Head of Patient Experience Improvement**
Inpatients % positive Standard: >=96%		Inpatient FFT rate has remained static for a number of months. New platform is being commissioned for FFT and Real-time surveys, and national guidance has been published about changes to FFT from April 2020, which will allow more flexibility in when we ask patients for their feedback, and other freetext options that will give us more useful insight.	**Deputy Director of Quality**

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Exception Reports – Responsive (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of bed days lost due to delays Standard: <=3.5%		High admissions during month-which led to increase in ASC (Adult Social Care)referrals. Less DTA(Discharge To Assess)beds available Less care available in community-private providers taking holidays 3 care homes have shut in 1 particular area leading to capacity issues. Increased levels of homeless patients who were vulnerable and had care needs	**Director of Unscheduled Care and Deputy Chief Operating Officer**
Cancer – 31 day diagnosis to treatment (first treatments) Standard: >=96%		GHFT performance 92.4% National performance 96.5% 274 tx 20 breaches 18 breaches in Urology	**Director of Planned Care and Deputy Chief Operating Officer**
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy) Standard: >=94%		GHFT performance 83.7% National performance 97.1% 86 tx 14 breaches 14 breaches in breast due to radiographer capacity issue	**Director of Planned Care and Deputy Chief Operating Officer**

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Exception Reports – Responsive (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Cancer – 31 day diagnosis to treatment (subsequent – surgery) **Standard: >=94%**		GHFT performance 89.4% National performance 92.2% 47 txt 5 breaches 4 breaches in urology	**Director of Planned Care and Deputy Chief Operating Officer**
Cancer – urgent referrals seen in under 2 weeks from GP **Standard: >=93%**		GHFT performance 86.0% National performance 90.9% DFS 1988 breaches - 279 216 from dermatology due to excessive demand in July 2ww performance meeting standard in September (un validated)	**Director of Planned Care and Deputy Chief Operating Officer**
Cancer 62 day referral to treatment (upgrades) **Standard: >=90%**		GHFT performance 83.3% National performance 83.4% tx 3.5 0.5 breaches	**Director of Planned Care and Deputy Chief Operating Officer**

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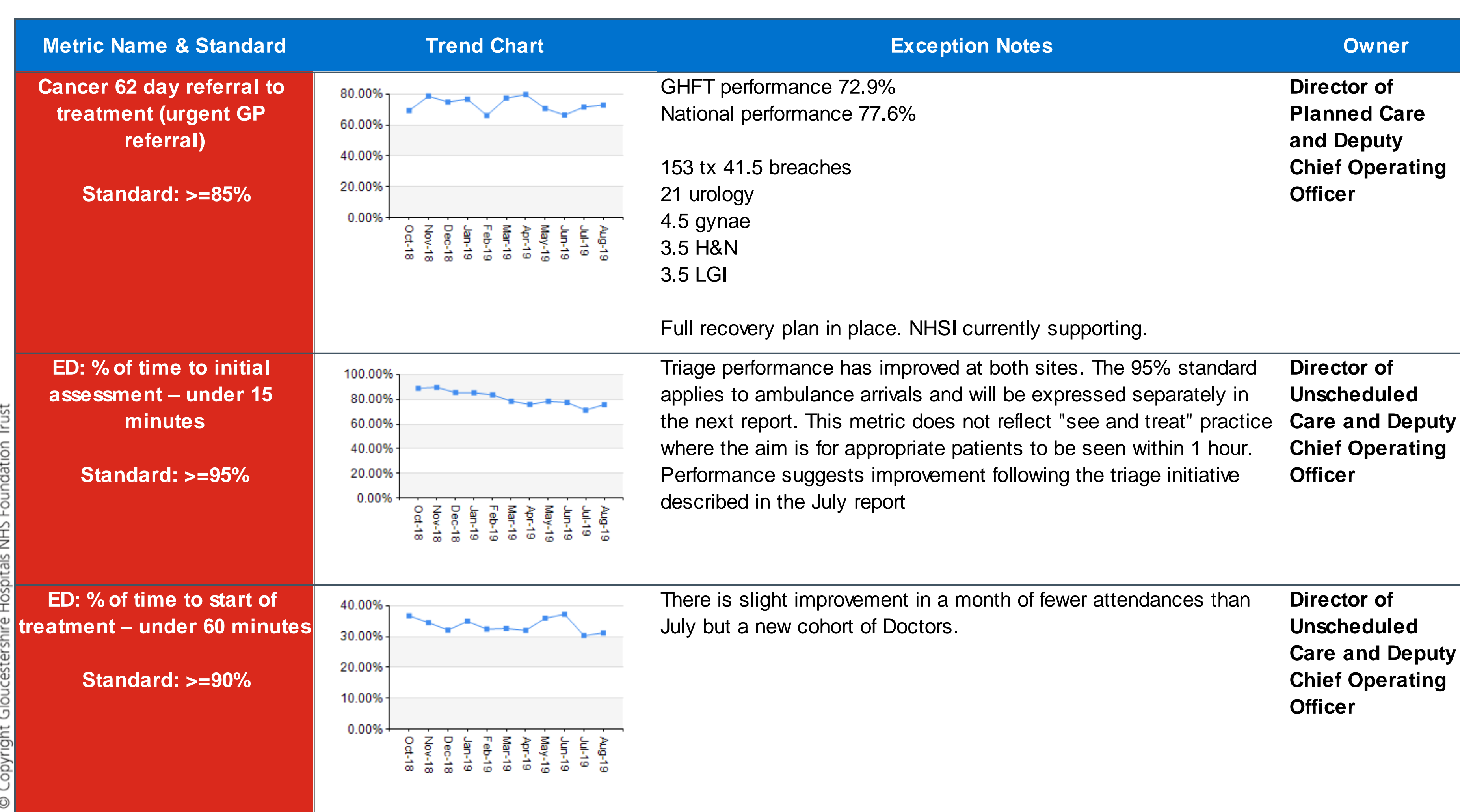
Exception Reports – Responsive (3)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
Cancer 62 day referral to treatment (urgent GP referral) Standard: >=85%		GHFT performance 72.9% National performance 77.6% 153 tx 41.5 breaches 21 urology 4.5 gynae 3.5 H&N 3.5 LGI Full recovery plan in place. NHSI currently supporting.	Director of Planned Care and Deputy Chief Operating Officer
ED: % of time to initial assessment – under 15 minutes Standard: >=95%		Triage performance has improved at both sites. The 95% standard applies to ambulance arrivals and will be expressed separately in the next report. This metric does not reflect "see and treat" practice where the aim is for appropriate patients to be seen within 1 hour. Performance suggests improvement following the triage initiative described in the July report	Director of Unscheduled Care and Deputy Chief Operating Officer
ED: % of time to start of treatment – under 60 minutes Standard: >=90%		There is slight improvement in a month of fewer attendances than July but a new cohort of Doctors.	Director of Unscheduled Care and Deputy Chief Operating Officer

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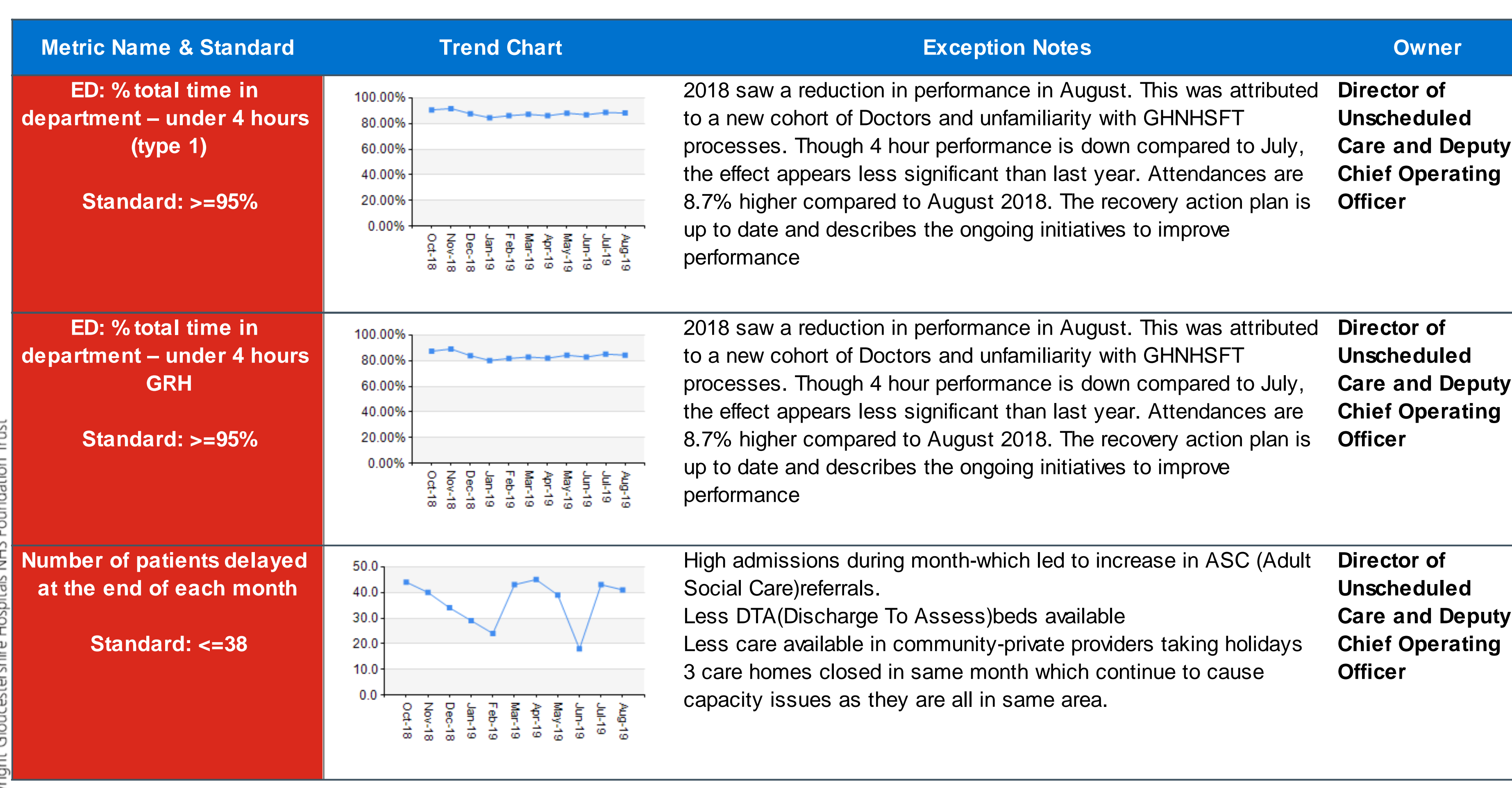
Exception Reports – Responsive (4)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % total time in department – under 4 hours (type 1) **Standard: >=95%**		2018 saw a reduction in performance in August. This was attributed to a new cohort of Doctors and unfamiliarity with GHNHSFT processes. Though 4 hour performance is down compared to July, the effect appears less significant than last year. Attendances are 8.7% higher compared to August 2018. The recovery action plan is up to date and describes the ongoing initiatives to improve performance	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % total time in department – under 4 hours GRH **Standard: >=95%**		2018 saw a reduction in performance in August. This was attributed to a new cohort of Doctors and unfamiliarity with GHNHSFT processes. Though 4 hour performance is down compared to July, the effect appears less significant than last year. Attendances are 8.7% higher compared to August 2018. The recovery action plan is up to date and describes the ongoing initiatives to improve performance	**Director of Unscheduled Care and Deputy Chief Operating Officer**
Number of patients delayed at the end of each month **Standard: <=38**		High admissions during month-which led to increase in ASC (Adult Social Care)referrals. Less DTA(Discharge To Assess)beds available Less care available in community-private providers taking holidays 3 care homes closed in same month which continue to cause capacity issues as they are all in same area.	**Director of Unscheduled Care and Deputy Chief Operating Officer**

