GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

The next meeting of the Gloucestershire Hospitals NHS Foundation Trust Main Board will be held on Friday 29 January 2016 in **Gallery Room, Gloucestershire Royal Hospital** commencing at 9.00 a.m**.** with tea and coffee. **(PLEASE NOTE VENUE FOR THIS MEETING)**

Professor Clair Chilvers
Chair

22 January 2016

AGENDA

				Approximate Timings
1.	Welcome and Apologies			09:00
2.	Declarations of Interest			
	Minutes of the Board and its Sub-Committees	(subject to ratification by the Board and its relevant sub-committees)		
3.	Minutes of the meeting held on 18 December 2015	**PAPER**	**To approve**	09:02
4.	Matters Arising	**PAPER**	**To note**	09:03
5.	Summary of the meeting of the Finance and Performance Committee to be held on 27 January 2016	**PAPER (To follow)** (Mr Gordon Mitchell)	**To note**	09:07
6.	Minutes of the meeting of the Finance and Performance Committee held on 16 December 2015	**PAPER** (Mr Gordon Mitchell)	**To note**	09:11
7.	Minutes of the meeting of the Health and Wellbeing Committee held on 5 January 2016	**PAPER** (Mr Tony Foster)	**To note**	09:15
8.	Summary and Minutes of the meeting of the Quality Committee held on 15 January 2016	**PAPER** (Mrs Helen Munro)	**To note**	09:19
9.	Summary of the meeting of the Sustainability Committee held on 18 January 2016	**PAPER** (Mrs Maria Bond)	**To note**	09:23
10.	Summary of the meeting of the Audit Committee held on 22 January 2016	**PAPER (To follow)** (Ms Anne Marie Millar)	**To note**	09:27
	Chief Executive's Report and Environmental Scan			
11.	January 2016	**PAPER** (Mrs Helen Simpson)	**To note**	09:30
	Governance and Operations			
12.	Integrated Performance Framework Report	**PAPER** (Mrs Helen Simpson)	**To endorse**	09:40
13.	Financial Performance Report	**PAPER** (Mrs Helen Simpson)	**To endorse**	09:55
14.	Emergency Pathway Report	**PAPER** (Mr Eric Gatling)	**To endorse**	10:10
15.	Nursing and Midwifery Staffing	**PAPER** (Mrs Maggie Arnold)	**To approve**	10:20
16.	Board Statements	**PAPER** (Mrs Helen Simpson)	**To approve**	10:25
17.	Risk Management Framework	**PAPER** (Mr Andrew Seaton)	**To approve**	10:35
18.	Seven Day Services Update	**PAPER** (Mr Bob Pearce)	**To note**	10:45

	Patient Story			
	The Board will adjourn at 11.00am to consider a patient story.			11:00
	Next Meeting			
19.	Items for the next meeting and Any Other Business	**DISCUSSION (All)**	**To Discuss**	11:30
	Staff Questions			
20.	A period of 10 minutes will be provided to respond to questions submitted by members of staff.		**To Discuss**	11:35
	Public Questions			
21.	A period of 10 minutes will be provided for members of the public to ask questions submitted in accordance with the Board's procedure.		**Close**	11:45 11:55
	Break			

Date of the next meeting: The next meeting of the Main Board will take place at on **Friday 26 February 2016** in the Board Room. 1 College Lawn, Cheltenham **at 9.00am.**

Public Bodies (Admissions to Meetings) Act 1960

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

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE TRUST BOARD HELD IN THE BOARD ROOM, 1 COLLEGE LAWN, CHELTENHAM ON FRIDAY 18 DECEMBER 2015 AT 9 AM

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	Prof Clair Chilvers	Chair
	Dr Frank Harsent	Chief Executive
	Dr Sally Pearson	Director of Clinical Strategy
	Dr Sean Elyan	Medical Director
	Mrs Maggie Arnold	Director of Nursing
	Mr Eric Gatling	Director of Service Delivery
	Mr Dave Smith	Director of Human Resources and Organisational Development
	Mrs Helen Simpson	Finance Director and Deputy Chief Executive
	Mr Gordon Mitchell	Senior Independent Director/ Vice Chair
	Mr Tony Foster	Non-Executive Director
	Mr Clive Lewis	Non-Executive Director
	Ms Anne Marie Millar	Non-Executive Director
	Mrs Helen Munro	Non-Executive Director
APOLOGIES	Mrs Maria Bond	Non-Executive Director
IN ATTENDANCE	Mr Martin Wood	Trust Secretary
	Mr Bob Pearce	Deputy Director of Service Delivery
	Mr Dhushy Mahendran	Chief of Service – Women and Children's
PUBLIC/PRESS	Gen Jeremy Rowan	Ministry of Defence
	Mr Bren McInerney	Public
	Mr Craig Macfarlane	Head of Communications

The Chair welcomed all to the meeting. In particular she welcomed General Rowan, Head of the Army Medical Service, who was observing the Board meeting as a guest of the Trust.

ACTION

368/15 DECLARATIONS OF INTEREST

There were none.

369/15 MINUTES OF THE MEETING HELD ON 27 NOVEMBER 2015

RESOLVED: That the minutes of the meeting held on 27 November 2015 were agreed as a correct record and signed by the Chair.

370/15 MATTERS ARISING

344/15 Chief Executive's Report and Environmental Scan – New Vision: The Associate Director of Transformation undertook to consider the suggestion from Mr Foster on the role Non-Executive Directors can play in taking forward the new vision.

348/15 Nurse and Midwifery Staffing and Revalidation: In response to a question from Mrs Bond, the Nursing Director explained that Nurses on sick leave or maternity leave were not classified as leavers and the Trust had to pay for the cost of cover. The Nursing Director

undertook to include in future reports information on Nurses on sick leave and maternity leave to provide a fuller picture of the staffing situation. *The Nursing Director reported that this information is included in the report which appeared later in the Agenda. Completed. (In the light of this response the future target relating to Nurse and Midwifery Staffing and Revalidation was also completed).*

The Nursing Director said that a focus group would be established to monitor revalidation but she acknowledged that there is always a risk with the process. The Medical Director added that three months before revalidations Doctors are reminded of the process and the Chief Executive said that the Executive Team will look at the possibility of introducing a similar system for nurse revalidation. *The Chief Executive reported that to take this forward funding has been identified for the appointment of a Revalidation Officer to learn lessons from the Medical Director's Team in respect of doctors' revalidation which it is hoped will resolve the retention rate. The Nursing Director added that the Nursing and Midwifery Committee appreciated this level of support. Completed.*

352/15 Staff Questions: The Director of Human Resources and Organisational Development also committed to inviting the questioner to meet him to discuss the matter further. *The Director of Human Resources and Organisational Development reported that he is to meet the questioner on 22 December 2015. Completed.*

349/15 Emergency Preparedness Resilience and Response: The Director of Clinical Strategy reported that since the last Board meeting a letter had been received from Dame Barbara Hakin, National Director Commissioning Operations at NHS England, requesting in the light of NHS preparedness for a major incident that all Trusts immediately review and provide assurance to four statements. The letter from Dame Barbara Hakin and the Trust's assurance to those four statements had been circulated to Board members.

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

RESOLVED: That the level of assurance to the four statements be endorsed. [0905]

371/15 SUMMARY OF THE MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE HELD ON 16 DECEMBER 2015

The Chair of the Committee, Mr Gordon Mitchell, presented the summary of the minutes of the meeting of the Finance and Performance Committee held on 16 December 2015. He reported on those matters considered by the Committee which were not included on the agenda as separate items. Firstly, an update on the implementation of Service Line Reporting was presented providing a description and timetable of the areas for implementation. This work had taken a long time to develop but was now gaining momentum. As part of the Lord Carter Efficiency Review an external analysis has been undertaken to review the Trust in terms of its comparative data by both productivity and performance. In response to a question from the Chair, the Chief Executive said that the Finance Director be invited to present the detail of Service Line Reporting at the Board Seminar on 3 February 2016. Secondly, the Committee reviewed its terms of reference and concluded that no changes were necessary.

HS
(MW to note for Agenda)

The Chair thanked Mr Mitchell for his report.

RESOLVED: That the summary minutes be noted. [0908]

372/15 MINUTES OF THE MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE HELD ON 25 NOVEMBER 2015

RESOLVED: That the minutes of the meeting of the Finance and Performance Committee held on 25 November 2015 be noted. [0908]

373/15 SUMMARY AND MINUTES OF THE MEETING OF THE SUSTAINABILITY COMMITTEE HELD ON 23 NOVEMBER 2015

In the absence of the Chair of the Committee the Finance Director presented the summary and minutes of the meeting of the Sustainability Committee held on 23 November 2015. She highlighted that 49 members of staff have become sustainability champions with their first task to consider how to motivate and encourage colleagues to adopt more sustainable ways of working. The Communications Team is compiling a bank of sustainability information for inclusion in Outline. The carbon reduction target is challenging and a message is to be distributed to staff to reduce energy consumption. The introduction of the Combined Heat and Power Plant had helped in achieving a reduction in carbon emissions. The Committee received two informative presentations; one from the Associate Director, Education and Development, on sustainability as a culture change through education and engagement and, secondly, from the Pharmacy Director on pharmacy sustainable service provision.

The Chair thanked the Finance Director for her report.

RESOLVED: That the summary and minutes be noted. [0910]

374/15 SUMMARY AND MINUTES OF THE MEETING OF THE QUALITY COMMITTEE HELD ON 4 DECEMBER 2015

Mr Foster as Chair of the meeting presented the summary and minutes of the meeting of the Quality Committee held on 4 December 2015. He highlighted that the Committee considered in detail the areas to form the draft quality priorities for 2016/17 and the timetable for the production of the Quality Report. An informative and forward looking quality presentation in Women and Children's Division had been made by the Divisional Nursing Director and the Lead for Quality and Governance to supplement the written report.

The Chair invited the Chief of Service for Women and Children's Division to inform the staff concerned of this positive feedback. **DM**

The Chair thanked the Mr Foster for his report.

RESOLVED: That the summary and minutes be noted. [0912]

375/15 CHIEF EXECUTIVE'S REPORT AND ENVIRONMENTAL SCAN

The Chief Executive presented his report and highlighted the following:-

- **National:** The publication of the planning guidance for 2016/17 and the changes to the tariffs are now expected in the New Year following Monitor and NHS Board meetings in December

2015.

- **Our Trust:** The SmartCare programme remains on track with a phase 1 live date of 2 May 2016. This is a Bank Holiday weekend to avoid patient cancellations and staff and Executive Directors will be on duty over this period. ED will go live over that weekend. A programme of staff training is to be developed with actual training commencing in March 2016 which will ensure that staff are released to undertake training. The Nursing Director has discussed the detailed arrangements with the Nursing and Midwifery Committee to ensure good planning. An encouraging response has been received from that Committee for "superusers" to help with the introduction of SmartCare. The Chief Executive said in response to questions from Mr Mitchell and Mr Foster that SmartCare builds information around the patient. It will take several years for a complete reduction in paper records. The Director of Clinical Strategy added that the first new patient details will be entered on the system in November 2016 and over time paper patient notes will diminish.

The Chair invited the Board to consider the items in the Trust Risk Register and the following points were raised:-

- The Chief Executive said in response to a question from Mrs Munro that the risk rating score in relation to M1 (Inability of the local health and social care system to manage demand within the current capacity leading to significant fluctuation of attendances in ED) is unlike to reduce until there is evidence that the system-wide schemes are working.

- C3 (Risks arising from the sequence of surgical related Never Events leading to potential regulatory intervention and the potential effects on the reputation of the Trust) – the Chief Executive advised that the original risk rating of 15 (3x5) should remain in the light of the two new Never Events.

- N22 (The Trust investigates all grade 3 and 4 graded pressure ulcers as incidents and potential safeguarding issues, this system has been improved and has resulted in larger numbers of reported incidents) – to be removed from the Trust Risk Register following improvement in the system which is to be monitored through the Safety Thermometer.

- S118 (As consequence of increased emergency activity (see risk M1) the Day care unit and other similar non inpatient areas with beds are opened overnight to house inpatients causing an increased patient safety risk, a reduced patient experience and a negative effect on Day Surgery activity and efficiency and increased cancellations on the day) – likelihood score to be increased to 5 (from 4) 5x4=20.

- S127 (The Trust has reported a higher than expected mortality rate for patients with fractured neck of femur) – the extensive review has been undertaken and the risk rating score is to be reviewed.

The Chair thanked the Chief Executive for his report.

RESOLVED: That the report be noted. [0925]

376/15 INTEGRATED PERFORMANCE FRAMEWORK REPORT

The Finance Director presented the Integrated Performance Framework Report and drew attention to the key highlights on performance in relation to the 18 week Referral to Treatment (RTT) standard for incomplete pathways, the 14 day cancer target for patients urgently referred by their GP despite rising referrals, the 31 day cancer targets and the percentage of stroke patients spending 90% of their time on a stroke ward. Of the areas of exception on performance she drew attention to the increase in November 2015 in the number of delayed discharges at month end and the number of medically fit patients remaining in a hospital bed leading to an inability to discharge impacting on performance. In October 2015 the Trust did not achieve the 62 day standard for patients waiting for first treatment for cancer following urgent GP referral. The position is improving and is meeting the recovery plan trajectory. The percentage of eligible patients with a VTE assessment continues to fall with an action plan to address this. GP referrals are running at higher levels than last year and were 3.2% over last year at the end of November 2015 compared to 2.9% at the end of October 2015. Emergency admissions are running at higher levels than plan and were 6% over plan at the end of November 2015.

The Nursing Director reported that in November 2015 there were four post 48 hour C Difficile infections which are being reviewed to determine whether they were avoidable or not. Even with these cases the Trust just remains below its target.

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

- In response to a question from the Chair, the Director of Service Delivery confirmed that it is the Acute Care Units which are causing the VTE performance to be below the target. The turnaround of patients is so quick that the assessment is not undertaken. The Trust needs to look at how to capture the data and the type of patient not subject to an assessment. There is now a dedicated clinical lead but gaps in the rota and the high use of locums is not helping the situation. The Chair invited the Medical Director and the Director of Service Delivery to look at other staff undertaking the assessment provided there is a consistent approach. **SE/EG**
- Mr Mitchell referred to the number of delayed discharges at the end of November 2015 which were approximately three times higher than normal levels. The Director of Service Delivery said in response that this is a result of the increase in demand and patients waiting for onward packages of care or a Social Services assessment. The figures are agreed with Gloucestershire County Council. The Nursing Director has a weekly telephone call with partners discussing in depth every case. In some instances it is agreed that nursing care is required but there is no agreement about who should pay. This then increases bed occupancy levels. There are also delays in community hospital beds becoming available. The Chief Executive added that on the morning of the Board meeting there were 80 medically fit patients in the County, 60 in the Trust and 20 in Gloucestershire Care Services. There are 64 patients waiting over two days and this figure is increasing. This concern has been raised with Monitor and NHS England in the

last two weeks. The Clinical Commissioning Group's view is that it will not fall below 40.

- In response to a question from Mrs Munro, the Nursing Director said that approximately 98% of medically fit patients are elderly.
- The Medical Director said in response to a question from Mr Foster that it is Social Services and the Ward Team who determine the appropriate care. The methodology is agreed but in some instances there are difficulties in accessing services. There are approximately 400 empty nursing home beds in the County.
- Mr Mitchell commented that within the Trust there are patients on the wrong ward and asked how this will impact during the Christmas period. In response, the Director of Service Delivery said that guidance from Monitor and the Trust Development Authority states that 20% of beds should be vacated by Christmas Eve and for the Trust this is 170 beds which is normally achieved. The beds then become occupied on 28 December. Gloucestershire Care Services have opened an extra 12 beds in the week before Christmas. During the first two weeks of January approximately 50 beds will be not booked for surgery to ease the pressures from Christmas. The position will be monitored.
- The Chair said that this situation should be raised with the Gloucestershire Strategic Forum. **CC**

The Chair thanked the Finance Director for the report.

RESOLVED: That the Integrated Performance Framework Report be noted and the actions being taken to improve organisational performance be endorsed. [0944]

377/15 FINANCIAL PERFORMANCE REPORT

The Finance Director presented the Financial Performance Report stating that the financial position of the Trust at the end of November 2015 is a surplus of £0.7m on income and expenditure which is £0.1m lower than the position reported in October 2015. Operational pressures continue and temporary staffing expenditure is £0.4m higher than the expenditure in October 2015. If agency pay expenditure in months July – October 2015 had been contained at the level in May 2015 the reported overall surplus would have improved to £4.0m. The Trust needs to continue to improve its controls on the use of agency staff, discretionary expenditure and accelerate the delivery of the Cost Improvement Programme to bring the overall position back into line with plan as soon as possible. The Monitor Risk Assessment under the new framework shows a Financial Sustainability Risk Rating of 3. The surplus of £0.7m on the income and expenditure position represents an adverse variance of £2.1m from the planned position of £2.8m surplus of income over expenditure at the end of November 2015. The cash position has deteriorated to £3.6m at the end of November 2015. New measures are in place to improve the position over the coming months. She expressed the hope that the cash position would improve in December 2015 as a result of the robust action being taken. The impact of the emergency cap cumulative to November 2015 was £835k. The focus in January 2016 for the Cost Improvement Programme is on Corporate Division where there is an under reporting of savings. The Director of Estates and Facilities is undertaking a due diligence exercise in relation to the capital programme resulting in a

slight underspend. However, the capital programme will be fully committed by the end of the financial year. The financial position remains very challenging and it is important to maintain a surplus which will be the focus in the quarter four.

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

- In response to a question from Ms Millar, the Finance Director clarified that the Monitor Risk Assessment under the new framework is a Financial Sustainability Risk Rating of 3. The rating would move to 2 should the Trust be in deficit.
- Ms Millar asked for the projected cash position for December 2015/January 2016. In response, the Finance Director said that for December 2015 the cash position is estimated to be £4.5m. On 15 December 2015 a payment was received from Specialist Commissioners and a part payment has been received from the Worcestershire Acute Trust as a result of escalation. Mr Mitchell referred to the additional £43m received by that Trust and the Finance Director said that the matter would be further escalated if the Trust did not receive full payment. The Chief Executive added that if necessary an approach will be made to the Chief Executive of NHS Improvement. He said in response to a suggestion from Mr Foster that it was not appropriate to withdraw services provided to Worcester.
- Mr Foster referred to debtors commenting that the position has deteriorated and that the proportion of private patient debt appeared high. The Finance Director said that the position is affected by Gloucestershire Care Services and Specialised Commissioners withholding payments whilst patient details are provided to confirm the work undertaken. The private patient debt is subject to discussions with insurance companies on providing justification for the payments.
- The Director of Clinical Strategy asked for details of the creditor payment position which the Finance Director undertook to provide to the Board. **HS**
- The Chair congratulated the Finance Director and the Cost Improvement Programme Director for an improved position with the programme compared to the corresponding time last year.
- Mr Mitchell commented that the Trust is one of a few Trusts nationally with a financial surplus. The Chief Executive added that the Chief Executive of NHS England is moving towards geographical areas balancing finances rather than individual organisations.

The Chair thanked the Finance Director for the report.

RESOLVED: That the actions to address the issues identified in the report will continue in 2015/16 and progress will continue to be reported monthly to the Finance and Performance Committee and the Board. [0959]

378/15 EMERGENCY PATHWAY REPORT

The Director of Service Delivery presented the Emergency Pathway Report by exception given the discussion in minute 376/15 above and highlighted the following:-

- The 95% four hour target for Emergency Department performance was not successfully met in November 2015 with

Trustwide performance reported as 88.1%.

- Consultants are now providing cover seven days a week until midnight at Gloucestershire Royal Hospital and until 10.00pm at Cheltenham General Hospital.
- The key actions going forward are that the Trust continues to support joint working with the Monitor Operational Support team on the delivery of the improvement plan. The Programme Director for Unscheduled Care is to develop and implement the revised Emergency Care Board Action Plan. The Trust is continuing with the winter preparations.

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

- The Chief Executive reported that two locum Emergency Department consultants have been recruited making a total of 19. One appointment is to cover maternity leave and the second appointment is to cover gaps in the Registrar rotas.
- The Chair invited the Director of Service Delivery to include in future reports information on surges in demand which adversely impact on performance. **EG**
- The Medical Director reported that Dr Kate Hellier has been released from normal duties to provide a focus on reducing length of stay.

The Chair thanked the Director of Service Delivery for the report.

RESOLVED: That the report be noted and the actions being taken to improve performance be endorsed. [1005]

379/15 NURSING AND MIDWIFERY STAFFING AND REVALIDATION

The Nursing Director presented the report updating the Board on the exception report made regarding compliance with the 'Hard Truths' – Safer Staffing Commitments for November 2015. In line with the set parameters for the safer staffing guidance there were no reported exceptions for November 2015. The Nursing Director drew attention to the key workforce initiatives noting that some overseas nurses are being put off from accepting posts unless they can bring their families to the UK. Incentives have been introduced to recruit and retain nurses in General Old Age Medicine (GOAM) and stroke wards. The Trust needs to look at the unfunded beds and the impact on nurse staffing. Details of the sickness and maternity absence were now included in the nurse recruitment projection.

The Nursing Director then presented the results of the Care Contact Time Audit undertaken in November 2015. At the Chief Nursing Officers' Annual Conference it was highlighted within Lord Carter's presentation that Boards must assure themselves that nurses who are not ward based must demonstrate "value" to patient care. In addition nurses and midwives, as a precious resource, should not be undertaking any non-clinical duties e.g. procurement. Therefore for this month's exercise the Trust decided to review specialist nurses and the next exercise could possibly review office based nurses. It is difficult to draw comparisons from the data, as it is recognised that care contact time will vary between specialist nurses as their roles vary depending on the speciality they are working in, and the complexity

and needs of the patients they see. This data should not be used in isolation but triangulating the results with other indicators in use to establish safe nurse staffing requirements. The Care Contact Time audit will continue to be repeated on a six monthly basis.
During the course of the discussion, the following were the points raised:-

- The Chief of Service for Women and Children's Division said that it is the non-patient contact time which needs to be understood.
- The Medical Director commented that the results of the Contact Time Audit with assist the Trust in identifying areas where administrative staff can assist nurses.
- The Medical Director suggested that social media be used to recruit both nurses and junior doctors. The Director of Human Resources and Organisational Development added that the nurse and medical recruitment teams will need to be brought together to achieve this.
- Mr Foster commented on the adverse impact on EU nurse recruitment by the new rules issued by the Nursing and Midwifery Council (NMC) for European nurses seeking registration in the UK from January 2016 which includes a rigorous English language test. In response, the Nursing Director said that it is dangerous for the patient if nurses do not have a good command of the English language. The Trust offers language support to nurses.
- The Nursing Director commented that the data requested in the Carter Report is being collated and it will be challenging for the Trust to implement the new matrix.

The Chair thanked the Nursing Director for the report.

RESOLVED: That the report be endorsed. [1018]

380/15 COMPLAINTS AND CONCERNS Q2 JULY – SEPTEMBER 2015

The Nursing Director presented the report providing information on the complaints and concerns reported to the Trust during quarter 2 2015/16. During Quarter 2, 2015-16, the Trust received a total number of 233 complaints which equates to an average of approximately 18 complaints per week, which is similar to the number of complaints received during the previous quarter. There had been an increase in the number of complaints received in the Medicine and Surgery Divisions. The increase in Medicine Division was partly as a result of Unscheduled Care returning to the Division. There was also an increase in complaints received in Estates and Facilities Division relating to patients smoking on Trust premises and provision of car parking facilities. The Trust's internal standard to provide a written response to complaints within 35 working days in 95% of cases was met in 84% of cases during Quarter 2. This is a decrease in performance compared to the Trust average for 2014-15 (86%), but an increase on the previous quarter (77%). Response time is affected by a number of issues including complexity of complaint but also is affected by availability of health records, staff availability and delay in receiving consent. Discussions are continuing with the Trust's Information Governance Committee as to the processes of sharing complaint – related information.

During the course of the discussion the Chair referred to complaints

about staff attitude and asked if extra training is provided to staff when complaints are upheld. In response the Nursing Director said that if an individual is named in an upheld complaint then this can be addressed. She stressed that the ability to complain is a gift from which the Trust can make improvements.

The Chair thanked the Nursing Director for the report.

RESOLVED: That the complaints and concerns report for quarter 2 2015/16 be noted. [1020]

381/15 MINUTES OF THE EXTRAORDINARY MEETING OF THE COUNCIL OF GOVERNORS HELD ON 9 DECEMBER 2015

The Chair presented the minutes of the extraordinary meeting of the Council of Governors held on 9 December 2015.

RESOLVED: That the minutes be noted. [1020]

382/15 ITEMS FOR THE NEXT MEETING AND ANY OTHER BUSINESS

Items for the next meeting: The Trust Secretary reported that a patient story is to take place at 11.00am to accommodate the patient and the Agenda will be constructed on that basis.

Any other business: The Chair reported the following announcements:-

Volunteers' Annual Luncheon The Chair had presented certificates to volunteers at the Cheltenham Volunteers Annual Awards on 14 December 2015; one for 20 years of service and one for 25 years of service. Mr Matt Holmes, Editor of the Gloucestershire Echo, attended.

Switching on the Christmas Tree Lights at Gloucestershire Royal Hospital The Bishop of Gloucester switched on the Christmas tree lights with carols from the Caring Chorus.

Caring Chorus will be singing carols on 19 December 2015 at Gloucester Cathedral at 11.00 am and 12.00 noon as part of Carols on the Hour.

Battledown Ward The Daisychain charity which has a local shop has transformed the waiting area and consulting room making it more child friendly.

Charity Christmas Ball had been a success and should be repeated. [1028]

383/15 STAFF QUESTIONS

The Director of Human Resources and Organisational Development advised that no staff questions had been submitted for the meeting. However, an article will appear in Outline encouraging staff both to attend INVOLVE sessions and to submit questions to the Board. The Director of Human Resources and Organisational Development informed the Board that he presents a revised INVOLVE question and answer session to staff based in Beacon House.

384/15 PUBLIC QUESTIONS

There were none submitted for this meeting. The Trust Secretary advised that with the agreement of Mr McInerney his question will be presented to the Board in January 2016.

385/15 DATE OF NEXT MEETING

The next **Public** meeting of the **Main Board** will take place at **9am** on **Friday 29 January 2016** in the **Gallery Room, Gloucestershire Royal Hospital**.

386/15 EXCLUSION OF THE PUBLIC

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

The meeting ended at 10.27 pm.

Chair
29 January 2016

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – JANUARY 2016

MATTERS ARISING

CURRENT TARGETS

Target Date	Month/Minute/Item	Action with	Detail & Response
January 2016	December 2015 Minute 376/15 Integrated Performance Framework Report	**SE/EG** **CC**	The Chair invited the Medical Director and the Director of Service Delivery to look at other staff undertaking VTE assessments provided there is a consistent approach. *Ongoing.* The Chair said that the situation regarding the availability of community beds should be raised with the Gloucestershire Strategic Forum. *Ongoing.*
January 2016	December 2015 Minute 377/15 Financial Performance Report	**HS**	The Director of Clinical Strategy asked for details of the creditor payment position which the Finance Director undertook to provide to the Board. *Ongoing.*

FUTURE TARGETS

There are none.

COMPLETED TARGETS

Target Date	Month/Minute/Item	Action with	Detail & Response
December 2015	November 2015 Minute 344/15 Chief Executive's Report and Environmental Scan – New Vision	**RW**	The Associate Director of Transformation undertook to consider the suggestion from Mr Foster on the role Non-Executive Directors can play in taking forward the new Vision. *The Chief Executive reported that the Associate Director of Transformation is to contact Mr Foster to consider his suggestions for Non-Executive Director involvement in taking forward the new vision. Completed.*
December 2015	November 2015 Minute 348/15 Nurse and Midwifery Staffing and Revalidation	**MA**	In response to a question from Mrs Bond, the Nursing Director explain that nurses on sick leave or maternity leave were not classified as leavers and the Trust had to pay for the cost of cover. The Nursing Director undertook to include in future reports information on nurses on sick leave and maternity leave to provide a fuller picture of the staffing situation. *The Nursing Director reported that this information is included in the report which appeared later in the Agenda. Completed. (In the light of this response the future target relating to Nurse and Midwifery Staffing*

			and Revalidation was also completed).
		EXEC TEAM	The Nursing Director said that a Focus Group will be established to monitor revalidation but she acknowledged that there is always a risk with the process. The Medical Director added that three months before revalidation doctors are reminded of the process and the Chief Executive said that the Executive Team will look at the possibility of introducing a similar system for nurse revalidation. *The Chief Executive reported that to take this forward funding has been identified for the appointment of a Revalidation Officer to learn lessons from the Medical Director's Team in respect of doctors' revalidation which it is hoped will resolve the retention rate. The Nursing Director added that the Nursing and Midwifery Committee appreciated this level of support. Completed.*
December 2015	November 2015 Minute 352/15 Staff Questions	**DS**	The Director of Human Resources and Organisational Development also committed to inviting the questioner to meet with him to discuss the matter further. *The Director of Human Resources and Organisational Development reported that he is to meet the questioner on 22 December 2015. Completed.*

ITEM 5

SUMMARY OF THE MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE TO BE HELD ON 27 JANUARY 2016

PAPER (To follow)

Mr Gordon Mitchell
Chair

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE TRUST FINANCE AND PERFORMANCE COMMITTEE HELD IN THE BOARDROOM, 1 COLLEGE LAWN, CHELTENHAM ON WEDNESDAY 16 DECEMBER 2015 AT 10AM

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

PRESENT	Mr G Mitchell	Non-Executive Director (Chair)
	Dr F Harsent	Chief Executive
	Mr E Gatling	Director of Service Delivery
	Mrs H Simpson	Finance Director and Deputy Chief Executive
APOLOGIES	Mrs M Bond	Non-Executive Director
	Mr T Foster	Non-Executive Director
IN ATTENDANCE	Mr M Wood	Trust Secretary
	Mrs K Campbell	PA to the Director of Service Delivery

The Chair welcomed the members of the Committee to the meeting.

ACTION

149/15 DECLARATIONS OF INTEREST

There were none.

150/15 MINUTES OF THE FINANCE AND PERFORMANCE COMMITTEE HELD ON 25 NOVEMBER 2015

RESOLVED: That the minutes of the meeting of the Finance and Performance Committee held on 25 November 2015 were agreed as a correct record and signed by the Chair.

151/15 MATTERS ARISING

138/15 Financial Performance Report: The Chair invited the Finance Director to provide in future reports headline information on the impact of offering overtime payments for certain grades of Nursing staff. *The Finance Director reported that the payments have commenced and have been well received. The report to the January 2016 meeting of the Committee will contain details of the overtime payments made. Completed.*

152/15 FINANCIAL PERFORMANCE REPORT

The Finance Director presented the Financial Performance Report stating that the financial position of the Trust at the end of November 2015 is a surplus of £0.7m on income and expenditure which is £0.1m lower than the position reported for the period to 31 October 2015. Operational pressures continue and temporary staffing expenditure is £0.4m higher than the expenditure in October 2015. If agency pay expenditure in months July – October 2015 had been contained at the level in May 2015 the reported overall surplus would have improved to £4.0m. The Trust needs to continue to improve its controls on the use of agency staff, discretionary expenditure and accelerate the delivery of the Cost Improvement Programme to bring the overall position back into line with plan as soon as possible. The Monitor Risk Assessment under the new framework shows a Financial Sustainability Risk Rating

of 3. The surplus of £0.7m on the income and expenditure position represents an adverse variance of £2.1m from the planned position of £2.8m surplus of income over expenditure at the end of November 2015. The cash position has deteriorated to £3.6m at the end of November 2015. New measures are in place to improve the position over the coming months. A small initial payment has been received from the Worcestershire Acute Trust as a result of the robust action being taken. The impact of the emergency cap cumulative to November 2015 was £835k. The focus for the Cost Improvement Programme is on Corporate Division in addition to a refocus on the clinical Divisions. The Director of Estates and Facilities is undertaking a due diligence exercise in relation to the capital programme resulting in a slight underspend. However, it is anticipated that the capital programme will be fully committed by the end of the financial year. Negotiations continue with the Clinical Commissioning Group and Gloucestershire Care Services (GCS) particularly on the level of recharges. The financial position remains very challenging.

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

- In response to a question from the Chair about the financial gap with GCS, the Finance Director said that £2.2m is the amount challenged by the Trust to GCS. Gloucestershire Care Services had previously withdrawn from the joint estates and pharmacy provision and the Trust has been reasonable. GCS has not reciprocated our reasonable approach. The Chief Executive expressed the view that arbitration would be a last resort. The Finance Director added that actions are in place to reduce the reliance on Thornbury nurses although the Trust is mindful of the impact this may have on services especially paediatrics. Thornbury will not be used for HCAs from next week Nurses from the Philippines are being to commence work with the Trust.
- The Chair sought information on the Trust's response to the Carter Efficiency Review. In response the Chief Executive said that a return involving a considerable amount of work was submitted last week on the Trust's position. The Trust will need to look at what is realistic rather than look at bulk numbers. There is not an understanding centrally of the Trusts two site operation. There are national issues which is not helping a joined up approach. Discussions will take place in quarter four, the outcome of which will be presented to the Committee.
- The Director of Service Delivery reported that elective work is to be reduced in the first two weeks of January 2016 to reduce pressures following the Christmas period. There are still gaps in Registrar rotas over the Christmas period and efforts are continuing to provide cover.

The Chair thanked the Finance Director for the report.

RESOLVED: That the actions to address the issues identified in the report will continue in 2015/16 and progress will continue to be reported monthly to the Finance and Performance Committee and the Board.

153/15 INTEGRATED PERFORMANCE MANAGEMENT FRAMEWORK

The Finance Director presented the Integrated Performance

Framework Report stating that demand which is exceeding both the contractual plan and historical levels and the number of patients medically fit for discharge and occupying an acute hospital bed is putting pressure on services and impacting on performance targets. Based on experience to date she had little confidence in the CCG demand management schemes delivering improvements in the current financial year. In November 2015 there were four post 48 hour *C Difficile* infections which are being reviewed to determine whether they were avoidable or not. Even with these cases the Trust just remains below its target. Of the key highlights on performance she drew attention to the 62 day standard for patients waiting for first treatment for cancer following urgent GP referral is improving and is meeting the recovery plan trajectory although the Trust did not meet the standard in October 2015. The percentage of eligible patients with a VTE risk assessment continues to improve although still below the target with an action plan to address this. The main issues are the number of medically fit patients, the number of emergency admissions and overall demand which continues to increase.

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

- The Chair sought an assessment of the performance position for the forthcoming month. In response, the Director of Service Delivery said that the Trust is not meeting the 62 day cancer target. The 18 week Referral to Treatment (RTT) performance is on plan. The diagnostic pathway continues to improve. The Trust will lose work and therefore income in January and ways of reinstating this work by additional capacity are being examined. Demand continues to be above planned levels.
- The Chief Executive said that on the morning of the Committee meeting there were 51 patients on the medically fit list which the Accountable Officer of the Clinical Commissioning Group deems acceptable although she now recognises that this is a serious issue. The Director of Service Delivery added that there needs to be greater visibility about the delays in community provision.

The Chair thanked the Finance Director for the report.

RESOLVED: That the Integrated Performance Framework Report be noted and the actions being taken to improve organisational performance be endorsed.

154/15 EMERGENCY PATHWAY REPORT

The Director of Service Delivery presented the Emergency Pathway Report and highlighted the following:-

- The 95% four-hour target for Emergency Department performance was not, at 88.1%, met in November 2015, but this was a slight improvement from the October 2015 figure.
- Details of arrangements to cope with increased demand during winter and, in particular, for the Christmas period were covered in the report.
- Some performance trends were adverse, but the inclusion of a dashboard clarified areas that needed to be concentrated on.
- There had been a 23% increase in admissions in September 2015.
- The new Interim Programme Director Programme, who will

lead the recovery plan for ED performance, had now started work with the Trust.
- The key risks remain demand exceeding both contractual plan and historical levels, the number of medically-fit patients for discharge, gaps in ED doctors' rotas despite recruiting additional consultants.
- Enhanced performance is dependent on a number of countywide projects to manage demand and improve discharge processes

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

- The Chief Executive expressed concern about the continuing increase in admissions. The Director of Service Delivery advised that a "deep dive" investigation had shown that most of the September 2015 increase comprised working-age adults. This had not, however, shown as a spike on the graph possibly because of same-day discharges, but further work was being done on this.
- The main factors affecting performance over the Christmas period would be the ability to discharge medically-fit patients in a timely manner and dealing with any future outbreaks of *Norovirus*. The Chief Executive advised that, in line with Monitor's recommendation, elective surgery appointments would be reduced for the first two weeks of January 2016.

The Chair thanked the Director of Service Delivery for the report.

RESOLVED: That the update report be noted and the actions being taken to improve performance be endorsed.

155/15 SERVICE LINE REPORTING UPDATE

The Finance Director presented the report updating the Committee on Service Line Reporting (SLR), the purpose of SLR being to improve understanding of the overall actual profitability of Trust services

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

HS/EG

- The Chief Executive informed the Committee that moving to a new Pathology system should provide better, more detailed data and enable managers to take SLR forward.
- The Chair noted that there would be further discussion of SLR in future meetings.

The Chair thanked the Finance Director for the report.

RESOLVED: That the current position in respect of the roll out of Service Line Management across the Trust be noted.

156/15 PROGRESS UPDATE ON 2015/2016 CONTRACTING PROCESS

The Finance Director presented the report updating the Committee on progress to the 2015/2016 Contracting Process and noted that most of the points in the report had already been covered in previous items. The contract with the Clinical Commissioning Group (CCG) remained under pressure with negotiations continuing on the additional costs

resulting from the volume and premium cost of agency nurses to help meet increased demand. The cost of additional rates to consultants to cover hard-to-fill middle grade doctor posts has also been raised formally with the CCG.

The Chair thanked the Finance Director for the report.

RESOLVED: That progress made in managing the 2015/2016 contracts be noted.

157/15 REVIEW OF TERMS OF REFERENCE

The Committee reviewed its terms of reference and concluded that no changes were required.

158/15 MINUTES OF THE EFFICIENCY AND SERVICE IMPROVEMENT BOARD MEETING HELD ON 9 DECEMBER 2015

The Finance Director presented the minutes of the meeting of the Efficiency and Service Improvement Board held on 9 December 2015 and noted that meetings continue to be well-attended. The plan was for these meetings to continue into the next financial year

The Chair thanked the Finance Director for the minutes.

RESOLVED: That the minutes be noted.

159/15 FINANCE AND PERFORMANCE COMMITTEE WORK PLAN

There were no changes to the Committee's workplan, but the Director of Service Delivery advised that this would be reviewed in January.

160/15 ANY OTHER BUSINESS

There were no further items of business.

161/15 DATE OF NEXT MEETING

The next meeting of the Gloucestershire Hospitals NHS Foundation Trust Finance and Performance Committee will be held on **Wednesday 27 January 2016** in the **Boardroom, 1 College Lawn, Cheltenham** commencing at **10am**.

Papers for the next meeting: Completed papers for the next meeting are to be logged with the Trust Secretary no later than 3pm on **Monday 18 January 2016**.

The meeting closed at 10.56am.