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Exception Reports – Responsive (5)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of patients stable for discharge Standard: <=70		High admissions during month-which led to increase in ASC (Adult Social Care)referrals. Less DTA(Discharge To Assess)beds available Less care available in community-private providers taking holidays 3 private providers for Nursing home and care home beds have closed down, leading to particular shortages in those areas Higher then average numbers of homeless patients who are identified as vulnerable and needing support	Director of Unscheduled Care and Deputy Chief Operating Officer
Number of patients waiting over 104 days with a TCI date Standard: Zero		Number of patients waiting over 104 days with a TCI date 13 Weekly check and challenge 104 email out to clinicians Revised long waiting cancer patient policy	Director of Planned Care and Deputy Chief Operating Officer
Number of patients waiting over 104 days without a TCI date Standard: <=24		Number of patients waiting over 104 days without a TCI date 32	Director of Planned Care and Deputy Chief Operating Officer

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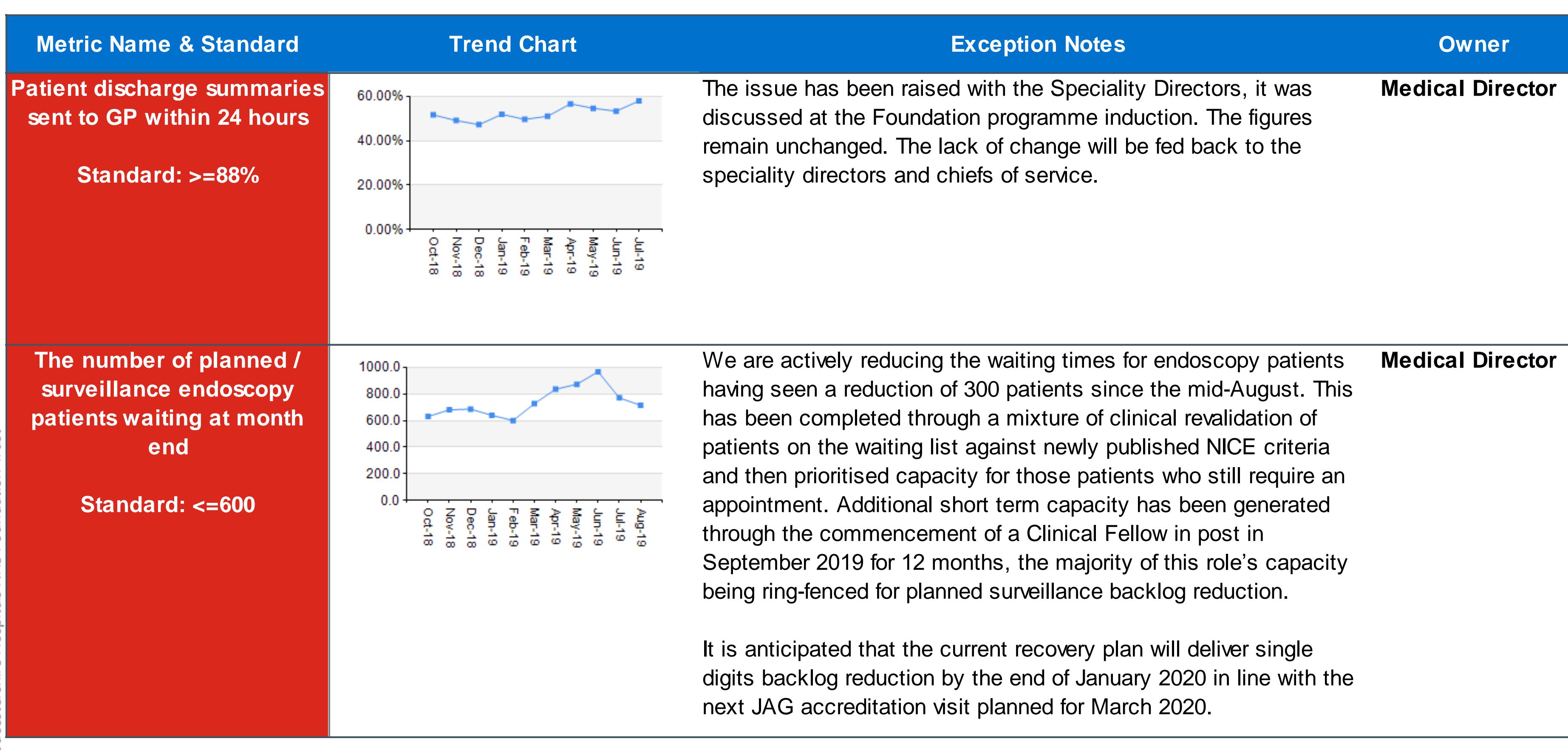
Exception Reports – Responsive (6)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
Patient discharge summaries sent to GP within 24 hours **Standard: >=88%**	60.00% 40.00% 20.00% 0.00% Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19	The issue has been raised with the Speciality Directors, it was discussed at the Foundation programme induction. The figures remain unchanged. The lack of change will be fed back to the speciality directors and chiefs of service.	**Medical Director**
The number of planned / surveillance endoscopy patients waiting at month end **Standard: <=600**	1000.0 800.0 600.0 400.0 200.0 0.0 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19	We are actively reducing the waiting times for endoscopy patients having seen a reduction of 300 patients since the mid-August. This has been completed through a mixture of clinical revalidation of patients on the waiting list against newly published NICE criteria and then prioritised capacity for those patients who still require an appointment. Additional short term capacity has been generated through the commencement of a Clinical Fellow in post in September 2019 for 12 months, the majority of this role's capacity being ring-fenced for planned surveillance backlog reduction. It is anticipated that the current recovery plan will deliver single digits backlog reduction by the end of January 2020 in line with the next JAG accreditation visit planned for March 2020.	**Medical Director**

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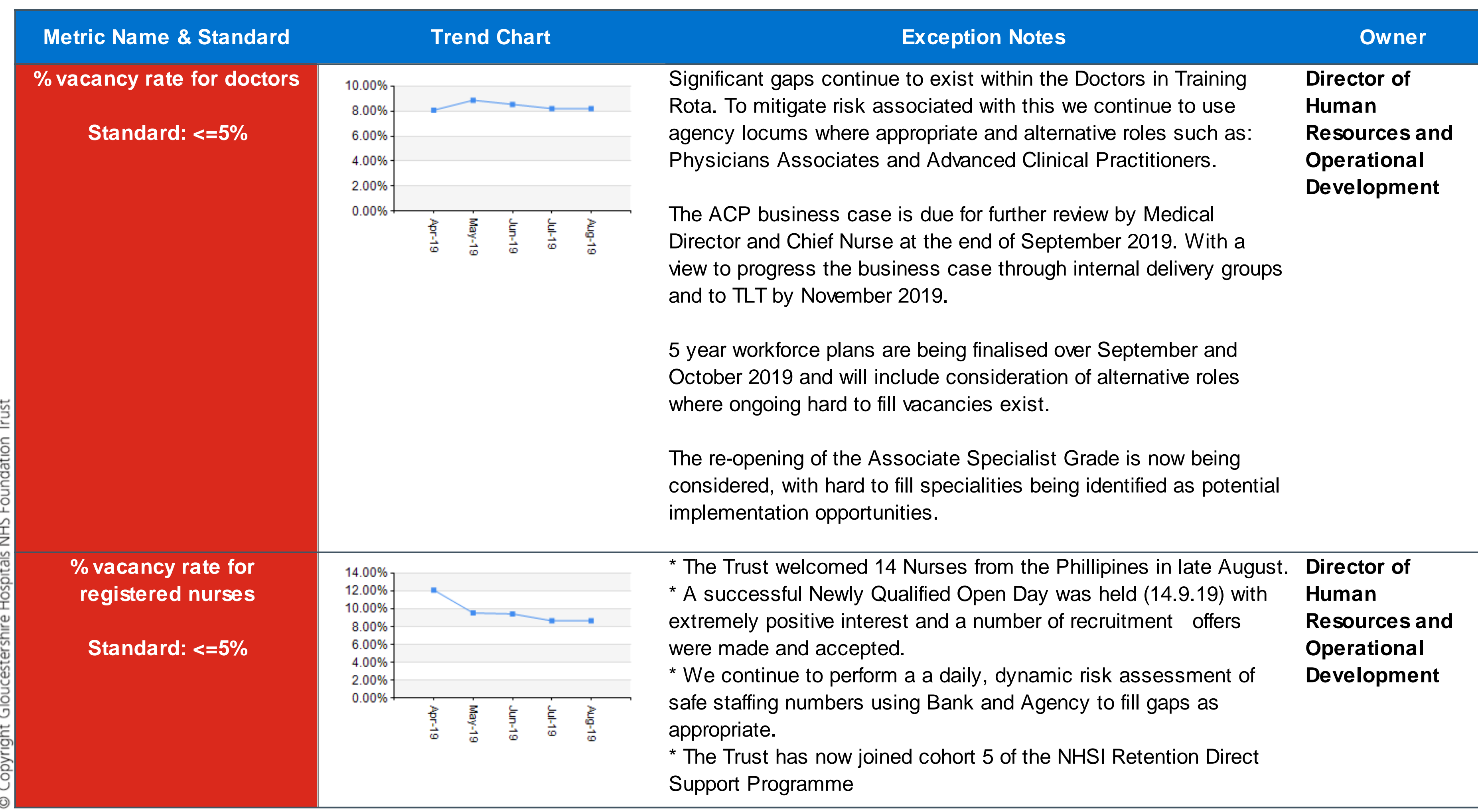
Exception Reports – Well Led (1)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
% vacancy rate for doctors **Standard: <=5%**		Significant gaps continue to exist within the Doctors in Training Rota. To mitigate risk associated with this we continue to use agency locums where appropriate and alternative roles such as: Physicians Associates and Advanced Clinical Practitioners. The ACP business case is due for further review by Medical Director and Chief Nurse at the end of September 2019. With a view to progress the business case through internal delivery groups and to TLT by November 2019. 5 year workforce plans are being finalised over September and October 2019 and will include consideration of alternative roles where ongoing hard to fill vacancies exist. The re-opening of the Associate Specialist Grade is now being considered, with hard to fill specialities being identified as potential implementation opportunities.	**Director of Human Resources and Operational Development**
% vacancy rate for registered nurses **Standard: <=5%**		* The Trust welcomed 14 Nurses from the Phillipines in late August. * A successful Newly Qualified Open Day was held (14.9.19) with extremely positive interest and a number of recruitment offers were made and accepted. * We continue to perform a a daily, dynamic risk assessment of safe staffing numbers using Bank and Agency to fill gaps as appropriate. * The Trust has now joined cohort 5 of the NHSI Retention Direct Support Programme	**Director of Human Resources and Operational Development**