Chair
27 January 2016

GLOUCESTERSHIRE HOSPITALS NHS TRUST

MEETING OF THE HEALTH AND WELLBEING COMMITTEE
TUESDAY 5 JANUARY 2016
9.00 AM IN THE BOARDROOM, 1 COLLEGE LAWN, CHELTENHAM

PRESENT:

Tony Foster	TF	Non-Executive Director (Chair)
Sally Pearson	SP	Director of Clinical Strategy
Dave Smith	DS	Director of HR and Organisational Development
Kate Jeal	KJ	Communications Specialist
Catherine Boyce	CB	Clinical Strategy Manager
Emma Ralston	ER	Staff side representative
Carol MacIndoe	CM	Trust Governor (Staff)
Jane Evans	JE	Associate Director of Facilities
Jenny Bowker	JW	Associate Director of Strategic Planning (GCCG)
Elaine Watson	EW	Interim Manager Countywide Services/Head of Health Improvement (GCS)
Julie Shepherd	JS	Physiotherapy Manager CGH
Karen Tomasino	KT	Lead Nurse, Paediatrics
Tanya Richardson	TR	Locum Consultant Special Education Needs & Disabilities Provision

APOLOGIES:

Paul Garrett	PG	Deputy Nursing Director
Jane Hadlington	JH	Staff side, Chair Staff H&WB Group
Coral Hollywood	CH	Heptology Consultant
Joanna Glasscock	JG	Service Manager/Specialist Advisor Smoking Cessation (GSSS)
Sarah Scott	SS	Interim Director of Public Health (GCC)
Lisa Riddington	LR	Library Services Manager
Heather Beer	HB	Head of Patient Experience
Fiona Brown	FB	Dietician
Den Powell	DP	Trust Governor (Public)
Shirley Butler	SB	Occupational Health Specialist

Attending for item 4/16

Dr AbithaKujambal Vellore	DrA	Consultant Paediatrician
Henry Tellwright	HT	Dietician paediatric services
Dr Gail Bohin	GB	Clinical Psychologist, Clinical Lead Specialist Weight Management Service

ACTION

1/16 **APOLOGIES –** noted as above.

2/16 **MINUTES OF PREVIOUS MEETING**

Agreed subject to the following minor amendment:

- **Ref 28/15** - "Countywide Priorities Forum" should read "Clinical Priorities Forum)

3/16 **MATTERS ARISING** (where not covered elsewhere on the agenda)

- ***Trust H&WB film*** *(ref 27/15)* **–** now available on the website at http://www.gloshospitals.nhs.uk/en/About-Us/About-the-Trust/Health--Wellbeing-NEW/
- ***Remote monitoring and "Florence"*** *(ref 25/15)* **-** JB to ask the CCG's Clinical Programme Groups to consider where there were opportunities within their patient pathways for secondary care to use "Florence". **JB**
- ***Smokefree signage*** *(ref 31/15)* - the use of capital funds was being explored in light of an unsuccessful bid to the Charitable Funds Committee. DS to follow-up with finance colleagues. SP would also contact a potential sponsor. **DS→HS SP**
- ***SB4op*** *(ref 27/15)* – Matt Pearce was meeting with primary care and other colleagues and working to ensure reference was made to SB4op in appropriate care pathways.
- ***Increasing access to resilience training*** *(ref 34/15)* – a proposal to fund additional sessions, to increase capacity in 2016, was to be drawn up. **(L Morrison)**
- ***Staff H&WB data*** *(ref 34/15)* – DS advised that since the staff survey was already very long, alternative means of seeking data were to be explored. The desirability of seeking data which would be compatible with data gathered through other countywide H&WB surveys was highlighted. JB would advise DS of what might be relevant questions to pose. **JB**

ACTION

PATIENTS' HEALTH AND WELLBEING

4/16 PRESENTATIONS ON OBESITY

TF welcomed Dr AbithaKujambal Vellore, Henry Tellwright and Dr Gail Bohin to the meeting, for their presentation on aspects of childhood and adult obesity.

TR provided a brief overview of the epidemiology of obesity drawn from a recent GCC/CCG seminar on obesity – a priority area for the Gloucestershire H&WB Strategy.

Dr A and HT explained the types of issues affecting some young people with whom they were in contact, many with co-morbidities and in need of intense support. They explained the limitations on the services available at present. Dietetic colleagues offered short individual clinic slots for referred young patients, providing dietary advice and some focus on behaviour change and goal setting. Research which they had undertaken on single-handed dietician intervention indicated that this was not effective. They outlined other models of service elsewhere and highlighted NICE guidance which supported a multi-disciplinary team approach for the specialist service (paediatrician, dietician, psychologist, exercise therapist and specialist nurse). Appointments should be frequent to maintain motivation, a whole family approach should be adopted and there should be good links between primary care weight management programmes and a specialist paediatric weight management service.

GB gave an overview of morbid obesity in adults and explained the range and extreme complexity of the issues which frequently lay behind the obesity itself and which would often benefit from very specialised counselling and support – for example grief therapy, trauma counselling, relationship therapy. She also gave colleagues some insight into how patients might feel when the subject of weight is raised. GB suggested that the NHS might be trying to tackle a complex problem with simple solutions – for example dieting was known to be predictive of weight gain. She also suggested that there might be a need to deconstruct obesity and use a different level of thinking than used in other areas of physical health and a need to move away from a culture which generally blames and shames people with a weight concern.

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

- current models of specialist support for children with weight management problems, based strongly on dietetic input, reflected past models of service, when obesity was not a widespread concern;
- unlike for adult services, there was no comprehensive and integrated weight management pathway for children and it was agreed that this should be flagged as an important gap to be addressed by the county, particularly in light of the National Childhood Obesity Strategy was due to be published shortly;
- a need for closer links in both directions between adult Tier 2 and Tier 3 services;
- a need to consider how to support staff in maintaining a healthy weight.

TF thanked colleagues for their presentation and for giving colleagues greater insight into the complexity of obesity. He indicated that he would welcome a further discussion with the presenters and asked CB to identify a suitable date. **CB et al**

5/16 DEVELOPMENT OF THE TRUST'S PATIENT H&WB STRATEGY

CB/KJ presented a storyboard setting out a proposed format for the Trust's Patient H&WB Strategy - an introduction to set the document in context followed by sections on the countywide priority areas, with the addition of further sections on smoking and screening programmes and cross cutting enabling activities e.g. training, media and communications etc. The Strategy would be underpinned with a more detailed work programme for implementation in the year ahead and beyond.

There was broad agreement to the approach proposed and the use of case studies. A number of further areas for inclusion were proposed, including breastfeeding, drug misuse, domestic violence and reference to the "SHIFT" approach.

It was agreed that:

- the relevant service leads would be approached to assist in the development of the sections on each of the priority areas and to advise on appropriate case studies and items for inclusion in the work programme; **CB/KJ**
- where responses to the questionnaire circulated following the last meeting were still outstanding, these would be followed up; **CB**
- the final draft strategy would be prepared for the Committee's April meeting with a view to taking this to the May Board, possibly accompanied by a short presentation. **CB/KJ**

ACTION

6/16 MAKING EVERY CONTACT COUNT (MECC)

A paper prepared by PG was noted. This explained that MECC is a long-term strategy, adopted widely in the country and that the approach encourages conversations, based on behaviour change methodologies, empowering healthier lifestyle choices. GCC had commissioned training for front line staff in the public and community and voluntary sectors to use their multiple contacts with the public to start these conversations with patients, clients or carers. Two cohorts of twenty GHT Health Care Assistants and Registered Nurses had been trained, to be followed by further cohort of physiotherapists, occupational therapists and junior doctors. Feedback on the training was positive, but time was felt to be the main limitation to implementation in the workplace. The future of the training after March 2016 was not known.

In the course of discussion, it was recognised that MECC training was an important enabling element of the Trust's H&WB Strategy. In the absence of the existing training, alternative solutions, possibly e-learning would need to be identified. SP would seek clarification from GCC colleagues about future plans for the training. It was proposed that a "train the trainer" approach might increase spread of the training. **SP**

DS enquired whether the training had encouraged those undertaking the training to think differently about their own health and wellbeing. It was proposed that this might be added to future course evaluations. **PG**

7/16 IDENTIFICATION OF PROJECT FOR MEDICAL STUDENT PLACEMENT

SP reported that a 5th year medical student had expressed a strong interest in undertaking a public health or H&WB related project during a 4 week placement in GHT. KT agreed to seek a potential subject area in which the student could undertake a self-directed project alongside clinical colleagues, and advise SP as soon as possible. **KT→SP**

8/16 SMOKING CESSATION MONITORING REPORT

The latest quarterly report was noted. Whilst local general acute referrals fluctuated, the overall downward trend reflected national trends. However, concern was expressed over an unexpected decline during the year in the number of women recorded as smoking at booking, despite the existence of an opt out scheme and the requirement for CO_2 monitoring. KT was requested to ask Kay Davies to work with midwifery and GSSS colleagues to investigate and produce an updated action plan for consideration at the next meeting of the Committee. **KT→ (K Davies)**

9/16 BREAST FEEDING MONITORING REPORT

The latest report was noted. Some concern was raised at the proportion of mothers who initiated breastfeeding or use breast milk, but who then ceased to do so by the time of discharge. KT reported that a bid for additional breastfeeding support had been unsuccessful and that although members of the Breastfeeding Network visited the unit to inform mothers of the existence of the Network, they were not actively involved in supporting mothers on the unit. KT would request Kate Harrison to produce an action plan for the next meeting. It was noted that a short video was being produced in the maternity department which would also include messages on the importance of breastfeeding and smoking cessation. **KT→ (K Harrison)**

HEALTH AND WELLBEING OF THE WIDER COMMUNITY

10/16

- **Healthy Individuals Programme Group –** JB reported briefly on the November meeting and highlighted a number of Items:
  - Self-Management and the Expert Patient Programme which also highlighted the need for accessible information and on line resources;
  - "Pre-hab" – consideration was being given to running a pilot project using this approach, which advocated programmed H&WB and lifestyle interventions prior to surgery or other interventions, in order to optimise outcomes.
- **Living a Healthy Life in Gloucestershire – Have your say** – it was noted that GCC was now seeking views on the future provision of a range of healthy lifestyle services www.gloucestershire.gov.uk/consulthealthylifestyle (until 5.3.2016)

  It was agreed that a formal Trust response should be made as well as any individual responses which colleagues might wish to make directly. Everyone was asked to pass comments to CB by 22 February for inclusion in the GHT response. **ALL →CB**

- **Gloucestershire H&WB Board** - minutes of the November meeting were noted. Key items included Mental Health, Better Care Fund, the Devolution Bid and timescales for the Countywide H&WB Strategy Action Cards. It was noted that in the latest Indices of multiple deprivation, 13 areas of the county now fell within the top most deprived areas in the county, compared with 10 in 2010.

STAFF AND HEALTH AND WELLBEING

11/16 MEETING OF STAFF HEALTH AND WELLBEING GROUP – 15 DECEMBER

The minutes of the meeting held on 15 December were noted. DS highlighted a number of areas:

- **No time to lose –** an initiative on the potential for higher incidence of cancer for shift workers. G Monaghan to present data at the next Staff H&WB meeting.
- **Pedometers –** 50 obtained and plans being developed to encourage their use. It was proposed that the Step Jockey initiative which currently enabled people to track their progress as they used the Tower Block stairs should be extended to corridor areas too. KJ to raise with J Turk. New posters to support the initiative were being considered. **KJ→ (J Turk)**
- **Goals for 2016** – these included the ageing workforce, mental health, healthy eating; clubs/physical activity for which short-life project groups were to be set up. DS to bring the terms of reference and goals to the next H&WB Committee. DS was liaising with Sandwell NHS Trust about their initiative on an ageing workforce. **DS**
- **Healthy Eating** – JE reported on a range of healthy eating initiatives which the Catering Department had introduced. Despite the challenge of ensuring significant levels of income, and the competition from commercial outlets, the team was to be congratulated on its achievements to date, recognising that some changes would take longer to implement. The new catering manager would be an integral part of the short life group on healthy eating and a number of further initiatives were underway. Attention was drawn to a "Healthy January" programme of activities. The catering website pages were to be updated and KJ offered design support,

12/16 NICE PUBLIC HEALTH RELATED GUIDANCE

- **NG16 Dementia, disability, and frailty in later life: midlife approaches to delay or prevent onset** - noted that much of the guidance related to other organisations and that a range of actions were being explored by colleagues to make healthy choices easier in catering and retail outlets.
- **QS92 Smoking Harm Reduction** – gap analysis noted.
- **NG13 Workplace policy and working practices for improving the health and wellbeing of employees –** a gap analysis, being undertaken with the Staff H&WB Group, was nearing completion.

13/16 ANY OTHER BUSINESS

- **Extending the duration of future meetings –** TF proposed that future meeting be extended by 10-30 minutes to give sufficient time for more in depth discussion. **CB (All to note)**
- **Potential items for next meeting or future meetings**
  - Staff survey results
  - Obesity - follow-up
  - Draft Patient H&WB Strategy
  - Reducing alcohol harm

14/16 FUTURE MEETINGS

Tuesday 5 April, Tuesday 5 July, Tuesday 4 October (9.00 – 11.30)
9.00 am, Boardroom, Trust Headquarters, Cheltenham, unless otherwise notified.

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

SUMMARY OF THE MINUTES OF THE MEETING OF THE TRUST QUALITY COMMITTEE HELD ON FRIDAY 15 JANUARY 2016

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

004/16 EXPERIENCE BASED CO-DESIGN IN STROKE SERVICES

The Committee received an informative presentation from Mrs Sandra Attwood and Mrs Katherine Holland on experience based co-design in stroke services which is an experience based approach to enable staff and patients to work together to co-design services by gathering experiences of patients and staff through a number of means. As part of the next steps a celebratory event is to be held in April 2016 following completion of the co-design projects.

005/16 STROKE AND TIA SERVICES

Dr Kate Hellier gave an informative presentation on stroke and TIA services covering the ward moves and the location of services, performance and future proposals. Performance is improving but it is acknowledged that further work needs to be done. Business cases are in the course of preparation for additional stroke specialist nurses, stroke consultants and for the delivery of dedicated HASU nursing staff. The Committee wish to see pace in the determination of business cases but recognise that they have to be considered in the light of the Trust's overall programme and resources.

006/15 ENDORSEMENT OF QUALITY RRIORITIES FOR 2016/17

Following stakeholder consultation and taking into account the National Planning Guidance, the Committee endorsed the quality priorities for 2016/17.

007/15 DIVISIONAL ATTENDANCE - ESTATES AND FACILITIES

The Committee noted the current performance in the Division and at the invitation of the Director of Estates and Facilities have made suggestions for areas to be included in future reports. In addition to the data the report should take a more forward looking approach with timeframes, responsible person and whether timeframes are achieved. The due diligence exercise being undertaken by the Director of Estates and Facilities is nearing completion and will be used as a basis for future work.

008/15 SERIOUS UNTOWARD INCIDENTS

The Director of Safety gave an update on the current Serious Untoward Incidents, Never Events, High level reviews and RIDDOR reported incidents. The Committee invited the Director of Safety to consider adjusting his monthly Board report to provided updates on open serious incidents and his adjusted report appears elsewhere on the agenda.

009/16 MEDICINE OPTIMISATION BI-ANNUAL REPORT 2015/16

The Committee noted the Pharmacy Director's Bi-annual Report for 2015/16. He provided a video showing the work of homecare in the supply of medicines. The introduction of SmartCare will provide an opportunity to reduce medication errors.

010/15 MORTALITY CODING UPDATE

The Medical Director and Mrs Vicky Butcher from Dr Foster Intelligence updated the Committee on the impact of coding on the Trust's mortality measures. Mrs Butcher focused on the site comparison of mortality, casemix and coding. The Committee endorsed the development of optimum and standardised clinical coding.

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE TRUST QUALITY COMMITTEE HELD IN THE BOARDROOM, 1 COLLEGE LAWN, CHELTENHAM ON FRIDAY 15 JANUARY 2016 AT 9.30 AM

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

PRESENT	Mrs H Munro	Non-Executive Director (Chair)
	Dr F Harsent	Chief Executive
	Mr T Foster	Non-Executive Director
	Dr S Pearson	Director of Clinical Strategy
	Mrs M Arnold	Nursing Director
	Dr S Elyan	Medical Director
	Mr A Seaton	Director of Safety
	Mrs H Beer	Head of Patient Experience
	Mrs K Haughton	CCG Quality Lead
	Mrs P Adams	Governor – Staff, AHPs
	Dr P Jackson	Governor – Forest of Dean District Council Area
	Mrs C Johnson	Governor – Forest of Dean District Council Area
	Mrs A Lewis	Governor – Tewkesbury District Council Area
	Ms F Storr	Governor – Gloucester City Council Area
IN ATTENDANCE	Mr M Wood	Trust Secretary
APOLOGIES	Prof C Chilvers	Chair of the Trust

The Chair welcomed all to the meeting.

ACTION

001/16 DECLARATIONS OF INTEREST

There were none.

002/16 MINUTES OF THE QUALITY COMMITTEE MEETING HELD ON 4 DECEMBER 2015

RESOLVED: That the minutes of the meeting of the Quality Committee held on 4 December 2015 were agreed as a correct record and signed by the Chair.

003/16 MATTERS ARISING

116/15 CQC Safety Template: The Medical Director commented that the way forward is to empower staff to deliver and that Surgery Division be invited to the Committee in December 2015 to provide an update on the action plan for that Division. *This will now form part of the Division's next presentation to the Committee. Completed.*

078/15 Medicines Optimisation Annual Report: The Pharmacy Director acknowledged that there is further work which needs to be undertaken to reduce medication errors. It is a difficult to identify the right metrics as there are about 70, to achieve and focus the work these have to be prioritised. The Director of Safety commented that it is valuable to present learning which can be looked at in detail in the Medication Safety Group. He suggested that the Committee receive updates at six monthly intervals on the work of the group. *This item*

appeared later in the agenda. Completed.

054/15 Stroke Performance: The Chief of Service said that he would be happy to attend the Committee in six months' time to demonstrate improvement based on the stroke pathway delivery plan. *This item appeared later in the agenda. Completed.*

075/15 Understanding Mortality: The Chair said that understanding mortality is a key issue for the Committee and that an update should be presented to the Committee in three or four months' time. The Medical Director reported that this update will be presented to the Committee in January 2016. *This item appeared later in the agenda. Completed.*

114/15 Serious Untoward Incidents: Mrs Adams said that learning should be shared throughout the Trust and not within the relevant Division. The Director of Safety acknowledged that the learning is shared with the Committee and the Board but not in detail elsewhere. The Medical Director added that something similar to the Medical Alerts could be undertaken for Serious Untoward Incidents which the Director of Safety said that he would consider. Lessons learnt briefings are put on a website for the matrons and wards staff to share as appropriate. *The Director of Safety reported a library of lessons learnt is now available on the Trust's intranet. Completed.*

004/16 EXPERIENCE BASED CO DESIGN IN STROKE SERVICES

(Dr Kate Hellier, Mrs Sandra Attwood, Modern Matron Stroke, Neurology Renal and ARU, and Mrs Kathrine Holland, Patient Experience Manager, attended the meeting for the presentation of this item)

Mrs Attwood and Mrs Holland gave a presentation on experience based co-design in stroke services which is an experience based approach to enable staff and patients to work together to co-design services by gathering experiences of patients and staff through a number of means. The reconfiguration of stroke services on one site was a good time to undertake a review. A six stage process has been developed putting patient experience at the heart of the quality improvement effort whilst not forgetting staff. As part of the presentation a video was shown of patient interviews about what patients and staff have prioritised. The next steps include an celebratory event in April 2016 following the completion of the co-design projects.

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

- Mrs Haughton said that the balance of physiotherapy between the Trust and the community needs to be redirected.
- The Medical Director said that there are benefits to patients with the same domestic staff working on stroke wards.
- Mr Foster asked whether some of the ideas from the project would have been made if the project had not been undertaken. In response, Mrs Attwood said that some ideas had already arisen but the project has provided the momentum to take them forward.
- Mrs Attwood said in response to questions from Mr Foster and Ms Storr that carers were interviewed as part of the project but staff did not assume that visitors are carers. Dr Hellier added that some cares are overwhelmed by the situation.

- The Director of Safety added that it would be useful for the project to be part of the new academy. The Nursing Director has established a project on the support for dementia carers.

The Chair thanked Mrs Attwood and Mrs Holland for the presentation.

RESOLVED: That the presentation be noted.

005/16 STROKE AND TIA SERVICES

(Dr Kate Hellier, Mrs Sandra Attwood and Mrs Katherine Holland attended the meeting for the presentation of this item)

Dr Hellier gave a presentation giving an update on stroke and TIA services covering ward moves, performance and future proposals. Ward 6A and 6B ward moves have been completed delivering 51 stroke beds across whole floor with acute admissions cohorted to end of 6B. Ward 8a Neurology ward includes 8 stroke beds. Thrombolysis is provided 24/7 via the Emergency Department at Gloucestershire Royal Hospital to 6B. Seven Day TIA services commenced on 9 January 2016. Performance included details of the SSNAP Score; the time for stroke patients to scan and to the Stroke Unit within 4 Hours; 90% patient stay on stroke ward; time to stroke consultant within 24 hours and stroke speech and language therapy nurse within 24 Hours; Occupational Therapy Physiotherapy; standards of discharge and discharge process.

For the future a business cases are in the course of preparation for additional stroke specialist nurses, stroke consultants and for the delivery of dedicated HASU nursing staff. An implementation date is awaited for the stroke data capture system to enhance SSNAP collection and enable real-time analysis and improvement of the patient pathways.

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

- Mrs Haughton asked if radiographer capacity is an issue. In response, Dr Hellier said that it is not currently an issue. The Nursing Director is part of a working group looking a providing radiographer services seven days a week.
- In response to a question from the Chair, Dr Hellier expressed, subject to the latest SSANP data, confidence that there has been an improvement in performance if there was an imminent regulatory inspection.
- Dr Hellier referred to the time taken for a decision on business cases. The Committee wished to see pace in this area but recognised that business cases have to be considered in the light of the Trust's overall programme and resources.
- In response to a question from the Chair about the implementation date for the stroke data capture system, the Director of Clinical Strategy said that the interface with PALS is being address which is linked to the introduction of SmartCare.
- Dr Jackson referred to the issues of staff retention and Mrs Atwood said that it is a difficult situation and staff need a passion for the particular work. The "golden hello" payment is helping.

The Chair thanked Dr Hellier for her presentation. The Committee applauded the work of Dr Hellier and her team and that being led by Mrs

Attwood and Mrs Holland on Experience Based Co Design in Stroke Services.
RESOLVED: That the presentation be noted.

006/16 ENDORSEMENT OF QUALITY PRIORITIES FOR 2016/17

The Director of Clinical Strategy gave a presentation on the feedback from stakeholders on the quality priorities for 2016. Since the December 2015 meeting of the Committee there had been a request to align priorities to the CQC Key Lines of Enquiry. The National Planning Guidance had included four clinical standards for seven day services; access standards for A&E, 92% achievement of the 18 week Referral to Treatment and 62 day cancer wait; early diagnosis linked to the six week diagnostic target; the publishing of avoidable mortality rates; antimicrobial resistance; recommendations of the National Maternity Review; Improvement based on patient feedback in maternity and end of life; dementia diagnosis and NHS uptake of affordable and cost effective new innovations.

Consultations had been held with the Joint Board and Governors at a session in December 2015, the Clinical Commissioning Group, Gloucestershire Healthwatch and Gloucestershire County Council's Heath and Care Overview and Scrutiny Committee and their respective comments had been taken into account as far as possible.

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

- The Director of Clinical Strategy said that the National Planning Guidance linked avoidable mortality rates to seven day services and there was a discussion as to whether the data supported this approach. The Chief Executive expressed the view that there can be a link between the two depending on the interpretation of avoidable mortality. The Medical Director expressed the view that there is an over focus on mortality and a more suitable approach would be the provision of robust services seven days a week. Mrs Adams commented that seven day services will reduce avoidable harm, for example pressure ulcers.
- The Committee agreed that the regular reporting on Stroke and TIA services through the Medicine Division meant that there was sufficient focus on this area without it being identified as a specific priority.
- In response to a question form Mrs Lewis, the Director of Clinical Strategy said that there are systems in place in the health community to improve hospital discharges. This is a priority for Healthwatch who say that there is little evidence that they are effective. The Committee agreed that discharge systems within the health community be added as a quality priority.

The Chair thanked the Director of Clinical Strategy for the presentation.

RESOLEVED: That the following form the quality priorities for 2016/17 together with the above amendments:-

<u>Well led</u>
Integrated services and pathways

To develop the Gloucestershire Safety and Quality Improvement Academy

To introduce a robust mechanism for reviewing and reporting on avoidable deaths.

Safe

Reducing the likelihood of fractures being missed in our emergency departments

To implement the National Safety Standards for Invasive Procedures

Effective

Reducing the number of lower limb amputations in people with diabetes

Improving the management of patients requiring emergency abdominal surgery

To ensure antibiotics are prescribed in accordance with local formularies

To reuce the mortality from fractured neck of femur

Responsive

Improving how patients flow through our services, removing any unnecessary waits with a particular emphasis on early diagnosis of cancer.

To improve the experience of discharge for our patients

Improving care for people who use our services and have dementia and delirium

Learning from users through shadowing and co-design

Improving the experience for children and their families as they move from paediatric to adult services

Caring

Living with and beyond Cancer

To improve our End of Life Care

007/16 DIVISIONAL ATTENDANCE – ESTATES AND FACILITIES

(Mr Neil Jackson, Director of Estates and Facilities attended the meeting for the discussion of this item)

The Director of Estates and Facilities presented his first report to the Committee providing a review of performance. He invited the Committee to consider whether there are any areas which they would like to be reviewed in greater detail. The Director of Estates and Facilities is undertaking a due diligence exercise which is nearing completion. To date there is good work particularly with the estates strategy. The catering service has achieved the top 5* rating for food hygiene and

several schemes are underway to improve the cost effectiveness and quality of service. Medical Engineering is addressing the backlog of work. The increased clinical workload and longer operational hours are putting the Portering Service under severe strain. The areas of challenge include a greater understanding of the service requirements and its core business to deliver improvements including contract management. There are opportunities to look at the whole Trust infrastructure to see how the estate can be best utilised for the right facilities. Bringing together back office functions will lead to changes in the estate to drive transformation.

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

- The Chair invited the Director of Estates and Facilities to reinstate in future reports the performance data for ward and department cleaning which was incorporated into previous reports to the Committee. **NJ**
- In response to a question from the Chair about the staff restructuring, the Director of Estates and Facilities said that the focus is to bring services “in-house” and to introduce a skill mix in more than one function to provide greater flexibility.
- In response to a question from the Chair about the planned service improvements in the catering service, the Director of Estates and Facilities said that the service needs to be consolidated with a greater understanding between the roles of nurses and catering staff.
- Mrs Lewis asked if there had been an improvement in recruitment in particular in the Portering Service. In response the Director of Estates and Facilities commented that generally there has been an improvement and with regard to portering the Division is looking at combing resources to improve the service. Arrangements are being made to speed up the recruitment process.
- The Director of Estates and Facilities said in response to a question from Mrs Lewis that menus are beginning to be offered in other languages.
- The Director of Safety commented that continuity of domestic staff on stroke wards had lead to an improved patient experience. He added that a new security meeting is to be established to review incidents of violence and aggression.
- Mr Foster invited the Director of Estates and Facilities to include in future reports in addition to the data a more forward looking approach with timeframes, responsible person and whether timeframes are achieved. The Chief Executive added that future reports should contain information of the performance of domestics.
- Mrs Adams said that the Trust should ensure that the best use is made of the existing estate noting the office space in the Tower Building at Gloucestershire Royal Hospital. The Chief Executive said that this is part of a broader issue for the Trust with the challenge to find other accommodation within the estate to enable moves to take place.

The Chair thanked the Director of Estates and Facilities for his report.

RESOLVED: That the report be noted.

008/16 SERIOUS UNTOWARD INCIDENTS

The Director of Safety briefed the Committee on current serious untoward incidents (SUIs), Never Events, high level reviews and RIDDOR reported incidents. He drew attention to the following open serious incidents:-

- Detection of rust coloured leakage in cystoscope following cleaning process – the Trust is working with Public Health England and awaiting the results of the risk assessment which will determine whether the 900 patients affected should be contacted. He stressed that the risk to patients is extremely low.
- Never event – misinterpretation of placement of naso gastric placement on x-ray – Training is underway for medical staff on interpretation of x-rays identified and appropriateness for overnight feeding. The main issue is to increase the amount of pH testing of gastric content prior to feeding as opposed to x-ray as pH testing is the safest method..
- Near miss never event – wrong side implant presented to joint. This was a repeat of a never event from 2015 where processes had been agreed and breached on this occasion. The Director of Safety is to meet the Chief of Service to undertake a technical analysis of the process. Mrs Haughton expressed concern over this incident. Dr Jackson hoped that the review would examine how the process was breached in its entirety. The Chair invited the Director of Safety to report back to the Committee when the investigation has been concluded. She also invited the Director of Safety to consider adjusting his Board report so that the Board receives updates on open serious incidents to every Board meeting. **AS**

The Chair thanked the Director of Safety for the report.

RESOLVED: That the report be noted.

009/16 MEDICINE OPTIMISATION BI-ANNUAL REPORT 2015/16

(Mr Martin Pratt, Pharmacy Director, attended the meeting for the discussion of this item)

The Pharmacy Director presented his bi-annual report updating the previous report in June 2015 regarding progress made in relation to the medicines optimisation agenda. He drew attention to one of the two areas of outstanding practice identified by the CQC regarding the Patients' Own Controlled Drugs register which was created by pharmacy and has been adopted and sold to many hospitals within NHS South. At the West of England Academic Health Science Network Annual Conference Pharmacy won the award in the category "Tomorrow's workforce" for our work developing Pharmacist Independent Prescriber.

The Pharmacy Director showed a video of the work of homecare in the supply of medicines. He then made a presentation covering pharmacy homecare, national comparisons where the Medication Optimisation Dashboard is not intended to be used as a performance management tool but is designed to encourage localised discussions about how well patients are being supported to get maximum benefit from medicines and medication errors.

During the course of the discussion, the following were the points

made:-

- In response to a question from Mrs Lewis, the Pharmacy Director confirmed that the scheme launched by NHS England in 2015 to part fund the employment of 400 clinical pharmacists within GP practices for a three year period is underway. The view is that they will become independent prescribers to improve drug usage and see patients. The Pharmacy Director added that Independent Prescribing Pharmacists bring benefits to patients and financial savings to the Trust with benefits to GPs for the provision of the service. This will impact on the availability on the Trust to provide ward-based pharmacy teams. The Chair invited the Pharmacy Director to inform the Committee of the impact on the Trust in his next report to the Committee. **MP**
- The Chair referred to the compliance with the Policy for Ordering, Prescribing and Administering Medicines (POPAM) noting that a programme of monthly audits has now been adopted to improve monitoring, feedback and safety. The Medical Director added that robust data is necessary for effective audits.
- The Chair invited the Pharmacy Director to ensure that future reports to the Committee contained up-to-date information. Mrs Haughton said that the Clinical Commissioning Group has not received the data for the QIPP monies which the Pharmacy Director undertook to provide. **MP**
- Mr Foster enquired whether the introduction of SmartCare will impact on medication errors. In response, the Pharmacy Director said that SmartCare will provide an opportunity to reduce medication errors. The Chief Executive added that there are different types of errors and SmartCare will provide a date and time in the process for issuing medicines.

The Chair thanked the Pharmacy Director for the report and presentation.

RESOLVED: That the report and the level of assurance provided.

010/16 MORTALITY CODING UPDATE

(Mrs Vicky Butcher, Dr Foster Intelligence, attended the meeting for the presentation of this item)

The Medical Director presented the report updating the Committee on the impact of coding on the Trust's mortality measures. Since the presentation to the Committee in July 2015, Dr Foster has been working with the Hospital Mortality Indicators Group (HMIG) and the Information Team to better understand the recording of coding. In particular the consistent capture of comorbidities has a significant impact on the calculated mortality. This arises because the likelihood of death increases for a given diagnosis if the patient has other conditions (comorbidities) in addition to their admission diagnosis. The possible explanations for observed differences in coding have been discussed in the HMIG. The Group's view is that the differences in comorbidity recording are unlikely to be a true representation of the clinical situation between the two sites. There are different approaches to data capture where in Gloucestershire Royal Hospital it is predominately a remote process based in the coding department away from clinical areas and in Cheltenham General Hospital coding is undertaken on the ward. HMIG consider that coding processes should be standardised across the Trust.

Mrs Butcher gave a presentation on the site comparison of mortality, casemix and coding. There are differences in the standardised mortality ratio for the 2 main sites within the Trust with Gloucestershire Royal Hospital having a statistically significantly higher than expected mortality ratio where Cheltenham General Hospital has a mortality ratio that is within the expected range. Gloucestershire Royal Hospital has a higher crude mortality rate and lower expected mortality rate in comparison with Cheltenham General Hospital. Work undertaken in September 2015 indicates that there are differences in the casemix of patients treated at the two main sites. This work was based on data for the 2013/14 financial year as this was the most recent full financial year for which a national benchmark was available at that time. Based on casemix, the issue is should Gloucestershire Royal potentially have a higher expected rate of mortality.

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

- In response to a question from Mr Foster, the Medical Director confirmed that it is more difficult to capture comorbidities in the Emergency Department, particularly at Gloucestershire Royal Hospital, compared to elective admissions due mainly to the working environment.
- Dr Jackson asked whether the introduction of SmartCare will assist in capturing the data. In response, the Medical Director said that SmartCare will provide the opportunity for comorbidity notes to be carried forward. However, the process needs to be right with a link between coders and clinicians. Additional support needs to be provided to coders especially during the streamlining of the process.
- Mrs Butcher confirmed that the data used by Dr Fosters is three month in arrears.

The Chair thanked the Medical Director for the report and Mrs Butcher for the presentation.

RESOLVED: That the development of optimum and standardised clinical coding be endorsed.

011/16 MINUTES OF THE HEALTH AND SAFETY COMMITTEE MEETING HELD ON 21 DECEMBER 2015

The Director of Safety presented the minutes of the meeting of the Health and Safety Committee held on 21 December 2015. He highlighted that the national figures for violence and aggression between patients on staff had reduced to 76 from 114 last year.

The Chair thanked the Director of Safety for the minutes.

RESOLVED: That the minutes be noted.

012/16 MINUTES OF THE PATIENT SAFETY FORUM MEETING HELD ON 9 DECEMBER 2015

The Director of Safety presented the minutes of the meeting of the Patient Safety Forum held on 9 December 2015. He highlighted the missed diagnoses project focussing on missed fractures in the Emergency Department which is progressing well.

The Chair thanked the Director of Safety for the minutes.

RESOLVED: That the minutes be noted.

013/16 NOTES OF THE RESEARCH AND INNOVATION FORUM MEETING HELD ON 8 DECEMBER 2015

The Director of Clinical Strategy presented the notes of the meeting of the Research and Innovation Forum held on 8 December 2015. She drew attention to the West of England LCRN where strategies to increase recruitment have been discussed. This will impact on research trials and is an issue for the portfolio. The reports from Trust Sponsored Studies highlighted the governance arrangements. The last two research for Gloucestershire events were very successful.

The Chair thanked the Director of Clinical Strategy for the notes.

RESOLVED: That the notes be noted.

014/16 MINUTES OF THE PATIENT EXPERIENCE STRATEGIC GROUP MEETING HELD ON 12 NOVEMBER 2015

The Head of Patient Experience presented the minutes of the meeting of the Patient Experience Strategic Group held on 12 November 2015.

The Chair thanked the Head of Patient Experience for the minutes.

RESOLVED: That the minutes be noted.

015/16 MINUTES OF THE HOSPITALS MEDICINE MANAGEMENT COMMITTEE MEETING HELD ON 21 OCTOBER 2015

The Medical Director presented the minutes of the Hospitals Medicines Management Committee meeting held on 21 October 2015.

The Chair thanked the Medical Director for the minutes.

RESOLVED: That the minutes be noted.

016/16 ANY OTHER BUSINESS

Board Patient Story: The Chief Executive reported that following the presentation of a patient story at a recent Board meeting involving a child, funding has been secured for the Divisional Director of Nursing for Women and Children's Division to provide training in behaviours. This is anticipated to take two years to conclude largely due to the number of staff involved.

CCG Request for data: The Director of Clinical Strategy informed the Committee that data will be required for the CCGs improving services project and arrangements are being made for this to be provided centrally within the Trust.

017/16 QUALITY COMMITTEE WORK PLAN

The Trust Secretary was invited to update the Committee's Workplan as follows:- **MW**

- To liaise with Dr Kate Hellier to present in either March or April 2016 on her work with IHR on safety and patient flow.
- To liaise with the Director of Clinical Strategy to prepare future agendas following the Key Lines of Enquiry (KLOEs) approved earlier in the meeting as part of the Quality Report.

018/16 COMMITTEE REFLECTION AND DEVELOPMENT

Following the suggestion made as part of the Board Governance review, the Chair invited attendees to reflect on the meeting and the following observations were made:-

- The opportunity afforded to junior members of staff to present and explain their work to a Board Committee.
- The quality of the reports and the information contained therein where further work is underway to provide greater consistency in the four main Divisional reports.
- The Chair and Trust Secretary to design a feedback form to be completed after Divisional attendances **HM/MW**

The Chair thanked attendees for their observations.

019/16 DATE OF NEXT MEETING

The next meeting of the **Quality Committee** will be held on **Friday 11 March 2016** in the **Boardroom, 1 College Lawn, Cheltenham** commencing at **9.30am**.

The meeting ended at 12.17pm

Chair
11 March 2016

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

SUMMARY OF THE MINUTES OF THE MEETING OF THE TRUST SUSTAINABILITY COMMITTEE HELD ON MONDAY 18 JANUARY 2016

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

004/16	**SMARTCARE & SUSTAINABILITY- PRESENTATION BY GARETH EVANS**
	Gareth Evans, SmartCare Programme Manager presented an overview of SmartCare, the Integrated Clinical Information System which is being rolled out to support the Trust and enable it to satisfy the requirements of Government initiatives for the move to a digital and paperless environment in 2018. The aim is to provide current and sustainable systems and technical infrastructure to support the provision of high quality patient care. Sustainability was not a priority when the business case was being considered, but sustainability benefits include considerably reduced paper use, with 90% of nursing and surgery documentation becoming electronic, and medication errors anticipated to be reduced as instances of incorrect prescribing and associated waste. The hosting of the applications at low carbon data centres has also contributed to minimising the impacts of the technology.
005/16	**MONITORING REPORTS: PROCUREMENT**
	Alex Gent reported on progress against the P4CR Flexible Framework. It was agreed at the November meeting that a different approach would be applied to engaging with key suppliers to achieve Level 1, and a meeting was subsequently arranged with Harris Ethical Ltd who provide a free consultancy to help support this (in conjunction with Atkins). This engagement includes requesting information based on spend and number of deliveries from six of our largest suppliers for their proposals on how they can work more sustainably with the Trust, and then replicate the model out to wider supply base.
005/16	**MONITORING REPORTS: CARBON AND ENERGY – CARBON EMISSIONS**
	Andy Heasman reported on current position. Achieving the targeted reduction in carbon of 10% still remains challenging, further programmes to encourage the reduction in energy use are being implemented to mitigate this as far as practicable. The year-end report for the first year of operation for the CGH Combined Heat Power Plant (CHP) is outstanding from Vital Energi, however, the draft version confirms the target savings have been achieved. A planned meeting on the 20th of January will review suppler performance and the proposed business case for the development of a CHP at GRH.
005/16	**MONITORING REPORTS: SUSTAINABILITY TEAM**
	Dee Gibson-Wain confirmed that the quarterly meetings are up and running and the enthusiastic team have compiled a list of various projects to pursue. New sustainability intranet pages were also review and approved by the committee.
008/16	**FORWARD PROGRAMME**
	The forward plan was reviewed which includes further enhancements to the Monitor return, presentations on travel plan strategy, workstyles, and a dry run of the executive development training on sustainability.
010/16	**SHARING GOOD PRACTICE**
	This was the first meeting held via video conference between the sites. It was agreed that this worked well, saved significant time and stress. Future meetings of this committee will therefore be held as video conferencing calls. This raised the challenge of prioritising room with VC equipment for VC use.

ITEM 10

SUMMARY OF THE MEETING OF THE AUDIT COMMITTEE TO BE HELD ON 22 JANUARY 2016

PAPER (To follow)

Ms Anne Marie Millar
Chair

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – JANUARY 2016

REPORT OF THE CHIEF EXECUTIVE

1. National

1.1 Dame Eileen Sills has been appointed as the National Freedom of Speak Up Guardian to support whistle-blowers in the NHS and improve reporting culture. Her service will be hosted by the Care Quality Commission but be independent.

2. Regional

2.1 The latest minutes of the West of England Academic Health Science Network are attached at Annex A.

3. Regulators

3.1 Every year the General Medical Council reviews a number of Deaneries to assess the quality of training for junior medical staff. In 2016/17 the Severn Deanery has been chosen for a review and within that process our Trust has been selected for a visit in April.

4. Our Trust

4.1 The recent holiday period saw very high demand for emergency admissions. From 26th December – 6th January some 315 additional patients over our normal run rate, required admission. On overage that was 26 patients per day i.e. an additional ward of patients.

4.2 The fourth SAFER week was held during the week of 18th – 22nd January 2016.

4.3 The SmartCare Programme moves closer to implementation of Phase 1 at the beginning of May. There has been a lot of focus on the training of staff, and in chasing up the small proportion of staff who require a Smartcard. On the technical side the team are preparing for the next major release of software which is due on 1st February.

4.4 Maria Bond attended the meeting of the Health and Safety Committee just before Christmas in her role as lead Non-Executive Director for this area.

4.5 Last week the Clinical Excellence Award round for 2015/16 was completed.

4.6 This month's learning from complaints/concerns include:

You said	We did
Problem with birthing ball in delivery suite	The Delivery suite has purchased additional anti-burst birthing balls and are introducing a daily equipment checklist to inspect for signs of wear and tear.
A respiratory referral rejected because not enough detail and addressed to incorrect specialty.	A review of referral letters has taken place to ensure correct level of detail and accuracy.
Delay in answering the telephone in ENT outpatients department	Admin leads have put plans in place to prevent this from happening again including review of existing workforce

4.7 The Risk Register is at Annex B.

Dr Frank Harsent
Chief Executive

January 2016

Meeting of the West of England Academic Health Science Network Board

To be held on Wednesday 2 December 2015 Commencing at 10:45am until 1:15pm in G1, Redwood Education Centre, Gloucestershire Royal Hospital, Great Western Road, Gloucester, GL1 3NN

Minutes:

Present:

James Scott	Vice-Chair (Chair in Steve West's absence)
Deborah Evans	Managing Director
Heather Mitchell	Chief Executive, SEQOL
Iain Tulley	Chief Executive, Avon and Wiltshire Mental Health Partnership NHS Trust
Ian Orpen	Chair, Bath and North East Somerset Clinical Commissioning Group
Mary Backhouse	Chief Clinical Officer, North Somerset Clinical g Group
Robert Woolley	Chief Executive, University Hospitals Bristol NHS Foundation Trust

In attendance:

Natasha Swinscoe	Director of Development
Anna Burhouse	Director of Quality
Lars Sundstrom	Director of Enterprise
Nick Leggett	Public Contributor
Adele Webb	Public Contributor
Emma Mollison	Board Secretary

Agenda item

1. Apologies

Steve Chair	Chair
Frank Harsent	Chief Executive, Gloucestershire Hospitals NHS Foundation Trust
Derek Sprague	Local Education Training Board Director, Health Education South West
Jenny Donovan	Director, CLAHRCW*est*

2. Minutes of meeting of 16 September and Matters arising

The minutes were agreed as an accurate record of the meeting.

Page 3, item 5.2 Finance Update: An in-year Income and Expenditure report to be produced and circulated to the Board following the budget meetings for individual workstreams. The information has been collected and this report can now be produced.

Action: Natasha Swinscoe

All other matters arising from September's Board meeting will be covered during the closed Board session.

Tenure of Board members

The West of England AHSN Board minutes of 10 December 2013 (page 6 para 8.3) stated that the Board have made all appointments, including the West of England AHSN Directors for up to a maximum of three years.

There are three changes to Board membership currently in progress:

- John Iredale, Pro Vice Chancellor for Health at the University of Bristol has replaced Jane Millar, University of Bath as the University Representative
- Iain Tulley – replacement not yet confirmed
- Frank Harsent – replacement not yet confirmed

Board members were asked to discuss the tenure of Board members.

Board members discussed the importance of continuity for the remainder of the AHSN's current 5 year licence. Board representatives felt it important to discuss with their member organisations to ensure they still feel they are successfully representing their mandate. It was agreed that with changes already taking place and to ensure continuity, Board members tenure would be extended for a further 2 years until the end of the current AHSN licence.

Action: Board members to discuss this with their relevant representing community and reply to Deborah Evans/Natasha Swinscoe.

3. Future of WEAHSN – Decisions from Discussion Seminar

The Board were invited to discuss each of the questions raised under point 7 of the Closed Board Session Futures paper:

- **Section 4.1:**

  Board members unanimously agreed that the West of England AHSN should convert from a CLG to a hosted organisation for years 4 and 5.

- **Section 4.3:** A redundancy reserve was discussed and Board members agreed that whilst fundamental accounting principles need to be recognised, a realistic redundancy reserve should be in place for both years 4 and 5. Board members also discussed the importance of working towards realistic estimates to ensure that the positive work of the West of England AHSN continues and funds are not put in a redundancy reserve if they could be used to support Business Plan delivery.

- **Section 5:** With agreement that the West of England AHSN should move to becoming a hosted organisation, the impact of this scenario no longer needs to be considered.

- **Section 6.4:** The Board noted that the most recent call for membership fees covered years 2 and 3, it was now important to decide whether or not further fees are sought from organisations.

  Board members discussed the following two points in relation to the membership funding model:

  - Will base fees for years 4 and 5 be reinstated?

  Board members unanimously agreed to membership fees being reinstated and of the urgency needed to inform organisations of this decision.

  Action: Natasha Swinscoe

  - Will membership fees be increased?

  Board members discussed the importance of communicating with member organisations the added value of the West of England AHSN and to ask them for their own feedback about how the West of England AHSN could help support their business plan going forward.

  Board members unanimously decided not to increase the membership fee for year 4.

- Priorities for years 4 and 5:

  Board members discussed the importance of the West of England AHSN continuing with and building upon its high quality work.

- Defining the legacy:

  Board members agreed the use of the word 'legacy' is too presumptuous and that it would be more appropriate to talk about this in terms of the West of England AHSN's past achievements/successes.

- Extraordinary General Meeting:

  Board members have taken a clear decision in terms of the future of the West of England AHSN so at present an Extraordinary General Meeting is not necessary. One may become necessary when funding for year 4 is confirmed.

  Action: Natasha Swinscoe

4. 2014/15 Audit report

Grant Thornton presented their findings to the West of England AHSN Audit Committee on 20 November 2015. There are no issues to report to the Board and following their approval must be submitted to Companies House by 31 December 2015.

Board members unanimously approved the 2014/15 accounts, including the accompanying Letter of Representation.

Grant Thornton are to be made aware of the decisions taken during this Board meeting.

Action: Natasha Swinscoe

5. Items for Information

5.1 Managing Directors Report

The West of England Genomics Partnership visit from NHS England took place on 19 November 2015.The assessment interview went well and a recommendation to the Genomics England Board will be made public on 16 December 2015. If successful, the service will go live from early January 2016. Prior to the assessment interview a number of individuals were interviewed with the focus on rare disease or cancer experience, this had resulted in a group of 20 individuals who are contributing to the West of England Genomics Medical Centre and they will have their first meeting in the New Year.

The Open Prescribing Platform was receiving positive feedback. The West of England AHSN has offered the other 14 AHSN's the opportunity to promote it to CCG's as an AHSN offer.

The Board:

Noted the Managing Directors Report.

5.2 Governance Report

There was nothing further to highlight to Board members following on from the discussions and decisions that have already taken place during the Board meeting.

The Board:

Noted the progress made since September 2015 including the Risk Register update.

5.3 Enterprise Report

The West of England AHSN Test Bed application for the Diabetes Digital Coach progressed to the interview stage which took place on Tuesday 1 December 2015. Of the 10 interviewed, 5 will be successful in receiving the grant and the West of England AHSN will be informed mid-December of the outcome. If unsuccessful, a smaller scale initiative will be implemented.

The Board would like a presentation about the Diabetes Digital Coach at the next Board meeting.

Action: Lars Sundstrom

The Industry Advisory Group met by teleconference which was valuable in assessing development of the workstream and in considering priorities for 2016/17. It was proposed to focus on working with 20 companies which was well endorsed by group members.

The Board:

Noted the Enterprise Update.

5.4 Evidence into Practice Update

Phase two of the 'Don't Wait to Anticoagulate' programme which commenced on 2 November 2015 was progressing well and almost 70% of GP practices had signed up across Gloucestershire Clinical Commissioning Group. There is a unique portal on the website: www.dontwaittoanticoagulate.net for patients to download information about their medication and to compare specifications. This work had been nominated for several posters and awards and had been presented to other AHSN's and at the 'Commissioning Live' event in Manchester. It had been estimated that throughout the 11 innovator practices in the first few weeks of the project, between 6-7 strokes had been saved.

The Board would like a presentation about the Health Foundation Flow at the next Board meeting.

Action: Anna Burhouse

The Board:

Noted the progress of the projects in the report.

5.5 Capacity and Capability Update

Chief Executives have been asked to nominate Improvement Coaches by early January 2016. An intensive induction programme was scheduled for March 2016.

A number of successful events have taken place throughout the year, a masterclass entitled 'Putting patients at the Heart of Quality Improvement' hosted by the Royal United Hospital Bath will provide delegates with the opportunity to learn and practice 'co-design' improvement techniques.

The Board:

Noted the progress made since September 2015 and approved the ongoing direction of travel.

5.6 Patient Safety Programme Update

The ED Checklist was currently being rolled out in Weston Area Health Trust, Gloucestershire Hospitals Trust and North Bristol Trust. The West of England AHSN was actively working with staff members and running training sessions. Emma Redfern had helped with its smooth implementation.

Heather Pritchard (Mental Health Collaborative Programme Manager) was now in post and will be working across the 5 AHSN's in the South of England for the Mental Health Collaborative. Heather is meeting with all the AHSN's and Patient Safety leads in each trust in January 2016, this will help to redefine what the mental health collaborative will be focusing on.

The Board:

Noted the progress on the development of the Patient Safety Collaborative.

5.7 Informatics Report

A positive meeting between the South Western Ambulance Service Foundation Trust and the West of England AHSN had taken place on Tuesday 1 December 2015. SWASFT are grateful for the help they are receiving to communicate more successfully with the Emergency Departments.

An ambitious Test Bed proposal supporting the use of the early warning score was unsuccessful in progressing to the interview stage. However, there was some innovative ideas to take the proposal forward in a different way.

The Board:

Noted the progress made since September 2015.

6. AOB

Remuneration Committee

West of England AHSN staff members, excluding Deborah Evans left the room.

The Remuneration Committee met on 17 November 2015 to enable an informed discussion to take place in relation to current arrangements for the remuneration of its senior team.

Salaries of the Chairman, Associate Clinical Director, Managing Director and Director of Development were agreed with no changes.

In July 2014 the Director of Change, Innovation and Service Improvement asked to have her pay reviewed. Deborah recommended that Anna's pay be brought in line with the Director of Developments.

Board members unanimously agreed to this salary change and for it to be backdated to July 2014.

Action: Deborah Evans

A recommendation was made to change the job title of the Director of Development to the Chief Operating Officer.

Board members unanimously agreed with the change in job title.

Action: Natasha Swinscoe

Deborah Evans left the room.

Due to personal circumstances Deborah has asked if she can reduce her working hours from four to two days per week, spread out over three shorter days. Board members recognised Deborah's skills and her regional and national connections.

Board members unanimously agreed to a reduction in Deborah's working hours which will commence from Easter 2016.

Note of thanks

The Board thanked Iain Tulley for his contribution to the West of England AHSN over the past two and a half years and wished him well for the future.

7. Date of next meeting

Wednesday 2 March 2016, 10.45-13.15
Boardroom, Oasis Centre, Royal United Hospitals NHS Foundation Trust, Combe Park, Bath, BA1 3NG

ANNEX B

TRUST RISK REGISTER – DECEMBER 2015

Risk	Controls	Responsible Director & Key Meeting	Assurance Committee	Review date	Likelihood score	Impact score	Risk rating score

M1
Inability of the local health and social care system to manage demand within the current capacity leading to significant fluctuation of attendances in ED
	• Weekly Emergency Care Board
	• Emergency Care Plan
	  ○ Addressing three main areas of concern
	  ▪ Demand
	  ▪ Staffing (Medical & Nursing)
	  ▪ Beds and capacity
	• Monthly Emergency Care Board report
	• Delivery of relevant QIPP plans & CQiUNs
	• Monthly County System Resilience group
		Director of Service Delivery
		
		Emergency Care Board
			Finance and Performance	Monthly	5	5	25

M1a The clinical risk of delay in treating patients arriving at Accident and Emergency during periods of high demand or staff shortage		Director of Service Delivery Emergency Care Board	Trust Board	Monthly	5	4	20
M1b Lack of availability of key groups of staff to fill vacancies caused by insufficient training programmes and regional allocations resulting reduced ability to meet operational and clinical targets and standards.	• Develop plan to manage the expected medical staffing shortfall by developing Advanced Nurse Practitioners and aligning with Health Education South West on development of Physician Associate role.	Medical Director Medical Staffing Review Group	Trust Management Team	Monthly	5	4	20
HR2b A lack of trained nurses (permanent & bank\agency) due to insufficient training places, a higher than expected turnover & new restrictions on overseas (non-European) retention rules leading to a failure to match nursing recruitment requirements.	• Proactive nurse recruitment strategy • Recruitment strategy group • Nurse Recruitment business case • Splitting of recruitment team to create dedicated nurse\HCA recruitment facility	Director of Human Resources & Organisational Development Recruitment Strategy Group	Trust Management Team	Monthly	5	4	20

Risk	Controls	Responsible Director & Key Meeting	Assurance Committee	Review date	Likelihood score	Impact score	Risk rating score
M1c The hospital is at full capacity with limited ability to accommodate surges in admissions with the consequence of an increasing LOS, increased use of temporary staffing and increased cancellations on the day of surgery due to outliers. This directly affects the Trust ability to respond to mass casualties in a major incident **This now incorporates C13 & C8**	• Implement the LOS plan to reduce LOS by 0.5 days, as part of the Emergency Care Plan • Complete capacity modelling exercise to identify further improvement • Examine wider community alternatives to support capacity surges • Delivery of Winter plan • Monitor Support visit plans • The EPRR self-assessment standards & action plan	Director of Service Delivery Emergency Care Board	F&P Board TMT	Monthly	4	4	16
F2 Failure to develop and implement in a timely fashion appropriate CIP projects and action plans to bring spend back to budgeted levels. Agency spend remains high and is impacted by both unfunded beds and supply of substantive	• Pay spend is reviewed by WRG, Delivery Board and ESIB and progress is discussed in detail within these meetings. Each Division is tasked with developing CIP programme to deliver appropriate savings in year. Nurse recruitment issues being addressed through comprehensive Nurse Recruitment Strategy, overseen by Recruitment Strategy Group.	Director of Human Resources & Organisational Development - Workforce Review Board	Finance & Performance committee	Monthly	4	5	20
C3 Risk arising from the sequence of Never Events leading to potential regulatory intervention and the potential effects on the reputation of the Trust . (Risk reduced following completion of High Level Review – to be removed)	• Each event has had a full root cause analysis and resulting action plan and is monitored for closure and completion of the actions as part of our governance arrangements • Introduction of National Standards for Invasive Procedures	Medical Director Director of Safety Patient Safety Forum	Quality Committee	Monthly	(2) 3	(4) 5	(8) 15

Risk	Controls	Responsible Director & Key Meeting	Assurance Committee	Review date	Likelihood score	Impact score	Risk rating score
DSp1 Inability to maintain business continuity for the OPMAS computer systems	• OPMAS contingency Mitigation Plan • Chemotherapy Sub Group • Oncology, Haematology and Palliative Care Board	Director of Service Delivery Emergency Planning Group	TMT	Monthly	3	5	15
N17 Increasing number of adolescents (12-17yrs) presenting with self harming behaviour are admitted because of required medical care but stay longer periods of time in the acute (paediatric or adult) wards as there appears to be insufficient external facilities for their mental health care. There is significant risk of these patients further harming themselves or other patients and visitors.	• Updating following review of current process and incidents to enhance local controls • The Local & Specialist Commissioners have been alerted. • CQC and the Safeguarding Board (County Board and Executive County) Board have been informed of the concerns.	Director of Nursing Safeguarding Board	TMT	Monthly	4	4	16
C11 Failure of timely transport arrangements provided by the new Commissioner led contract with ARRIVA, this detrimentally affects the patient experience, leads to cancellation of procedures and adds staffing costs to supervisor OP waiting for transport	• Agreed Recovery plan and monitoring • Weekly performance dashboard • Regular contract performance meetings • Sharing of individual patient stories	Director of Service Delivery	TMT	Monthly	5	3	15

Risk	Controls	Responsible Director	Assurance Committee	Review date	Likelihood score	Impact score	Risk rating score
C12 Delayed discharge of patients who are on the medically fit list above the agreed 40 limit leading to detrimental effects on capacity and flow of patients through the hospital from ED to ward	• Delivery of the Emergency care action plan • Monthly County System Resilience group • Weekly review of medically fit list by system Nursing Directors	Director of Service Delivery	Emergency Care Board	Monthly	5	4	20
F7 Delay in providing follow up appointments in a number of specialties - Neurology, Cardiology, Rheumatology, Paediatrics, Ophthalmology	• Establish Speciality specific plans • Monitor performance at Divisional Operational performance meetings	Director of Service Delivery	Planned Care Board	Monthly	4	4	16
S118 As consequence of increased emergency activity (see risk M1) the Day care unit and other similar non inpatient areas with beds are opened overnight to house inpatients causing an increased patient safety risk, a reduced patient experience and a negative effect on Day Surgery activity and efficiency and increased cancellations on the day	• Resource DCU as a 23hr Unit • Day to day bed management systems including community wide capacity tele-conferences and escalation procedures • Daily senior clinical manager meetings to manage safety, experience and activity whilst unit is open at night • Monitor Support visit plans	Director of Service Delivery	Emergency care Board	Monthly	5	4	20
S100 Continued failure to meet 62 day cancer standard leading to delayed treatment, caused by increased demand and insufficient available capacity in the relevant timeframes.	• Improve the access information provided to patients • Resolve pathway problems in Urology, Lower GI, Gynae, Lung & Head & Neck • Weekly internal monitoring with leads by Executive and at Monthly performance reviews. • Performance Management at Cancer management board • Performance trajectory report for each specialty	Director of Service Delivery	Cancer Management Board.	Monthly	5	4	20

Risk	Controls	Responsible Director	Assurance Committee	Review date	Likelihood score	Impact score	Risk rating score
S127 The Trust has reported a higher than expected mortality rate for patients with fractured neck of femur	• Dedicated MDT fractured neck of femur clinical review group • Fractured neck of femur action plan • External review arranged • Divisional Governance Monitoring	Medical Director	Quality committee Mortality Review Group	Monthly	4	4	16
New Risk With the introduction of a new system of Nurse Revalidation there is a risk of poor compliance to the recommendations leading to large numbers of nurses losing their registration, causing a significant impact on staffing.	• Continue with the current professional education support • Appoint a coordinator to manage the internal system • Establish a clear internal process • Improve the monitoring and governance systems that advise the Board	Nursing Director	TMT	Monthly	4	4	16
New Risk Ageing and out of support Network hardware, Single internet Circuit causing increased likelihood of Hardware Failures, decreasing likelihood and increased costs of finding replacement parts, reduction in resilience Leading to loss of IT services in physical locations and systems, operational disruption, reduces efficiency of clinical delivery and patient throughput (using manual processes) backlog of data entry	• Network procurement in final stages of business case development and approvals • Countywide Technology Blueprint Board, IT Partnership Board	Director of Clinical Strategy & Director of CITS	IM&T Board	Monthly	4	4	16

INTEGRATED PERFORMANCE MANAGEMENT FRAMEWORK

EXECUTIVE SUMMARY

TRUST BOARD – JANUARY 2016

1.0 INTRODUCTION

This report summarises the key highlights and exceptions in Trust performance up until the end of December 2015 for the financial year 2015/16.

2.0 KEY HIGHLIGHTS ON PERFORMANCE

- GP referrals are running at higher levels than last year and were 2.9% over last year at the end of December. Despite these rising referrals the Trust continues to meet the 18 Week RTT standard at Trust level for incomplete pathways as it has done each month this financial year.

- Again, despite rising referrals, the Trust has met the 14 day cancer target for patients urgently referred by their GP in November and for patients referred urgently with non-cancer breast symptoms. Based on reduced activity in December the 14 day cancer standard is predicted just to be missed for the quarter for urgent GP referrals and will be achieved for patients urgently referred with non-cancer breast symptoms.

- The Trust continues to meet the 31 day Cancer targets, having achieved standard in each month of this year.

- The Trust is exceeding the recovery plan for the 62 day cancer standard in December.

- Average length of stay for non elective patients at 5.5 days for December is below the Trust target of 5.8 days.

- The percentage of stroke patients spending 90% of their time on a stroke ward at over 81% continues to exceed the 80% target.

- There has been a marked fall in the percentage of operations cancelled on the day for a non medical reason to 0.7% in December

3.0 AREAS OF EXCEPTION ON PERFORMANCE

- Emergency admissions continue to increase and were particularly high in December, ending as 6.9% over plan at the end of month. The percentage of patients spending less than 4 hours in the Emergency Department was 82.6% compared to the target of 95%. A recovery plan is in place. Year to date the number of ambulance handovers delayed over 30 and 60 minutes continues to run below the total for last year.

- The number of delayed discharges at month end and the number of medically fit patients remaining in a hospital bed continue to run at high levels and above agreed system wide standards. This inability to discharge has impacted on our performance.

- There were 8 breaches of the mixed sex accommodation standard in December. This is related to high numbers of patients attending ED.

- There was one patient reportable MRSA patient in December. In November , there was a pre 48 hour case of MRSA bacteraemia which was found to be a contaminant under the PIR process and this case is automatically allocated to the Trust

- There was one Never Event in December.

- The percentage of eligible patients with VTE risk assessment continues to fall. There is an action plan to address this.

RECOMMENDATIONS

The Trust Board is requested to note the Integrated Performance Framework Report and to endorse the actions being taken to improve organisational performance.

Author: **Helen Munro, Head of Information**

Presenting Director **Helen Simpson, Deputy CEO & Executive Director of Finance**

Date: **January 2015**

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

PERFORMANCE AGAINST MONITOR COMPLIANCE FRAMEWORK

1 Aim

This summary aims to highlight key trends and performance issues facing the Trust in Quarter 3.

2 Background

The detailed breakdown of performance is available within the Performance Management Framework; this summary aims to act as a means to assure the Board, in making the quarterly declaration of its Governance Risk Rating to Monitor.

3 Governance Declaration

			2014/15				2015/16							
MONITOR TARGETS & INDICATORS		**Target**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Oct**	**Nov**	**Dec**	**Monitor weighting**	**Current position for Q3**
C-Diff Toxin Detection (post 48 hour annual target)		37/yr	9	6	8	13	8	10	10	3	4	3	1.0	
Incomplete pathways - % waited under 18 weeks		92%	92.2%	92.0%	92.3%	92.1%	92.3%	92.0%	92.0%	92.2%	92.3%	92.0%	1.0	
A&E 4 Hour Wait		95%	93.3%	94.3%	89.5%	82.7%	93.4%	89.7%	85.6%	86.1%	88.2%	82.6%	1.0	1.0
Cancer	31 Days for all subsequent drugs	98%	100%	100%	100%	100%	100%	100%		100%	100%		1.0	
	31 days for surgery	94%	99.0%	100%	100%	98.8%	100%	100%		98.8%	100%			
	31 days to Radiotherapy	94%	100%	98.6%	99.8%	100%	100%	100%		100%	100%			
	62 Days from referral to treatment from consultant screening ref	90%	91.4%	97.1%	92.4%	91.3%	97.3%	94.0%		97.1%	92.3%		1.0	1.0
	62 Days to Treatment (excluding rare cancers)	85%	88.1%	86.1%	78.4%	77.1%	73.9%	75.6%		77.7%	81.4%			
	14 Days to First Appt	93%	90.5%	94.1%	94.3%	88.8%	91.5%	90.9%		94.6%	93.2%		1.0	1.0
	14 days symptomatic breast (cancer not initially suspected)	93%	66.1%	93.6%	96.6%	94.9%	95.2%	91.8%		91.3%	94.6%			
	31 Days from Diagnosis to Treatment	96%	99.6%	99.8%	99.5%	100%	99.5%	99.7%		100%	100%		1.0	
			2.0	1.0	2.0	3.0	3.0	3.0						3.0

KEY: Actual Provisional

Gloucestershire Hospitals NHS
NHS Foundation Trust

PERFORMANCE MANAGEMENT FRAMEWORK 2015-16

January 2016

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TRUST PERFORMANCE - as at end December 2015

DOMAIN: OUR BUSINESS

Measure	Standard	Target Set By	Frequency	Current Data Mth/Qtr	2014/15 Q1	2014/15 Q2	2014/15 Q3	2014/15 Q4	2015/16 Q1	2015/16 Q2	2015/16 Q3	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Year end position	Basis of year / quarter end assessment
Monitor Financial Risk Rating	level 3	Monitor	M	Nov	3	3	3	3	3	3		3	3	3	3	3	3	3	3	3		year end cumulative
Achieve planned Income & Expenditure position at year end	Achieved or better at year end	Monitor	M	YTD	-£0.6m	-£3.7m	-£3.3m	-£2.2m	-£1.4m	-£1.6m		£0.1m	£0m	-£1.4m	-£3.1m	-£1.5m	-£1.6m	-£2.1m	-£2.1m	-£1.6m		year end cumulative
Emergency readmissions within 30 days - elective & emergency	Q1<6%; Q2<5.8%; Q3<5.6%; Q4<5.4%	Trust	M in arrears	Nov	6.3%	6.4%	6.2%	5.8%	6.4%	6.4%		6.5%	6.5%	6.3%	6.3%	6.5%	6.5%	6.4%	5.9%			current quarter end
GP referrals year to date - within 2.5% of previous year	range +2.5% to -2.5%	Trust	M	YTD	4.7%	4.6%	5.0%	5.9%	4.9%	4.4%	2.9%	7.1%	4.6%	4.9%	4.7%	4.5%	4.4%	2.9%	3.2%	2.9%		year end cumulative
Elective spells year to date - within 2.5% of plan	range ≥-1% to plan	Trust	M	YTD	0.0%	-5.5%**	-4.6%**	-3.3%**	-1.3%	5.1%	5.0%	-8.7%	1.3%	-1.3%	1.0%	3.1%	5.0%	5.1%	4.8%	5.0%		year end cumulative
Emergency Spells year to date - within 2.5% of plan	range ≤2.5% over plan	Trust	M	YTD	-4.2%	-3.0%**	-2.3%	-3.1%	2.4%	4.0%	6.9%	-	-	0.1%	1.4%	1.6%	4.0%	5.0%	5.9%	6.9%		year end cumulative
LOS for general and acute non elective spells	Q1 /Q2 <5.4days, Q3 /Q4 <5.8days	Trust	M	Dec	5.9	5.6	5.8	6.4	5.8	5.6	5.7	6.1	5.9	5.5	5.7	5.4	5.6	5.6	5.9	5.5		year end cumulative
LOS for general and acute elective IP spells	≤ 3.4 days	Trust	M	Dec	3.7	3.8	3.6	3.5	3.6	3.6	3.6	3.2	3.7	4.0	3.5	3.8	3.4	3.5	3.8	3.5		year end cumulative
OP attendance & procedures year to date - within 2.5% of plan	range +2.5% to -2.5%	Trust	M	YTD	-3.0%	-3.2%**	-2.2%**	-1.3%	-0.5%	0.6%	0.6%	-	-	-0.5%	-0.7%	0.1%	0.6%	0.8%	0.7%	0.6%		year end cumulative
% records submitted nationally with valid GP code	≥ 99%	Trust	M *	Oct	99.9%	100%	99.8%	100%	100%	100%		100%	100%	100%	100%	100%	100%	100%				year end cumulative
% records submitted nationally with valid NHS number	≥ 99%	Trust	M *	Oct	99.6%	99.7%	99.8%	99.8%	99.8%	99.7%		99.8%	99.8%	99.8%	99.8%	99.6%	99.7%	99.5%				year end cumulative
Carbon Utilisation **	-1.5%	Trust	M in arrears	Nov	-2.6%	-11.6%	-14.0%	-4.9%	-8.9%	-9.4%		-10.1%	-10.7%	-5.8%	-12.7%	-11.7%	-3.9%	-4.3%	-4.7%			current quarter end

* in arrears/national timetable

KEY: **Actual** **Provisional**

TRUST PERFORMANCE - as at end December 2015

DOMAIN: OUR SERVICES

Measure	Standard	Target Set By	Frequency	Current Data Mth/Qtr	2014/15 Q1	2014/15 Q2	2014/15 Q3	2014/15 Q4	2015/16 Q1	2015/16 Q2	2015/16 Q3	April	May	June	July	August	Sept	Oct	Nov	Dec	Year end position	Basis of year / quarter end assessment
INFECTION CONTROL																						
Number of Clostridium Difficile (C-Diff) infections - post 48 hours	37 cases/year	Monitor	M	Dec	9	6	8	13	8	10	10	4	4	0	4	4	2	3	4	3		year end cumulative
Number of Methicillin-Resistant Staphylococcus Aureus (MRSA) infections - post 48 hours	0	GCCG	M	Dec	0	0	1	1	0	0	2	0	0	0	0	0	0	0	1*	1		year end cumulative
MORTALITY																						
Summary Hospital-Level Mortality Indicator (SHMI)	≤ 1.10	Trust	Quarterly, 6 months in arrears	Apr 2014 – Mar 2015	-	-	-	-	-			1.09	-	-	-	-	-	-	1.09			year end cumulative
Crude Mortality rates	<2%	Trust	M	Dec	1.3%	1.2%	1.4%	1.6%	1.3%	1.0%	1.2%	1.5%	1.4%	1.0%	1.0%	1.2%	0.98%	1.3%	1.3%	1.1%		year end cumulative
SAFETY																						
Number of Never Events	0	GCCG	M	Dec	0	1	0	2	0	1	1	0	0	0	1	0	0	0	0	1		year end cumulative
% women seen by midwife by 12 weeks	90%	GCCG	M	Dec	90.3%	91.6%	90.8%	90.5%	90.3%	90.0%	89.6%	89.7%	88.7%	92.5%	90.5%	89.8%	89.1%	90.3%	90.1%	88.1%		year end cumulative
% stroke patients spending 90% of time on stroke ward	80%	GCCG	M	Dec	82.9%	80.7%	74.6%	67.4%	80.4%	78.7%	91.4%	70.6%	82.6%	86.0%	70.5%	81.7%	88%	91.3%	95.6%	82.4%		year end cumulative
% of eligible patients with VTE risk assessment	95%	GCCG	M	Dec	93.1%	93.2%	93.0%	93.8%	94.5%	93.7%	92.4%	94.3%	93.9%	95.4%	94.6%	94.4%	93.1%	94.1%	93.6%	89.6%		year end cumulative
ED																						
% patients spending 4 hours or less in ED	≥ 95%	Monitor	M	Dec	93.3%	94.3%	89.5%	82.7%	93.4%	89.7%	85.6%	91.6%	93.5%	95.0%	93.8%	86.1%	89.1%	86.1% **	88.2%	82.6%		current quarter end
Number of ambulance handovers delayed over 30 minutes	< previous year	GCCG	M	Dec	283	184	248	324	192	191	213	52	88	52	37	87	67	66	68	79		year end cumulative
Number of ambulance handovers delayed over 60 minutes	< previous year	GCCG	M	Dec	37	26	27	51	13	21	28	3	7	3	3	11	7	6	2	20		year end cumulative

* Pre 48 hour case of MRSA bacteraemia was found to be a contaminant under PIR process is automatically allocated to the Trust

** 86.2% of adjusted to take account of IT failure 31.10.15

TRUST PERFORMANCE - as at end December 2015

DOMAIN: OUR SERVICES

CQUINS

NATIONAL CQUINS

Measure	Standard	Indicator Weighting	Data Collection Frequency	Reporting Frequency	Current Data Mth/Qtr	2015/16 Q1	Q2	Q3	April	May	June	July	August	Sept	Oct	Nov	Dec	Year End Target
Acute Kidney Infection (AKI)	Q1 - Audit/baseline, Q2 & Q3 negotiated Target from baseline, Q4 Key items in discharge summaries	0.25%	M	Q	Q3	5%	19%	29%	0%	3%	12%	25%	20%	11%	14%	29%	44%	Q4 Target
Sepsis Screening 2a	2a to be completed before 2b implemented. Q1- 2a in place and baseline data established, Q2 2b baseline data established. Q3 locally agreed target from baseline achieved for 2a and 2b. Q4 Targets achieved (sliding scale to apply)	0.25%	M	Q	Q2	69%	83%		69%	54%	84%	82%	**83%**	**83%**				Q4 Target
Sepsis Antibiotic Administration 2b			M	Q	Q2	N/A	32%		N/A	N/A	N/A	33%	36%	32.0%				Q4 Target
Safer Flow Bundle 1.1 Senior review - Implementation of the SAFER flow bundle for all inpatients (excluding Paediatrics and Maternity) within GRH and CGH.	End of Q4 - 80%	0.5%	Q	Q				Audit/ Report							Report			80% Senior Review
Safer Flow Bundle 1.2 All patients to have an EDD - Implementation for all inpatients (excluding Paediatrics and Maternity) within GRH and CGH.	Q Reporting		Q	Q											Report			Q4 Target
Safer Flow Bundle 1.3 - Flow from ACU for all inpatients (excluding Paediatrics and Maternity) within GRH and CGH.	Q Reporting		M	Q											Report			Q4 Target
Safer Flow Bundle 1.4 - Early discharge - Implementation of the SAFER flow bundle for all inpatients (excluding Paediatrics and Maternity) within GRH and CGH.	Q Reporting		M	Q											Report			Q4 Target
Safer Flow Bundle 1.5 - Daily senior review of long length of stay patients - for all inpatients (excluding Paediatrics and Maternity) within GRH and CGH.	Q Reporting		M	Q											Report			Q4 Target
Dementia - Seek/Assess (33.3%)	End Q1 – 86% End Q2 – 87% End Q3 – 88% End Q4 – 90%	0.25%	M	M	Nov	25%			88.8%	88.1%	89.2%	90.7%	91.1%	86.2%	88.0%	89%		
Dementia - Investigate (33.3%)	End Q1 – 86% End Q2 – 87% End Q3 – 88% End Q4 – 90%		M	M	Nov				100%	100%	100%	100%	100%	100%	100%	100%		
Dementia - Refer (33.3%)	End Q1 – 86% End Q2 – 87% End Q3 – 88% End Q4 – 90%		M	M	Nov				100%	100%	100%	100%	100%	100%	100%	100%		
Delerium	Q1 - Develop Assessment tool, Q2 Roll out to selected wards Q3 Further wards rollout, Q4 Further ward rollout and audit		M	Q	Nov	25%			On target	On target	On target	On target	On target	On target	On target	on target		Achieve project aim and Q4 report

LOCAL CQUINS

Measure	Standard	Indicator Weighting	Data Collection Frequency	Reporting Frequency	Current Data Mth/Qtr	2015/16 Q1	Q2	Q3	April	May	June	July	August	Sept	Oct	Nov	Dec	Year End Target
Planned Process for the Transition from Child to Adult Services	Q1 - Develop Policy, Q2 Implement Q3 & Q4 test and audit - 2 year plan	0.250%	Q	Q														
Frailty	Q1 - Develop Assessment tool, Q2 Implement Q3 Audit & locally agree baseline improvement Q4 agreed target with sliding scale	0.187%	M	Q														
Configuring Emergency Surgical Services	Q1-Q2 - baseline, Q3 &Q4 agreed target from baseline	0.187%	M	Q		G					Report and baselines			REPORT			TARGET TBC	Q4 TARGET
Reduction to the number/rate of Lower Limb amputations through the deployment of a MDT approach	Q1 - Develop Plan Q2 Program Report Q3 & Q4 audit	0.187%	M	Q							REPORT			REPORT			TARGET TBC	Q4 TARGET
Cancer Survivourship	Q1-Q3 Implementation Q4 Outcome measure	0.500%	M	M							REPORT			REPORT			REPORT	Q4 TARGET

SPECIALISED CQUINS

2015/16

Measure	Standard	Indicator Weighting	Data Collection Frequency	Reporting Frequency	Current Data Mth/Qtr	Q1	Q2	Q3	April	May	June	July	August	Sept	Oct	Nov	Dec	Year end target
Mandatory Clinical Utilisation Review (CUR)	No Q1. Q2 - establish projectr team for CUR installation and implementation. Q3 - Operational and mobilisation plan to be agreed with commissioners. Q4 - Software installed in accordance to agreed plan. Training completed by agreed 'Go live date (must be before 1/04/16; use of system can be demonstrated and daily of use CUR can be evidenced in agreed bed numbers.Payment based on % number days used	0.4%	M	M		N/A												Q4 - 1a-1f met
Std 1 Clinical Utilisation Review Installation and Implementation:																		
1a) Provider has established and can evidence a project team																		
1b) Provider and commissioner have an agreed and documented plan with a scope of services which includes i) beds on which CUR will be used, ii) staff roles which will undertake the review function. iii)Number of staff to use tool and recieve training. iv) timeframe for installation and implementation including a "Go Live" date.																		
1c) Provider & commissioner have an agreed and documented operational /mobilisation plan including i) governance structure ii) reporting mechanisms iii) established IT software & interface methodology.																		
1d) Appropriate information flows established, datasets and a schedule of regular reports are agreed with commissioners.																		
1e) Software installed in accordance to agreed plan.Training completed by agreed 'Go Live date', use of system can be demonstrated and daily use of CUR can be evidenced in agreed bed numbers																		
1f) Software & interfaces are installed and Live and training is completed by the agreed "Go Live" date. Daily use in practice of CUR can be evidenced in agreed bed numbers -payment is based on % of days used.																		
Oncotype DX Testing and Data collection:	No Q1; Q2 - Q4 Data collection against indicators	0.4%	Q	Q														Q4 Target
Increasing Home Renal Dialysis	Q1 baseline and targets agreed for Q1-Q4; Q2, Q3 & Q4 - achieve agreed targets	0.4%	Q	Q							Report			target from baseline		target from baseline		Q4 Target
Reduce Delayed Discharges from ICU to ward level care by improving bed management in wards	Quarterly reports	0.4%	Q	Q					100%; 8%			100%; 2%						99%; 0%
2 Year outcomes for infants < 30weeks gestation	Completed design and implementation of action plan in year 1, 50% of eligible babies having data recorded in year 2 (based on 2014/2015 birth rate) and 75% of eligible babies having data recorded in year 3 (based on 2014/2015 birth rate) for full payment	0.4%		Q					On target	On target	Report	On target	On target	Report	On target	On target		Q4 target