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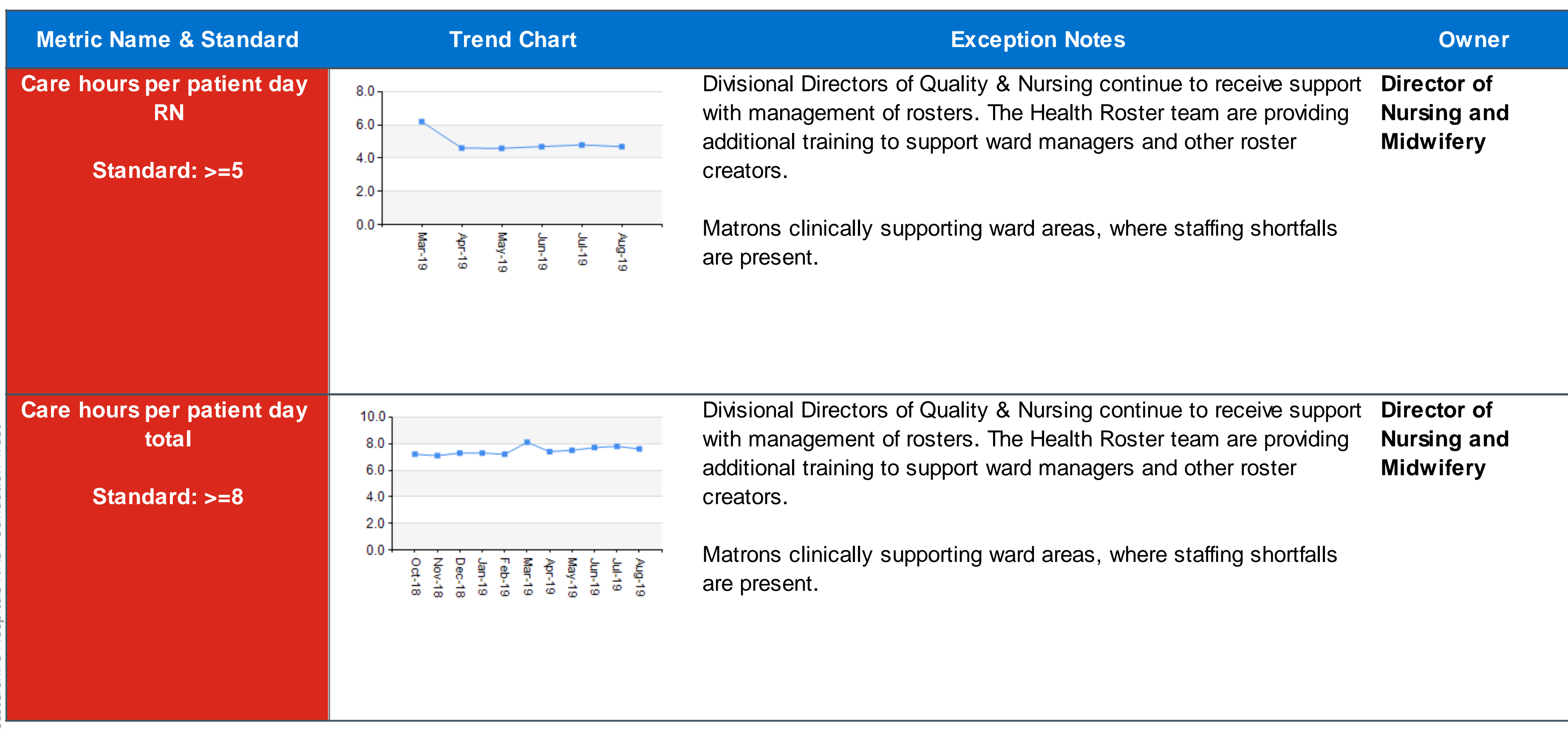
Exception Reports – Well Led (2)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
Care hours per patient day RN **Standard: >=5**	8.0 6.0 4.0 2.0 0.0 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19	Divisional Directors of Quality & Nursing continue to receive support with management of rosters. The Health Roster team are providing additional training to support ward managers and other roster creators. Matrons clinically supporting ward areas, where staffing shortfalls are present.	**Director of Nursing and Midwifery**
Care hours per patient day total **Standard: >=8**	10.0 8.0 6.0 4.0 2.0 0.0 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19	Divisional Directors of Quality & Nursing continue to receive support with management of rosters. The Health Roster team are providing additional training to support ward managers and other roster creators. Matrons clinically supporting ward areas, where staffing shortfalls are present.	**Director of Nursing and Midwifery**

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Benchmarking (1)

Standard (dashed grey line) **England** (dark grey) **Other providers** (blue)
GHT (light blue) **Best in class*** (green)

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

Metric	Period	Peer Group	Rank	Quartile
Diagnostics	July-19	15%, 10%, 5%, 0% — Aintree University…, County Durham And…, University Hospitals…, Gloucestershire…, Norfolk And Norwich…, Western Sussex…, Epsom And St Helier…, Oxford University…, South Tees Hospitals…, Worcestershire Acute…, England, Great Western Hospitals…, United Lincolnshire…, Portsmouth Hospitals…, University Hospitals Of…, York Teaching Hospital…	63 / 168	2nd
Dementia	June-19	100%, 80%, 60%, 40%, 20%, 0% — Bolton NHS FT, County Durham And…, University Hospitals Of…, South Tees Hospitals…, Great Western Hospitals…, Norfolk And Norwich…, England, Western Sussex…, Oxford University…, York Teaching Hospital…, Gloucestershire…	83 / 83	4th

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Benchmarking (2)

Standard (grey dashed line) **England** (dark grey) **Other providers** (blue)
GHT (light blue) **Best in class*** (green)

*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)	August-19	100% 95% 90% 85% 80% 75% 70% 65%; Liverpool Women'S…, Gloucestershire…, South Tees Hospitals…, Epsom And St Helier…, Western Sussex…, England, Oxford University…, University Hospitals…, Great Western Hospitals…, University Hospitals Of…, York Teaching Hospital…, County Durham And…, United Lincolnshire…, Norfolk And Norwich…, Worcestershire Acute…	19 / 119	1st
Cancer 62 Days GP Referrals	July-19	100% 90% 80% 70% 60%; Bridgewater Community…, County Durham And…, Epsom And St Helier…, Great Western Hospitals…, University Hospitals…, South Tees Hospitals…, York Teaching Hospital…, Portsmouth Hospitals…, England, Western Sussex…, Norfolk And Norwich…, United Lincolnshire…, Gloucestershire…, University Hospitals Of…, Oxford University…, Worcestershire Acute…	111 / 141	4th

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Benchmarking (3)

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	July-19	100%, 90%, 80%, 70%, 60%; Berkshire Healthcare…, County Durham And…, University Hospitals Of…, Epsom And St Helier…, England, South Tees Hospitals…, University Hospitals…, United Lincolnshire…, Western Sussex…, Norfolk And Norwich…, Portsmouth Hospitals…, Great Western Hospitals…, Oxford University…, Gloucestershire…, Worcestershire Acute…, York Teaching Hospital…	149 / 178	4th
VTE (published quarterly)	June-19	100.00%, 98.00%, 96.00%, 94.00%, 92.00%, 90.00%, 88.00%, 86.00%; Cambridgeshire And…, Great Western Hospitals…, Norfolk And Norwich…, Oxford University…, County Durham And…, United Lincolnshire…, University Hospitals…, York Teaching Hospital…, Worcestershire Acute…, Western Sussex…, Gloucestershire…, University Hospitals Of…, Portsmouth Hospitals…, England, South Tees Hospitals…, Epsom And St Helier…	80 / 146	3rd

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Benchmarking (4)

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	July-19	100%, 90%, 80%, 70%, 60%; Luton And Dunstable…, Western Sussex…, County Durham And…, Portsmouth Hospitals…, Oxford University…, England, Epsom And St Helier…, Gloucestershire…, United Lincolnshire…, University Hospitals…, Great Western Hospitals…, Norfolk And Norwich…, University Hospitals Of…, Worcestershire Acute…, York Teaching Hospital…	102 / 129	4th
FFT - Inpatient	July-19	100.00%, 90.00%, 80.00%, 70.00%, 60.00%; Liverpool Heart And…, South Tees Hospitals…, County Durham And…, Portsmouth Hospitals…, Western Sussex…, York Teaching Hospital…, Norfolk And Norwich…, Oxford University…, University Hospitals Of…, Worcestershire Acute…, England, Epsom And St Helier…, Great Western Hospitals…, United Lincolnshire…, Gloucestershire…, University Hospitals…	132 / 144	4th

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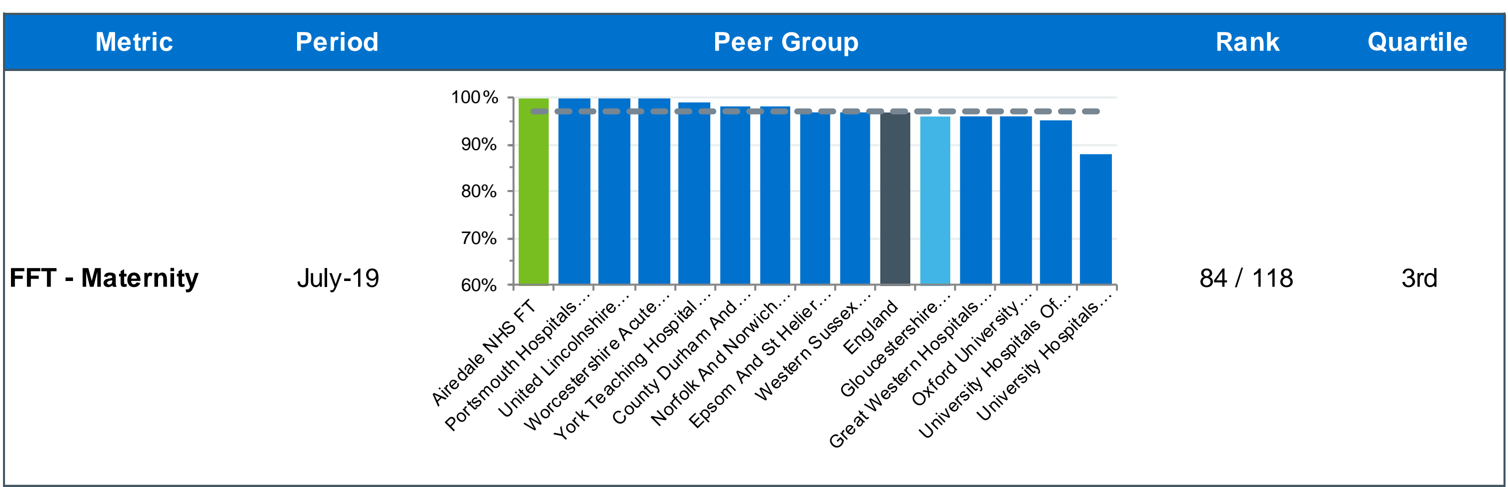
Benchmarking (5)

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	July-19		84 / 118	3rd

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REPORT TO MAIN BOARD – October 2019

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

This report describes the business conducted at the Finance and Digital Committee held on September 26th 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
Financial Performance Report	5 months' cumulative deficit at £11.2 million (on a Control total basis) is a £0.5 million favourable variance against plan i.e. no change from month 4. Key favourable variances: - Commissioner income £1.6m - Other income £1.0m - Pay £1.2m Partially offset by non-pay adverse variance Detailed variance analysis presented	Detailed discussion of variances. Are there further opportunities for blocking contracts?	Quality of analysis and answers provides strong assurance Such opportunities are kept under review and have been utilized in prior years. Currently not considered appropriate/necessary	
	Cash balance (£17 million) continues to be relatively high representing cash held following loan receipts for committed capital expenditure	Is a cash flow forecast routinely prepared?	Yes – will be incorporated in future reports	
	Balance sheet commentary	What is the reason for the increase c. 50% increase in other liabilities?		Analysis to be provided

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	Challenges and opportunities for balance of year described in detail	What is the confidence level for the Q3 and Q 4 projections?	3rd Quarter plan considered doable. Activity levels represent a minor risk.	4th Quarter remains under close review
Capital Programme Update	Capital programme summary by project reviewed. Year's budget reverted to original plan , NHSI having removed the requirement to reduce by 20%		Well documented programme	
Cost Improvement Programme Update	Year to date performance of £6.2 million is an over achievement of £2.0 million against plan. Full year projection at £14.7 million continues to show an overall under performance against plan. Pipeline of new projects under review and recovery measures described	How effective are processes to identify new opportunities? Are resources adequate?	Significant work on opportunity.	Additional resource to be recruited/deployed for data analysis to support accuracy and provide higher levels of detail.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Agency Report	Review of current levels of expenditure. Summary of the impact of the techniques and tools now in place to control cost.	Should the approach to reviewing this topic be modified?	Comprehensive controls now in place. With the report reviewed in detail in the people and OD committee it is appropriate to cover this in the Finance report going forward	Total labour cost report to be developed covering all elements of pay, reported annually
Integrated Care System	Briefing on the process and action required to comply with the 5 year plan submission High level review of the system wide financial numbers and resulting challenge	What is the timetable/when & how will Committee and Board be advised?	Reviews to be scheduled	Work in progress and decisions to be made on what level of result to commit to
Gloucestershire Cancer Institute - Strategic Outline Case	Summary presentation of the proposal covering background, scope, options and funding requirement	What is the impact on Trust finances? Why was this not included in the earlier Estates Strategy review? What is the confidence level for funding? Do we have capacity to absorb the project	Modelling indicates revenue potential adequate to cover operating cost impact	To be integrated in Estates Strategy A matter for the Trustee of the Charity Need to demonstrate we do

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Finance Committee Work Plan	Revised work plan incorporating significant updates reviewed and agreed			Detail of approach to August and December meetings to be finalised
Digital Care Board Project Report	Detailed project progress report (Excl the separate 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.	
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 programmes status review covering - Desktop Imaging - Imprivata implementation - Next Generation telephony - Windows 2003 Upgrade - Fax replacement - MDT video conferencing - PC Refresh	What is the size of the Windows 2003 issue?	Comprehensive report received detailing project status and issues. 1 programme identified as "Red"	39 servers remain to be dealt with (started at >100). Resource limited

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	- Firewall replacement - Back up solution - Email archiving - Network remediation - Core Fibre - Wi-Fi Review			

Rob Graves
Finance & Digital Committee

TRUST BOARD – October 2019
Cabinet Suite, Shire Hall commencing at 12:30

Report Title
Financial Performance Report – Month 5 2019/20
Sponsor and Author(s)
Author: Jonathan Shuter, Director of Operational Finance Sponsor: Sarah Stansfield, Director of Finance
Executive Summary

Purpose

This report provides the Board with details of the financial performance for the period ended 31st August 2019.

Key issues to note

- At Month 05 the Trust is reporting a cumulative deficit of £10.5m, which is £0.5m favourable to plan.
- Commissioner income is £1.6m favourable against plan.
- Other NHS patient related income is £0.4m favourable against plan.
- Private and paying patients' income is £0.6m favourable to plan.
- Other operating income (including Hosted Services) is £1.1m favourable to plan.
- Pay expenditure is showing a favourable variance of £0.6m.
- Non-pay expenditure is showing an adverse variance of £3.9m.
- Non-operating costs are £4.8m 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.

Conclusions

The Trust position is favourable to plan as at Month 5 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	

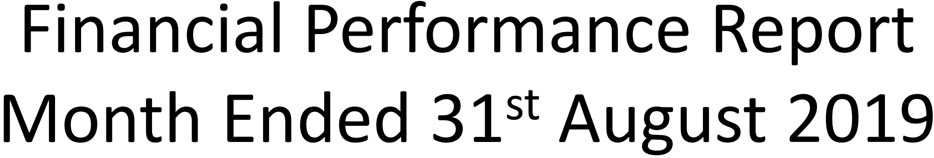
Date the paper was presented to previous Committees and/or TLT

Audit & Assurance Committee	Finance & Digital Committee	Estates & Facilities Committee	People & OD Committee	Quality & Performance Committee	Remuneration Committee	Trust Leadership Team	Other (specify)
	29TH August 2019						

Outcome of discussion when presented to previous Committees/TLT

The paper was scrutinised at Finance & Digital Committee. A number of challenges were received and these are reflected in the Chair’s report from the Committee.

Report to the Trust Board



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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 5.

The financial position as at the end of August 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 August the Group's consolidated position shows a year to date deficit of £10.5m. This is £0.5m 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.

	TRUST POSITION			GMS POSITION			GROUP POSITION *		
Month 05 Cumulative Financial Position	**Budget £000s**	**Actuals £000s**	**Variance £000s**	**Budget £000s**	**Actuals £000s**	**Variance £000s**	**Budget £000s**	**Actuals £000s**	**Variance £000s**
SLA & Commissioning Income	197,841	199,450	1,609	0	0	0	197,841	199,450	1,609
PP, Overseas and RTA Income	2,001	2,598	598	0	0	0	2,001	2,598	598
Other Income from Patient Activities	190	638	448	0	0	0	190	638	448
Operating Income	30,983	31,992	1,009	19,167	19,280	114	32,605	33,741	1,136
Total Income	**231,014**	**234,678**	**3,664**	**19,167**	**19,280**	**114**	**232,637**	**236,427**	**3,790**
Pay	148,649	147,494	1,155	7,706	8,222	(516)	156,216	155,634	582
Non-Pay	83,927	88,181	(4,254)	10,453	10,173	279	76,975	80,904	(3,930)
Total Expenditure	**232,576**	**235,675**	**(3,099)**	**18,159**	**18,395**	**(236)**	**233,190**	**236,539**	**(3,348)**
EBITDA	**(1,561)**	**(997)**	**565**	**1,008**	**885**	**(122)**	**(554)**	**(111)**	**442**
EBITDA %age	**(0.7%)**	**(0.4%)**	**0.3%**	**5.3%**	**4.6%**	**(0.7%)**	**(0.2%)**	**(0.0%)**	**0.2%**
Non-Operating Costs	9,627	14,593	(4,966)	1,008	885	122	10,635	15,478	(4,844)
Surplus/(Deficit) with Impairments	**(11,188)**	**(15,590)**	**(4,402)**	**0**	**0**	**0**	**(11,188)**	**(15,590)**	**(4,402)**
Less Fixed Asset Impairments	0	4,918	4,918	0	0	0	0	4,918	4,918
Surplus/(Deficit) excluding Impairments	**(11,188)**	**(10,672)**	**516**	**0**	**0**	**0**	**(11,188)**	**(10,672)**	**516**
Excluding Donated Assets	184	183	(2)	0	0	0	184	183	(2)
Control Total Surplus/(Deficit)	**(11,004)**	**(10,490)**	**514**	**0**	**0**	**0**	**(11,004)**	**(10,490)**	**514**

* Group Position excludes £18.2m of intergroup transactions including dividends

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Group Statement of Comprehensive Income

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

In August the Group's consolidated position shows an in month deficit of £2.5m on a control total basis, a favourable variance to plan of £51k.

Month 05 Financial Position	Annual Budget £000s	M05 Budget £000s	M05 Actuals £000s	M05 Variance £000s	M05 Cumulative Budget £000s	M05 Cumulative Actuals £000s	M05 Cumulative Variance £000s
SLA & Commissioning Income	482,404	38,577	38,898	321	197,841	199,450	1,609
PP, Overseas and RTA Income	4,802	400	427	27	2,001	2,598	598
Other Income from Patient Activities	456	38	70	32	190	638	448
Operating Income	84,330	6,681	7,978	1,297	32,605	33,741	1,136
Total Income	**571,992**	**45,697**	**47,373**	**1,676**	**232,637**	**236,427**	**3,790**
Pay	365,118	31,000	31,732	(732)	156,216	155,634	582
Non-Pay	182,289	15,154	16,061	(907)	76,975	80,904	(3,930)
Total Expenditure	**547,406**	**46,155**	**47,794**	**(1,639)**	**233,190**	**236,539**	**(3,348)**
EBITDA	**24,586**	**(458)**	**(421)**	**37**	**(554)**	**(111)**	**442**
EBITDA %age	**4.3%**	**(1.0%)**	**(0.9%)**	**0.1%**	**(0.2%)**	**(0.0%)**	**0.2%**
Non-Operating Costs	25,526	2,127	2,113	14	10,635	15,478	(4,844)
Surplus/(Deficit) with Impairments	**(941)**	**(2,585)**	**(2,534)**	**51**	**(11,188)**	**(15,590)**	**(4,402)**
Less Fixed Asset Impairments	0	0	0	0	0	4,918	4,918
Surplus/(Deficit) excluding Impairments	**(941)**	**(2,585)**	**(2,534)**	**51**	**(11,188)**	**(10,672)**	**516**
Excluding Donated Assets	(558)	37	37	(0)	184	183	(2)
Control Total Surplus/(Deficit)	**(1,500)**	**(2,548)**	**(2,497)**	**51**	**(11,004)**	**(10,490)**	**514**

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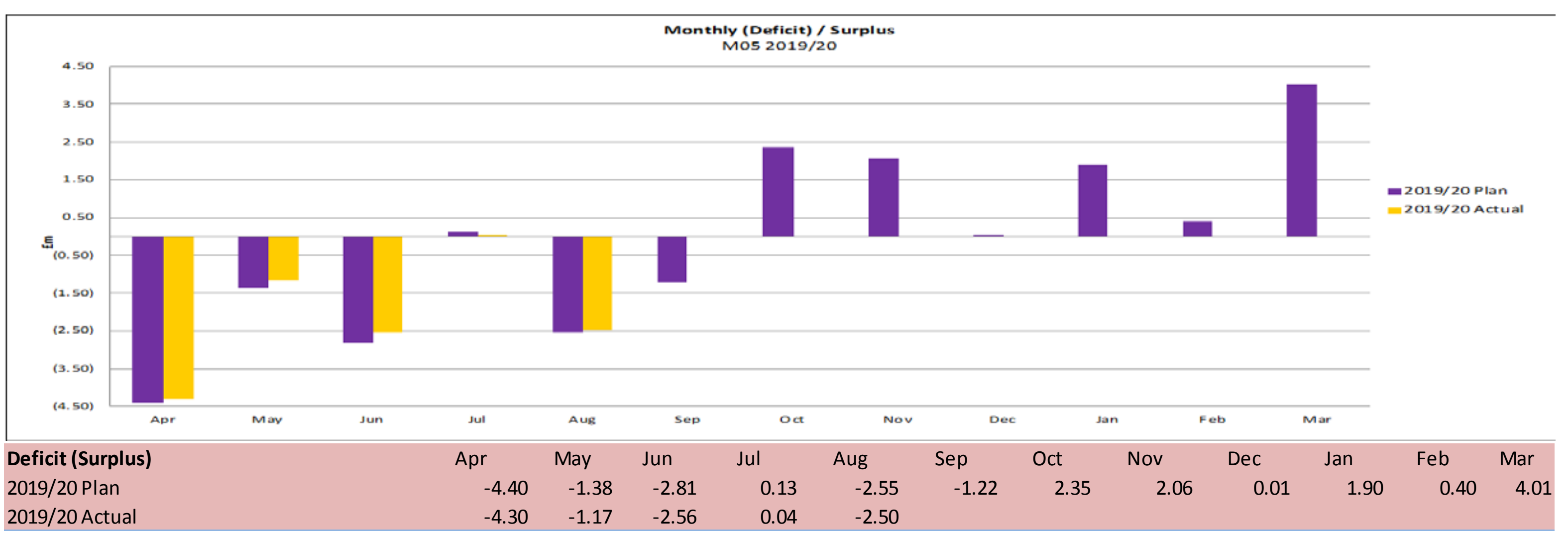
2019/20 Position Trend

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.