TRUST PERFORMANCE - as at end December 2015

DOMAIN: OUR PATIENTS

PATIENT EXPERIENCE

Measure	Standard	Target Set By	Frequency	Data Mnth/Qtr	2014/15 Q1	2014/15 Q2	2014/15 Q3	2014/15 Q4	2015/16 Q1	2015/16 Q2	2015/16 Q3	April	May	June	July	August	Sept	Oct	Nov	Dec	Year end position	Basis of year / quarter end assessment
18 WEEKS																						
Incomplete pathways - % waited under 18 weeks	≥ 92%	Monitor	M	Dec	92.2%	92.0%	92.3%	92.1%	92.3%	92.0%	92.0%	92.4%	92.3%	92.2%	92.4%	92.1%	92.0%	92.2%	92.3%	92.0%		current quarter end
15 key Diagnostic tests : numbers waiting over 6 weeks at month end	<1% of nos waiting at month end	GCCG	M	Dec	0.4%	1.5%	2.2%	1.4%	4.3%	5.1%	2.1%	5.2%	6.6%	4.3%	5.6%	7.1%	5.1%	1.3%	1.2%	2.1%		year end snapshot
Planned/surveillance endoscopy patients - nos. waiting at month end with and without dates	<1% of nos waiting at month end	GCCG	M	Dec	60	138	2	79	400	206	142	219	353	400	455	505	206	83	79	142		year end snapshot
CANCER																						
Max 2 week wait for patients urgently referred by GP	≥ 93%	Monitor	M	Nov	90.5%	94.1%	94.3%	88.8%	91.5%	90.9%		90.1%	94.0%	90.5%	88.9%	90.0%	94.2%	94.6%	93.2%			current quarter end
Max 2 week wait for patients referred with non cancer breast symptoms	≥ 93%	Monitor	M	Nov	66.1%	93.6%	96.6%	94.9%	95.2%	91.8%		93.6%	97.6%	95.1%	90.9%	92.3%	93.0%	91.3%	94.6%			current quarter end
Max wait 31 days decision to treat to treatment	≥ 96%	Monitor	M	Nov	99.6%	99.8%	99.5%	100%	99.5%	99.7%		100.0%	99.5%	99.6%	99.7%	99.6%	99.7%	100%	100%			current quarter end
Max wait 31 days decision to treat to subsequent treatment : surgery	≥ 94%	Monitor	M	Nov	99.0%	100%	100%	98.8%	100%	100%		100%	100%	100%	100%	100%	100%	98.8%	100%			current quarter end
Max wait 31 days decision to treat to subsequent treatment : drugs	≥ 98%	Monitor	M	Nov	100%	100%	100%	100%	100%	100%		100%	100%	100%	100%	100%	100%	100%	100%			current quarter end
Max wait 31 days decision to treat to subsequent treatment : Radiotherapy	≥ 94%	Monitor	M	Nov	100%	98.6%	99.8%	100%	100%	100%		100%	100%	100%	100%	100%	100%	100%	100%			current quarter end
Max wait 62 days from urgent GP referral to 1st treatment (exl.rare cancers)	≥ 85%	Monitor	M	Nov	88.1%	86.1%	78.4%	77.1%	73.9%	75.6%		74.4%	72.0%	72.9%	70.8%	85.1%	72.9%	77.7%	81.4%			current quarter end
Max wait 62 days from national screening programme to 1st treatment ***	≥ 90%	Monitor	M	Nov	91.4%	97.1%	92.4%	91.3%	97.3%	94.0%		98.3%	93.8%	98.1%	95.1%	92.6%	93.3%	97.1%	92.3%			current quarter end
Max wait 62 days from consultant upgrade to 1st treatment	≥ 90%	GCCG	M	Nov	85.7%	100%	94.1%	100%	60%	92.9%		50%	100%	60.0%	100%	88.9%	100%	100%	100%			current quarter end
DELAYED DISCHARGES																						
Number of delayed discharges at month end (DTOCs)	<14	Trust	M	Dec	9	5	14	13	11	13	19	8	8	11	11	16	13	8	26	19		year end snapshot
No. of medically fit patients - over/day	≤ 40	Trust	M	Dec	55	60	57	66	40	56	51	67	55	52	64	51	56	40	54	51		Total days
Bed days occupied by medically fit patients		Trust	M	Dec	4120	4,799	5,637	5,264	1,189	1,334	1.486	1,566	1,398	1,189	1,638	1,581	1,344	1,264	1,652	1.486		Total
Patient Discharge Summaries sent to GP within 24 hours	≥85%	GCCG	M in arrears	YTD	86.5%	87.1%	85.4%	86.7%	87.7%	89.1%		88.3%	89.2%	87.3%	90.0%	89.6%	88.7%	89.2%	88.7%			current quarter end
Number of Breaches of Mixed sex accommodation	0	GCCG	M	Dec	0	0	0	0	0	0	17	0	0	0	0	0	0	9	0	8		year end snapshot
CANCELLATIONS																						
Elective Patients cancelled on day of surgery for a non medical reason	≤ 0.8%	Trust	M	Dec	1.1%	1.4%	1.5%	1.7%	1.1%	1.2%	1.3%	1.2%	1.2%	0.9%	1.4%	1.3%	1.0%	1.6%	1.5%	0.7%		year end cumulative
Patients cancelled and not rebooked in 28 days	0	GCCG	M	Dec	9	9	19	41	17	18	15	6	6	5	2	8	8	8	4	3		year end cumulative

NO LONGER A NATIONAL TARGET

Measure	Standard	Target Set By	Frequency	Data Mnth/Qtr	2014/15 Q1	2014/15 Q2	2014/15 Q3	2014/15 Q4	2015/16 Q1	2015/16 Q2	2015/16 Q3	April	May	June	July	August	Sept	Oct	Nov	Dec	Year end position	Basis of year / quarter end assessment
18 WEEKS																						
Admitted pathways - % treated in 18 weeks *	≥ 90%	Trust	M	Dec	91.3%	90.5%	90.8%	90.1%	89.0%	88.7%	84.1%	87.4%	90.0%	89.6%	90.1%	87.7%	88.1%	84.8%	86.5%	84.0%		current quarter end
Non-admitted pathways - % treated in 18 weeks *	≥ 95%	Trust	M	Dec	95.2%	95.2%	95.0%	95.1%	95.1%	94.3%	94.9%	95.0%	95.2%	95.1%	95.0%	94.5%	93.5%	92.4%	92.1%	90.9%		current quarter end
Provider failure to ensure sufficient appointment slots available on choose & book (excluding 2 week waits) **	<4%	GCCG	M	May	9.9%	8.1%	6.8%	8.1%	-	-		10.0%	11.8%	-	-	-	-	-	-	-	-	year end snapshot

** National data, not available from HSCIC since move from national Choose and Book System to E-Referrals

*** Figures July - Sept refreshed to give final position at Q2 end.

TRUST PERFORMANCE - as at end December 2015

DOMAIN: OUR STAFF

Measure	Standard	Target Set By	Frequency	Current Data Mth/Qtr	2014/15 Q1	2014/15 Q2	2014/15 Q3	2014/15 Q4	2015/16 Q1	2015/16 Q2	2015/16 Q3	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Year end position	Basis of year / quarter end assessment
Total PayBill spend £'000	target + 0.5%	Trust	M	Dec	£22,224	£22,804	£22,946	£23,193	£23,757	£23,789	£23,424	£23,325	£23,045	£23,757	£23,451	£23,432	£23,789	£23,631	£24,089	£23,424		year end cumulative
Total worked FTE	target + 0.5%	Trust	M	Dec	6,343.1	6,474.3	6,494.0	6,623.0	6,576.0	6,628.0	6,623.0	6,541.0	6,509.0	6,576.0	6,582.0	6,608.0	6,628.0	6,610.0	6,644.0	6,623.0		year end cumulative
Annual sickness absence rate *	<3.5	Trust	M in arrears	Nov	3.76%	3.70%	3.70%	3.72%	3.79%	3.76%		3.80%	3.79%	3.80%	3.78%	3.79%	3.76%	3.76%	3.76%			year end cumulative
Staff who have annual appraisal	90%	Trust	M	Dec	83.0%	87.0%	88.0%	84.0%	85.0%	83.0%		83.0%	85.0%	85.0%	84.0%	83.0%	83.0%	83.0%	83.0%	85.0%		year end cumulative
Percentage of staff having well structured appraisals in last 12 months	45%	Trust	A	Mar	-	-	-	38%##	38%##	38%##	38%##	38%##	38%##	38%##	38%##	38%##	38%##	38%##	38%##	38%##		
Staff who completed mandatory training	90%	Trust	M	Dec	89.0%	91.0%	91*%	91.0%	92%*	92%*		91.0%	92.0%*	92.0%*	92.0%	92.0%	91.0%	91.0%	91.0%	91.0%*		year end cumulative
Staff Engagement indicator (as measured by the annual staff survey)	3.75	Trust	A	Mar	3.6%#	3.6%#	3.6%#	3.66##	3.66##	3.66##	3.66##	3.66##	3.66##	3.66##	3.66##	3.66##	3.66##	3.66##	3.66##	3.66##		annual
Improve Communication between senior managers and staff (as measured by the annual staff survey)	40%	Trust	A	Mar	30%#	30%#	30%#	35%##	35%##	35%##	35.0%##	35.0%##	35.0%##	35.0%##	35.0%##	35.0%##	35.0%##	35.0%# #	35.0%##	35.0%##		annual
Turnover rate (FTE)	7.5 -9.5%	Trust	M in arrears	Nov	9.04%	9.67%	10.57%	11.17%	11.16%	11.29%		11.17%	11.22%	11.09%	10.79%	10.99%	11.29%	11.14%	11.03%			year end cumulative

* 93% excluding Bank only staff
** 2012 annual Staff Survey result
# 2013 annual Staff Survey Result
2014 annual Staff Survey Result

The Monitor Plan includes GP Trainees who are excluded from figures reported here. From April 14 it has not been possible to obtain a plan figure to deduct from the overall total in order to derive the 'Plan without GP/PH Trainees'. Instead the actual cost/worked fte of these staff has been deducted from the total Planned expenditure/fte figure.
Changes have been applied retrospectively to April 14.
Further updates to FTE/Paybill targets applied Nov 14

*From 01 April 2015, Sickness Absence Rate excludes GP Trainees - this will have the effect of apparently increasing Sickness Absence initially.

TRUST PERFORMANCE - as at end December 2015

RISK ASSESSMENT - FORWARD LOOK

Measure	Standard	Target Set By	Comments
OUR BUSINESS			
Emergency Spells year to date - within 2.5% of plan	range ≤2.5% over plan	Trust	Emergency admissions are increasing to plan as the year progresses.
LOS for general and acute elective IP spells	≤ 3.4 days	Trust	LOS remains an issue. Gloucestershire wide action plan to address admissions avoidance and discharge processes. Note as admission avoidance schemes deliver - LOS may increase.
OUR SERVICES			
% patients spending 4 hours or less in ED	≥ 95%	Monitor	This remains a risk. Trust emergency care action plan in place plus Gloucestershire System wide resilience programme. This also impacts onto ambulance handovers and cancelled operations.
% of eligible patients with VTE risk assessment	95%	GCCG	Although compliance was achieved in June 15 due to process and paperwork revisions, this has been an area of underperformance for some time so remains a risk until the Trust has assurance that new processes have been embedded.
OUR PATIENTS			
Max wait 62 days from urgent GP referral to 1st treatment (exl.rare cancers)	≥ 85%	Monitor	A full recovery plan is in place and performance to this plan managed through the Cancer Management Board and the System wide resilience Group.
Number of delayed discharges at month end (DTOCs)	<14	Trust	Actions are being picked up as part of the emergency services plan.
No. of medically fit patients - over/day	≤ 40	Trust	
OUR STAFF			
Total PayBill spend £'000	≥ 95%	Monitor	This main risk here is around workforce supply and in part the impact of Government policy where non-EU Nurses are not exempt from sponsorship rules that hinders planned reductions in agency staffing levels and complaince with Monitor direction on the capping of agency levels.

EMERGENCY READMISSION WITHIN 30 DAYS - ELECTIVE & EMERGENCY

Trust Standard financial penalty

This relates to patients readmitted as an emergency within 30 days of either an elective or emergency discharge

Standard	Month	Actual	RAG for current month
<5.8%	Nov-15	5.9%	R

What is driving the reported overperformance

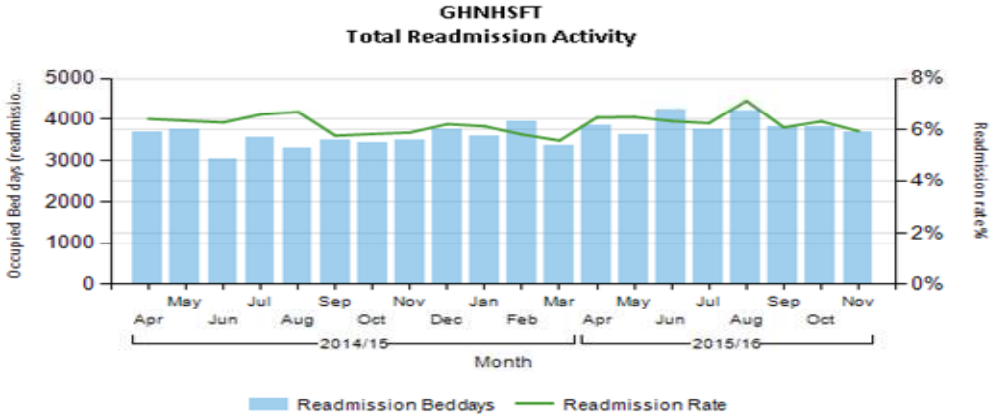
The emergency re-admission rate has been relatively constant this financial year although there has been a dip in November.

Actions taken to improve performance

This is being reviewed by the Emergency Care Board.

Expected date to meet standard	Apr-16
Lead Director	Director of Service Delivery

Activity



EMERGENCY SPELLS

Trust Standard

Number of emergency spells year to date to plan. Non elective spells not included

Standard	Month	Actual	RAG for current month
within 2.5% of plan	YTD	6.9%	R

What is driving the reported underperformance

Emergency spells are increasing in the winter months. The average/day is as follows;

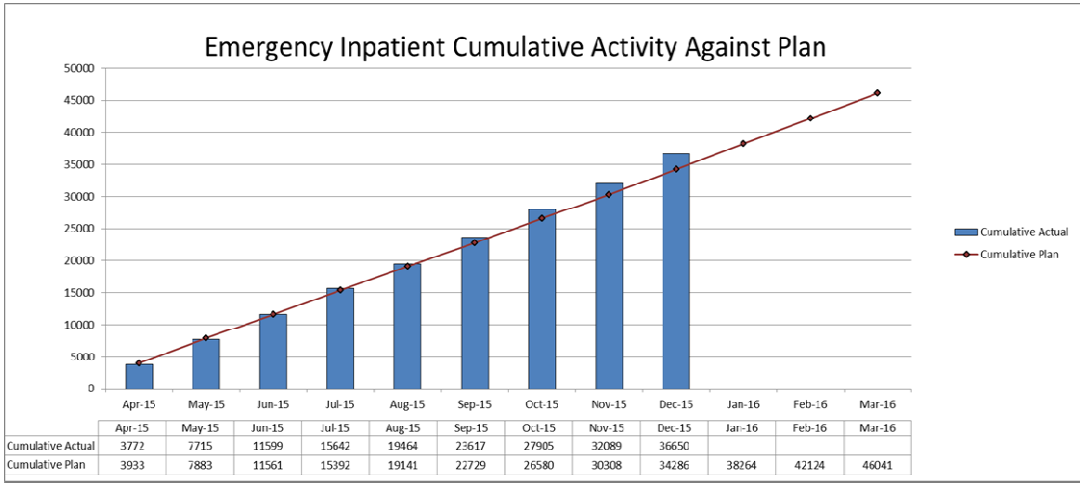
April	May	June	July	Aug	Sept	Oct	Nov	Dec
128	127	129	130	124	140	138	139	147

Actions taken to improve performance

Please refer to Emergency Pathway Report.

Expected date to meet standard	Apr-16
Lead Director	Director of Service Delivery

Activity



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Cumulative Actual	3772	7715	11599	15642	19464	23617	27905	32089	36650			
Cumulative Plan	3933	7883	11561	15392	19141	22729	26580	30308	34286	38264	42124	46041

OUR SERVICES

MRSA

GCCG Standard Financial Penalty

Number of MRSA cases - post 48 hours attributable to GHNHSFT

Standard	Month	Actual	RAG for current month
0	Dec-15	1	R

What is driving the reported underperformance

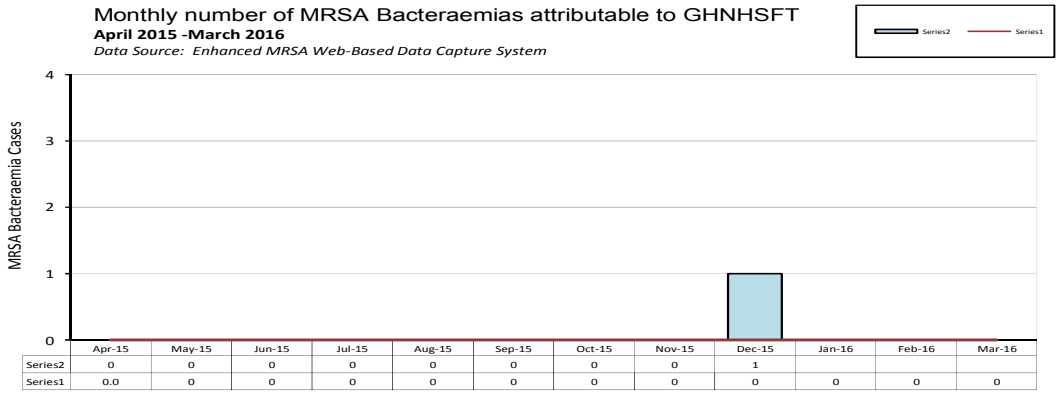
From root cause analysis an infected cannuale was thought to be the root cause of the December case and a missed opportunity for MRSA screening on admission. In November 2015 a pre 48 hour case of MRSA bacteraemia was found to be a contaminant under the PIR process this case is automatically allocated to the Trust.

Actions taken to improve performance

Training and competency assessment for staff that cannulate is already in place.Aseptic non touch technique a framework fo aspetic pratcice is being rolled out trustwide. A recent MRSA screening audit has revealed that compliance with screening is higher than the national average. Lessons learnt from the investigation will be shared trustwide

Expected date to meet standard	Jan-16
Lead Director	Director of Nursing

Activity



NEVER EVENTS

GCCG Standard Financial Penalty

Specified events that should never happen

Standard	Month	Actual	RAG for current month
0	Dec-15	1	R

What is driving the reported underperformance

One Never Event in Critical Care GRH occurred involving the use of a nasogastric feeding tube.

Actions taken to improve performance

The incident has been formally reported and will now undergo full root cause analysis, reports will be produced following contractual standards. Safety briefings will be sent out to clinical areas of lessons learnt as relevant.

Expected date to meet standard	Mar-16
Lead Director	Director of Safety

Activity

OUR SERVICES

% OF ELIGIBLE PATIENTS WITH VTE RISK ASSESSMENT

GCCG Financial Penalty

This relates to the percentage of eligible patients with a VTE risk assessment

Standard	Month	Actual	RAG for current month
95%	Dec-15	89.6%	R

What is driving the reported underperformance

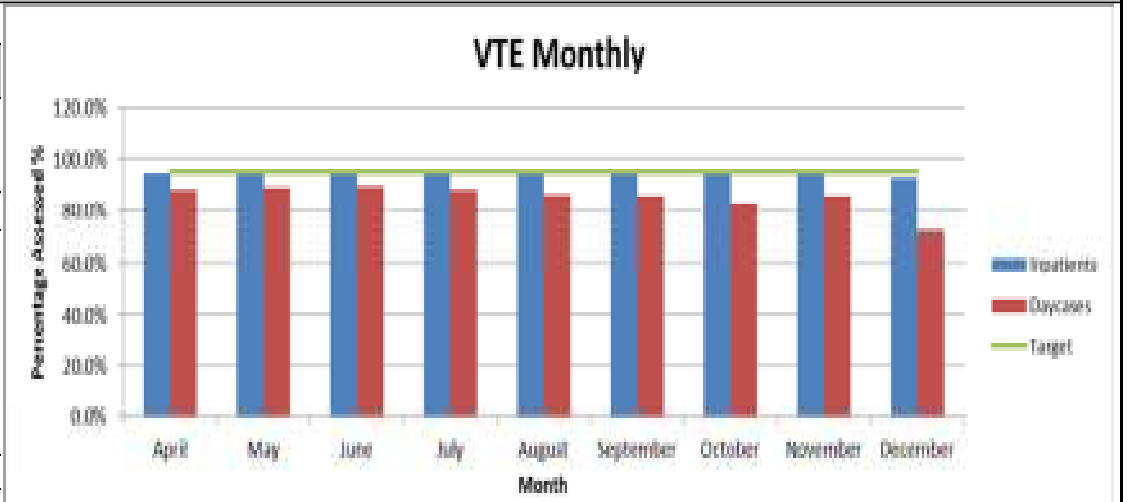
Further improvements to embed the system changes in the process and team ownership in ACUA are being made to improve the position.

Actions taken to improve performance

Regular multidisciplinary team, doctors, nurses, pharmacists and ward clerks
Improve the rate of prescription charts arriving with the patient from ED
Optimise specific roles, pharmacists, ward clerk, doctors, nurses.
Rota VTE champions at the weekend to check compliance
Share individual performance of clinicians.
There has been a continued fall in Day case assessment. There has been an increase in the total number of eligible patients as our daycase numbers increase. The Surgical Division are taking steps to change the pathway for these patients.

Expected date to meet standard	Mar-16
Lead Director	Director of Safety

Activity



TOTAL TIME IN EMERGENCY DEPARTMENT

Monitor Standard
GCCG Financial Penalty

This relates to the percentage of patients spending 4 hours or less in Emergency Department -Trust

Standard	Month	Actual	RAG for current month
≥ 95%	Dec-15	82.6%	R

What is driving the reported underperformance

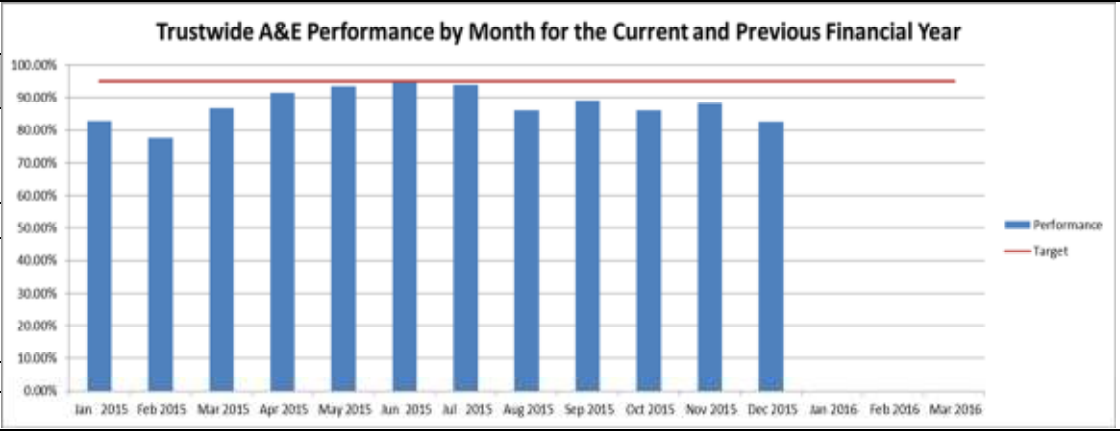
Please refer to Emergency Pathway Report

Actions taken to improve performance

Recovery plan in place focusing on:-
- internal flow
- ED Department
- Admission avoidance

Expected date to meet standard	Apr-16
Lead Director	Director of Service Delivery

Activity



OUR SERVICES

AMBULANCE HANDOVERS DELAYED OVER 30 MINUTES

GCCG Standard
Financial Penalty

Number of ambulance handovers to ED over 30 minutes

Standard	Month	Actual	RAG for current month
< previous year	Dec-15	79	R

What is driving the reported underperformance

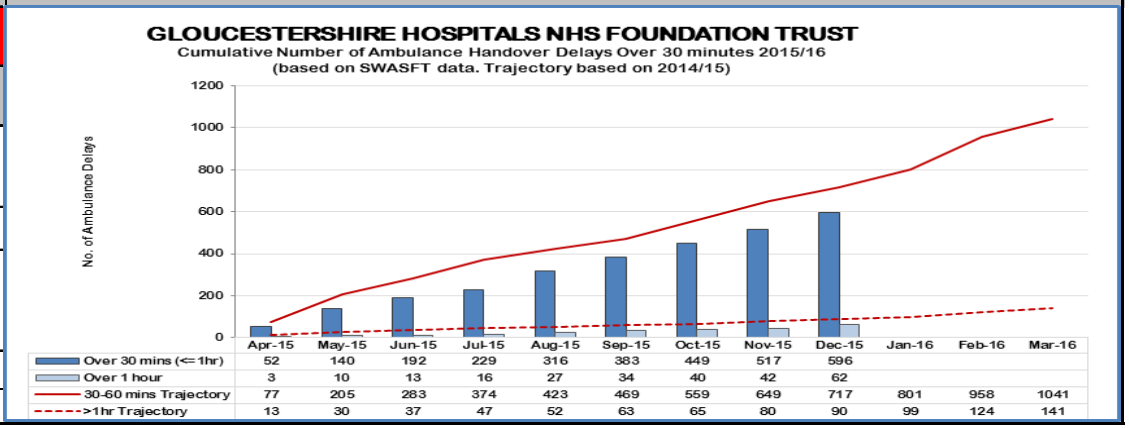
Please refer to Emergency Pathway Report

Actions taken to improve performance

Please refer to Emergency Pathway Report

Expected date to meet standard	Apr-16
Lead Director	Director of Service Delivery

Activity



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Over 30 mins (<= 1hr)	52	140	192	229	316	383	449	517	596			
Over 1 hour	3	10	13	16	27	34	40	42	62			
30-60 mins Trajectory	77	205	283	374	423	469	559	649	717	801	958	1041
>1hr Trajectory	13	30	37	47	52	63	65	80	90	99	124	141

AMBULANCE HANDOVERS DELAYED OVER 60 MINUTES

GCCG Standard
Financial Penalty

Number of ambulance handovers to ED over 60 minutes

Standard	Month	Actual	RAG for current month
< previous year	Dec-15	20	R

What is driving the reported underperformance

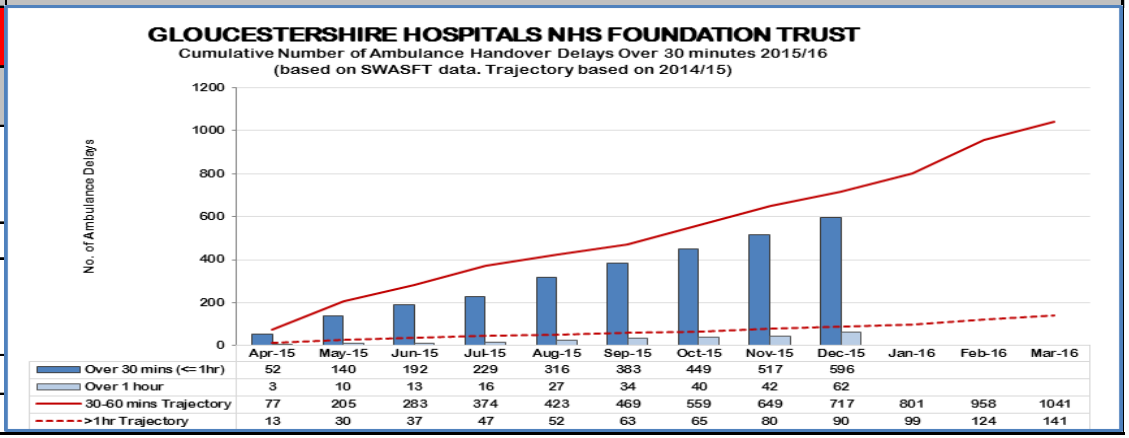
Please refer to Emergency Pathway Report

Actions taken to improve performance

Please refer to Emergency Pathway Report

Expected date to meet standard	Apr-16
Lead Director	Director of Service Delivery

Activity



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Over 30 mins (<= 1hr)	52	140	192	229	316	383	449	517	596			
Over 1 hour	3	10	13	16	27	34	40	42	62			
30-60 mins Trajectory	77	205	283	374	423	469	559	649	717	801	958	1041
>1hr Trajectory	13	30	37	47	52	63	65	80	90	99	124	141

ACUTE KIDNEY INFECTION (AKI)				National CQUIN Standard
AKI Diagnosis, treatment and planned care after discharge.				
Standard	**Month**	**Actual**	**RAG for current month**	**Activity**
>90% of 4 key items in discharge summaries Q4	**Dec-15**	**44%**	**R**	
What is driving the reported underperformance				
The project required us to create a new electronic recording process associated with the electronic discharge summary. This was launched on July 1st with supporting briefings and education, through testing several changes have been made through the 2nd quarter. It was predicted that the results would steadily improve but in Sept and October there was a significant and unexpected drop in results.With further changes the results have reached 44% in December from 14% in October. This means the target of 30% average over the 3rd quarter by 1%. Negotiations are ongoing with the CCG to mediate any loss of income.				
Actions taken to improve performance				
In September a group of F2 doctors were taken through the Silver Academy training for Improvement. This has resulted in the major changes in the results. Actions include Peer teaching and demonstation of the system by the F2s of the infoflex system. Redesign of the infoflex system through user evaluation. Other actions include sharing results with Divisions and directly with consulatnts, SAS doctors and junior doctors. General awareness raising and screensavers. The target for the 4th quarter is 90% average which will be very difficult to achieve. Income loss is on a sliding scale starting from 50%.				
Expected date to meet standard				
Lead Director				

OUR PATIENTS

DIAGNOSTIC WAITS OVER 6 WEEKS

GCCG Standard Financial Penalty

This relates to number waiting over 6 weeks for 15 key Diagnostic tests

Standard	Month	Actual	RAG for current month
<1% of nos waiting at month end	Dec-15	2.1%	R

What is driving the reported underperformance

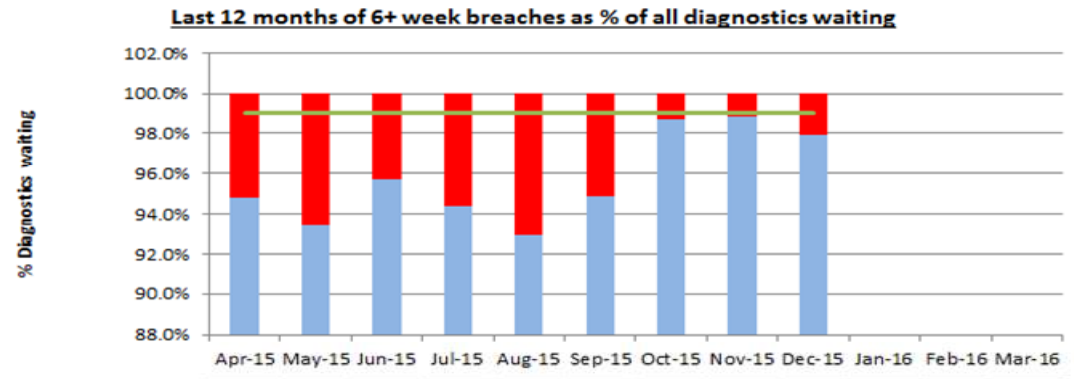
176 patients of which Neurophysiology 113, Urodynamics 32, Echos 10, MRI 10, Audiology 7, other imaging 3, Cystoscopy 1.

Actions taken to improve performance

Previous actions to address endoscopy and echos have delivered. There is now a short term issue in neurophysiology and the Medical Division has a plan to reduce.

Expected date to meet standard	Mar-16
Lead Director	Director of Service Delivery

Activity



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
% Breaches	5.2%	6.6%	4.3%	5.6%	7.1%	5.1%	1.3%	1.2%	2.1%			
% Non Breaches	94.8%	93.4%	95.7%	94.4%	92.9%	94.9%	98.7%	98.8%	97.9%			
Target	99%	99%	99%	99%	99%	99%	99%	99%	99%			

PLANNED SURVEILLANCE ENDOSCOPY PATIENTS

GCCG Standard Financial Penalty

Number of patients waiting over 6 weeks past their 'to be seen' date on planned endoscopy waiting list at month end

Standard	Month	Actual	RAG for current month
<1% of nos waiting at month end	Dec-15	142	R

What is driving the reported underperformance

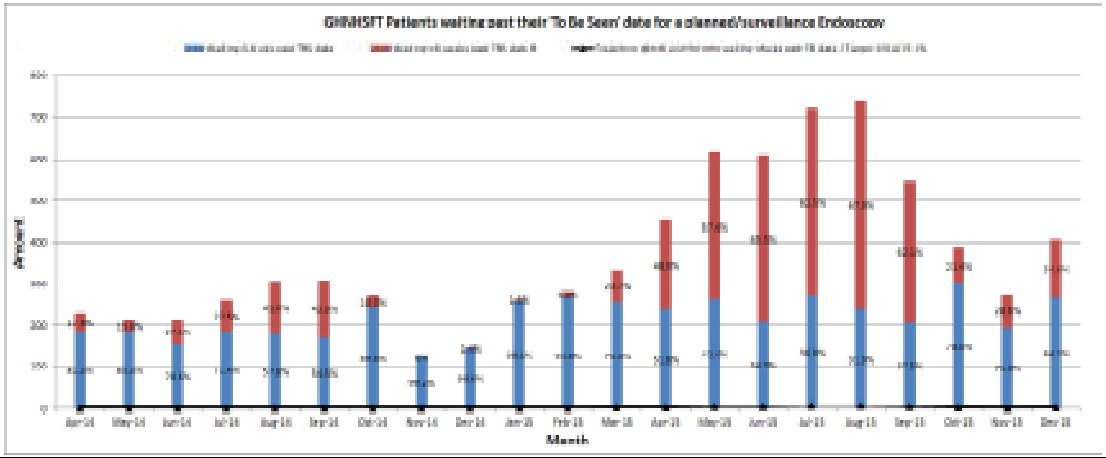
The Christmas period impacted on activity.

Actions taken to improve performance

Additional activity is being undertaken. Recovery plan in place.

Expected date to meet standard	Mar-16
Lead Director	Director of Service Delivery

Activity



MAXIMUM 62 DAYS FROM URGENT GP REFERRAL TO 1ST TREATMENT

GCCG Standard

This relates to patients referred urgently by their GP to first treatment date and excludes rare cancers

Standard	Month	Actual	RAG for current month
≥ 85%	Nov-15	81.4%	R

What is driving the reported underperformance

The position by tumour site for November is as follows. The position is above the Recovery Trajectory for November at 78%

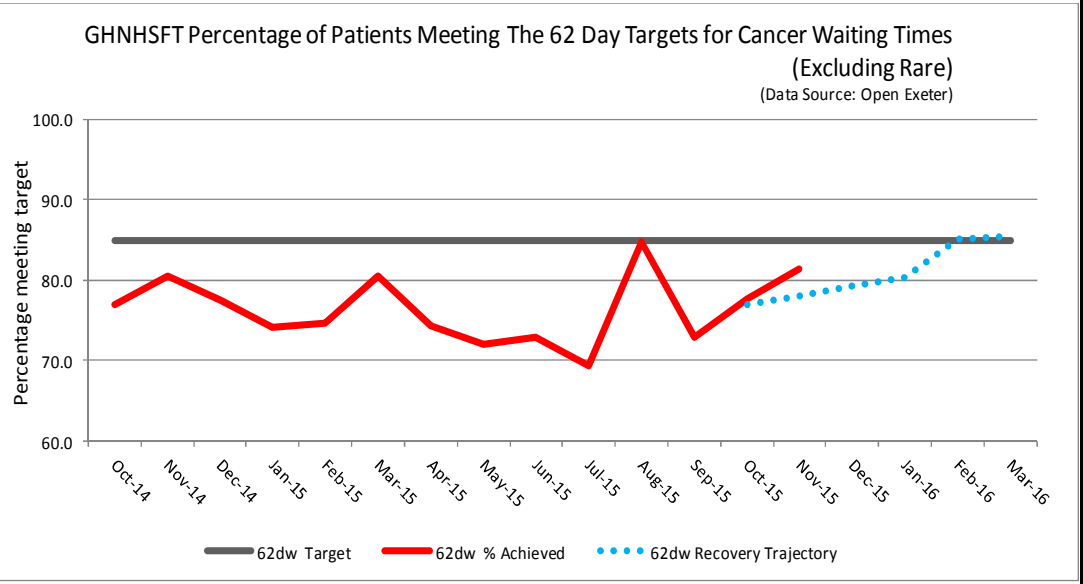
Tumour Site	Total	Breaches	%
Breast	28	2	92.9
Gynae	5	1	80.0
Haematology	6	0	100.0
Head & Neck	8	4	50.0
Lower GI	18	5	72.2
Lung	9	1.5	83.3
Sarcoma	1	0	100.0
Skin	25	0	100.0
Upper GI	8	2.5	72.2
Urology	36	11	69.3
All Other	1	0	100.0
Total	**140**	**26**	**81.4**

Actions taken to improve performance

A detailed cancer action plan prepared with help of Intensive Support Team. Progress to delivery of plan reviewed monthly at Cancer Services Managerment Group.

Expected date to meet standard	Feb-16
Lead Director	Director of Service Delivery

Activity



DELAYED DISCHARGES AT MONTH END

GCCG Standard

This relates to the number of delayed discharges at month end classified in national reporting

Standard	Month	Actual	RAG for current month
≤14	Dec-15	19	R

What is driving the reported underperformance

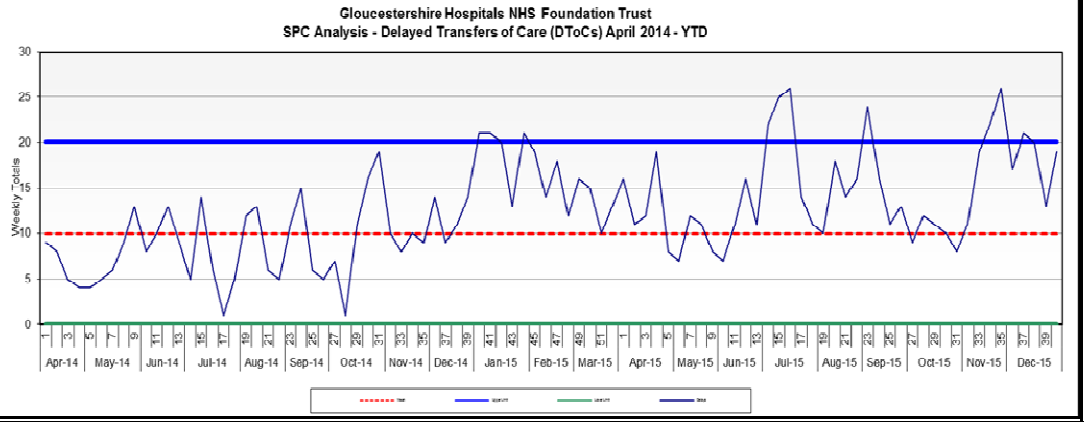
Please refer to Emergency Care Report

Actions taken to improve performance

Please refer to Emergency Care Report

Expected date to meet standard	Apr-16
Lead Director	Director of Service Delivery

Activity



MEDICALLY FIT PATIENTS

Trust Standard

Average per day in month

Standard	Month	Actual	RAG for current month
≤ 40	Dec-15	51	R

What is driving the reported underperformance

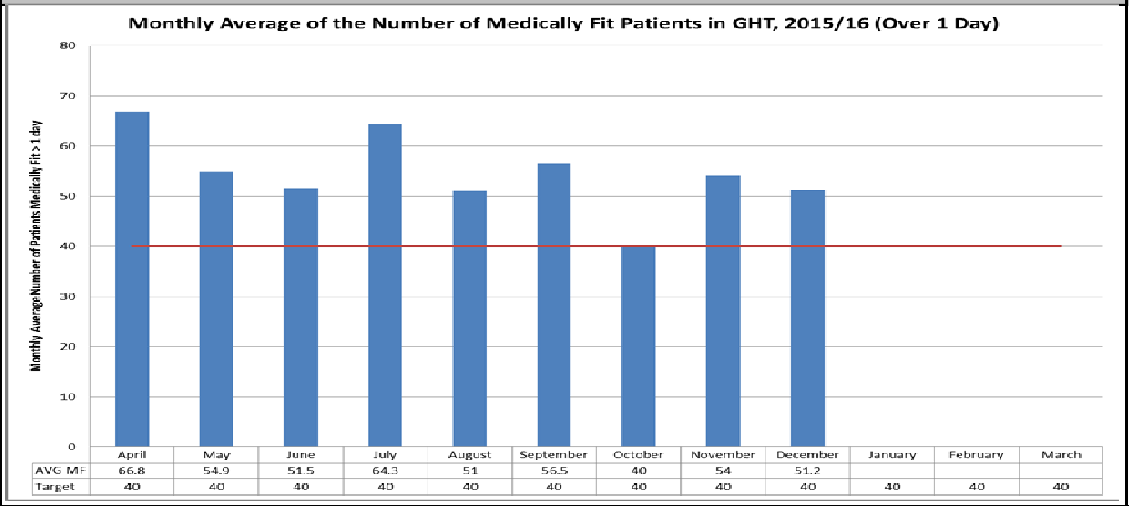
Please refer to Emergency Care Report

Actions taken to improve performance

Please refer to Emergency Care Report

Expected date to meet standard	Apr-16
Lead Director	Director of Service Delivery

Activity



BREACHES OF MIXED SEX ACCOMMODATION

GCCG Standard
Financial Penalty

Numbers of patients breaching same sex accommodation

Standard	Month	Actual	RAG for current month
0	Dec-15	8	R

What is driving the reported underperformance

The underperformance has been due to the number of attendees in the emergency department

Actions taken to improve performance

Review of patient flow in ED.