Deficit (Surplus)	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							

Deficit (Surplus)	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							

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Detailed Income & Expenditure

Gloucestershire Hospitals NHS
NHS Foundation Trust

Month 05 Financial Position	M05 Budget £000s	M05 Actuals £000s	M05 Variance £000s	M05 Cumulative Budget £000s	M05 Cumulative Actuals £000s	M05 Cumulative Variance £000s
SLA & Commissioning Income	38,577	38,898	321	197,841	199,450	1,609
PP, Overseas and RTA Income	400	427	27	2,001	2,598	598
Other Income from Patient Activities	38	70	32	190	638	448
Operating Income	6,681	7,978	1,297	32,605	33,741	1,136
Total Income	**45,697**	**47,373**	**1,676**	**232,637**	**236,427**	**3,790**
Pay						
Substantive	28,949	29,098	(149)	146,117	142,475	3,643
Bank	983	1,281	(299)	4,885	6,223	(1,338)
Agency	1,069	1,353	(284)	5,213	6,936	(1,723)
Total Pay	**31,000**	**31,732**	**(732)**	**156,216**	**155,634**	**582**
Non Pay						
Drugs	5,371	5,502	(131)	27,688	29,730	(2,042)
Clinical Supplies	3,256	3,133	124	16,307	16,662	(356)
Other Non-Pay	6,527	7,427	(900)	32,980	34,512	(1,532)
Total Non Pay	**15,154**	**16,061**	**(907)**	**76,975**	**80,904**	**(3,930)**
Total Expenditure	**46,155**	**47,794**	**(1,639)**	**233,190**	**236,539**	**(3,348)**
EBITDA	**(458)**	**(421)**	**37**	**(554)**	**(111)**	**442**
EBITDA %age	**(1.0%)**	**(0.9%)**	**0.1%**	**(0.2%)**	**(0.0%)**	**0.2%**
Non-Operating Costs	2,127	2,113	14	10,635	15,478	(4,844)
Surplus/(Deficit)	**(2,585)**	**(2,534)**	**51**	**(11,188)**	**(15,590)**	**(4,402)**
Fixed Asset Impairments	0	0	0	0	4,918	4,918
Surplus/(Deficit) after Impairments	**(2,585)**	**(2,534)**	**51**	**(11,188)**	**(10,672)**	**516**
Excluding Donated Assets	37	37	(0)	184	183	(2)
Surplus/(Deficit)	**(2,548)**	**(2,497)**	**51**	**(11,004)**	**(10,490)**	**514**

Non-Pay – expenditure is showing a year to date £3.9m overspend, reflecting overspends on pass through drugs and clinical supplies which are offset within income (£2.3m). The clinical supplies overspend of £0.4m reflects the continuing hire from Cobalt of MRI and CT Scanners (£0.3m), and tube repairs (£0.1m). The overspend on other non pay of £1.5m reflects expenditure mainly for outsourced clinical services e.g. D&S outsourced reporting (£0.2m), Glanso and 18 Weeks activity.

SLA & Commissioning Income – is reporting an over performance of £1.6m 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 £0.6m, reflecting private Oncology patients in D&S.

Other Operating income – the year to date over performance of £1.1m reflects higher GP and public health trainee income of £0.9m linked to recovery of additional costs at rotation changeover.

Pay – expenditure is showing an in month overspend of £0.7m, reflecting the GP/Public Health GP rotation changeover costs of £0.9m. Cumulatively there is an underspend of £0.6m, reflecting an underspend on substantive budgets (£3.6m), offset by overspends on bank (£1.3m) and agency (£1.7m) budgets.

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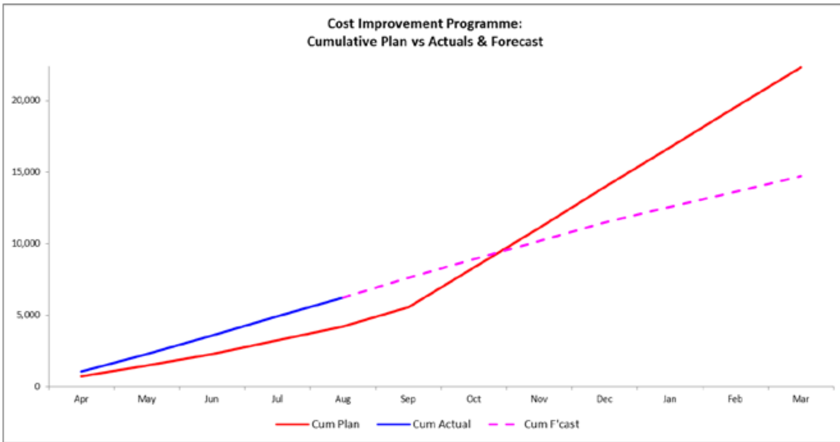
Cost Improvement Programme

1. At Month 5 the Trust has delivered £6.2m of CIP against the year to date NHS Improvement target of £4.2m, a favourable variance of £2m. Within the month, the Trust has delivered £1.3m of CIP against an in-month NHSI target of £1m, a favourable variance of £0.4m largely due to vacancy factor (i.e. underspend against pay budgets).

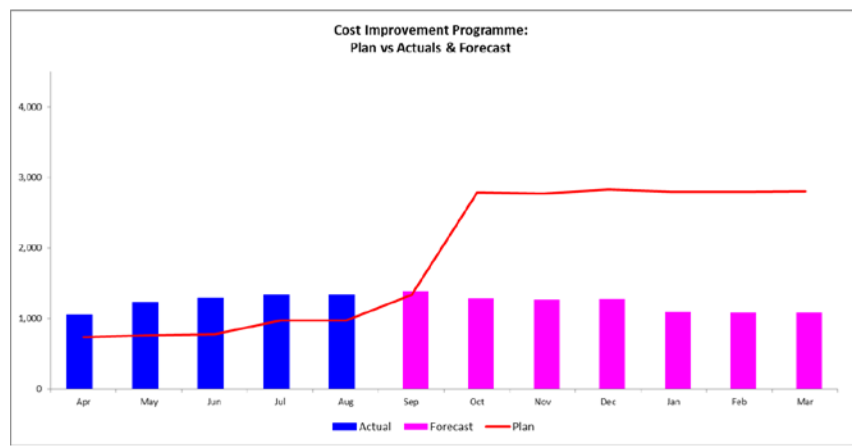
2. At Month 5 Divisional year end forecasts identify delivery of £14.7m against the Trust's target of £22.4m. This is an improvement of £1.2m since Month 4 and leaves an under performance against target of £7.6m. The improvement is mainly attributed to recovery measures as outlined in Month 3.

3. Recovery measures to close the gap continue to be actively pursued. The list of Divisional, cross cutting and unpalatable 'opportunities' continue to be progressed with some benefits showing in Month 5.

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



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LISTENING HELPING EXCELLING IMPROVING UNITING CARING BEST CARE FOR EVERYONE

Balance Sheet (1)

Trust Financial Position	Opening Balance 31st March 2019 £000	GROUP Balance as at M5 £000	B/S movements from 31st March 2019 £000
Non-Current Assests			
Intangible Assets	10,412	5,168	(5,244)
Property, Plant and Equipment	231,007	231,528	521
Trade and Other Receivables	4,640	4,658	18
Investment in GMS		0	
Total Non-Current Assets	**246,059**	**241,354**	**(4,705)**
Current Assets			
Inventories	7,571	7,745	174
Trade and Other Receivables	25,964	31,048	5,084
Cash and Cash Equivalents	7,317	17,768	10,451
Total Current Assets	**40,852**	**56,561**	**15,709**
Current Liabilities			
Trade and Other Payables	(54,315)	(60,874)	(6,559)
Other Liabilities	(5,837)	(8,717)	(2,880)
Borrowings	(12,527)	(11,954)	573
Provisions	(160)	(160)	0
Total Current Liabilities	**(72,839)**	**(81,705)**	**(8,866)**
Net Current Assets	**(31,987)**	**(25,144)**	**6,843**
Non-Current Liabilities			
Other Liabilities	(6,860)	(6,704)	156
Borrowings	(135,294)	(152,969)	(17,675)
Provisions	(1,434)	(1,434)	0
Total Non-Current Liabilities	**(143,588)**	**(161,107)**	**(17,519)**
Total Assets Employed	**70,484**	**55,103**	**(15,381)**
Financed by Taxpayers Equity			
Public Dividend Capital	172,676	172,676	0
Equity		0	
Reserves	23,915	23,915	0
Retained Earnings	(125,898)	(141,488)	(15,590)
Total Taxpayers' Equity	**70,693**	**55,103**	**(15,590)**

The table shows the M05 balance sheet and movements from the 2018/19 closing balance sheet, supporting narrative is on the following page.

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The commentary below reflects the Month 5 balance sheet position against the 2018/19 outturn

Current Assets

- Inventories decreased in month but have increased in year by £0.2m reflecting an increase in pharmacy stock.
- Cash has increased by £10.5m since the year-end, reflecting the deficit income and expenditure position, offset by borrowing, the movement in working balances and the timing of capital expenditure.

Non-Current Liabilities

- Borrowings have increased by £17.7m, reflecting working capital loan support of £8.7m and a capital loan of £10m, offset by the repayment of loans approved in prior years.

Retained Earnings

- The retained earnings reduction of £15.6m reflects the impact of the in year deficit.

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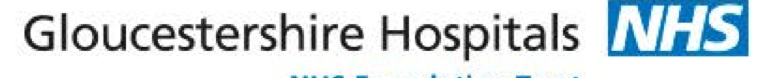
Better Payment Practice Code (BPPC)



	Cumulative for Financial Year		Current Month August	
	Number	£'000	Number	£'000
Total Bills Paid Within period	44,716	97,144	7,901	17,519
Total Bill paid within Target	38,145	81,754	7,066	13,620
Percentage of Bills paid within target	85%	84%	89%	78%

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

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

Liabilities – Borrowings

Analysis of Borrowing	As at 31st August 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	21,276
Capital Loan	14,217
Distress Funding	95,564
Obligations under finance leases	4,185
Obligations under PFI contracts	17,727
Balance Outstanding	**152,969**
Total Balance Outstanding	**164,923**

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 £18.7m of additional in-year borrowing from the DoH, £8.7m deficit support and a £10m capital loan.

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Cashflow : August

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

The cash flow for August 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 £8.7m 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 £12.5m of committed cash:

Committed cash from 2018/19	£3.5m
Balanced of £10m capital loan	£4.7m
Loan repayment in September	£1.4m
Accrued capital expenditure	£2.6m
PDC payment	£0.3m

The remaining cash balance of £5.3m represents Group working capital.

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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 downside risks that need to be highlighted. The table below summarises the downside forecast year end income and expenditure position for the Trust. This position reflects the forecast Cost Improvement Programme (CIP) gap £7.6m, 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 downside position assumes the repayment to the Trust off all 52 week wait fines currently being levied by NHS England & Improvement, and that winter capacity measures are delivered within existing forecast expenditure.

Month 05 Forecast Outturn	FY Plan	M05 Downside FOT	Variance
Total Income	571,992	583,304	11,312
Pay	(365,118)	(373,115)	(7,997)
Non Pay	(182,289)	(192,238)	(9,949)
EBITDA	24,584	17,951	(6,633)
Non Operating Costs	(25,526)	(30,727)	(5,201)
Surplus / (Deficit)	**(942)**	**(12,776)**	**(11,834)**
Fixed Asset Impairments	0	4,918	4,918
Surplus / (Deficit) after Impairments	**(942)**	**(7,858)**	**(6,916)**
Exlcuding Donated Assets	(558)	(562)	(4)
Potential loss of PSF for Q4	0	(5,531)	(5,531)
Control Total Surplus / (Deficit)	**(1,500)**	**(13,951)**	**(12,451)**

The downside position would deliver the Quarter 3 control total, and Divisions are continuing to work on financial recovery actions to mitigate the £6.9m 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 £12.5m.

There remain additional risks, largely around receipt of funding for activity over-performance from commissioners which could deteriorate the downside position further.

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Capital Programme

The table below summarises capital expenditure at month 5 and the forecast outturn for 2019/20.

Capital Programme Expenditure Summary position at 31st August 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	865	2,096	1,231	2,605	2,825	220
Environmental Works	116	0	(116)	350	350	0
Non Health & Safety Projects	395	601	206	975	1,088	113
Committed Schemes	154	150	(4)	460	480	20
Service Reconfiguration	3	0	(3)	9	9	0
Major Equipment Replacement	7	1	(6)	1,020	1,021	1
IM&T	3,586	3,985	399	9,883	9,883	0
MEF	829	245	(584)	2,490	2,490	0
Other Schemes	1,746	564	(1,183)	6,908	3,972	(2,937)
Contingency/Leases Capitalisation	263	0	(263)	1,300	3,882	2,582
Overspend/(Underspend)	**7,964**	**7,641**	**(323)**	**26,000**	**26,000**	**0**

During August, the following schemes were approved for funding via the contingency reserve by Capital Control Group:

- Roofing Repair to Little Oaks Nursery - £42k
- Fire Safety Remedial Works - £80k
- Security Remedial Works - £150k
- Access and Egress Remedial Works £60k
- Changing Places £40k

Points to note:

- Work continues within the Women's Centre, to replace the carbon steel piping. H&S budgets have been reprioritised to accommodate this replacement work.
- The EPR project is progressing to plan, with commercial milestone payments made to the supplier along with Citrix licences.
- The enabling works at Victoria Warehouse and Pullman Court continues and is estimated to complete within budget. The estates work is complete and the IT work is progressing.
- As reported last month, the Trust was requested by NHSI to reduce capital expenditure. The Trust has subsequently been informed that expenditure can revert back to original planned values, which is reflected in the M5 forecast. The forecast remains contingent on approval of loan funding.