Expected date to meet standard	
Lead Director	Maggie Arnold

Activity

PATIENTS CANCELLED AND NOT REBOOKED IN 28 DAYS

GCCG Standard
Financial Penalty

Standard	Month	Actual	RAG for current month
0	Dec-15	3	R

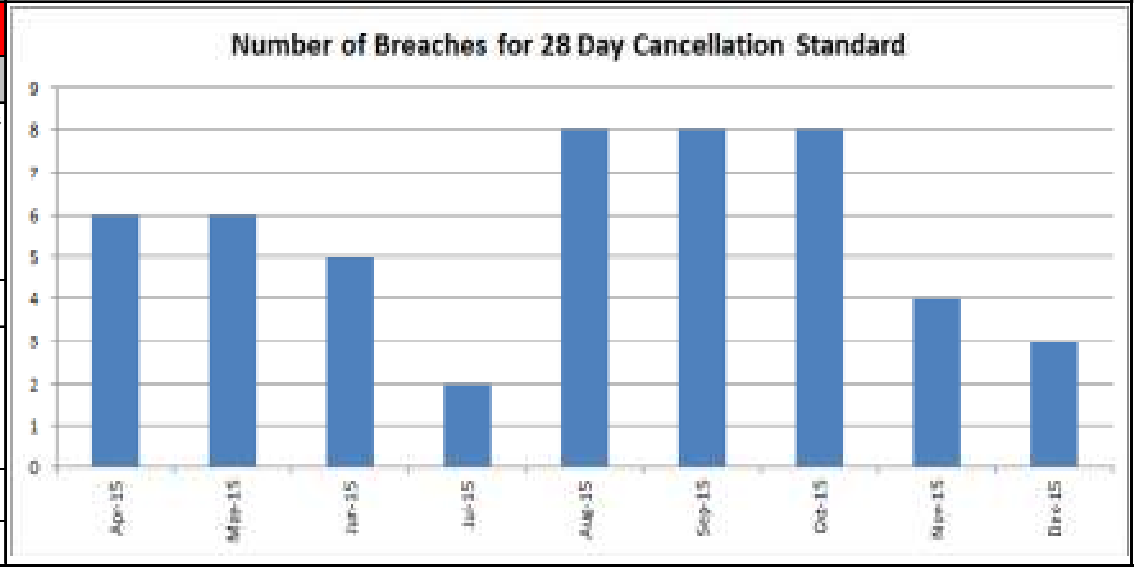
What is driving the reported underperformance

There is a report on cancelled operations which has been reported to the January Finance & Performance Board.

As above.

Expected date to meet standard	Apr-16
Lead Director	Director of Service Delivery

Activity



OUR STAFF

TOTAL PAYBILL

Trust Standard

Total Paybill spend £'000

Standard	Month	Actual	RAG for current month
target + 0.5%	**Dec-15**	**£23,424**	**R**

What is driving the reported underperformance

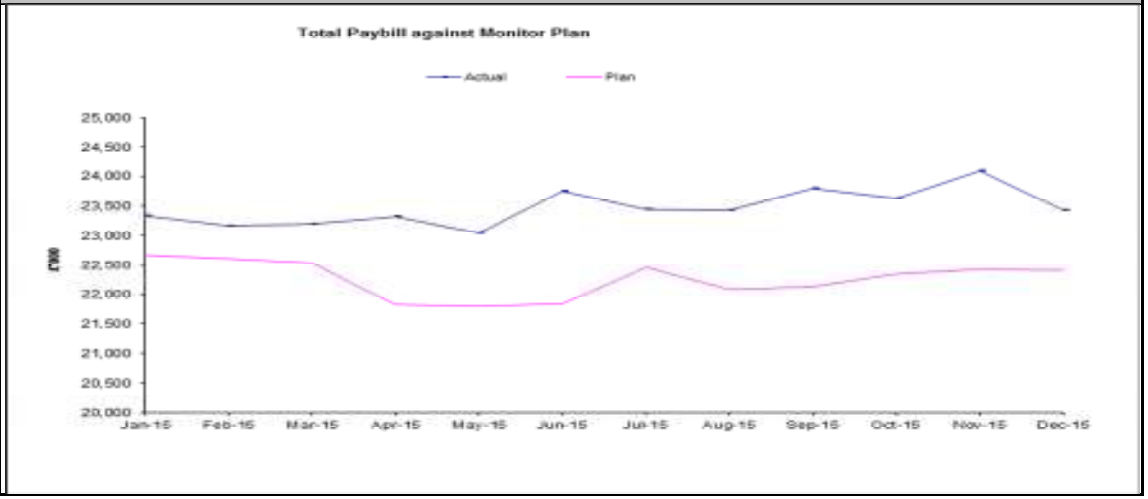
Expenditure was approx. £1,021,000 or 4.55% over plan.
There is an overall decrease of £665,000 from last month, Agency expenditure decreased by £495, Medicine Shared Services & Corporate accounts for most of this. Bank costs were also reduced by £199k - £141k of this being reduced Admin bank costs.

Actions taken to improve performance

An enhanced payments incentive for Nursing staff as an inducement to do additional shifts was introduced in early December. This payment is 'equivalent to overtime' which enables us to incentivise any shift over and above that worked in the contract. This will be a key part of our campaign this Winter to reduce reliance upon agency and we are expecting senior nurses to communicate this positively to our nurses and engage them in the fight against spiralling agency costs. This needs time to work through and it is likely that the reduction in December was linked to the reduced activity just prior to Xmas and reduced availability of agency staff as opposed to sustainable change.

Expected date to meet standard	
Lead Director	Director of HR and OD

Activity



TURNOVER RATE (FTE)

Trust Standard

Standard	Month	Actual	RAG for current month
9.50%	**Nov-15**	**11.03%**	**R**

What is driving the reported underperformance

Staff Nurse turnover has levelled except in Medicine Division, where it is now 21.85%

HCA Turnover in Medicine is 21.41%

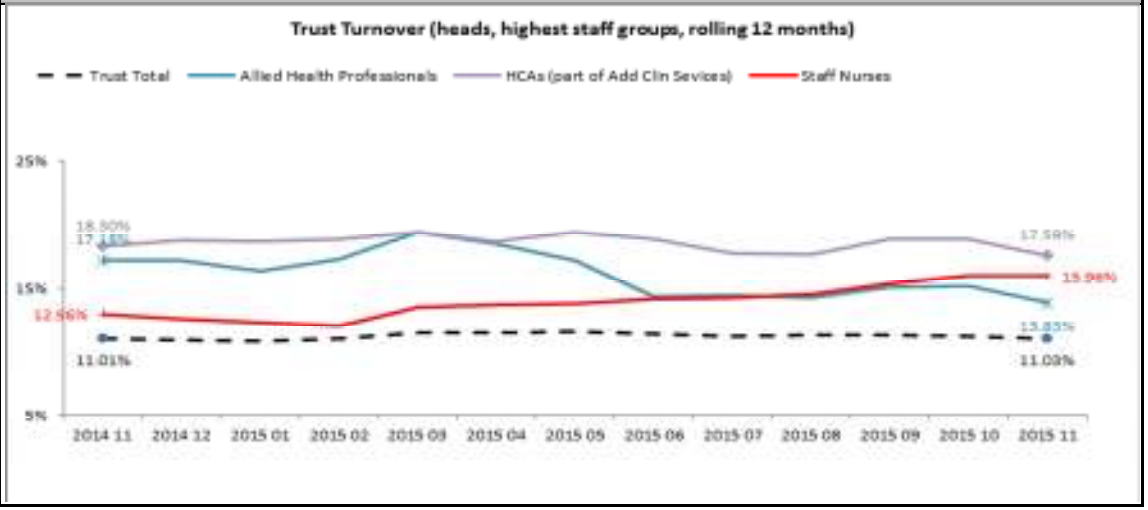
AHP turnover is down slightly - Physiotherapist is down to 16.85% (from 21.985) although Occupational Therapists are now 18.18% (from 16.67).

Actions taken to improve performance

A Recruitment and Retention Premium Payment has been announced in GOAM and has been very well received, albeit it is too early to say if this is impacting significantly at this stage. The Retention Group are looking at short/medium and long term strategies and the common theme coming through relates to career development and progression through AfC. Retention of staff needs to be a key in-year objective and there needs to be shared ownership between managers and central functions.

Expected date to meet standard	
Lead Director	Director of HR and OD

Activity



PERFORMANCE MANAGEMENT FRAMEWORK

RAG MEASUREMENTS : IM KPIs

OUR PATIENTS		R	A	G
18 weeks RTT	% of admitted patients seen in 18 weeks	Less than 90% seen in 18 weeks in last month		90%+ seen in 18 weeks in last month
	% of non admitted patients seen in 18 weeks	Less than 95% seen in 18 weeks		95%+ seen in 18 weeks
	% incomplete pathways under 18 weeks	Less than 92% waited under 18 weeks		92% or more waited under 18 weeks
Diagnostic Waits	Patients waiting over 6 weeks at month end for 15 key tests	More than 1.5% of patients waiting over 6 weeks	Between 1% and 1.5% of patients waiting over 6 weeks	Less than 1% of patients waiting over 6 weeks
	Patients waiting over 6 weeks from due date at month end for planned endoscopy	More than 20% of patients waiting over 6 weeks (small numbers)	Between 1% and 20% of patients waiting over 6 weeks (small numbers)	Less than 1% of patients waiting over 6 weeks (small numbers)
Cancer Waits	Patients referred urgently for suspected cancer seen in 14 days	less than 93% seen in 14 days	**For all cancer KPIs, a RAG of amber indicates underperformance but rectification plans in place to deliver by quarter end.**	93%+ seen in 14 days
	Patients referred for breast symptoms seen in 14 days	less than 93% seen in 14 days		93%+ seen in 14 days
	Max 31 day wait from decision to treat to first treatment	less than 96% treated within 31 days diagnosis to 1st treatment		96%+ treated within 31 days diagnosis to 1st treatment
	Max 31 day wait from decision to treat to subsequent treatment (surgery)	less than 94% treated within 31 days		94%+ treated within 31 days
	Wait from decision to treat to subsequent treatment (drugs)	less than 98% treated within 31 days		98%+ treated within 31 days
	Wait from decision to treat to subsequent treatment (radiotherapy)	less than 94% treated within 31 days		94%+ treated within 31 days
	Wait from GP urgent referral to first treatment (*excludes rare cancers)*	85% or less treated within 62 days		85% + first treated within 62 days from urgent GP referral
	Wait from national screening programme to 1st treatment	Less than 90% treated within 62 days from detection through national survey programme		90%+ treated within 62 days from detection through national screening programme
	Wait from consultant upgrade to 1st treatment	Under 90% treated within 62 days of consultant upgrade		90% + treated within 62 days of consultant upgrade
Discharges	Number of delayed discharges at month end	17 or more at census	16 or less at census	14 or less at census
	Bed days occupied by medially fit patients			
	% of discharge summaries sent by next working day	Less than 85% sent by next working day		More than 85% sent by next working day
Cancellations	Patients cancelled by hospital on day of surgery for a non clinical reason as a % of G&A elective admissions	More than 0.9% cancelled on day	Less than 0.9% cancelled on day	Less than 0.8% cancelled on day
	Patients cancelled and not rebooked in 28 days	2+ patients cancelled and not rebooked in 28 days	1 patient cancelled on day and not rebooked	0 patients cancelled on day and not rebooked in 28 days

OUR BUSINESS		R	A	G
Re-admissions	Following either elective or emergency admission	More than 5.8%	Less than or equal to 5.8%	Less than 5.6%
Activity to Plan	Referrals to Plan	More than 5% above or below plan	Between 2.5% and 5% above or below plan	Within 2.5% of plan above plan or below plan
	Elective spells to plan	Less than -2.5%	More than -2.5%	More than -1%
	Emergency spells to plan	More than 5% above plan	Between 2.5% and 5% above plan	Within 2.5% of plan or below plan
	OP Attendance and procedures to plan	More than 5% above or below plan	Between 2.5% and 5% above or below plan	Within 2.5% of plan above plan or below plan
LOS	Admitted emergency patient provider spell General and Acute Specialities LOS	More than 6 days	Less than 6 days	Less than 5.8 days
	Admitted elective patient provider spell General and Acute Specialities LOS	More than 3.6 days	Less than 3.6 days	Less than 3.4 days
Data Quality	% records submitted nationally with valid GP code	More than 1% below national average	Within 1% below national average	National average or better
	% records submitted nationally with valid NHS number	More than 1% below national average	Within 1% below national average	National average or better

OUR SERVICES				
Mortality	Hospital Standardised Mortality Ratio (HMSR)	>1.10		<1.10
	Crude Mortality rates	>2.5%	<2.5%	<2%
Seen by Midwife	% of women recorded as seen by midwife at 12 weeks	Less than 81%	81% or more	90% or more
Stroke Patients	% of stroke patients spending 90% of stay on stroke ward	Less than 80%		80% or more
VTE	% of eligible patients with VTE risk assessment	Less than 94%	94% or more	95% or more
Waits in ED	% patients treated in A&E in under 4 hours - Trustwide	More than 95% seen in 4 hours in month		95% or less seen in 4 hours in month
Ambulances queuing	ambulances delayed 30 – 60 minutes	More than number at same time last year		Less than number at same time last year
	ambulances delayed over 60 minutes	More than number at same time last year		Less than number at same time last year

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

REPORT OF THE FINANCE DIRECTOR

FINANCIAL PERFORMANCE FOR THE PERIOD TO 31ST DECEMBER 2015

1. Executive Summary

The table below summarises the performance for the year to 31 December 2015 against key elements of the Trust's plan and financial duties.

	Month 9 YTD actual	Month 9 YTD plan	Variance	Full Year Plan
Delivering planned surplus	£0.5m	£2.1m	(£1.6m)	£4.0m
Monitor Financial Sustainability Risk Rating	3	3	(0)	3
Better Payment Practice Code (by value)	68%	95%	(27%)	95%
Capital expenditure	£7.4m	£8.8m	£1.4m	£16.5m

Key Issues:

- The financial position of the Trust at the end of month 9 is a surplus of £0.5m on income and expenditure. This is £0.2m lower than the position reported in Month 8.

- Although operational pressures continue, temporary staffing expenditure is £0.8m lower than the expenditure in Month 8 and is the best reported position since Month 2.

- The Trust needs to continue to improve its controls on the use of agency staff, discretionary expenditure and accelerate the delivery of its Cost Improvement Programme to bring the overall position back in to line with plan as soon as possible.

- The Monitor risk assessment under the new framework shows a Financial Sustainability Risk Rating of 3.

- The surplus of £0.5m on the income and expenditure position represents an adverse variance of £1.6m from the planned position of £2.1m surplus of income over expenditure at the end of month 9.

- The cash position has improved to £5.8m at the end of the month. New measures are in place to improve this position over the coming months.

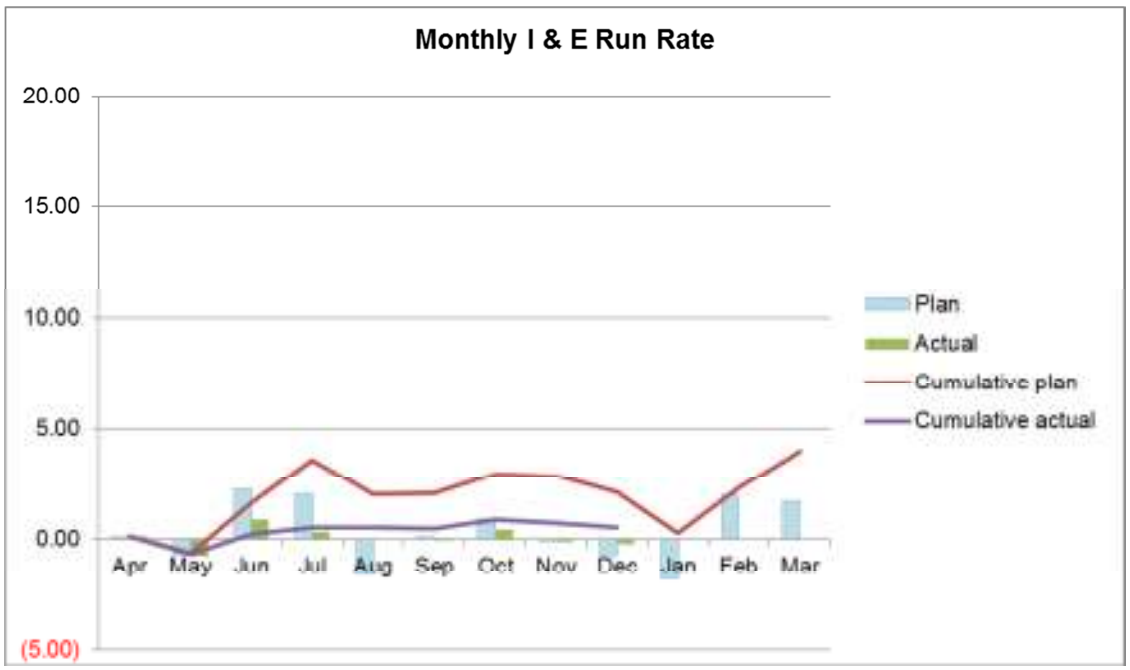
- The impact of the emergency cap cumulative to Month 9 was £981k.

2. Financial Position to 31 December 2015

The position at month 9 of the 2015/16 financial year is a surplus of £0.5m on income and expenditure, which represents an adverse variance of £1.6m against plan, as summarised in the table below.

	Annual Plan £000's	YTD Plan £000's	YTD Actual £000's	YTD Variance £000's
SLA & Commissioning Income	414,441	310,457	317,167	6,710
PP, Overseas and RTA Income	5,557	4,190	4,334	144
Operating Income	62,785	47,177	48,117	941
Total Income	**482,783**	**361,824**	**369,618**	**7,795**
Pay	294,713	219,230	231,830	(12,600)
Non-Pay	160,180	122,561	120,813	1,748
Total Expenditure	**454,893**	**341,790**	**352,643**	**(10,852)**
EBITDA	**27,890**	**20,033**	**16,975**	**(3,058)**
EBITDA %age	**5.8%**	**5.5%**	**0**	**-0.9%**
Depreciation	12,391	9,293	8,183	1,110
Public Dividend Capital Payable	7,028	5,271	5,558	(287)
Interest Receivable / Payable	4,491	3,368	2,726	642
Funds Available for Investment	**3,980**	**2,101**	**508**	**(1,592)**

The graph below illustrates the run rate and performance against plan for the year.



The income and expenditure position at the end of December has deteriorated by £0.2m in the month to £0.5m surplus. The variance from plan however has improved by £0.5m between months.

Income from contracts is £6.7m above plan. However, the increased use of agency staff is having a negative impact on the Trusts savings plans and the overall pay expenditure. As the Board is aware there is a national supply issue for trained nursing and medical staff in hard to recruit specialties. The Trust continues to work hard to mitigate this risk without impacting on the quality of care provided.

A breakdown of the Income and Expenditure information in the above table into Divisional financial positions can be found at Appendix A.

3. Income

Total income for the first nine months of the 2015/16 financial year was £7.8m above the planned level. This is due to an over performance of income from contracts of £6.7m and an over performance in other income of £1.1m.

The table below shows the commissioner income position to the end of Month 9 by point of delivery. A breakdown of income by commissioner is shown in Appendix B.

	Activity			Contract Value £000		
Service	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
Referrals		44,036				
Elective Inpatient Spells	9,185	8,863	(322)	29,785	30,084	299
Daycase Spells	35,359	39,264	3,905	27,125	29,392	2,267
Non-elective Spells	1,073	1,024	(49)	1,885	1,693	(193)
Emergency Spells	34,287	36,593	2,306	63,869	67,289	3,421
Outpatient Attendances	340,617	338,588	(2,029)	37,961	38,592	631
Outpatient Procedures	90,080	94,737	4,657	13,306	13,468	162
A&E Attendances	94,878	94,874	(4)	11,348	11,552	204
Radiology Direct Access	30,368	29,474	(894)	2,085	1,857	(228)
Radiology Unbundled	11,312	14,540	3,228	1,270	1,518	247
Renal Dialysis	36,333	46,587	10,254	4,459	5,164	705
Excluded Drugs				32,585	35,432	2,847
Other Non-PbR				84,779	81,127	(3,651)
Grand Total				**310,457**	**317,167**	**6,710**

Key issues to note include:

- **Referrals**
  Referrals are 2.9% higher than the first 9 months of 2014/15 (+2.3% to month 8). Within this GP referrals are 2.2% ahead of the same period last year which is continuing to put significant pressure on divisions and their ability to deliver efficiency savings through cost improvement and QIPP schemes.

- **Elective/Daycase**
  Combined elective and day case activity is 8.0% above plan on activity and 4.5% above plan on income. When separated out, elective activity is 3.5% below plan on activity but 1.0% above plan on income whilst daycase activity is 6.6% above plan with income 4.6% above plan on the same comparative basis as last month.

- **Emergency Activity**
  The Emergency spells position is 6.7% above plan in activity terms, and income is above plan by 5.3%.

The impact on income of the Emergency Cap at month 9 was £981k, which is £100k in excess of the planned level of £887k and is a further reduction to the total income for the Trust.

- **Emergency Department**
  Emergency Department activity and income are broadly in line with plan. Work is continuing with the CCG to reduce the pressures being experienced by Emergency Department services across the county as demand pressures continue.

- **Outpatients**
  Outpatient activity and income are above plan by 0.6% and 1.5% respectively.

- **Radiology Direct Access**
  Radiology Direct Access activity and income are below plan by 2.9% and 10.9% respectively.

- **Unbundled Radiology**
  Activity and income levels are above plan by 28% and 19% respectively.

- **Excluded Drugs**
  Excluded drugs remain at 8.70% ahead of plan after the first nine months of 2015/16.

The income that the Trust is able to recover is based on a combination of the actual activity that is seen and treated by the Trust and the tariffs for that activity. The vast majority of the tariffs are either set by, or informed by, the national Payment by Results tariff framework that is issued jointly by Monitor and NHS England. On 14th August 2015 Monitor and NHS England launched "2016/17 national tariff proposals: Currency design and relative prices" a consultation on the 2016/17 tariff framework The consultation was open until the 14th September 2015 and the Trust has submitted a response to Monitor on the impact of the proposals. Monitor and NHS England will, having considered all consultation comments, publish the 2016/17 tariff imminently and at that point a separate briefing for the Board will be provided on the impact of tariff changes as they relate to the Trust.

4. Expenditure

Expenditure against plan for the first nine months of the 2015/16 financial year represents an overspending of £10.9m against approved budgets.

Pay Expenditure

At Trust level for the nine months ending December 2015 pay expenditure was above plan by £12.6m.

At a Divisional level the main contributory factor to the overspend was the impact of operational pressures within the health system. The system-wide operational issues have increased the challenge of the CIP Programme due to the cost of medical outliers and agency staff. Unachieved CIP remains a concern with recovery plans supported by the CIP Director, Director of Finance and Director of Service Delivery being put in place. Financial review meetings have taken place with the Divisions and specific initiatives have been agreed to improve the expenditure position.

Actual pay expenditure by staff group is shown in the table overleaf.

Pay Expenditure – Analysis by Staff Group	Annual Plan £000's	YTD Plan £000's	YTD Actual £000's	YTD Variance £000's	YTD Variance %
Divisional Pay:					
Senior Medical	49,424	36,743	38,383	(1,640)	-4.46%
Junior Medical	28,229	20,781	23,988	(3,207)	-15.43%
Nursing	100,067	74,447	78,565	(4,119)	-5.53%
Admin & Clerical and Management	32,383	24,096	26,030	(1,933)	-8.02%
Clinical Support Services	42,631	31,753	32,716	(963)	-3.03%
Other Non Clinical	9,518	7,092	7,387	(294)	-4.15%
Other staff (includes CIP target)	866	623	410	212	34.09%
Divisional Pay sub total					
Hosted Services Pay	25,974	19,481	19,962	(481)	-2.47%
Shared Services and Other Pay	5,620	4,215	4,390	(174)	-4.14%
Total	294,713	219,230	231,830	(12,600)	-5.75%

Key issues to note for the month include:

- Total Pay expenditure for November was just over £25.8m, which is £0.6m lower than November and the lowest month since July this year.
- Total temporary staffing expenditure during the month was £2.1m, which was £0.8m lower than previous month and similar to expenditure in Month 1, but still is £200k above the monthly average for 2014/15. It is anticipated that the reliance on temporary staffing will reduce as a result of the recent recruitment campaigns, although staff turnover is also having a significant impact on divisions.
- The level of Pay expenditure over plan of 5.7% is not in line with the total income recovery over plan of 2.1%.
- Cumulative Divisional pay overspends were most significant within Medicine/USC (£6.6m overspent) and Surgery (£5.4m overspent) which relates to both Nursing and Medical staff.
- Whilst Nursing is still showing the highest financial variance against plan at £4.1m (5.53%), the largest variance in terms of percentage from plan is Junior Medical staffing at 15.43% (£3.2m).
- To cope with the demand pressures and to cover the hard to fill middle grade medical posts in the Emergency Department, additional payments are being made to senior medical grade staff who are working additional sessions to cover these gaps.
- Unachieved pay savings are in part linked to the use of agency staff to cover hard to fill posts and are still the main contributor to the adverse pay position within divisions with the CIP targets currently profiled over 12 months.

The table on the next page illustrates a sub set of the pay expenditure above and shows the temporary staffing expenditure by staff group and expenditure type. Comparison of trends from previous months shows December expenditure at £0.8m lower than November but still £0.2m above the monthly average of 2014/15.

Temporary Staffing Expenditure – Analysis by Staff Group	Expenditure to date £000's
Medical Agency & Locum	6,980
Nursing Agency	4,852
Nursing Bank	4,820
Other Clinical staff	820
Non Clinical staff	3,175
Total	**20,647**

On 1st September, Monitor and the NHS Trust Development Authority (TDA) jointly issued a set of rules for nursing agency spending. The letter to the Trust set out spending ceilings for the Trust (which takes effect from 1st October) as well as the mandatory use of approved frameworks for procuring agency staff. In addition, following a short consultation period, Monitor introduced hourly cost rate caps for all agency/locum arrangements, with effect from 23rd November 2015.

For each Trust, they have set an annual limit for agency nursing expenditure as a percentage of total nursing staff spend. For the purpose of the ceiling rule, nursing is defined as registered general and specialist nursing staff, midwives and health visitors. The ceiling percentages initially set for the Trust was 5% for Q3 and Q4 of 2015/16, 4% for 2016/17 and dropping to 3% for 2017/18 and 2018/19. The Quarter 1 2015/16 position for the trust on this new agency nursing rate was 6% with the average over Quarter 2 increasing to 7.5%. The Trust had written to Monitor requesting a reconsideration of the cap for the Trust to 7%, and have now received confirmation of a cap agreement of 6% for Quarters 3 and 4. Although this will be challenging, the Trust continues to pursue recruitment campaigns to fill vacancies and to proactively manage its use of nursing agency across the trust.

Non Pay Expenditure

During December non-pay expenditure remained on plan and is now cumulatively below plan by £1.7m for the year to date. Within this total non-pay position the Divisional non-pay underspend has decreased to £0.2m in Month 9 with Hosted Services and Shared Services Non Pay underspend remaining at £1.5m in Month 9.

Actual monthly non pay expenditure is shown in the table below.

Non-Pay Expenditure	Annual Plan £000's	YTD Plan £000's	YTD Actual £000's	YTD Variance £000's	YTD Variance %
Divisional Non Pay:					
Drugs	51,851	38,373	39,933	(1,559)	-4.06%
Medical and Surgical Equipment (MSE)	40,527	30,801	30,652	149	0.5%
Contract Services and Service received	20,126	15,175	16,676	(1,501)	-9.89%
Energy / Utilities	5,602	4,234	4,249	(15)	-0.35%
Building and other Estate expenses	5,916	4,520	4,561	(40)	-0.89%
Establishment expenses	11,618	9,068	8,333	735	8.11%
Other Non-Pay (includes CIP target)	23,032	19,228	16,809	2,419	12.58%
Total Divisional Non Pay	158,671	121,400	121,212	188	0.16%
Hosted Services Non Pay	344	384	384	0	0.00%
Shared Services & Other Non Pay	1,165	777	(783)	1,560	200.78%
Total	160,180	122,561	120,813	1,748	1.43%

Key issues to note for the month include

- Overall Non-pay expenditure remained in line with plan.
- Drug expenditure overspent in comparison with plan in month 9 by £0.6m with a year to date position showing a £1.6m overspending.
- Medical & Surgical Equipment underspent in month 9 by £0.2m and is now £0.1m below plan for the year to date.
- Discussions continue with Gloucestershire Care Services around the charging arrangements to the Trust which is impacting on the non-pay position.

5. Savings Plans

The current status of CIP schemes is summarised in the table below.

Divisions	2015/16 In Year Targets £'000	Green £'000	Amber £'000	Red £'000
Surgery	6,959	6,147	812	0
Medicine	5,680	5,467	0	213
W&C	2,473	2,185	108	180
D&S	5,793	1,826	410	3,557
EFD	1,417	1,383	0	34
Corporate	1,681	922	0	759
Trustwide		200	0	0
Total (£'000)	**24,003**	**18,130**	**1,330**	**4,743**
Total (%)		**76%**	**6%**	**20%**

There have been changes made to support the delivery of CIP effective from 1st January 2016. The Director of Finance and Director of Service Delivery are reviewing and supporting divisions with the development of CIP proposals for next financial year in addition to the delivery of schemes for the final quarter of this year.

6. Risk Analysis

There are a number of financial and operational risks facing the Trust that could impact on its ability to deliver the planned £4m surplus. The main risks are outlined in the following table, together with a brief summary of the plans for mitigation:

Risk		Mitigation
	£m	
Identified savings do not deliver required level of expenditure reductions in the financial year.	3.4	Savings devolved to divisions and monthly divisional executive reviews in place to performance manage delivery by CIP Director. Half Yearly Financial Review undertaken
Pay expenditure run rate does not reduce	5.1	Fortnightly Divisional meetings
Activity performance not in accordance with plan	0.2	Additional support and executive review
There are potential financial penalties for missing contractual targets	1.5	Improvement plan to mitigate risks,
Total	**10.2**	

The Monitor Financial Sustainability Risk Rating is attached at Appendix C.

7. Statement of Financial Position 2015/16

The Trust's Statement of Financial Position is attached at Appendix D. There are no specific issues to bring to the Main Board's attention other than those outlined below.

Capital Programme

Capital programme expenditure during the first nine months of the year totalled £8.1m, which was £0.7m below the planned position of £8.8m. Details can be found in the table below.

Capital Programme 2015-16	Annual Plan £'000s	Mth 9 YTD Plan £000s	Mth 9 YTD Expenditure £'000s	Mth 9 Variance £'000s	Forecast £'000s
Building schemes	1,595	891	833	58	1,595
Infrastructure maintenance	2,438	2,245	1,809	436	2,438
Other estates	440	104	87	17	440
Service reconfigurations	1,180	413	158	255	1,180
Sub Total	**5,653**	**3,652**	**2,887**	**765**	**5,653**
Major equipment infrastructure works	1,336	524	266	258	1,336
Medical Equipment	3,006	2,518	2,500	18	3,006
Information Management & Technology	6,500	2,100	2,452	(352)	6,500
Total Expenditure	**16,495**	**8,795**	**8,105**	**690**	**16,495**

A detailed review of the capital programme is being undertaken by the Director of Estates and Facilities, Director of Finance and the Director of Service Delivery to confirm the 2015/16 forecast position and to inform the 2016/17 Capital Programme planning process.

Better Payment Practice Code (Creditors)

Cumulatively to the end of December 2015 (month 9) the BPPC performance was 68% by value and 41% by Number. Whilst there is no formal Monitor assessed or measured target a good practice benchmark is 95% and work to improve the Trust position against this benchmark is ongoing.

	Cumulative for Financial Year 2015/16 Month 9		Cumulative for Financial Year 2014/15 Month 9	
	£'000	Number	£'000	Number
Total Bills Paid Within period	243,741	88,086	245,412	81,725
Total Bill paid within Target	166,225	35,765	211,907	65,068
Percentage of Bills paid within target	68%	41%	86%	80%

Debtors

The Trusts aged debt analysis at the end of December 2015 is shown in the table below. A number of changes to processes and procedures have been implemented to reduce debt and ensure all organisations are following good practice guidance around payment of outstanding debt.

	<30 days	31-60 days	61-90 days	91-120 days	120+days	Total
English CCGs	4,899	3,399	17	174	228	8,716
Other English NHS	2,545	1,478	364	849	4,898	10,134
Other Territory NHS	50	39	26	14	482	611
Overseas Patients	20	23	17	63	286	408
Private Patients	236	128	32	21	351	767
Other Non-NHS	423	347	67	39	236	1,112
	8,171	**5,414**	**523**	**1,160**	**6,479**	**21,747**

Cash Balances

The Trust cash balance at the end of December 2015 stands at £5.8m. The cash position is illustrated in the table below.

Trust Cashflow Statement Dec-15	December £'000
Opening Bank Balance	3,568
Receipts	
Main CCG SLAs	33,696
All other NHS Organisations	2,528
Other Receipts	6,485
Total Receipts	42,709
Payments	
Payroll	(24,722)
Creditor(including capital)payments	(15,794)
Other Payments	0
Total Payments	(40,516)
Closing Bank Balance	5,761

8. Recommendation

The Board are asked to note:

- The financial position of the Trust at the end of month 9 is a surplus of £0.5m on income and expenditure. This is £0.2m less than the position reported at Month 8.
- The £0.5m surplus represents an adverse variance of £1.6m from the planned position of £2.1m surplus of income over expenditure at the end of December 2015.

- The Trust needs to continue to improve its controls on the use of agency staff, discretionary expenditure and accelerate the delivery of its Cost Improvement Programme to bring the overall position back in to line with plan as soon as possible.
- The new Monitor risk assessment framework shows a Financial Sustainability Risk Rating of 3.
- Actions to address the issues identified in this report will continue in 2015/16 and progress will continue to be reported monthly to the Finance and Performance Committee and the Foundation Trust Board.

Author: **David Bacon, Interim Deputy Director of Finance**

Presenting Director: **Helen Simpson, Finance Director**

Date: **January 2016**

Appendices

A Divisional budget positions
B Healthcare Contract Income by Commissioner
C Financial Sustainability Risk Rating
D Statement of Financial Position

APPENDIX A

DIVISIONAL POSITION AS AT THE END OF MONTH 9 - DECEMBER 2015

	TRUST TOTAL			DIVISIONAL VARIANCE POSITIONS						
	Plan £'000	Actual £'000	Variance £'000	Medicine & USC £'000	Surgery £'000	D & S £'000	W & C £'000	Corporate £'000	EFD £'000	Trustwide £'000
Commissioning Income	310,457	317,167	6,710	3,473	2,894	416	1,238	2,163	0	(3,473)
Operating income	51,367	52,451	1,084	(2,041)	(2,834)	(164)	(325)	245	(737)	6,941
Pay expenditure	219,230	231,830	(12,600)	(6,554)	(5,434)	(773)	(356)	(616)	(632)	1,765
Non pay expenditure	122,561	120,813	1,748	(2,394)	56	(920)	(375)	(461)	1,336	4,505
Non Operating Costs	17,933	16,467	1,465	0	0	0	0	0	0	1,465
Total	**2,102**	**509**	**(1,593)**	**(7,516)**	**(5,318)**	**(1,441)**	**182**	**1,331**	**(33)**	**11,202**
Last Month Variance	**2,839**	**710**	**(2,128)**	**(6,464)**	**(4,730)**	**(1,147)**	**(189)**	**1,615**	**(179)**	**8,966**
Movement	**(737)**	**(202)**	**535**	**(1,052)**	**(588)**	**(294)**	**371**	**(284)**	**147**	**2,236**

APPENDIX B

HEALTHCARE CONTRACT INCOME POSITION AS AT MONTH 9

2015/16 Healthcare contracts position as at Month 9	2015/16 Full year plan £000	Month 9 Plan £000	Month 9 Actuals £000	Variance £000
NHS Gloucestershire CCG	292,546	218,461	225,753	7,292
Worcestershire Health Community	10,828	8,088	8,025	(63)
NHS Hereford CCG	3,748	2,804	3,131	327
Wiltshire Health Community	2,979	2,226	1,970	(256)
NHS South Warwickshire CCG	250	187	151	(36)
Oxfordshire CCG	386	288	388	100
Specialist Commissioning Group	74,180	55,627	58,493	2,866
Welsh Commissioners	3,435	2,571	2,961	390
Other Commissioner Income	22,072	17,206	13,213	(3,994)
Non Contractual Agreements (NCAs)	4,017	2,999	3,083	84
NHS CLINICAL REVENUE	**414,441**	**310,457**	**317,168**	**6,710**

APPENDIX C

Monitor Financial Sustainability Risk Rating calculation December 2015

			Dec-15	
Continuity of Services	Balance Sheet Sustainability	**Capital Service**		
		Revenue Available for Capital Service	17,697	
		Capital Service	(10,321)	
		Sum = (calc above x no. of days)	**1.71**	**Key to scoring - Liquidity (25% weighting)**
		Rating	**2**	

4	3	2	1
>2.5	1.75-2.5	1.25-1.75	<1.25

			Current month	
	Liquidity	**Liquidity**		
		Working capital balance	(13,542)	
		Operating expenses within EBITDA	(352,643)	
		Sum = (calc above x no. of days)	(10.4)	**Key to scoring - Debt Service Cover (25%weighting)**
		Rating	**2**	

4	3	2	1
<0 days	(7) - 0 days	(14) - (7) days	>(14) days

Financial efficiency	Underlying performance	**I & E Margin**		
		Normalised Surplus (deficit)	509	
		Total Income	370,340	
		I&E Margin	**0.14%**	**Key to scoring - I & E Margin (25% weighting)**
		Rating	**3**	

4	3	2	1
>1%	0 - 1%	(1) - 0%	<(1)%

	Variance from plan	**I & E Margin Variance From Plan**		
		I & E Margin	0.14%	
		I & E Margin Variance from Plan	-0.44%	**Key to scoring - Variance in I& E Margin(25%weighting)**
		Rating	**3**	

4	3	2	1
>0%	(1) - 0%	(2) - (1)%	<(2)%

		OVERALL RATING	**3**

APPENDIX D

Gloucestershire Hospitals NHS Foundation Trust
Statement of Financial Position

Trust Financial Position as at 31 December 2015	**Opening Balance £000**	**Closing Balance £000**
Non-Current Assests	304,221	304,135
Current Assets		
Inventories	8,126	7,250
Trade and Other Receivables	38,873	38,280
Cash and Cash Equivalents	3,568	5,761
Total Current Assets	50,567	51,291
Current Liabilities	(56,470)	(57,582)
Net Current Assets	(5,903)	(6,291)
Non-Current Liabilities	(70,639)	(70,367)
Total Assets Employed	227,679	227,477
Financed by Taxpayers Equity		
Public Dividend Capital	165,519	165,519
Reserves	66,828	66,928
Retained Earnings	(4,668)	(4,970)
Total Taxpayers' Equity	227,679	227,477

EMERGENCY PATHWAY REPORT
MONTHLY PERFORMANCE REPORT: DECEMBER 2015
FOR MAIN BOARD IN JANUARY 2016

1. Executive Summary

Key Messages

- The 95% 4 hour target for Emergency Department performance was not successfully met in December 2015, with Trustwide performance reported as 82.6%. Neither site achieved the 95% standard in December.