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Recommendations

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 £10.5m at August 2019. This is £0.5m favourable against plan.

Author:	**Jonathan Shuter, Director of Operational Finance**
Presenting Director:	**Sarah Stansfield, Director of Finance**
Date:	**October 2019**

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TRUST BOARD – October 2019

Report Title
Enabling Strategy: Research
Sponsor and Author(s)
Author: Chantal Sunter, Head of Research and Development Sponsor: Simon Lanceley, Director of Strategy and Transformation
Executive Summary

Purpose
Submission of the Trusts new Research Strategy, following approval by People & Organisational Development Committee.
 	
Key issues to note
 	
• The original research strategy was renewed in 2018 and was provisionally approved by Main Board in January 2019, subject to approval of the new Trust Strategy in June 2019.
• Since January 2019 the following projects and initiatives have been incorporated into the Research Strategy:
    • References to the new Trust Strategy, in particular the driving research objective
    • The University Hospital status programme
    • Change in governance structure – Research now reports into People and Organisational Development (OD) Committee
    • Development of the Research 4 Gloucestershire vision and strategy
    • Development of key metrics following feedback from People & OD Committee
    • Feedback from Directors Operational Group, Trust Leadership Team and Research & Development forum (detailed below).
 	
• The strategy is based around four enabling pillars: Increasing visibility and awareness; Celebrating success; Increasing equity of access and Growing our collaborations.
 	
Conclusions
Board to note the new Research Strategy.
 	
Implications and Future Action Required
To define trajectories for strategic and operational metrics defined in the strategy.

Recommendations
To review, discuss and note
Impact Upon Strategic Objectives
This strategy is directly linked to one of the Trusts strategic objectives: *Driving Research*: We are research active, providing innovative and ground-breaking treatments; staff from all disciplines contribute to tomorrow's evidence base, enabling us to be one of the best University Hospitals in the UK.
Impact Upon Corporate Risks
No research risks are recorded on the Trust Risk Register.

The following risk (C2521S&T R&D) is recorded on the Corporate Division Risk Register, scored 4 x 2 = 8, relating to funding:
The risk of the loss of R&D funding is financial, a safety and in the HR domain. Loss of funding would create a large number of displaced staff who require redeployment or redundancy. Loss of staff would require the care of patients already trials to be picked up by other staff.

This strategy will help to reduce this risk by improving research activity and performance as report to Soth West Clinical Research Network. It will also help to mitigate the following risks being monitored by the R&D team

- Risk that we are unable to secure additional funding to support individuals and teams to dedicate time to research due to competing priorities limiting our ability to extend our research portfolio
- Risk that we do not identify and address relevant skills, capacity and capability gaps to allow us to achieve our research vision
- Risk that the business case to secure University Hospital status does not demonstrate an acceptable return on investment delaying the realisation of patient and staff benefits.

Regulatory and/or Legal Implications

Research activity is covered by specific regulatory framework administered by the Medicines and Health regulatory Authority. The MHRA inspected the Trust in October 2017.

Equality & Patient Impact

Research studies are accessible to all patients who meet the criteria of the studies.
Evidence shows that patients treated in research active hospitals have better outcomes (even if they themselves are not in a research study).

Resource Implications

Finance	X	Information Management & Technology	
Human Resources	X	Buildings	X

Action/Decision Required

For Decision		For Assurance		For Approval		For Information	X

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

Audit & Assurance Committee	Finance & Digital Committee	Estates & Facilities Committee	People & OD Committee	Quality & Performance Committee	Remuneration Committee	Trust Leadership Team	Other (specify)
			21 Aug 2019			07 Aug 2019	People and OD Delivery Group (30th July 2019) R&D Forum (13th Sept 2019)

Outcome of discussion when presented to previous Committees/TLT

- People and Organisational Development Delivery Group requested additional highlighting of educational research
- Trust Leadership Team requested additional highlighting of how colleagues could get support and asked how this linked with the Quality improvement strategy
- People and Organisational Development Committee wanted to ensure the format was consistent with other enabling strategies (design, graphics etc.)
- There was a question around Digital Health and whether we should specify digital trials, including Artificial Intelligence, as a key initiative area.
- TLT requested more information on international recruitment and communication.
- TLT requested that one of the objectives was to increase staff awareness of research techniques and approaches (link to Academy), e.g. critical appraisal tools, use of library etc.

Research Strategy

Foreword

The NHS Constitution (2009) says that research is part of core business which enables the NHS to improve the current and future health of the people it serves. By including Driving Research as a key objective in the Trust strategy for 2019 - 2024 this supports our vision of Best Care for Everyone.

We know that patients treated in research active hospitals have better outcomes, even if they themselves are not actually within a research study. This is what drives our priorities within our Research Strategy for 2019-2024. By delivering on these priorities we will be able to improve the health, well-being and experience of the communities we serve.

We want to ensure that research truly becomes business as usual being highly visible to both patients and colleagues. This will contribute to our "Journey to Outstanding" where research is now a measure within CQC ratings. We want to enthuse colleagues and patients about the clear benefits of research and provide advice, guidance and support to those colleagues with research interests and ambitions.

We want to make our community proud to be involved with a University Hospital.

Our strategy will enable us to build on existing good practice and expand our clinical and educational research portfolio so that more patients may benefit from improved outcomes, our colleagues have increased career and training opportunities that delivering research brings and the Trust benefits from improved staff recruitment and retention which will lead to better outcomes for all.

Chantal Sunter
Head of Research and Development

Simon Lanceley
Director of Strategy and Transformation

Summary and Enabling Pillars

Improving healthcare through research

Our research strategy has been developed through colleague, patient and partner engagement.

Patients treated in research active hospitals have better outcomes; together we have been defining how we can drive research in the trust to improve treatments and services for patients and colleagues.

Throughout these conversations it is clear that colleagues want us to be ambitious, live by our values of caring, listening and excelling. Our Journey to Outstanding ambitions have captured our imaginations to strive for improved services for our patients and our community and we believe that becoming an accredited University Hospital Trust will increase our capacity and capability to deliver best care for everyone.

We know from listening to you that if we focus on driving research as defined in our overall Trust Strategy, we will make a difference for one another and our patients:

> **We are research active, providing innovative and groundbreaking treatments; staff from all disciplines contribute to tomorrow's evidence base, enabling us to be one of the best University Hospitals in the UK**

Summary of enabling pillars

Increasing visibility and awareness:
Improving how we communicate our research activity to patients, colleagues, ICS partners, National Institute for Health Research (NIHR) and commercial partners.

Celebrating success:
Demonstrate how clinical and educational research is improving patient care, outcomes and experience and colleague experience, recruitment and retention.

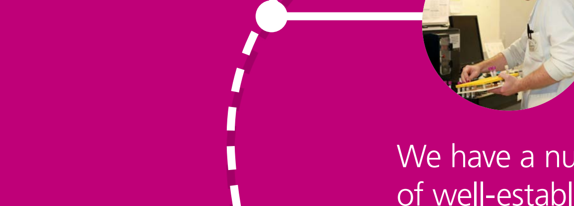
Increasing equity of access:
Improving access to clinical and educational research studies for patients with the aim that every patient can be offered the opportunity to be part of changing care

Growing our collaborations:
Increasing the number and variety of organisations we work with.

Where we are

We have over 100 studies open to recruitment across the Trust with more in follow up

We have active investigators in some areas conducting their own primary research funded by national and local funders



We have a number of well-established areas of research with large portfolios of research activity

We still have colleagues who do not recognise research as core activity

We provide advice, support and guidance to colleagues interested in research but we are not very good at publicising this service

We have good collaborative relationships with our local NIHR Clinical Research Network and our partners in Research 4 Gloucestershire (R4G)

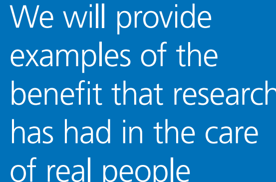
We do not have any research activity in some high prevalence disease areas

We do not have the infrastructure to support significant development and growth of home grown studies expected in a University Hospital Trust

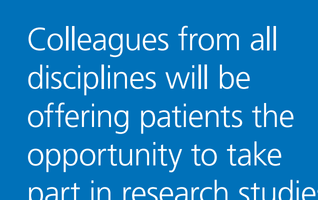
We do not always highlight where there are clear benefits to colleagues, patients and the Trust with improvements in practice resulting from research

We do lots of research studies that are not just clinical trials including public health and educational research but we need to improve how we communicate this

Where we want to get to



We will provide examples of the benefit that research has had in the care of real people



Colleagues from all disciplines will be offering patients the opportunity to take part in research studies

We will have increased numbers of locally led studies, research income and high quality outputs (publications)

We will have the infrastructure to support successful development and delivery of research including sponsorship, IP management and commercialisation of research outputs

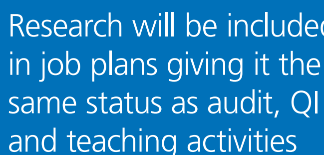
We will have more high profile local investigators including nurse, midwife and AHP Principal Investigators (PI's)

Colleagues will be aware of research in the Trust, enthused to contribute and appointed because of their research profiles

We will have increased income from NIHR and commercial trials

Research will be included in job plans giving it the same status as audit, QI and teaching activities

Colleagues will know where to go for advice, guidance and support for research related activities within the Trust



We will be known as a centre of excellence for both clinical and educational research and achieve University Hospital status

Enabling Pillars to deliver our strategy: **Increasing visibility and awareness:**

Our ambition is to improve how we communicate our research activity to patients, colleagues, Integrated Care System (ICS) partners, National Institute for Health Research (NIHR) and commercial partners.

Increasing visibility and awareness

We want to significantly increase the visibility of our research activities to our colleagues, patients and potential collaborators.

To achieve this we will develop a strategic approach to communications to raise our profile both internally and externally. Increased visibility within the trust will start as soon as new colleagues join us, with information being included at staff induction. We will collect information from new starters about their research experience and interests and actively nurture their aspirations. We will ensure that staff know how to access advice, guidance and support around all aspects of research from idea through to publication and beyond. We will develop a range of promotional materials and ensure that we use social and other trust media outlets to provide regular communications updates specific to research which will raise our profile internally and externally.

We will also include information about research to patients within their appointment letters.

Achieving University Hospital status will also promote ourselves as a research active organisation. We will submit a compelling business case to prioritise investment in research infrastructure to enable significant growth. This will enable us to support the submission of more grant applications which will result in potential for more funding from an increase in research activity and the grants themselves.

Increasing visibility and awareness

Key metrics

- University hospital status achieved
- Well known as a research active organisation.
- Information will be included at staff induction and newly appointed staff with an interest or experience in research will be followed up.
- Colleagues will know where and how to access advice, guidance and support about all aspects of research.
- There will be a range of promotional literature in a variety of formats to enhance visibility of research internally and externally
- Information about research will be included in appointment letters.
- Routinely reporting outcomes and benefits of hosted studies
- Increase in number of communication updates using social media and other Trust media outlets
- Increase in the number of patients recruited into studies
- Increase in number of staff contributing to research
- Research opportunities will be offered across a wider range of disease areas.

Enabling Pillars to deliver our strategy: **Celebrating success**

Our ambition is to demonstrate how research is improving patient care, outcomes and experience and colleague recruitment, career development, experience and retention.

Celebrating success

We will demonstrate how research improves patient care and staff opportunities to undertake fulfilling job roles:

We will achieve this by improving how well we communicate the benefits of research. This will also form part of the communications strategy described in pillar 1 but specifically we will develop a portfolio of patient stories, case studies from patients who have taken part in research about their experience. We will highlight our areas of excellence.

We will showcase improvements in practice through being early adopters of treatments and interventions, particularly where we have been a research site; this will clearly demonstrate benefits to colleagues, patients and the Trust. We will also acknowledge more consistently the contributions of patients and staff to the research endeavour.

Outcomes for colleagues

“I can see the impact that research has”

“I was able to share my experience”

“I benefited from new treatments early on”

“I know about the outcomes of research”

Outcomes for patients

Celebrating success

Key metrics

- Benefits to patients, colleagues and the organisation will be highly visible
- Improvements in practice through early implementation of interventions will be showcased
- Library of patient stories describing their research experience
- Personal thank you letters to colleagues for significant contributions
- Our areas of excellence will be highly visible
- The number and quality of research publications will be increased.

Enabling Pillars to deliver our strategy: **Increasing equity of access**

We want to improve access to research for patients with the aim that significantly more patients can access a study or be offered the opportunity to take part in one.

Increasing equity of access

Patients have a right to be invited to take part in research studies. We will improve access to research studies for patients with the aim that every patient can access a study or be offered one.

We will achieve this ambition by developing our workforce and infrastructure to support research. This will enable a more sustainable environment for research to flourish. We will establish a career structure for staff which aims to promote the role of Nurse, Midwife and Allied Health Professionals (NMAHP's – previously known as non-medic PI's) acting as Principal Investigators. We will establish research fellow positions, more clinical scientists, clinical academic positions and provide research placements for students.

We will pursue the inclusion of research within job plans so that it has equal status to teaching, QI and audit activities.

We recognise that such growth in infrastructure requires investment and as such we will submit a business case to the Board that will enable that growth. Resources are needed to ensure we have the capacity and capability to support the growth of research. This will enable both a successful University Hospital application and a change in the operational culture of the organisation to embrace research as core business.

Increasing equity of access

Key metrics

- Stable environment for research to flourish
- Career structure which includes research development
- More non-medical PI's
- More opportunities to offer students research placements
- More clinical research positions
- Good knowledge about research experience and interests of new staff
- Increased training opportunities
- Research included in job plans.
- R&D needs to be included in estates and facilities planning
- Properly resourced support services (HR, Finance, Legal, Comms etc.) specific to research
- Sufficient resources to facilitate sponsorship of studies, support for local lead investigators
- Sufficient resources to support and lead on Intellectual Property (IP) management and commercialisation of research outputs
- Sufficient resources to facilitate University Hospital status requirements
- GCP training is added to the Trust mandatory training for research active staff

Enabling Pillars to deliver our strategy: **Growing our collaborations**

We plan to strengthen our existing collaborations and increase the number and variety of organisations we work with.

Growing our collaborations

To enhance our profile and develop our strengths as a research active trust we need to strengthen our existing collaborations and establish new ones.

We will do this by continuing to develop our relationship with Research4Gloucestershire (R4G) with an ambition to develop joint appointments to cement its place as the research arm of the Integrated Care System (ICS). We will systematically gather information about existing collaborations that new and existing colleagues in the trust have already, and work to grow those to increase the number of collaborative grant applications.

We will strengthen our commercial offer to increase our commercial partnerships and include SME's (Small to Medium Enterprises). We will establish stronger links with universities with which we have areas of common interest. Internally we will strengthen our links with the Quality Improvement, Innovation and Library services. We will also further develop the Patient and Public Involvement (PPI) in our research activities.

Growing our collaborations

Outcomes for colleagues

"It's good to see joint appointments with our partners across Gloucestershire"

"Commercial partners are coming back to us, because they know we will deliver"

"I've had more opportunities to be involved in collaborative research grants"

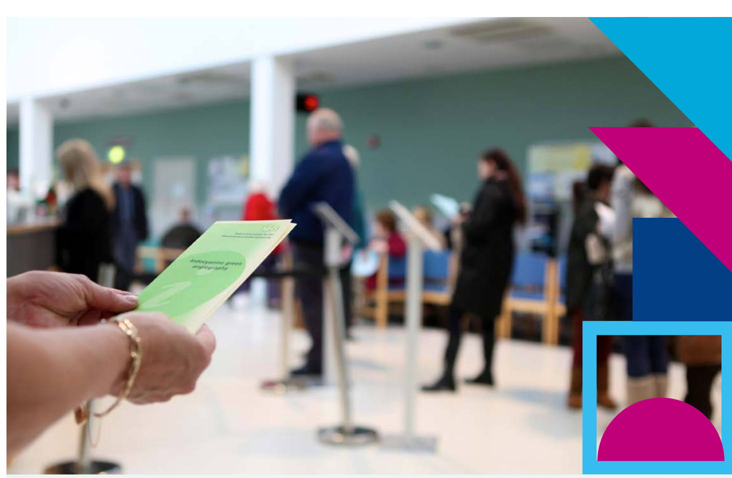
"The ICS and R4G have enabled us to use Gloucestershire as a test bed for system wide research"

Outcomes for patients

"It feels like the NHS services in Gloucestershire are joined up and working together more closely"

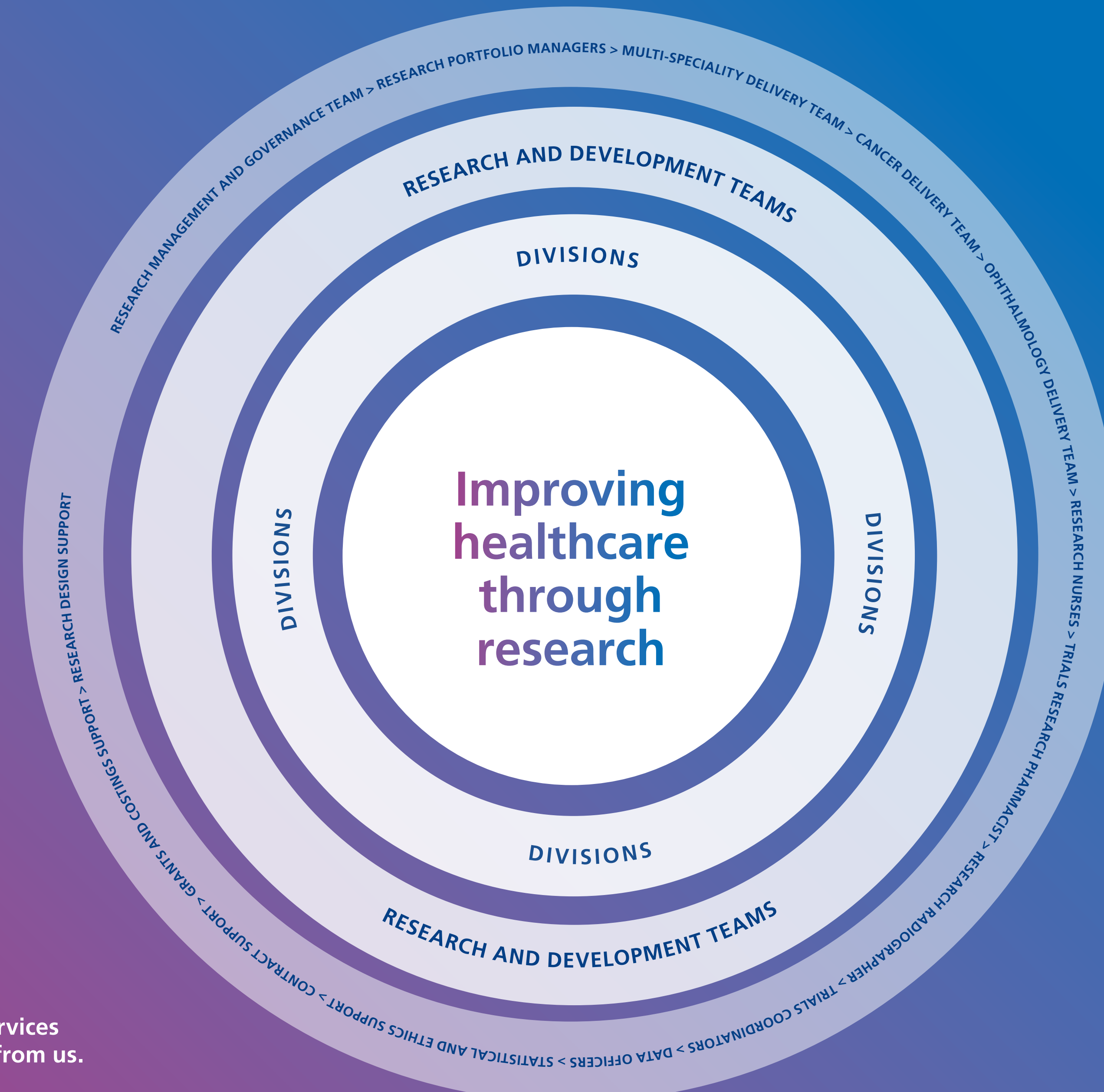
"I was asked to get involved in the design and development of research – it feels like patients are having more say"

"It is great to see that Gloucestershire are getting involved with cutting edge research"



Key metrics

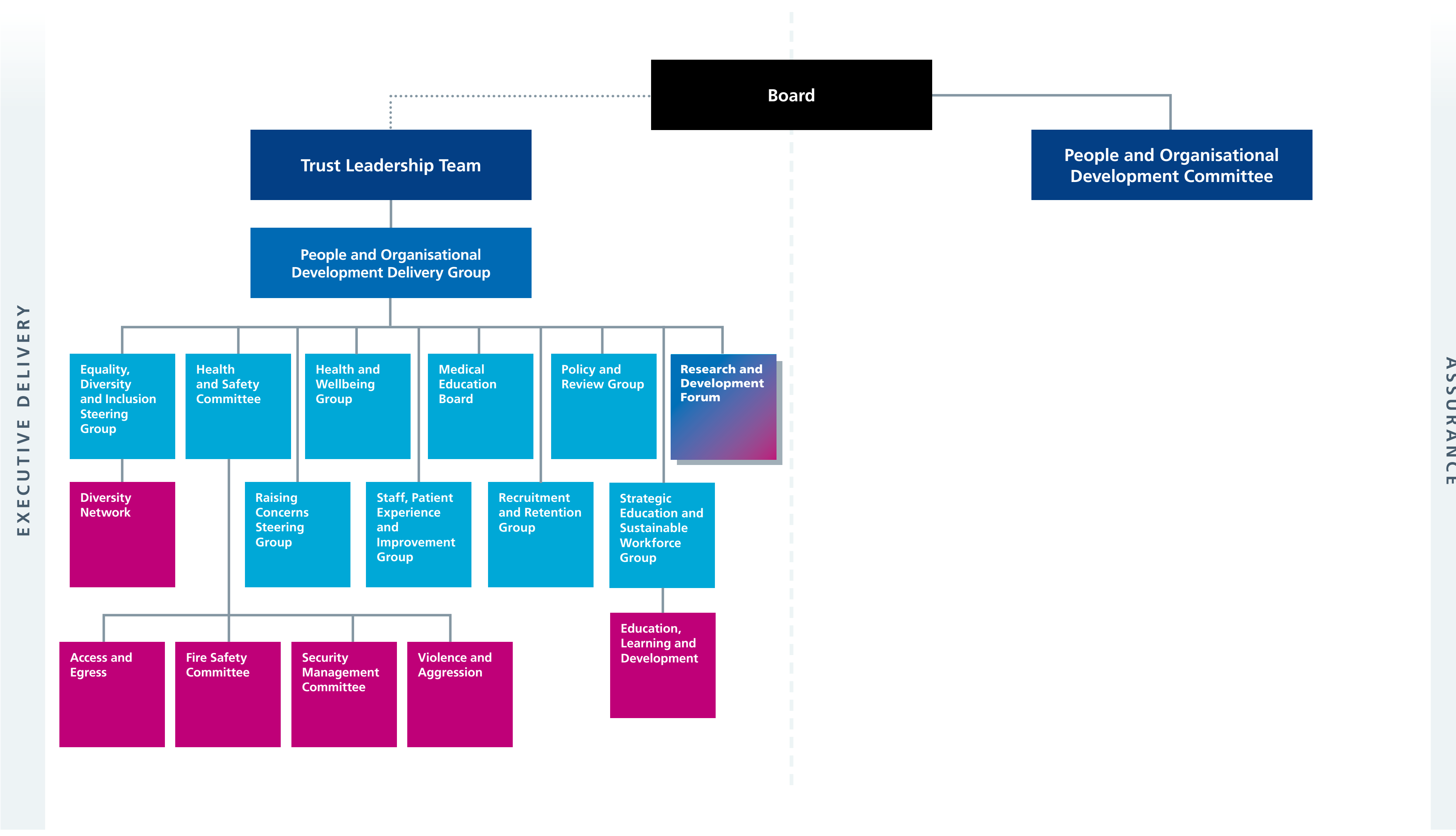
- Patient involvement in the design, delivery & evaluation of research
- Research 4 Gloucestershire joint appointments
- Increased collaborations with Universities
- Increased number of collaborative grants
- Potential benefits of Tissue Bank explored and business case submitted
- Increased commercial partnerships and links



This model describes how the research and development teams work on your behalf.