- The daily average number of Emergency Department attendances in December 2015 was 350 patients (10,844 for the month), compared to December 2014 (331 per day) and November 2015 (351 per day). The work of the GP in the Gloucestershire Royal Hospital Emergency Department is not included in the 2015 attendances.

- The daily average number of admissions from the Emergency Department in December 2015 was 123 patients (3,798 for the month), compared to December 2014 (114 per day) and November 2015 (117 per day). The admission rate in December 2015 was 35.02%, 0.6% up on last year and the highest rate since January 2015.

- General and Acute average length of stay for non-elective admissions in December 2015 was 5.5 days. The average Length of Stay for Quarter 3 was 5.6 days, delivering within the target of 5.8.

- The number of patients on the medically fit list has been at an average of 51 throughout December 2015. This is 3 patients less than the previous month, but remains above the system-wide plan of no more than 40 patients.

Key Risks

- Demand exceeding both the contractual plan and historical levels.

- The number of patients medically fit for discharge occupying an acute hospital bed.

- Despite recruiting additional consultants, gaps in Emergency Department doctors' rotas, especially at middle and junior grades, continue to remain the biggest risk to delivering Emergency Department performance.

- Enhanced performance is dependent on a number of countywide projects to streamline the urgent care system to manage Emergency Department demand, as well as speed up discharge processes at the Trust. This involves close working with health and social care partners. Details of these projects are contained within this report.

2. Report Purpose

To report performance on the key performance indicators, key risks identified and the latest Emergency Care Board milestone plan. The report reflects data up to 31st December 2015.

The emergency pathway performance management metrics enables the Board to track where changes are delivering sustainable performance and identify where further focus and effort is needed.

3. Emergency Pathway Metrics

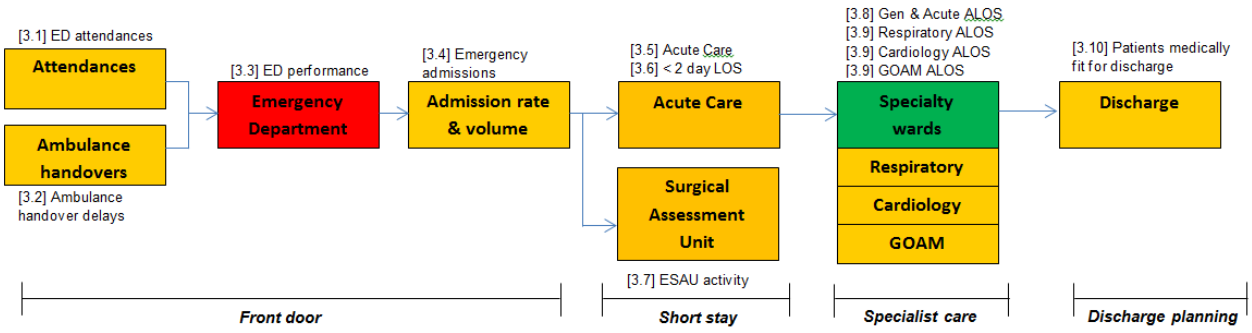
The diagram below shows the key processes within the emergency pathway.

Each process step is colour coded according to performance and sustainability, defined as:

- Blue - process in control, performance sustained > 3 months
- Green - process measure performance on target
- Amber - process measure performance moving in right direction but not achieving target
- Red - process measure performance off target.

The numbers in brackets refer to paragraph numbers that show the relevant process measure in more detail.

Figure 1 Emergency pathway key process measures:



An Emergency Care Action Plan to improve performance has been agreed with Monitor and the Trust is focusing on three key areas:

1. Patient Flow
2. Emergency Department
3. Admission Avoidance

3.1 Emergency Department Attendances

Aim: To ensure Emergency Department attendances remain in line with 2015/16 plan.

How: Work with:-

- South Western Ambulance Service NHS Foundation Trust (SWAST) to 'Smooth' emergency demand in the system;
- Integrated Discharge Team (IDT) within Emergency Department to increase direct admissions to community hospitals from Emergency Department;
- Develop the Older Person's Assessment and Liaison (OPAL) service;
- Maximise use of Minor Injury Units;
- Integrated Community Teams run by Gloucestershire Care Services NHS Trust

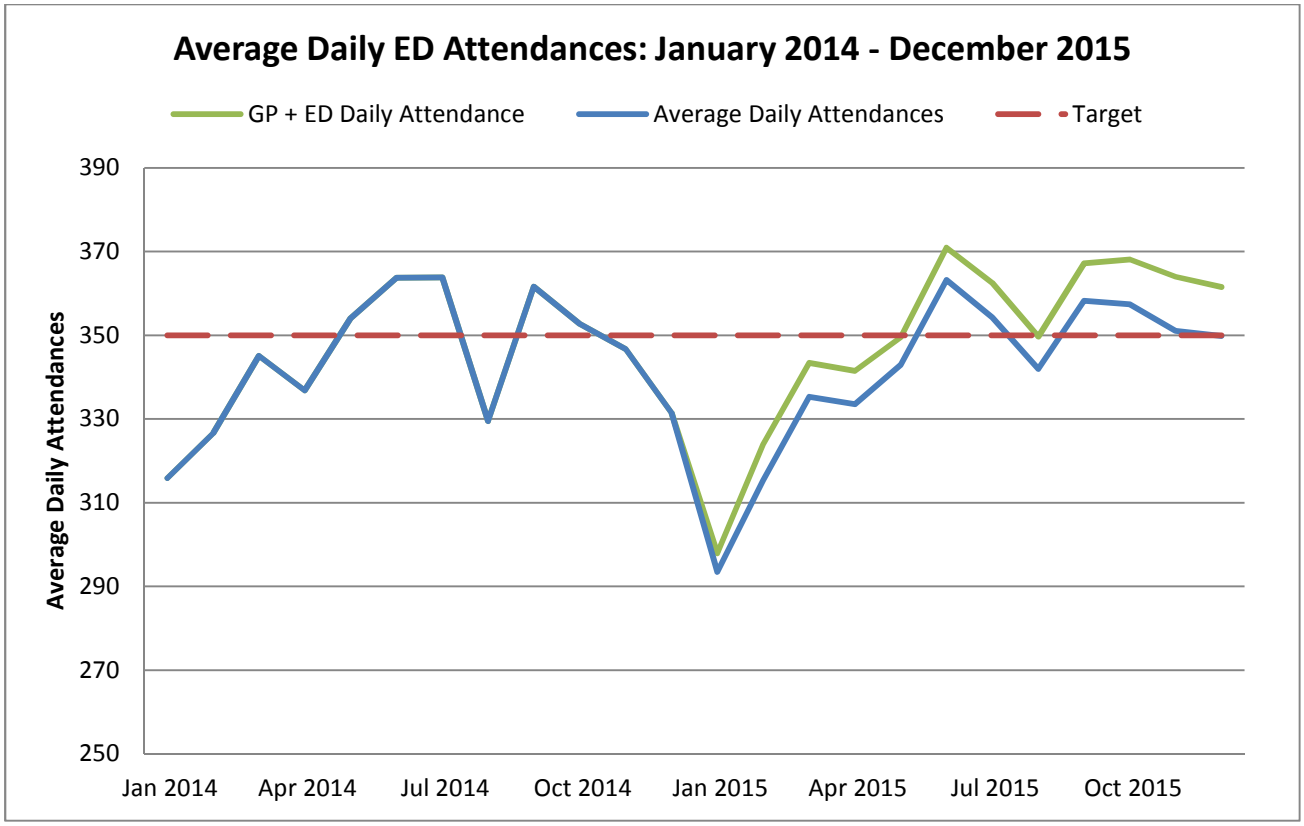
(All included in the Gloucestershire CCG Operational System Resilience Plan).

Narrative: There were 10,844 attendances in December 2015 (average of 350 per day) which is in line with the plan of 350 per day, compared to November 2015 with 10,532 attendances (average of 351 per day).

Continued working with community partners is in place to manage alternative options for patients. This includes additional capacity at the Gloucester Health Access Centre and a Primary Care Practioner based in the Emergency Department of Gloucestershire Royal. Appropriate patients arriving at the Emergency Department are immediately repatriated to Primary Care. These patients are represented by the green line on the chart below, and are in addition to Emergency Department attendances traditionally counted.

If the Primary Care pilot in the Emergency Department of Gloucestershire Royal was to cease, the additional walk-in patients currently managed by the service would have to be managed within the Emergency Department, if they could not be redirected elsewhere.

Emergency Department Attendances Chart:



Primary Care in Emergency Department

The Primary Care Pilot in the Gloucestershire Royal Hospital Emergency Department commenced in January 2015. The scheme is provided by South West Ambulance Trust, who also commenced delivery of the Gloucestershire GP Out-of-Hours service in April 2015, and is funded by Gloucestershire Clinical Commissioning Group.

A Primary Care Practitioner (either a GP or an Advanced Nurse Practitioner) works alongside the Emergency Department Monday to Friday 10:00 to 22:00, with a Primary Care Receptionist streaming patients into the Out-of-Hours service at weekends.

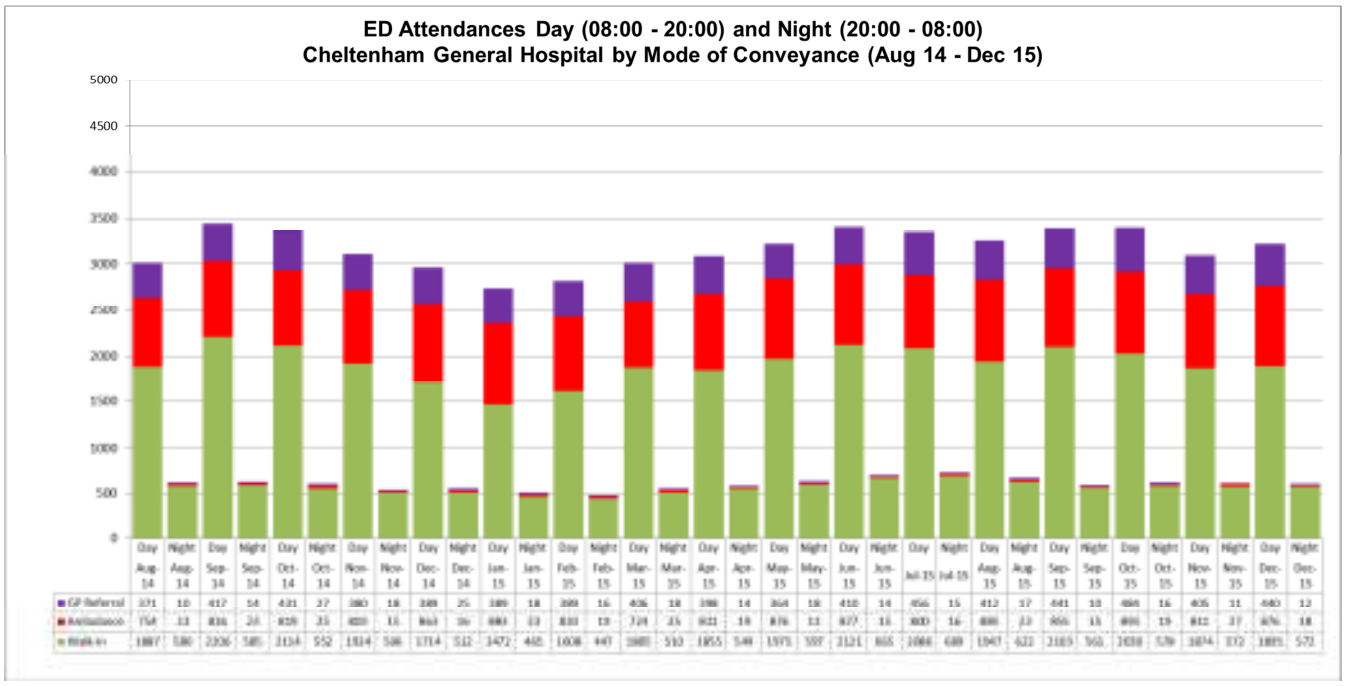
The table below shows a monthly breakdown of the impact of adding the number of Primary Care in Emergency Department cases (provided by Gloucestershire Clinical Commissioning Group), into the denominator of our Emergency Department performance calculation.

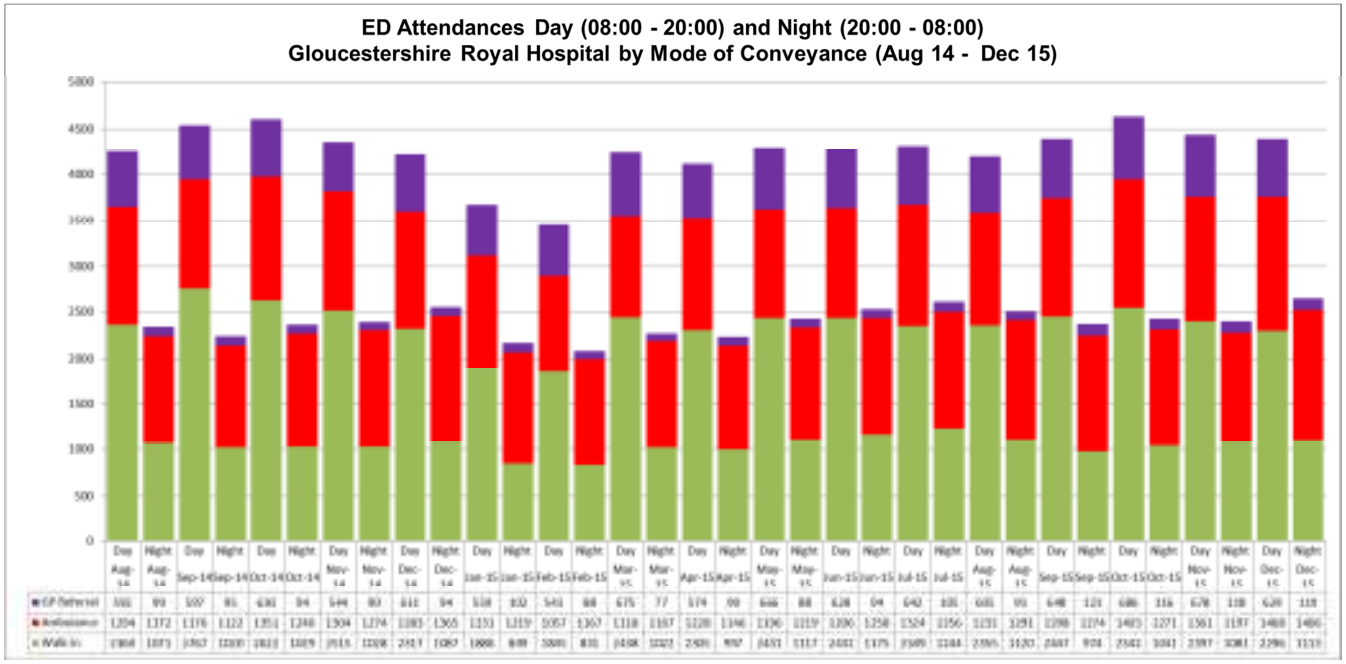
Arrival Month	ED Attendances	4 Hour Breaches	Performance	GP in ED Cases	Adjusted Performance
May 2015	10632	687	93.54%	203	93.66%
June 2015	10895	541	95.03%	234	95.14%
July 2015	10982	679	93.82%	256	93.96%
August 2015	10600	1481	86.03%	240	88.29%
September 2015	10747	1187	88.96%	268	89.22%
October 2015	11079	1538	86.12%	332	86.52%
November 2015	10532	1252	88.11%	386	88.53%
December 2015	10844	1882	82.64%	363	83.21%

Actions to be taken:

- Continue with Primary Care in Emergency Department pilot (now extended to March 2016) and managed by South West Ambulance Trust. The service is provided from a dedicated room near to Gloucestershire Royal Emergency Department reception (since September 2015). This has freed up the cubicle in the minors area;
- Streamlining Urgent Care Programme: the 'Streaming' function and pathways have been revised, and a pilot that tested the role of a Clinical Navigator took place over two days w/c 12th October. This proved successful and Gloucestershire Clinical Commissioning Group has agreed to fund the post until the end of March 2016, with a view to extend into 2016/17. Work is underway to ensure the Clinical Navigator is in place as soon as possible, including a comprehensive Memorandum of Understanding between the Trust and the Ambulance Service.
- Continued use of the Ambulatory Emergency Care service. The proposed Clinical Navigator would also be able to refer suitable patients presenting to the Emergency Department directly into the Ambulatory Emergency Care service.
- System-wide performance management of QIPP schemes.

Emergency Department Attendances by Mode of Conveyance Charts





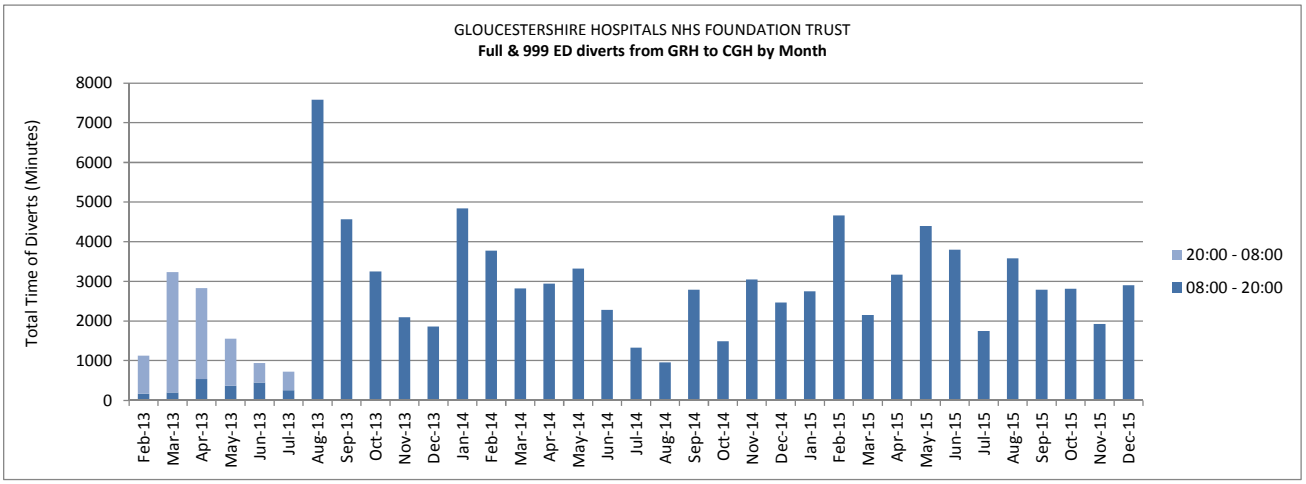
Narrative: In December 2015 there were 3,768 ambulance arrivals across both sites (average 122 per day). This is more than the same period last year, when there were 3,527 ambulance arrivals (average 113 per day). A number of patients can be referred by GPs direct into Cheltenham General overnight and although low numbers, this contributes to management of the bed base and in turn, reducing the level of diverts.

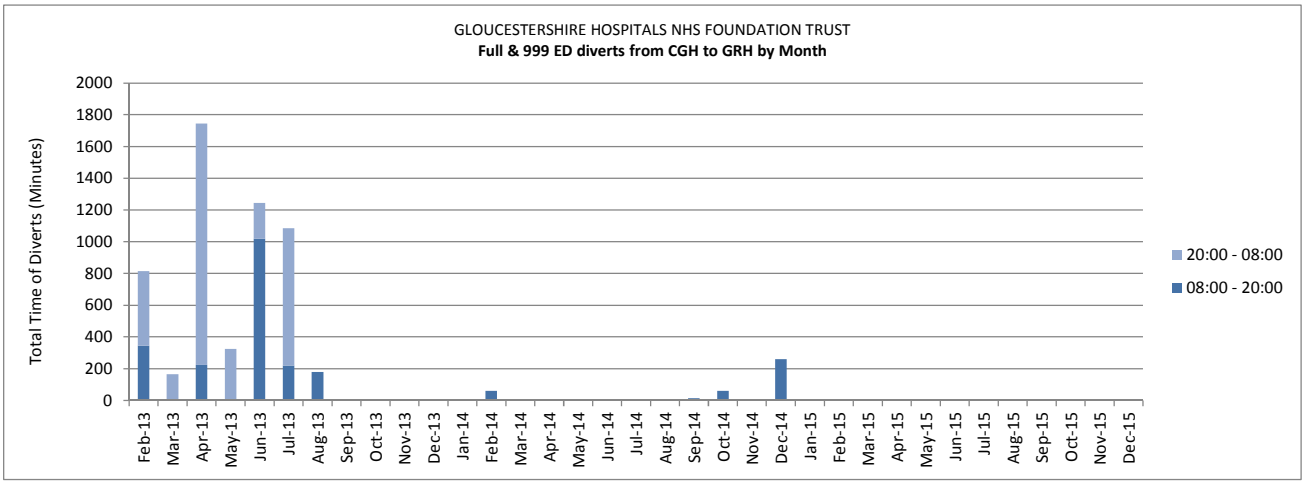
Diverts Between Gloucestershire Royal Hospital & Cheltenham General Hospital

Aim: To reduce the number of across site diverts.

How: Enable flow within each site to ensure consistently available bed space for patients requiring admission.

Narrative: The Trust is actively working with Gloucestershire Clinical Commissioning Group, Gloucestershire Care Services and South Western Ambulance Trust to manage flow from 8 GP Practices into Cheltenham General as opposed to Gloucestershire Royal. This amounts to approximately one admission per day, or six patient bed days per day. There were 11 occasions when a Full/999 divert took place in December compared to 10 last month. In addition, the total duration increased from 32.1 hours to 48.3 hours (average 3.2 hours per divert compared to 4.4 respectively).





From July 2015, all diverts will need to be agreed at an Executive level between both Gloucestershire Hospitals and South Western Ambulance Trust to minimise impact.

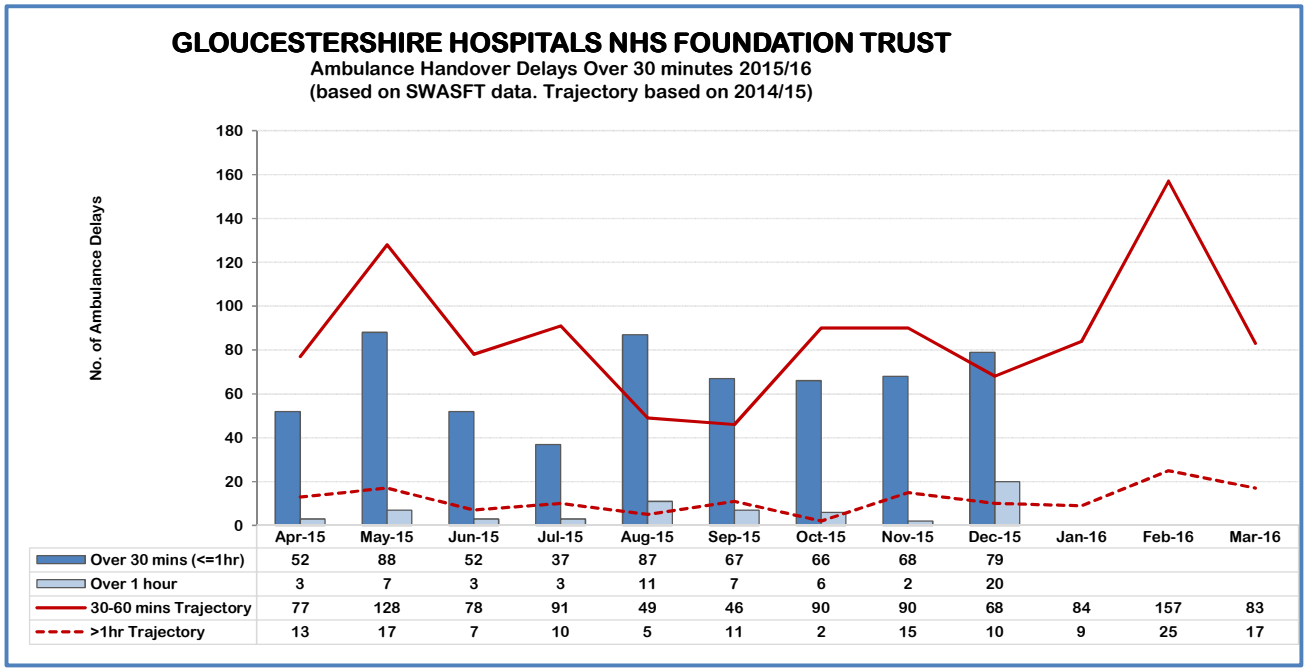
3.2 Ambulance Handover Delays

Aim: To reduce the number and time associated with ambulance handover delays.

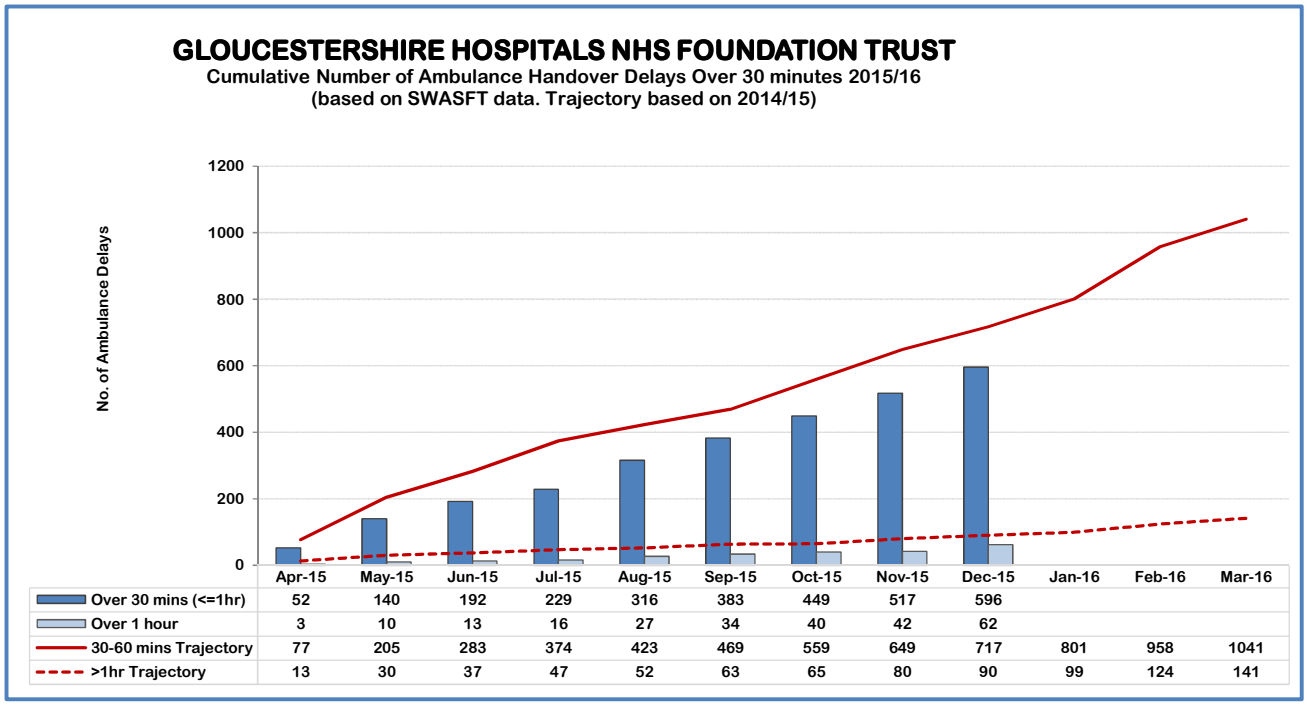
How: Doctor and nurse rotas better aligned to demand, revised handover process, improved reporting, trialling new 'flow coordinator' post, implementing capacity and escalation action cards and use of Rapid Assessment and Treatment (RAT) model.

Narrative: There were 99 ambulance handover delays in December 2015, of which 20 were over one hour. This is a significant increase from last month when there was a total of 70 and only two over one hour.

However, there is significant improvement compared to 2014/15, as shown in the cumulative graph below.



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Over 30 mins (<=1hr)	52	88	52	37	87	67	66	68	79			
Over 1 hour	3	7	3	3	11	7	6	2	20			
30-60 mins Trajectory	77	128	78	91	49	46	90	90	68	84	157	83
>1hr Trajectory	13	17	7	10	5	11	2	15	10	9	25	17



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Over 30 mins (<=1hr)	52	140	192	229	316	383	449	517	596			
Over 1 hour	3	10	13	16	27	34	40	42	62			
30-60 mins Trajectory	77	205	283	374	423	469	559	649	717	801	958	1041
>1hr Trajectory	13	30	37	47	52	63	65	80	90	99	124	141

3.3 Emergency Department Performance

Aim: To consistently deliver the national 4 hour performance standard.

How: Emergency Department and length of stay initiatives defined in Emergency Care Board action plan.

Narrative: The table below shows Emergency Department performance against the national standard. A comprehensive weekly Emergency Department performance metrics pack is used to track performance and direct interventions. December 2015 data shows that neither site successfully met the 95% standard. The overall Trust performance in December was 82.64%, which is the lowest performance recorded since February 2015.

In December, there was one >12-hour trolley wait within the Emergency Department. This was due to an exceptional clinical condition.

3.3.1 Four Hour Standard

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
CGH actual	97.60%	96.88%	97.14%	95.93%	96.99%	97.08%	93.02%	94.90%	85.34%	86.95%	83.36%	93.10%
GRH actual	91.69%	91.43%	91.06%	89.45%	95.61%	93.54%	93.08%	89.93%	82.77%	80.59%	73.93%	83.31%
National std	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Trust actual	93.81%	93.39%	93.27%	91.83%	96.10%	94.87%	93.06%	91.67%	83.64%	82.86%	77.45%	86.77%

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
CGH actual	95.20%	95.79%	97.25%	96.21%	92.32%	94.91%	91.12%	92.43%	89.25%			
GRH actual	89.50%	92.27%	93.70%	92.41%	82.40%	85.61%	83.27%	85.86%	79.06%			
National std	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Trust actual	91.59%	93.54%	95.03%	93.82%	86.06%	89.06%	86.12%	88.17%	82.64%			

NHS England (Type 1) Emergency Department performance for Quarter 3 2015/16 is due to be published on 11th February 2016, and up to date weekly data is no longer published by NHS England. The Trust's performance for Quarter 3 was 85.6%.

Factors affecting performance included:

- Admissions in excess of plan;
- Increased attendances out of hours;
- Delays in patient flow in the hospitals and across the system.

3.3.2 Breach Analysis

Narrative: A summary of the main contributing factors to Emergency Department 4 hour breaches in December 2015 is outlined in the following table:

November 2015						
	Total Breached	Breach due to Awaiting Assessment	Breach due to Awaiting Bed	Breach due to Undergoing Treatment	Breach due to ED Capacity	Others*
CGH	410	43	203	55	26	83
GRH	1472	279	598	131	288	176
Total	1882	322	801	186	314	259
%		17.11%	42.57%	9.88%	16.68%	13.76%

*'Others' includes waiting for Diagnostics, Porters, Transport and Specialists.

3.3.3 National Quality Indicators

Aim: To consistently deliver national Emergency Department quality standards.

How: Emergency Department and length of stay initiatives defined in Emergency Care Board action plan.

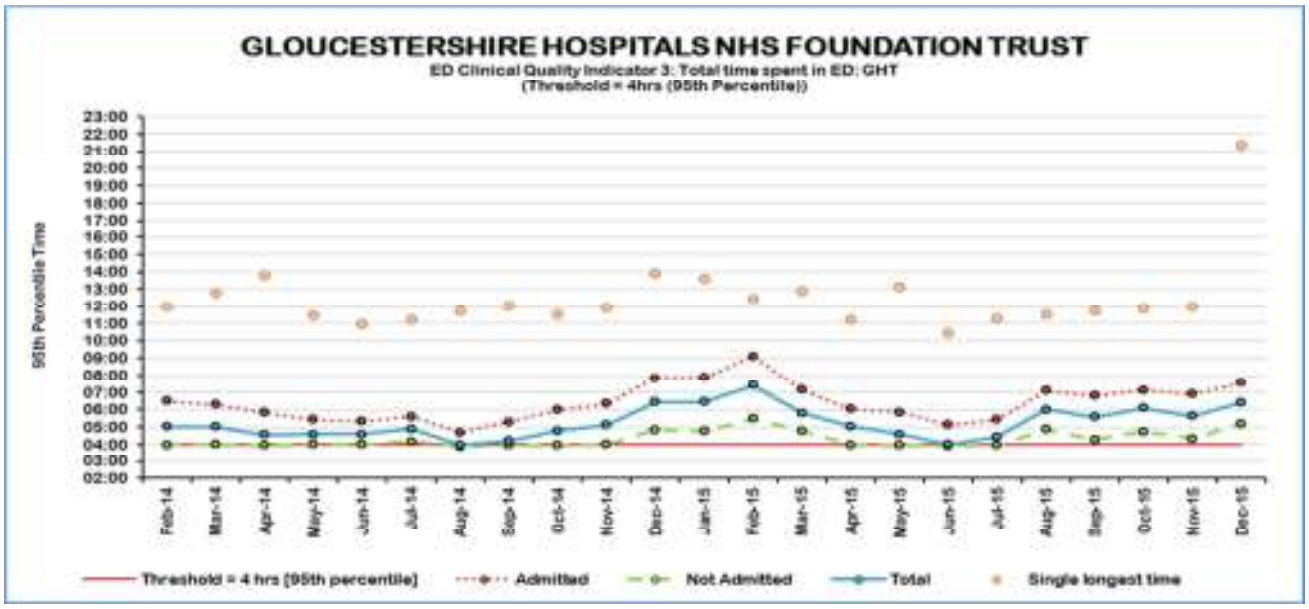
Narrative: The key Quality Indicators of Total Time in Department and Time to Treatment were not met in December.

Measure	Target	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Unplanned reattendance rate	<5%	1.40%	1.60%	1.80%	1.60%	1.40%	1.30%	1.30%	1.50%	1.40%	1.60%	1.40%	1.30%
Total time in department	95th % < 4hrs	06:26	07:25	05:49	05:03	04:36	04:00	04:26	06:01	05:35	06:05	05:38	06:25
Patients left without being seen	<5%	1.20%	2.00%	1.90%	1.20%	1.50%	1.60%	1.50%	2.40%	2.00%	2.20%	1.20%	1.70%
Time to Treatment	Median = 60 mins	00:48	01:05	01:01	00:55	00:50	00:59	00:57	01:13	01:08	01:14	00:57	01:10

Total Time Spent in the Department

Narrative: To better understand the distribution of time spent in the Emergency Department, activity has been plotted for admitted and non-admitted patients. This information is being used to improve awareness and target changes to process. The chart shows patients' time spent in the department reducing after the winter pressures (post February 2015) and with the actions being taken.

For Quarter 3 2015/16, there has been an increase in the total time spent in the department for both admitted and non-admitted patients, compared to the same period last year. The largest increases were in October and November. The 95th percentile time (for all patients) in December was 6 hours 25 minutes, compared to 6 hours 26 minutes the previous year.



The single longest wait in December is the patient aforementioned in section 3.3 with an exceptional clinical condition.

3.4 Emergency Admissions

3.4.1 Emergency Admission Rate

Aim: To ensure the admission rate from the Emergency Department remains in control.

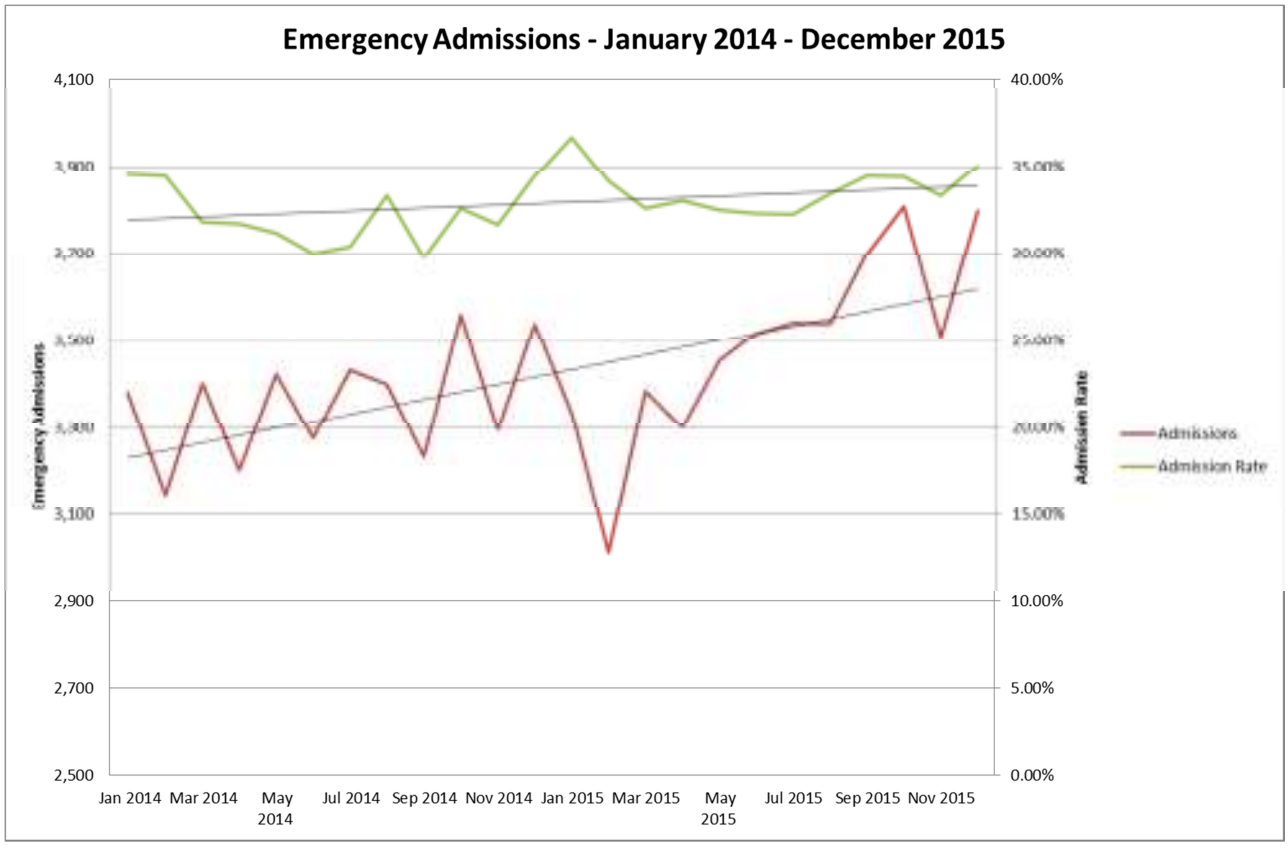
How: By avoiding admissions through alternatives as appropriate.

Narrative: The Emergency admission rate in December 2015 was 35.02% compared to November 2015 which was 33.32%. In December 2014, the admission rate was 34.42%.

In December 2015 there were 10,844 Emergency Department attendances and 3,798 patients were admitted (average 123 per day), compared to December 2014 when there were 10,276 attendances but 3,537 patients were admitted (average 114 per day).

A review was recently undertaken with Gloucestershire Clinical Commissioning Group at the System Resilience meeting with regard to the increasing Emergency Admission Rate. The largest increases compared to 2014/15 have been for diseases of the respiratory system, circulatory system and genito-urinary system. A focus on the Gloucester City locality identified four key actions:

- Further work is required to understand the potential role of Older Person's Assessment & Liaison to reduce emergency admissions;
- Review of emergency admission rates Out-of-Hours and on weekends;
- Linking up Primary Care and Emergency Department activity data to understand the pressure points in both systems and how they impact each other;
- Consideration of a direct flow from General Practice telephony systems into a central service. This will enhance escalation intelligence.

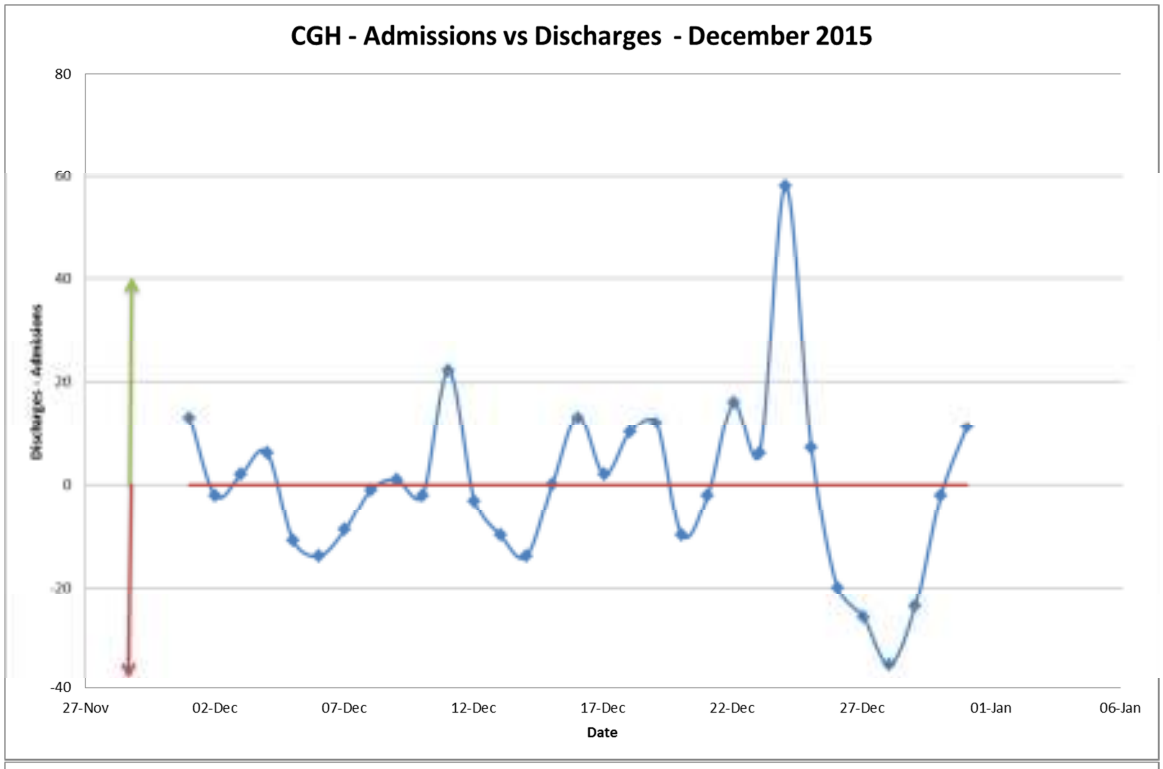


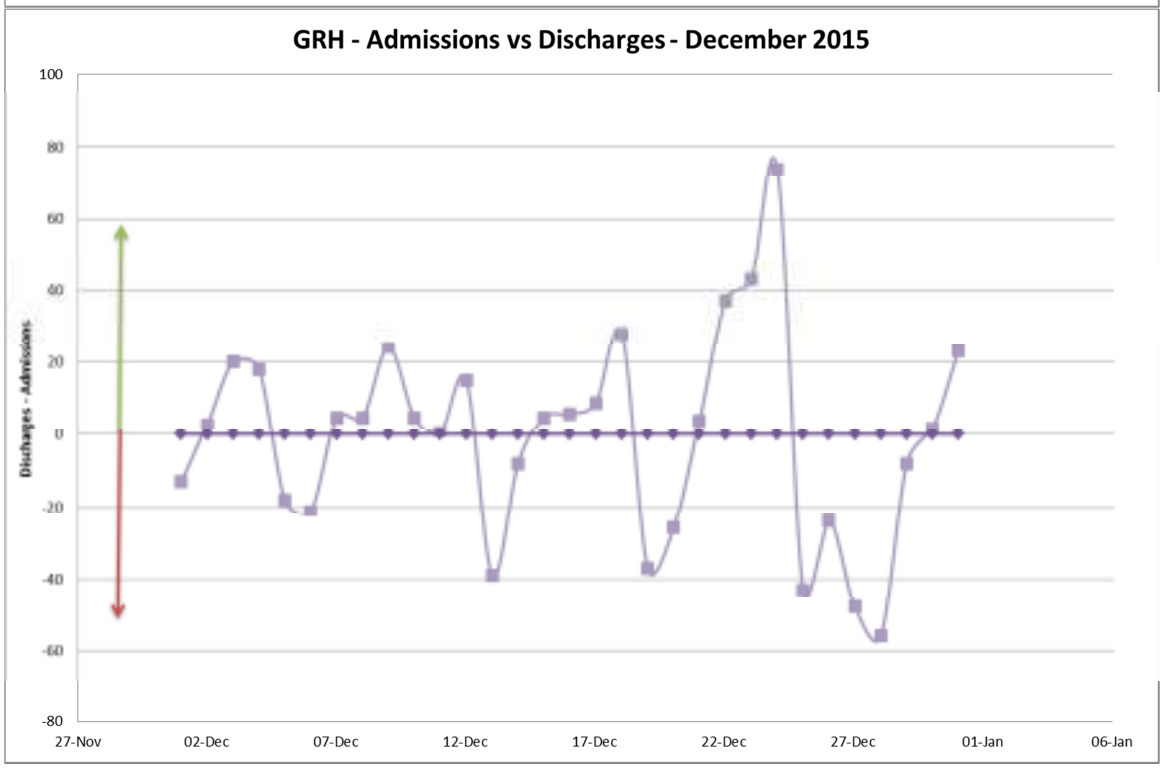
3.4.2 Admissions vs Discharges

Aim: To ensure the number of discharges on each site exceeds the number of admissions.

How: By ensuring the correct use of Estimated Dates of Discharge to meet the expected level of admissions each day.

Narrative: The following two graphs show the level of discharges on each site subtracted from the number of admissions. December 24th saw exceptional levels of discharges and over 20% of beds were empty. These filled by December 28th due to a low level of discharges over this period. On December 31st, the occupancy rose to 95%.





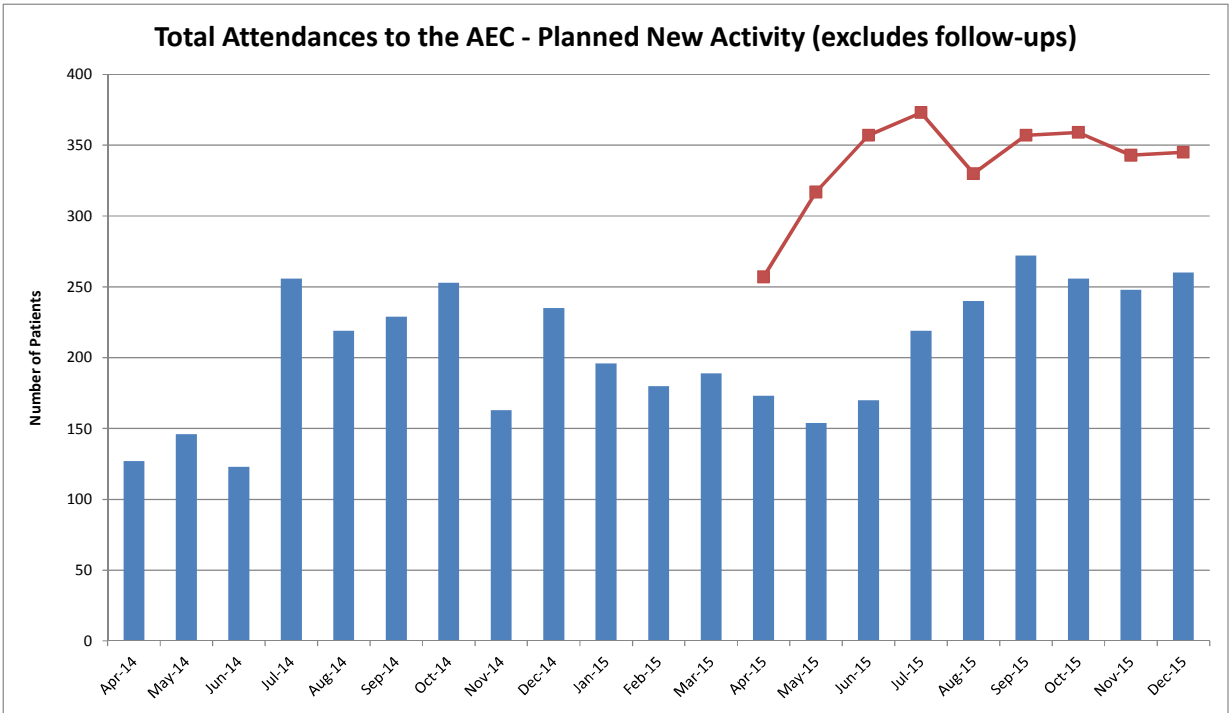
3.5 Ambulatory Emergency Care Attendances

Aim: To increase the number of emergency patients managed on an ambulatory pathway.

How: Expand pathways and remodel ambulatory services.

Narrative: The Ambulatory Emergency Care service accepts patients either direct from the Emergency Department or via the Single Point of Clinical Access from GPs and South West Ambulance Trust. The service is funded for 2015/16 on a block contract and the level of funding has enabled permanent staff to be recruited, which will increase opportunities to extend the opening hours and as a result, admission avoidance.

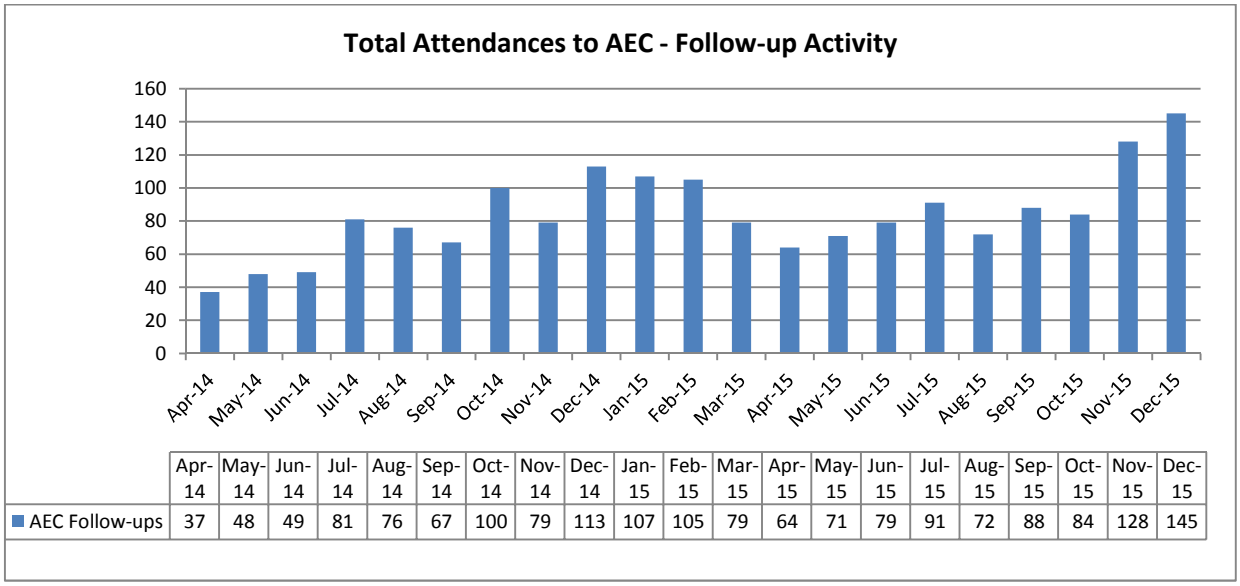
The chart below shows the actual number of new Ambulatory Emergency Care patients (excluding Follow ups) from April 2014. The plan for 2015/16 is based on actuals from 2014/15 plus the impact of the planned pathway developments. For Quarter 3 2015/16, it was projected that 16 new patients would be seen per day, across both sites. The actual average was 12.



	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Actual	127	146	123	256	219	229	253	163	235	196	180	189	173	154	170	219	240	272	256	248	260
Plan													257	317	357	373	330	357	359	343	345

The activity has been below the planned level of new attendances due to on-going issues with recruitment (and retention) and location of the units, particularly at Cheltenham General. However, there have been signs of improvement from August following implementation of initiatives identified with the Ambulatory Emergency Care Network.

In addition, the service has seen a number of follow-up attendances. Follow-up appointments are required in Ambulatory Emergency Care as they are used to avoid an unnecessary admission. The numbers from April 2015 are shown in the graph on the next page.



	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
AEC Follow-ups	37	48	49	81	76	67	100	79	113	107	105	79	64	71	79	91	72	88	84	128	145

A service review was undertaken in November, which identified a number of key actions to increase the number of new patients and as part of the Winter Plan, the Ambulatory Emergency Care service has increased its opening hours in order to capture the 'peaks' in Emergency Department attendances.

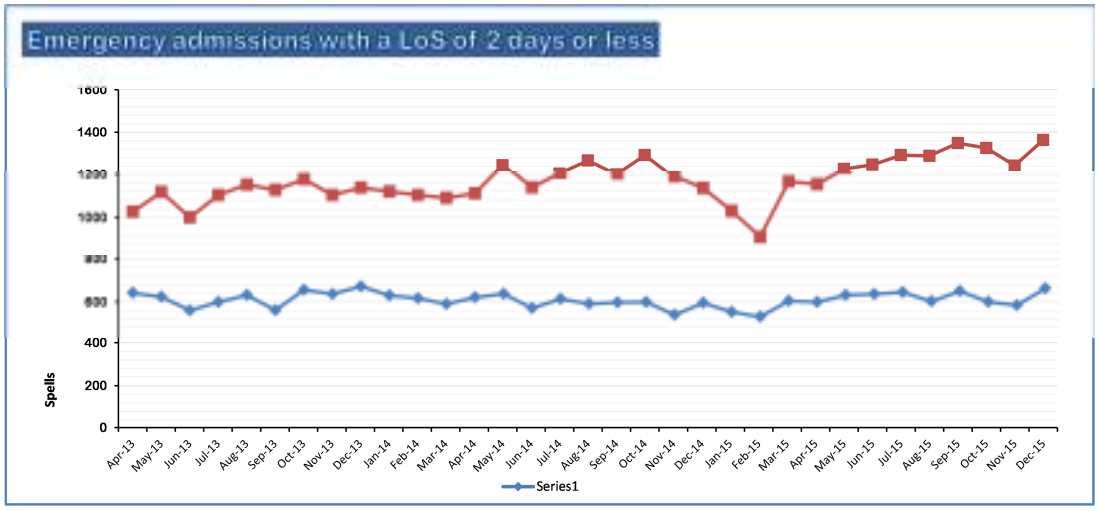
Ambulatory Emergency Care is a key strand of the High-Level Priorities Plan agreed with Monitor.

3.5.1 Patients Discharged with a Length of Stay of 2 days or less, who were admitted as an Emergency

Aim: To increase the number of short stay discharges.

How: Expand number of acute care beds at Gloucestershire Royal to match demand, Acute Physicians to focus on Acute Care Units, fewer medical outliers and OPAL (Older Persons' Assessment and Liaison team).

Narrative December 2015 showed 2,027 patients with a length of stay of 2 days or less Trustwide, a significant increase compared to November which showed 1,828 patients. A short stay ward in Gloucestershire Royal for patients requiring a stay of 48 hours or less went live on 19 November 2014. This ward has been reviewed and is shown to be successful provided it is not used for long stay patients. This is what happened from December 2014 to February 2015, when the Trust was in escalation.



3.6 General & Acute Emergency Admissions Average Length of Stay

Aim: To reduce Trustwide general and acute emergency length of stay to less than 5.4 days in Quarter 1 and Quarter 2 and 5.8 days in Quarter 3 and Quarter 4 2015/16.

How: Speciality driven action plans and continuation with: every patient reviewed every day; Estimated Discharge Date; ward level reports; discharge waiting areas; Blaylock tool and ticket home.

Narrative: Length of Stay targets have been set up for 2015/16. Divisions and Service Lines have been asked to develop internal action plans to bring down the Length of Stay in their area. In December 2015 the Average Length of Stay was 5.5 days which is a slight improvement than 5.9 days in November. The average Length of Stay for Quarter 3 was 5.6 days which is within the target of 5.8 days.

A new approach to patient flow was launched on Monday 9 March 2015 with emphasis on the SAFER bundle:

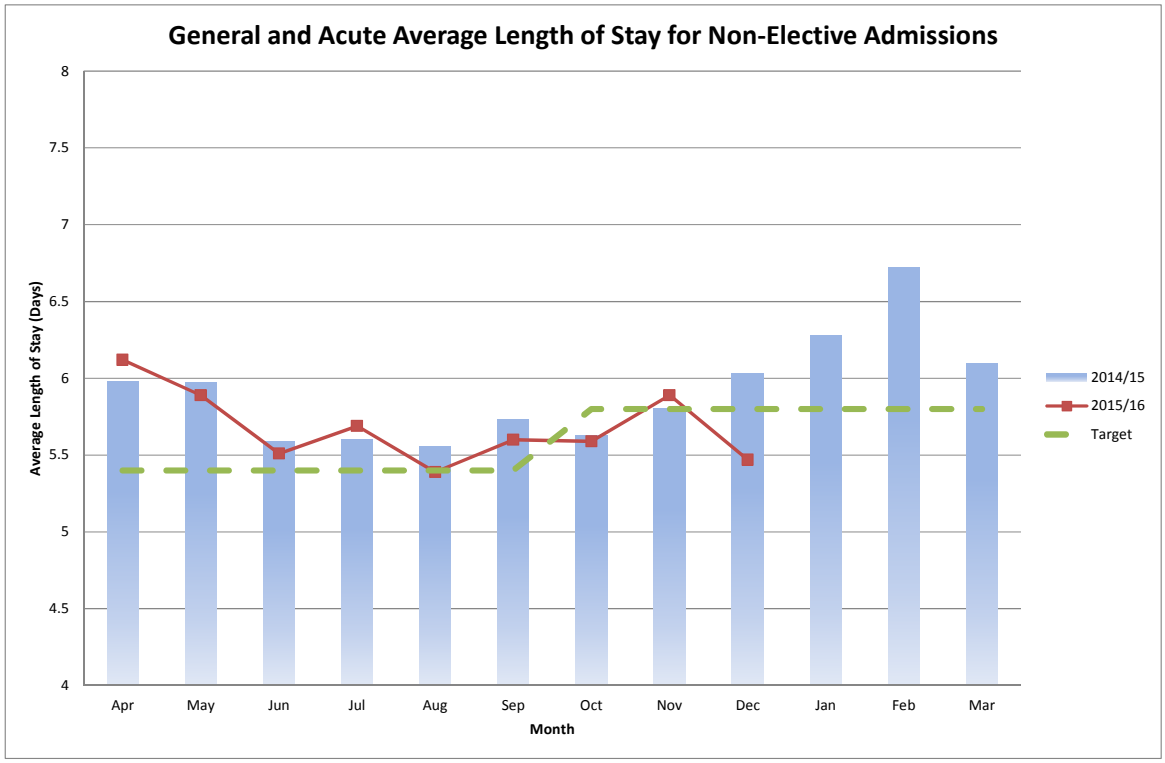
S: Senior Review – all patients will have a Consultant Review before 10:00 followed by a Ward or Board Round;
A: All patients will have a Planned Discharge Date (that patients are made aware of), based on the medically suitable for discharge status, agreed by the clinical teams;
F: Flow of patients will commence at the earliest opportunity from assessment units (AMU & SAU) to inpatient wards. Receiving wards from assessment units will commence before 10:00 daily.
E: Early discharge – 50% of our patients will be discharged from base inpatient wards before midday. TTOs for planned discharges should be prescribed and with Pharmacy by 15:00 the day prior to discharge.
R: Review - a weekly systematic review of patients with extended lengths of stay (> 14 days) to identify the issues and actions required to facilitate discharge. This will be led by senior leaders within the Trust.

Dr Kate Hellier, Consultant Elderly Care Physician, along with Bob Pearce, Director of 7 Day Services is leading the delivery of structured and consistent board rounds across the Trust, reviewing timings and content with the aim of reducing overall length of stay across the Trust. Dr Hellier will be completing this work in collaboration with the Institute for Healthcare Improvement based in Boston, USA.

In order to increase awareness and embed the SAFER bundle practices into business as usual, the third Trustwide "SAFER Week" took place between 7th & 13th December. These focussed weeks will occur monthly throughout the winter period, identifying positive actions to embed into business as usual. December's SAFER week focussed on embedding work undertaken previously, namely:

- Refinement of the Operational Management Meetings;
- Monitoring the time taken from bed request to bed allocation between Emergency Department and Acute Care Units;
- Efficiency of Board rounds, using the SORT criteria;
- Increased use of the Discharge Waiting Area;
- Awareness of the daily discharge targets by ward.

In addition, wards undertook audits as part of the SAFER CQUIN and initial monitoring of TTOs before 14:00, to inform the proposed future process.



Multi-Disciplinary Accelerated Discharge Event (MADE):

In line with NHS England winter planning guidance, the Trust is working with healthcare system partners to conduct an event on 11th and 14th January, coinciding with the fourth SAFER week. The event will focus on accelerated discharge of patients on the day and identifying the main reasons for discharge delays (both internal and external to the Trust). A subsequent event is also planned during February's SAFER week (8th – 14th).

3.7 Average Length of Stay of Targeted Specialties

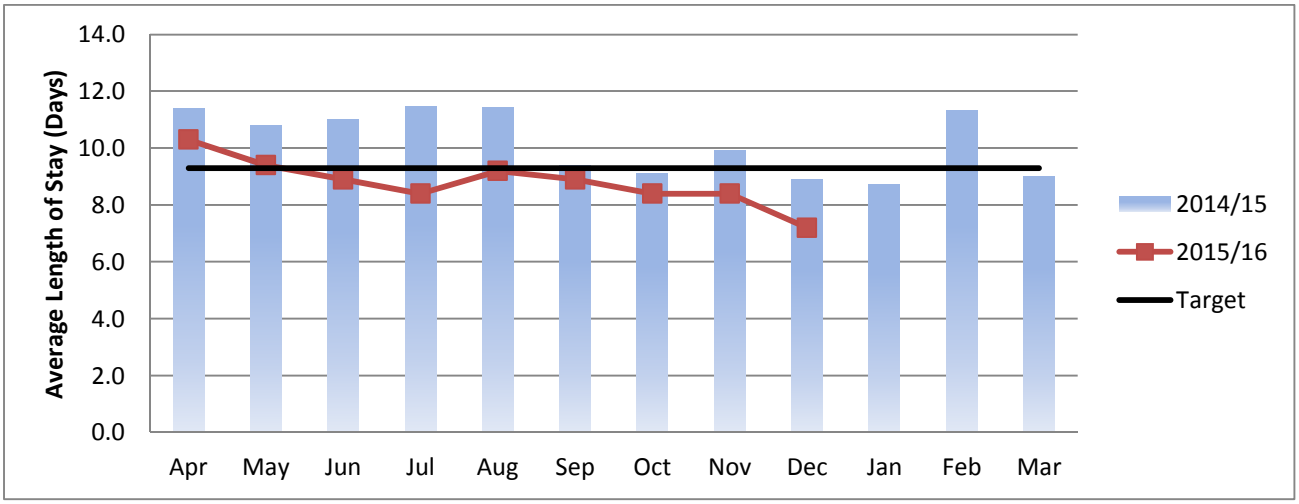
On continuation from last year Respiratory, Cardiology and General Old Age Medicine will be highlighted in this report. Their length of stay was benchmarked against the national average and best regional performances and improved targets have been set for these specialities. The reports below show Average Length of Stay in these three key specialties.

Respiratory, Cardiology and General Old Age Medicine have experienced their usual winter peak in presentations; the Division is working with the community to better manage this across the year.

The unique impact of the discharges on December 24th affects these figures.

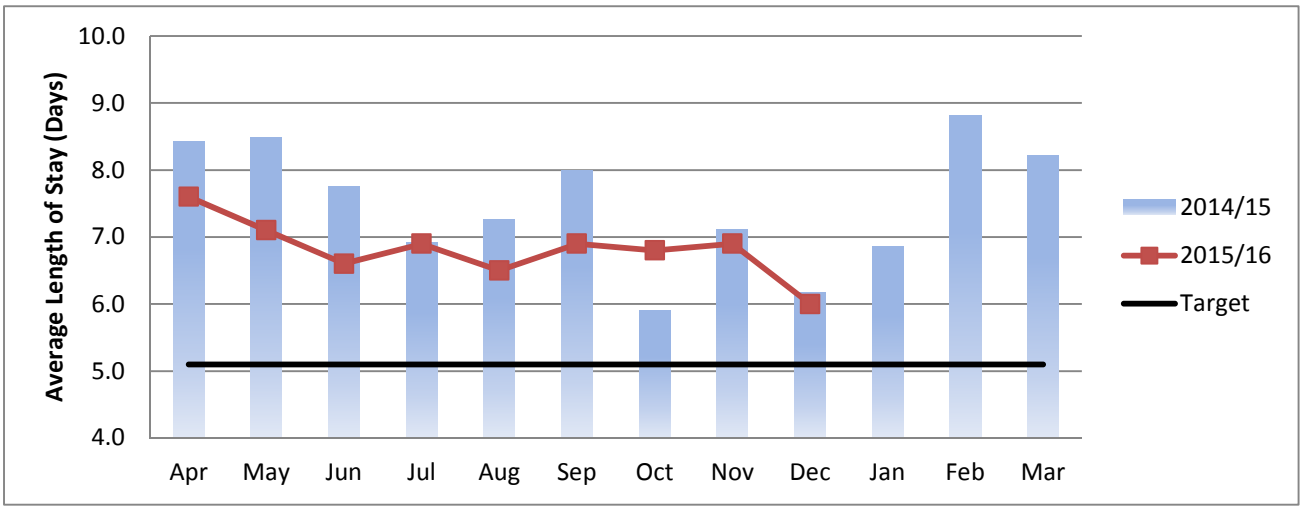
3.8.1 Respiratory Medicine - Average Length of Stay

Narrative: The internal target is set at 9.3 days for 2015/16. In December 2015 the Average Length of Stay remains well within the threshold at 7.2 days.



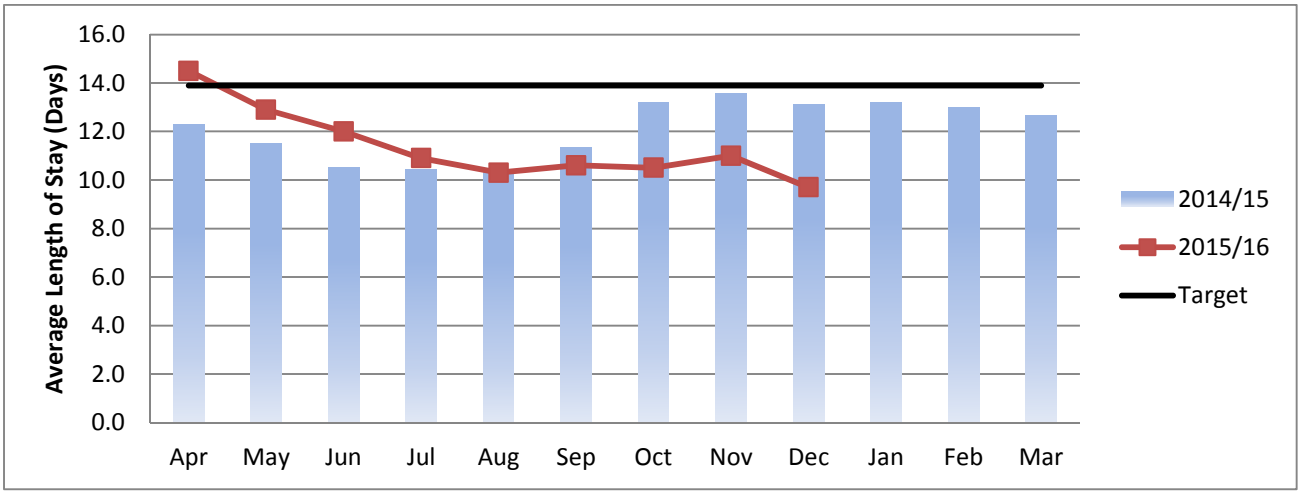
3.8.2 Cardiology - Average Length of Stay

Narrative: The internal target is set at 5.1 days for 2015/16. The Average Length of Stay for non-elective Cardiology discharges reduced to 6.0 days in December 2015, which is the lowest it's been all year, despite remaining above the threshold.



3.8.3 General Old Age Medicine (GOAM) – Average Length of Stay

Narrative: The internal target is set at 13.9 days for 2015/16. The General Old Age Medicine Average Length of Stay was 9.7 days in December 2015 and remains well within target.



3.9 Average Number of Patients Medically Fit for Discharge

Aim: To reduce the number of medically fit patients occupying an acute bed by speeding up the process of discharging a patient to a suitable alternative within the community.

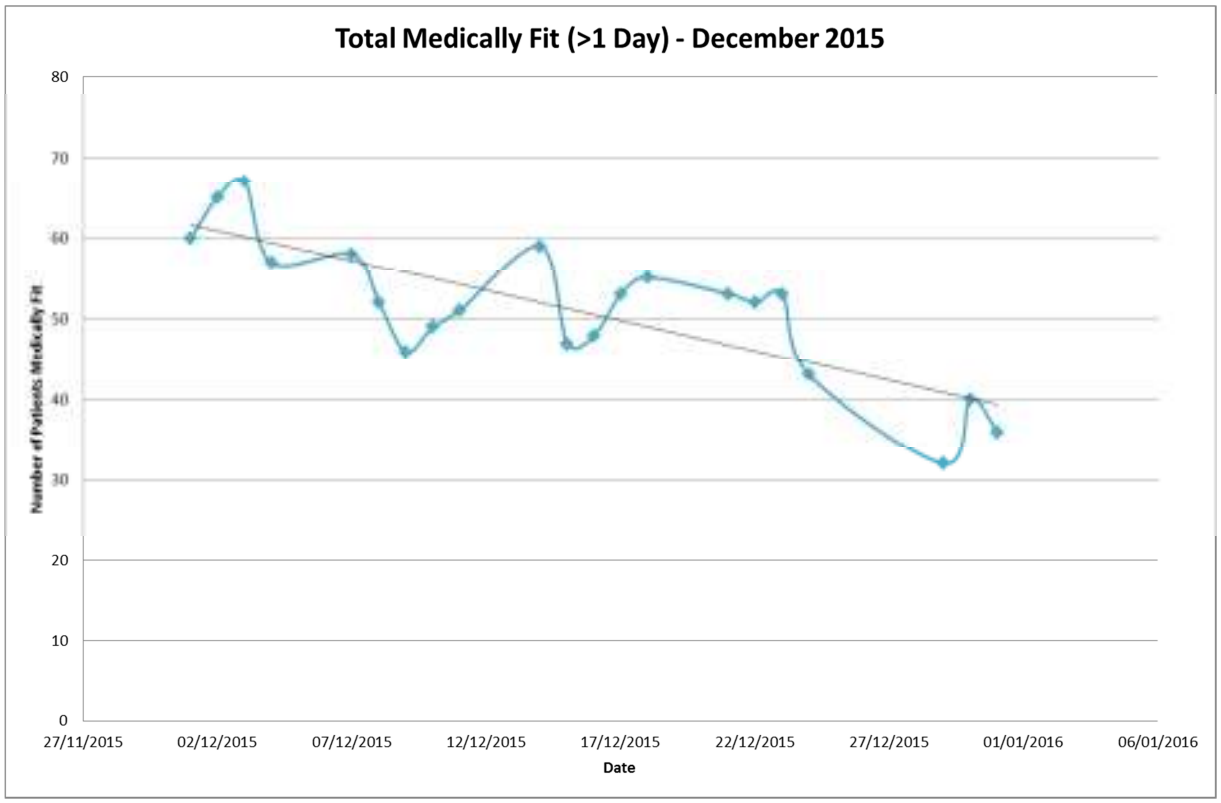
How: Focussing on a range of actions on safe and effective discharge processes. For the Trust and whole heath care system this is one of the key activities to manage.

Narrative: The number of people who are medically fit for discharge is managed daily with Gloucestershire Care Services NHS Trust and Gloucestershire Clinical Commissioning Group through a daily escalation call. Every bed day occupied longer than required to be in an acute hospital represents a cost of £200 per patient, per bed day.

Total Medically Fit – average number of patients per week for December 2015:

Week 1	61	**Week 2**	51
Week 3	51	**Week 4**	43

In December, there was an average of 30 medically fit patients who are occupying a nursing home bed, who would be occupying an acute bed if these nursing home beds were not available. As part of the system-wide resilience plan, the Clinical Commissioning Group will be investing in a total of 30 beds.



The number of patients medically fit has been an average of 51 for the month, with the number of medically fit patients reducing throughout December to 43 in week 4. This is on average a decrease of 3 medically fit patients, compared to November 2015 and will also have been influenced by high number of discharges on December 24th.

The patients reported as medically fit are designated with a "Current Status" to show who is responsible for the next stage of the patient's discharge/transfer. The following are the three most frequently seen "Current Status" for medically fit patients:

- With Single Point of Clinical Access, waiting for community services;
- With Ward and Integrated Discharge Team to activate existing support;
- In Assessment with Adult Social Care.

Currently, the Integrated Discharge Team manager is working to a 10 point plan of the most frequent reasons for delays across all systems both internal and external and to manage Medically Fit patients better in the future.

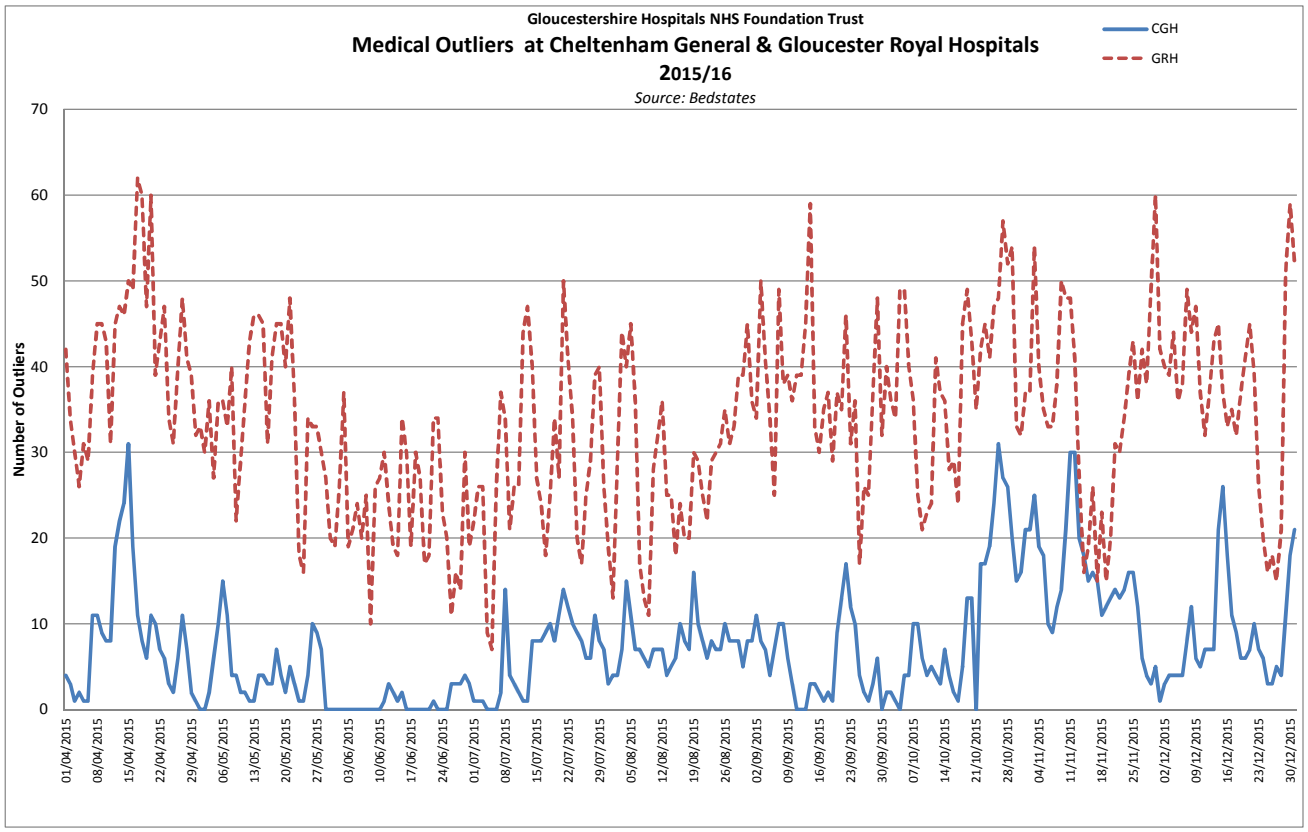
From September 2015, a weekly Senior Executive review of all Medically Fit patients will take place. This is being led by Mrs Arnold, Director of Nursing with her peers from across the system.

3.9.2 Medical Outliers

Aim: To reduce medical outliers to less than 10 across Trust so that patients are cared for on the right ward.

How: Expanded acute care beds at Gloucestershire Royal, Acute Physicians focused on front door, revised Acute Care Unit patient categorisation process, patient speciality allocation in Acute Care Units, initiatives as part of the length of stay project such as weekend discharge team and patient repatriation are focused on to reduce medical outliers.

Narrative: The daily average number of medical outliers was 43 at Gloucestershire Royal and 11 at Cheltenham General in December; compared to 35 and 15 respectively last month. A Length of stay review was held on 27 March with ECIST facilitating. The aim of which is to vacate escalation areas and to reduce the medical patients on surgical wards. This is the Trust's response to the National "Breaking the Cycle" initiative.