We aim to live our values and ensure our services are well connected so you can get the best from us.

People and OD to Research



Research
Strategy

V1,
August 2019

REPORT TO MAIN BOARD – OCTOBER 2019

From Audit and Assurance Committee Chair – Claire Feehily, Non-Executive Director

This report describes the business conducted at the Audit and Assurance Committee on 17th September 2019, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Counter Fraud Update (CF)	Regular update report on CF arrangements. Confirmed continued good progress on a range of initiatives as well as core activity. Fieldwork completed to develop a risk-based approach to CF. Success with e-learning package. Trust participating in national benchmarking exercise with NHS Counter-Fraud Authority. Memo of understanding with Gloucestershire Constabulary progressing.	In case of claim for additional hours not worked, have system weaknesses that were identified been strengthened? Has there been any national direction re any potential CF dimensions to EU exit?	Yes. Further controls now in place were described. System now said to be more robust. No, but Trust currently reviewing procurement ordering arrangements in case of a no-deal Brexit.	
Internal Audit (IA) update	Regular IA report included an update on the 2019/20 IA programme.			

	We considered reports on: Central Booking Office (CBO). Moderate assurance on both design and effectiveness of controls. Evidence of good practice and improved engagement. Management generally content with findings and timetable for implementing recommendations.	When would be the best time for a follow-up IA review to be undertaken to confirm whether improvements in current position have been maintained? Which key Trust policies are being rewritten (as referred to in report)?	A suite of KPIs has been developed for CBO and are reviewed monthly at Planned Care Delivery Board. Exec to maintain watching brief to determine best timing of IA revisit. The Access policy has been rewritten to bring it into line with other Trusts and with the Clinical Harm Policy. Now reviewed by NHSi.	Report to be further discussed at QandP Cttee.
	Learning from Serious Incidents and Deaths Moderate assurance for both design and effectiveness and some good practices identified. Finding of some variability in how death review arrangements were embedded across divisions.	Is there any risk associated with the differences between divisions? Discussion re frequency of Quality meetings within divisions and whether Executive Review process captures frequency of divisional meetings and relevant aspects from Serious Incidents. Why does the first	Robust arrangements are in place and Datix reporting and work of Bereavement team enables identification of any concerns. The policies will be updated	It hadn’t in the specific case but Execs had been assured that relevant SI processes had taken place.

		recommendation have an implementation date in 6 months' time.	earlier but the review of 30 days post discharge arrangements will require this timescale. Agreed that actions should have separate deadlines.	
	<u>Cost Improvement Programme (CIP) reporting</u> High level of assurance was provided for both design and effectiveness of controls. The Cttee commended the team for the evidence confirmed in the report. The delivery of CIP received significant scrutiny by Board as well as Cttees	Discussion took place as to how the QandP Cttee assurance dimensions re CIP might be extended.		
	<u>Follow-up Report</u> Regular report on status of recommendations from 2018/19 and 2019/20. The Cttee noted the good practice in this area.	How are Execs sighted on slippage of implementation dates?	Individual Exec is responsible for movement of dates and then only in exceptional circumstances. Overdue recommendations are reviewed and challenged by Exec team regularly. IA confirmed that performance on followups is much improved.	
	<u>Business Planning Follow up</u> Report received providing comprehensive assurance to the Cttee as to progress	How is divisional	Exec reviews have been	

	against recommendations of recent IA report. Overall, business planning confirmed as being in a much improved place.	performance in this area understood?	more constructive and have confirmed evidence of significantly greater consistency.	
Risk Assurance Report	Report received about how current risk arrangements are working and the effectiveness of reporting arrangements.	Confirmation that this report provides significant assurance. Discussion about those incidents that are currently open beyond their 30 day investigation period. What is the current position and risk associated with it? How will proposed revised arrangements demonstrate learning and improvements arising from analysis of incidents? Discussions re current Datix system, its fitness for purpose, and appropriateness of its functionality for operational settings.	 The review and escalation processes were described. The proposed new data sets and the intention to display trends were described. Investment possibility being considered in budget planning.	

Claire Feehily Chair of Audit and Assurance Committee, October 2019.

OPENTRUST BOARD – OCTOBER 2019
Cabinet Suite, Shire Hall commencing at 12.30pm

Report Title
EU Exit Briefing
Sponsor and Author(s)
Author: Sarah Stansfield, Director of Finance & SRO For EU Exit Sponsor: Sarah Stansfield, Director of Finance & SRO For EU Exit
Executive Summary
<u>Purpose</u> The purpose of this paper is to provide the Board with assurance on the work underway within the Trust around planning arrangements for an EU Exit scenario on the 31st October 2019. <u>Key issues to note</u> Planning and preparation is focussed on the nationally defined workstreams <u>Conclusions</u> It is proposed that the current action plan continues to be delivered and developed, under the leadership of the Director of Finance, utilising the task and finish structure already established. This action plan will also continue to be informed by any further additional national guidance that is published. EU Exit risks, where the score requires will be included on future iterations of the Trust Risk Register. The Board will continue to receive further updates as required for assurance purposes. <u>Implications and Future Action Required</u> The Board is asked to receive the briefing on the preparations the Trust is making for EU Exit.
Recommendations
The Board is asked to receive the briefing as assurance that the Trust is following national planning guidance on the preparations for EU Exit and has assessed any local risks and has plans in place to mitigate them.
Impact Upon Strategic Objectives
The long-term impacts of EU Exit are currently the subject of significant uncertainty. It is therefore difficult to estimate their effect on the strategic objectives.
Impact Upon Corporate Risks
There are numerous risks of an exit from the EU. National guidance and planning frameworks are in place to mitigate these risks.

Regulatory and/or Legal Implications			
There are numerous regulatory and legal potential implications of an exit from the EU. National guidance and planning frameworks are in place to mitigate these risks.			
Equality & Patient Impact			
There is a risk of impacts to patient care, largely due to potential interruptions in supply chain. This paper outlines the proposed steps being taken to mitigate these risks.			
Resource Implications			
Finance	x	Information Management & Technology	x
Human Resources	x	Buildings	

Action/Decision Required

For Decision		For Assurance	x	For Approval		For Information	

Date the paper was presented to previous Committees 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)

Outcome of discussion when presented to previous Committees/TLT

EU Exit briefing – October 2019

Purpose

The purpose of this paper is to continue to brief the Board on the work underway within the Trust around planning arrangements for an EU Exit scenario on the 31st October 2019.

Introduction

The UK is due to leave to European Union on the 31st October 2019 and as such planning is in place to mitigate any impacts of an exit from the EU.

Feedback from the central NHS EU Exit team informs the Trust that the health and care sector remains the sector of government considered to be the best prepared.

The Director of Finance has been nominated as the Senior Responsible Officer to lead on the necessary planning arrangements, focussed on the 'No Deal' scenario. This responsibility will transfer to the Chief Operating Officer as of the 1st November 2019.

National Planning

The Department of Health and Social Care (DHSC) is leading the response to the EU Exit across the health and social care sectors and the NHS Operational response in the event of the UK leaving the EU without a deal on 29 March 2019. The following are useful sources of information for patients:

As further information relating to the EU Exit preparations becomes available it will be published on the 'Preparing for EU Exit' pages of the NHS England website

https://www.england.nhs.uk/eu-exit/

Information for patients about the continuity of supply of medicines can be found on the NHS website. This includes a set of frequently asked questions.

https://www.nhs.uk/conditions/medicines-information/getting-your-medicines-if-theres-no-deal-eu-exit/

The latest information on reciprocal care arrangements – for those travelling in the EU, EEA and Switzerland in the event of a 'no-deal' scenario can be found on the NHS website.

https://www.nhs.uk/using-the-nhs/healthcare-abroad/healthcare-when-travelling-abroad/travelling-in-the-european-economic-area-eea-and-switzerland/

Local NHS Contingency Planning Assumptions

- The system planning is being led by the Local Resilience Forum and support by the CCG.
- Business continuity plans have been reviewed and updated where required

Specific Workstreams

The areas that national planning guidance has focussed on continue to be monitored. Whilst the impact of a 'no deal' exit on the health and adult social care sector is not limited to these areas, contingency plans are being developed nationally by the Department of Health and Social Care's

(DHSC's) Operational Response Centre to mitigate risks in other areas. The Trust is working to the national guidance issued and this is summarised below:

Supply of medicines, vaccines, medical devices and clinical consumables

UK healthcare providers should:

- not stockpile any medicines or vaccines beyond usual stock levels
- not write longer NHS prescriptions
- reassure the public that they don't need to stockpile

Chief and Responsible Pharmacists are responsible for ensuring their organisation doesn't stockpile medicines unnecessarily.

The government is working with industry to make sure that there is a continued supply of medicines, vaccines, medical devices and clinical consumables when the UK leaves the EU.

The Department for Health and Social Care (DHSC) has asked pharmaceutical companies that supply the UK from or through the EU or European Economic Area (EEA) to maintain and replenish an extra 6 weeks of stock on top of their usual buffer stock by 31 October 2019.

Supply of non-clinical consumables, goods and services

The Trust has reviewed the business continuity plans and contingency plans include any risks and issues with the supply of non-clinical consumables, goods and services.

Non-clinical goods and services include:

- IT service agreements and infrastructure
- waste management
- facilities management
- service maintenance contracts
- laundry services
- food and catering

Workforce

The Trust is:

- Regularly reviewing capacity and activity plans
- reviewing business continuity plans to ensure that the supply of staff needed to deliver services before and after Brexit is robust

Financial Implications

The centre has asked that all costs attributable to EU exit planning and response are logged by all NHS Trusts. There remains no confirmation from the DHSC that these costs will be reimbursed post 31st October.

No costs have currently been recorded.

Conclusion

It is proposed that the current planning continues to be delivered and developed, under the leadership of the Director of Finance, utilising the structures already established. Planning will continue to be informed by any further additional national guidance that is published. Board will continue to receive further updates as required for assurance purposes.

The Board is asked to receive the briefing on the preparations the Trust is making for Brexit and to agree any future assurance reporting requirements.

ITEM 14

GOVERNOR QUESTIONS

VERBAL

ALL

ITEM 15

STAFF QUESTIONS

VERBAL

ALL

ITEM 16

PUBLIC QUESTIONS

VERBAL

ALL

ITEM 17

NEW RISKS IDENTIFIED

VERBAL

ALL

ITEM 18

ITEMS FOR THE NEXT MEETING

VERBAL

ALL

ITEM 19

ANY OTHER BUSINESS

VERBAL

ALL