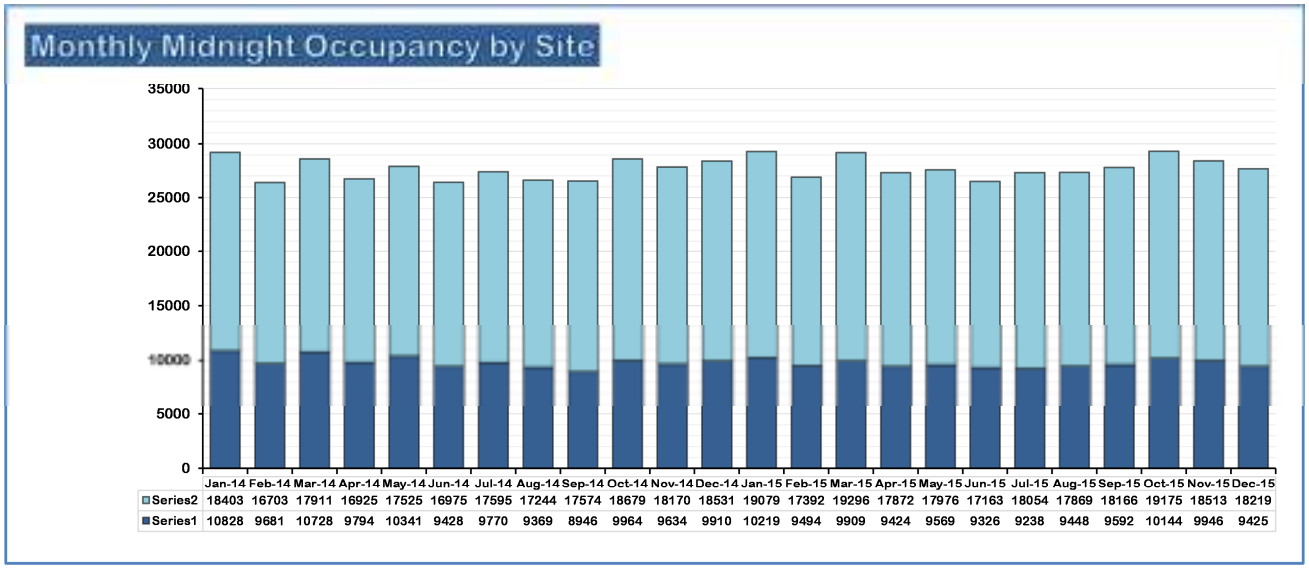


3.9.3 Midnight Bed Occupancy

Aim: To reduce the number of beds occupied and Trust percentage.

How: Every patient, every day, Estimated Date of Discharge, discharges, discharge waiting areas, Blaylock tool, ticket home, bed manager walk-downs.

Narrative: Bed occupancies in December 2015 were 27,644 (average 892 per day). In the same month last year bed occupancies were 28,441 (average 918 per day).



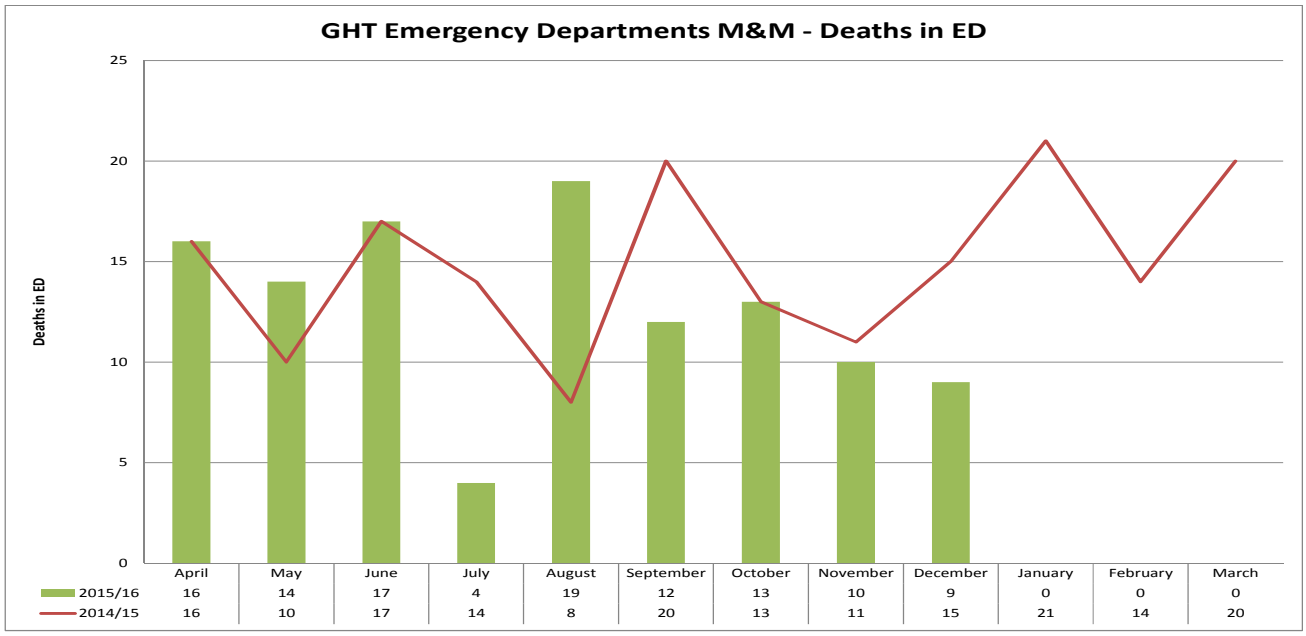
% Bed Occupancy (as at Thursday snapshot)

Week ending:	CGH	GRH	Total
06/12/2015	87.5%	97.8%	**93.7%**
13/12/2015	93.8%	96.7%	**95.6%**
20/12/2015	95.3%	96.9%	**96.2%**
27/12/2015	81.3%	87.9%	**85.2%**
03/01/2016	91.6%	96.8%	**94.7%**

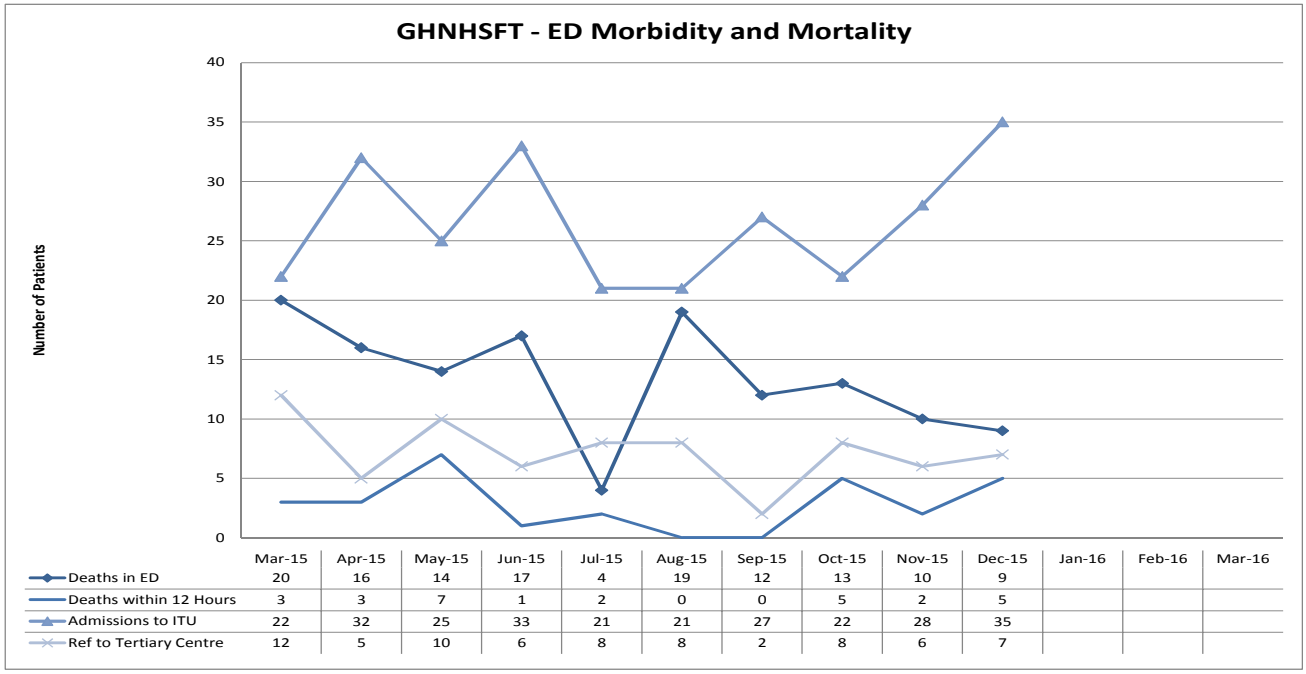
3.10 ED Morbidity and Mortality

Aim: To review the Morbidity and Mortality trend.

Narrative: During December 2015 there were 9 deaths in the Emergency Department, which is lower than December last year (-6). There were 35 admissions to ITU and 7 referrals to tertiary centres. All of the deaths are reviewed in detail at the Service Line Morbidity and Mortality Reviews. There are no significant issues arising from this data.



	April	May	June	July	August	September	October	November	December	January	February	March
2015/16	16	14	17	4	19	12	13	10	9	0	0	0
2014/15	16	10	17	14	8	20	13	11	15	21	14	20



	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Deaths in ED	20	16	14	17	4	19	12	13	10	9			
Deaths within 12 Hours	3	3	7	1	2	0	0	5	2	5			
Admissions to ITU	22	32	25	33	21	21	27	22	28	35			
Ref to Tertiary Centre	12	5	10	6	8	8	2	8	6	7			

3.11 Medical Staffing

Aim: To ensure sufficient doctors are on duty in the Emergency Department and Acute Medicine.

Narrative: Whilst there has been success in recruiting Emergency Department Consultants, there remain gaps in middle grade rotas especially in Acute Medicine. This is one of the main contributors to Emergency Department breaches. Regular review of the rotas is underway an in the interim locums will continue to be employed to cover.

The information in the table below is taken from the ledger and reports staff holding a Trust contract on the payroll closedown date.

		Establishment (wte)	In Post December (wte)	Variance In Post vs. Establishment	Variance vs. in Post in November
Emergency Department	Consultants	17.70	17.60	-0.10	0
	Trainee Doctors	34.49	29.70	-4.79	-1.0
Acute Medicine	Consultants	10.73	8.33	-2.40	0
	Trainee Doctors	83.83	66.00	-17.83	-0.40

A small team went to India in February 2015 with colleagues from Weston Area Health Care NHS Trust and 3 middle grade doctors were recruited, to start in August 2015. These doctors have now been delayed and the exact start dates are to be determined.

It is now unlikely that these doctors will start with the Trust and the department is looking at alternative ways to cover these gaps including the option to recruit Fellowship Doctors; Doctors from Europe (through other healthcare agencies) and other Doctors from India. The latter will take a different approach to the previous round, whereby only Doctors who have already passed their English exams will be considered, in order to expedite the process.

As part of the 2015/16 contract negotiations, the Trust secured funding for 3 Emergency Department Consultants and 4.8 Emergency Nurse Practitioners for the Emergency Department. The full Emergency Department rota went live from 1st November 2015, providing consultant cover until midnight, seven days a week.

Key Actions Going Forward

- The SAFER bundle has now been rolled-out to all Medical and Surgical Boards. All wards will be re-visited over the next couple of months, with the support of Dr. Kate Hellier.

- The fourth SAFER week scheduled for 11th – 17th January will focus on delivering continuous improvements made in the first three SAFER weeks and incorporate the Multi-Disciplinary Accelerated Discharge Event (MADE), which will take place across the whole local healthcare system.

- 7-Day Services: Following the progress made with the recruitment of additional ward clerks to support weekend cover, a further recruitment drive will take place in January 2016. The positions of Ward Clerk Manager and Ward Clerk Supervisor have now been filled and are due to commence mid-January.

- Support joint working with the Monitor Operational Support team.

- Continue monthly monitoring against the High-level Action Plan, based on the main Emergency Care Board Action Plan which highlights three key areas: Patient Flow;

Emergency Department and Admission Avoidance. This will be submitted to the Monitor Operational Support Team.

- Programme Director for Unscheduled Care to implement the revised Emergency Care Board Action Plan.

- Continue the development of Internal Professional Standards.

- Continue building on the Ambulatory Emergency Care model currently being delivered.

NURSE AND MIDWIFERY STAFFING
JANUARY 2016

1 Purpose

The aim of this paper is to update our Trust Board on the exception reports made regarding compliance with the 'Hard Truths' – Safer Staffing Commitments for December 2015.

2 Background

2.1 Monthly reports have been submitted to our Board on our nursing and midwifery staffing numbers. Information has been uploaded onto the UNIFY system as required as have links to NHS Choices. Information is also available on our own Trust website.

2.2 The exception report on the Safer Staffing data will be uploaded to NHS Choices and the UNIFY system on 15th January.

3 Findings

3.1 In line with the set parameters for the Safer Staffing guidance there are no outlying exceptions for December. Both Departments of Critical Care 'flex' their staff during periods of low patient numbers, so 'trigger' falsely, in that their staffing against their expected staffing level remains constant from a data perspective.

3.2 From the last report, work is ongoing to understand and action plan against the latest 'Care Contact Time' analysis focusing on Specialist Nurses.

4 Key Workforce Initiatives

4 Recruitment Update

4.1 UK Pipeline

- There are currently 19 UK-based nurses in the recruitment process due to commence employment in January/February. Following the January output of newly-qualified nurses, it is forecasted that the numbers of nurses in the pipeline will reduce during Spring 2016.
- A recruitment event for the newly-qualifying nurses completing their studies in Summer 2016 will be held on Saturday 27 February at Redwood Education Centre.
- A recruitment event for the newly-qualifying nurses completing their studies in January 2017 has also been provisionally booked for Saturday 17 September at Redwood Education Centre.

4.2 Overseas-Qualified Nurses

- The first cohort of nine overseas-qualified nurses will be sitting their International English Language Testing System (IELTS) examination on Saturday 23rd January. If successful, these nurses will then complete a 2-3 month Objective, Structured, Clinical Examination (OSCE) training programme and then take their OSCE examination at the University of Northampton.
- A further recruitment campaign for overseas-qualified nurses will commence in January with interviews scheduled to take place on Saturday 19 March at Redwood Education Centre, with a view to the successful candidates commencing employment in June 2016.

4.3 **EU Recruitment**

- Following the issuance of revised rules for European nurses seeking registration in the UK by the Nursing and Midwifery Council (NMC), the number of candidates applying for positions via our European agencies has decreased.
- There are currently 10 candidates from overseas being processed, and a further two candidates booked for interview.
- It is expected that contracts with some of the European agencies will be terminated, due to the inability of these agencies to provide nurses that meet the new NMC requirements.

4.4 **Philippines Recruitment**

- The Migration Advisory Committee is currently preparing a report to the Home Secretary about the longer-term inclusion of nurses on the Shortage Occupation List. Currently, nurses are only considered a shortage occupation until 01 April 2016. It is expected that the new report, due to be published on 15 February 2016, will recommend that this date is extended by at least 12 months.
- The final four nurses from the recruitment campaign in 2014 are due to join the Trust in January 2016.
- It is expected that the first nurses from the November 2015 campaign will join the Trust in February 2016.
- A further recruitment campaign in the Philippines has been scheduled for w/c 09 May 2016. This campaign will include a separate campaign via Skype for nurses within Paediatrics, Intensive Care, and Neonatal Intensive Care.

4.5 **Incentives and Promotion**

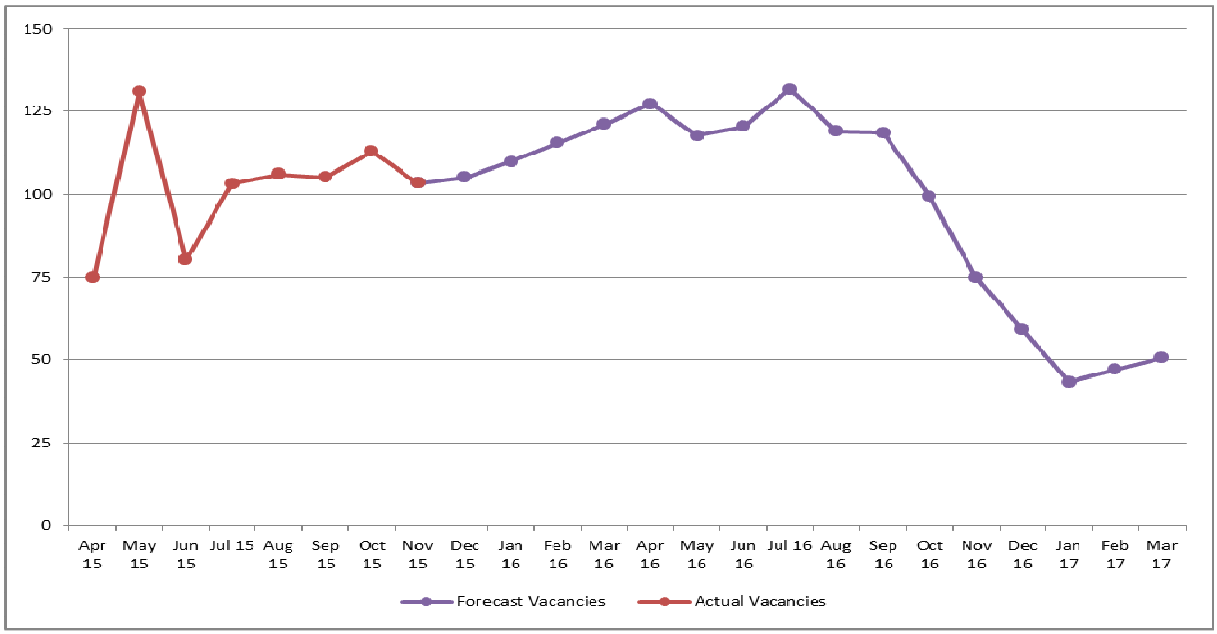
- A promotional advertisement for the Recruitment and Retention Premium for General and Old Age Medicine (GOAM) and Stroke has been created by the Communications Team, and will appear in the British Journal of Nursing in February 2016. Further external communications are being created.
- The £1200 incentive payment for General and Old Age Medicine (GOAM) is currently under review, and an options appraisal is due to be presented to Reward Strategy Group on 20 January 2016.
- From 01 December 2015, a pilot scheme has been agreed for four months, so that any Registered Nursing shifts worked in addition to substantive contracted hours will attract an enhanced rate of pay:

Band of Nurse	**Total enhanced payment for all work beyond contracted hours**	
	Monday to Saturday	**Sunday**
5, 6, 7 or 8a	Time + 50% **at their own band** regardless of shift being filled	Time + 65% **at their own band** regardless of shift being filled

4.6 **Nursing Workforce Metrics**

Division	**Band 5 Vacancies**	**Sickness**		**Turnover**	
		RGNs	**HCAs**	**RGNs**	**HCAs**
Diagnostic & Specialist	0	3.82%	4.56%	9.44%	15.58%
Medicine	71.52	4.02%	5.27%	17.35%	21.41%
Surgery	26.73	3.84%	5.09%	10.52%	14.96%
Women & Children	0	4.28%	3.70%	10.31%	13.33%

4.7 Vacancy Forecast



5 Next Steps and Communication

- Continue with proactive recruitment.
- Review the various incentive and reward schemes to ensure they have the requisite effect
- Publish data as required.

6 Recommendations

The Board is invited to endorse this report.

Authors: **Paul Garrett, Deputy Director of Nursing & Midwifery**
Adam Kirton, Nurse Recruitment Manager

Presenting Director: **Maggie Arnold Director of Nursing & Midwifery**

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

BOARD STATEMENTS

MAIN BOARD – JANUARY 2016

1. Introduction

NHS Foundation Trusts are required to confirm the following Board statements:

For Finance that:

The Board anticipates that the Trust will continue to maintain a Financial Sustainability Risk Rating of 3 for the financial year 2015/16.

For Governance that:

The Board is satisfied that plans in place are sufficient to ensure: on-going compliance with all existing targets as set out in the compliance framework (Appendix 1); and a commitment to comply with all known targets going forwards.

Otherwise:

The Board confirms that there are no matters arising in the quarter requiring an exception report to Monitor (Appendix 2) which have not already been reported.

(Appendices 1 and 2 are based on the Monitor Risk Assessment Framework (updated August 2015))

This paper sets out the issues that the Board must consider in making these declarations.

2. Finance

In August 2015 Monitor published an updated Risk Assessment Framework. One of the significant changes was to replace the Continuity of Service Rating (COSR) with a Financial Sustainability Risk Rating (FSRR). An extract from the updated Risk Assessment Framework showing the component parts of that rating calculation can be found at Appendix 3

The Trust consistently delivered a continuity of service rating of 3 throughout 2014/15 and although the surplus to date is below plan at the end of Quarter 3 in 2015/16 the Trust is currently achieving FSRR of 3. The Trust continues to experience ongoing demand pressures, and additional external expertise on cost improvements has been commissioned by the Trust to support Divisions and Corporate Departments in delivery of their plans.

Forecasting for the 2015/16 year as a whole indicates that the Trust's forecast year end surplus position will be below the original plan however, the overall financial position will remain in surplus and will maintain an FSRR rating of 3. However tight control needs to be maintained to ensure the forecast is achieved with ongoing identification and timely delivery of savings and improved activity performance remaining key to the delivery of an acceptable financial position for the year. The Board can therefore agree with the statement above for finance.

Governance

There are two performance challenges which mean that the Trust is not able to sign the Governance Statement.

The performance challenges against the compliance framework both of which were briefed in detail to the Finance and Performance Committee and are as follows:

A&E - The A&E 4 hour wait standard has not been achieved to date, following the closure of the investigation by Monitor. The investigation has been formally closed and our governance status on this target confirmed as green by Monitor. The Trust is working closely with Monitor on our plans to improve performance.

Cancer - The Trust did not meet the 62-day target for Q3 however, performance is improving and recovery plan in place to continue this improving trend this includes plans to manage increasing demand.

Performance against the compliance framework targets for the year are shown in the Performance Management Report elsewhere on the Agenda.

3. Any other Areas

There are no issues to raise with Monitor under this heading.

4. Conclusion

The Board will not be able to provide full assurance of the Governance Statement and will need to provide an exception report. In this report the Board needs to include the date when it expects to return to compliance against the targets. The Finance and Performance Committee will provide an update to the Board of the detailed scrutiny that it has had on these performance areas to help inform the Board in its decision making on the Board statements.

5. Recommendation

The Board is asked to consider that:-

1. The Board expects that the Trust will continue to maintain a Financial Sustainability Risk Rating of 3 for the 2015/16 financial year however this is not without a significant challenge that will require ongoing rigour across the Trust's activities, particularly regarding the delivery of its Cost Improvement Programme

2. An exception report is made to Monitor on the A&E 4 hour standard and Cancer 62 day standard. The Trust will continue working with Monitor and partners across the health system to design and deliver performance improvement plans and improve performance on these targets in the remainder of the 2015/16 financial year and moving in to 2016/17.

3. The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all other existing targets as set out in the compliance framework and a commitment to comply with all known targets going forward.

Author and Presenting Director: **Helen Simpson,**
Deputy Chief Executive/Director of Finance

January 2016

Table A1: Indicators and their thresholds

		Indicator	Threshold (A)	Weighting (B)	Monitoring Period
OUTCOMES	1	Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway **(C)**	92%	1.0	Quarterly
	2	A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge **(D)**	95%	1.0	Quarterly
	3	All cancers: 62-day wait for first treatment **(E)** from:		1.0	Quarterly
		Urgent GP referral for suspected cancer	85%		
		NHS Cancer Screening Service referral	90%		
	4	All cancers: 31-day wait for second or subsequent treatment **(F)**, comprising:		1.0	Quarterly
		Surgery	94%		
		Anti-cancer drug treatments	98%		
		Radiotherapy	94%		
	5	All cancers: 31-day wait from diagnosis to first treatment **(G)**	96%	1.0	Quarterly
	6	Cancer: two week wait from referral to date first seen **(H)**, comprising:		1.0	Quarterly
		All urgent referrals (cancer suspected)	93%		
		For symptomatic breast patients (cancer not initially suspected)	93%		
	7	Care Programme Approach (CPA) patients **(I)**, comprising:			
		Receiving follow-up contact within seven days of discharge	95%	1.0	Quarterly
		Having formal review within 12 months	95%		
	8	Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams **(J)**	95%	1.0	Quarterly
	9	Meeting commitment to serve new psychosis cases by early intervention teams **(K)**	95%	1.0	Quarterly
	10	Category A call – emergency response within 8 minutes **(L)**, comprising:			Quarterly
		Red 1 calls	75%	1.0	
		Red 2 calls	75%	1.0	
	11	Category A call – ambulance vehicle arrives within 19 minutes **(L)**	95%	1.0	Quarterly
	12	Early intervention in Psychosis (EIP): People experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral **(M)**	50%	1.0	Quarterly
	13	Improving access to psychological therapies (IAPT) **(N)**:			Quarterly
		People with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral	75%	1.0	
		People with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral	95%	1.0	
	14	Clostridium (C.) difficile – meeting the C. difficile objective **(O)**	de minimis applies	1.0	Quarterly
	15	Minimising mental health delayed transfers of care **(P)**	≤7.5%	1.0	Quarterly
	16	Mental health data completeness: identifiers **(Q)**	97%	1.0	Quarterly
	17	Mental health data completeness: outcomes for patients on CPA **(R)**	50%	1.0	Quarterly
	18	Certification against compliance with requirements regarding access to healthcare for people with a learning disability **(S)**	N/A	1.0	Quarterly
	19	Data completeness: community services **(T)**, comprising:			Quarterly
		RTT information	50%	1.0	
		referral information	50%		
		treatment activity information	50%		

Appendix 2

Table 3: Examples of where an exception report is required

	Examples

Continuity of services	• unplanned significant reductions in income or significant increases in costs
	• discussions with external auditors which may lead to a qualified audit report
	• future transactions potentially affecting the financial sustainability risk rating
	• risk of a failure to maintain registration with CQC for CRS
	• loss of accreditation of a CRS
	• proposals to vary CRS provision or dispose of assets, including:
	  ○ cessation or suspension of CRS
	  ○ variation in asset protection processes
	• proposed disposals of CRS-related assets

Financial governance	• requirements for additional working capital facilities • failure to comply with the statutory reporting guidance • adverse report from internal auditors • significant third-party investigations or reports that suggest potential material issues with governance • CQC inspections and their outcomes • performance penalties to commissioners
Governance	• third-party investigations or reports that could suggest material issues with financial, operational, clinical service quality or other aspects of the trust's activities that could indicate material issues with governance • CQC responsive or planned inspections and the outcomes/findings • changes in chair, senior independent director or executive director • any never events* • any patient suicide, homicide or absconsion (mental health trusts only) • non-compliance with safety and security directions and outcomes of safety and security audits (providers of high security mental health services only) • other serious incidents or patient safety issues that may impact compliance with the licence (eg serious incidents, complaints)
Other risks	• enforcement notices or other sanctions from other bodies implying potential or actual significant breach of a licence condition • patient group concerns • concerns from whistleblowers or complaints • any significant reputation issues, eg any adverse national press attention

*Never events should always be reported to us at the same time as to commissioners, even if they will later be deemed not to be never events.

Table 5: Calculating the financial sustainability risk rating for NHS foundation trusts

	Financial criteria	Weight (%)	Metric	Rating categories**			
				1*	2***	3	4
Continuity of services	Balance sheet sustainability	25	Capital service capacity (times)	<1.25x	1.25 - 1.75x	1.75- 2.5x	>2.5x
	Liquidity	25	Liquidity (days)	<(14) days	(14)-(7) days	(7)-0 days	>0 days
Financial efficiency	Underlying performance	25	I&E margin (%)	≤(1)%	(1)– 0%	0-1%	>1%
	Variance from plan	25	Variance in I&E margin as a % of income	≤(2)%	(2)-(1)%	(1)-0%	≥0%

*Scoring a 1 on any metric will cap the weighted rating to 2, potentially leading to investigation.

**Scores are rounded to the nearest number, ie if the trust scores 3.6 overall, this will be rounded to 4; if the trust scores 3.4, this will be rounded to 3.

***A 2* rating may be awarded to a trust where there is little likelihood of deterioration in its financial position.

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD/JANUARY 2016

RISK MANAGEMENT FRAMEWORK

1. PURPOSE

1.1 Gloucestershire Hospitals has a key strategic objective – to improve year on year the safety for staff (including contractors), patients and visitors to the hospital sites. There is also a requirement to meet the Health and Safety at Work etc Act (1974) and other external standards set down by a range of regulators.

1.2 The promotion of effective staff and patient safety improves staff morale and well being while reducing avoidable harm to patients and staff, it will also lead to reduced staff sickness absence and increased business efficiency. The challenge for the Trust is to continually improve safety, engaging staff in activities that will take this forward and embedding a **safety culture in the organisation.**

1.3 To provide the right environment for this to occur it is important to foster and support a culture where staff engage with risk control processes and contribute to identifying and participating in safety improvement programmes for patients and staff. This means that the Trust Board, managers and all staff openly support each other and see any accident or near miss, as an opportunity to learn and improve.

1.4 The purpose of this framework is to inform the organisation of the means by which effective safety for all will be achieved.

2. INTRODUCTION

2.1 The Risk Management Framework which is based on Health & Safety Guidance 65 describes the Trusts approach to safety management.

2.3 To meet the Trust's objective, to improve safety year on year a range of safety programmes has been established based on national initiatives and current risks. The Trust aims to participate in national, regional initiatives promoting improved health and safety management for all concerned, e.g. Sign Up for safety, Shattered Lives campaign (HSE), West of England Academic Health Science Network Patient Safety Collaborative.

3. LEADERSHIP AND POLICY

3.1 There is a legal requirement for the Trust to develop and formalise a Board-led Health and Safety Management Strategy, so as to demonstrate that it is an organisation that is committed to continually improving safety through 'leadership, planning, delivering, reviewing and monitoring of performance'.

3.2 Part of the strategy is to develop a leadership model to facilitate an effective safety culture. In practice this means that the executive team will support and develop the following key themes:

- **Visual Safety Leadership** through executive walkabouts and executives as safety leads.
- **Staff and Patient involvement and consultation** integrated into safety activity and improvement.

- **Promote a safety culture** with an open and fair process for the investigation of incidents and accidents.
- **Quality and Safety responsibilities** considered on appointment of senior staff.

3.3 The Risk Management Framework supports the development and implementation of the

- **Trust's Quality Framework –** describing the Trust's approach to improvement associated with Safety, Patient Experience and Effectiveness streams and assurance/ operational routes associated with its implementation
- **Patient Safety Strategy** – identifying key areas for focusing improvements e.g. leadership, ward, peri-operative, medications, etc
- **Staff, Contractors and Visitors Safety Strategy** – identifying key areas for focusing improvements e.g. leadership, falls, sharps, manual handling, stress, violence and aggression and also listing staff health and safety related policy/ procedural documents etc

3.4 This Framework is supported by implementation of other risk associated policies and procedures specific to aspects of risk management and its control e.g.

- **Health and Safety Policy** - specific to the implementation of the Health and Safety at Work act 1974, Management of Health and Safety at Work Regulations 1999 describing the topic of the month process for the annual review of key health and safety topics affecting staff groups the Trust
- **Procedure for Managing, Reporting and Investigating Incidents/ Accidents to include serious incidents** – supporting the process for reporting and learning from actual and near miss occasions
- **Risk Assessment and Procedure for Managing Risk Registers** – enabling the trust to carryout risk assessment by competent staff and prioritise and manage risks based on likelihood of recurrence and the severity of impact
- **Safety Alert and Action Procedure –** describing the management of all alerts, entering the organisation e.g. MHRA, NICE Confidential Enquires and recommendations arising from external visits etc

3.5 The Trust will continue the development of a library of policies and procedures ensuring safe systems of working for staff based on national evidence and guidance applied locally e.g. Marsden Nursing Manual, NICE guidance, Confidential and High Level Enquiries, HSE guidance etc. The Trust will develop an effective policy/ procedural management process to ensure review and updating of documents in line with legislation and local guidance (How to Write a Procedural Document).

3.6 Individual polices will identify the competency/ training base for the key roles as well as documenting the measurement for monitoring the effectiveness of the policy/ procedure.

3.7 By approving the Risk Management Framework, the Trust Board signs up to active involvement in making the Trust safer and their success will be openly measured against the agreed Performance Management Framework based on the Trust Annual Plan. The Board will receive updates quarterly (as a minimum) through the reporting mechanisms of the Quality Committee, Patient Safety Forum and Health and Safety Committee and Trust Management Team. (see Appendix 1 for table of safety reporting).

4. ORGANISING (ROLES AND RESPONSIBILITIES OF KEY STAFF AND COMMITTEES)

4.1 The Trust has identified key roles for the success of the implementation of the Risk Management Framework, and associated Patient and Staff Safety Strategies and the responsibilities attached to those posts. Training qualifications in Health and Safety are identified dependant on the role of the individual in the organisation.

4.2 This Framework demonstrates leadership at Board level and its commitment to the standardised approach to a risk management focused programme that embeds safety at all levels of the organisation. The Framework also aims to provide methodology for the challenge of the status quo and acceptance of current levels of avoidable harm.

4.3 Specifically the roles and responsibilities for Safety Management at committee level are

4.3.1 The **Trust Board** sets the direction for effective safety systems which are integral to the organisation's culture, its values and is demonstrated through the monitoring of safety performance standards and goals. All Board members take a lead in ensuring the communication and ongoing focus on safety and its benefits to all people attending the site for whatever reason. All executive members of the Trust Board are required to complete the IOSH Safety for Senior Executives training on risk management/ Health and Safety. Each year the Board will approve key safety objectives for executives which will feature in the performance management framework.

The **Trust Board** is responsible for:

- The ratification and annual review of the Risk Management Framework.
- The ratification and monitoring of the annual safety objectives (as part of the PMF).
- The identification, review and management of corporate and business risk
- Review of the Trust Risk Register (monthly minimum)
- Monitoring of the Assurance Framework (3 times a year)

4.4 The **Audit Committee,** chaired by a Non Executive Director, is responsible for:

Offering assurance to the Board that the Trust has a robust Assurance Framework which is operating satisfactorily and which ensures that the same level of scrutiny is given to clinical risks as to strategic, financial and operational risks. This will be done through consideration of the **Quality Report** and review of the Assurance Framework prior to the preparation of the Statement of Internal Control.

4.5 The **Trust Management Team,** chaired by the Chief Executive/ Director of Finance, is responsible for

- Monitoring of the risks on the Trust Risk Register
- Delivery of corporate objectives for the year
- Provision of advise to the board on both annual and strategic plans
- Monitoring of Trust performance through the Performance Management Framework
- Receive divisional quality reports demonstrating local monitoring of local quality and safety issues
- Annual presentation and review of divisional and directors risk register

4.6 The **Quality Committee,** chaired by a Non-Executive Director, is responsible for:

- Overseeing the development and implementation of the Quality Framework within the Trust and reporting progress by sharing minutes of meetings with the Trust Board.
- Monitoring quality and safety issues within the Divisions
- Providing assurance to the Trust Board on quality and safety issues

Appendix 1 Details the reporting arrangements for risk management processes to the Board/ Sub Committees of the Board

4.7 The **Patient Safety Forum** chaired by the Assistant Medical Director / Director of Safety is responsible for**:**

- Promoting the implementation of the Trust Patient Safety Strategy
- Ensuring action is taken where appropriate to minimise patient risk reported through trust risk processes e.g. incidents, complaints, PALS, inquests, claims
- Promote national patient safety initiatives e.g., NHS England, CQuINs, Sign Up for Safety
- Providing the interface between Divisional Management Teams approach to promoting patient safety and risk management with Quality Committee
- Gain assurance from specialist safety committees on risk management and patient safety issues e.g. medicines liaison, resuscitation, transfusion
- Review progress with implementation of national initiatives e.g. NCEPOD, high level reviews

4.8 The Trust **Health and Safety Committee** chaired by the Chief Executive / Director of Human Resources with staff side Health and Safety representatives/ specialist advisors reviewing staff/ visitors, public associated risk issues and where necessary referring to the Trust Management Team and Quality Committee for action and assurance. It is responsible for

- Promoting all aspects of health and safety management in the organisation and specifically the implementation of the Staff, Public and Visitor Safety Strategy
- Co-ordinating health and safety inspections/ audits of the organisation
- Monitoring of issues arising from accidents, incidents and near misses relating to Health and Safety at Work
- Review actions and implementation arising from Health and Safety Executive visits
- Ensure review, implementation and updating of Health and Safety Related policies and procedures in line with HSE guidance (ref HSG65)
- Gain feedback from staff safety representatives of concerns raised by individual staff members
- Gain assurance /feedback from divisional Health and Safety committees on compliance with Trust Health and Safety programmes / annual health checks

4.9 The **Safety and Experience Review Group** chaired by the Director of Safety, membership includes Trust executives and Commissioners Governance lead monitoring the investigation and identification of root causes as a result of serious incidents/ complaints/ claims/ inquests. This group reports to the Patient Safety Forum / Quality Committee and the Trust Quality Contract Group to ensure timely management of such incidents.

Terms of reference for the Board subcommittees and Safety related committees are found in Appendix 2

4.10 **Divisional Management Boards** are responsible for:

- Establishing operational procedures that describe implementation of the Trust Risk Management Framework and the monitoring of risk related activities in the division

- Maintaining a Divisional Risk Registers and escalation of significant risks to the Trust Management Team where the Division is unable to take appropriate action. (See Risk Assessment and Procedure for Managing Risk Registers)

- Monitoring the function of the **Divisional Health and Safety** and **Divisional Quality/ Risk Management' committee** enabling management and escalation to Trust level of issues/ concerns arising from local review/ management and ensuring compliance throughout the division.

4.11 **Additional groups** will be convened to ensure compliance with national and local guidance initiatives using the planning, delivering, reviewing and monitoring framework. The reporting lines for these groups will be agreed and documented in the terms of reference ensuring sound governance processes for the organisation. Examples include Infection Control Committee, Medicines Safety Group, Decontamination and Medical Devices Group, Transfusion Committee, Resuscitation Committee, Radiation Protection Committee, Security Management Group

4.12 The **Chief Executive** is the Accounting Officer for Gloucestershire Hospitals NHS Foundation Trust. He is the Trust executive lead for safety management and is accountable for ensuring that the Trust can discharge its legal duty for all aspects of safety each year, and specifically for the health and safety of staff, visitors and contractors on Trust premises. He is chair of the Trust Health and Safety Committee.

4.13 A **Non-Executive Director** acts as scrutiniser for health and safety at Board level and liaises directly with the Chief Executive and is assured that effective health and safety is being addressed. The NED lead will play a key role ensuring the processes to support and assure the Board facing significant staff safety risks are robust and will have particular responsibility for monitoring annual H&S objectives. This person is required to complete the IOSH Safety for Senior Executives training on risk management/ Health and Safety and will attend two H&S committees per year.

4.14 **The Executive Team** have responsibilities for effective safety for all aspects of care for staff (including contractors), patients and visitors to the site. Each member of the executive team will ensure that safety risks are identified and assessed and integrated into their planning and delivery of services with appropriate levels of monitoring to ensure compliance. They will make adequate arrangements to provide or access competent advice on health and safety issues for themselves and their teams. Each member of the executive team will also carry out programmed executive visits to wards and departments to ensure safety processes are in place and provide a direct forum for staff to discuss safety matters..

Specific roles for members of the executive are

- **Deputy Chief Executive / Director of Finance -** Has executive responsibility for the management of finances ensuring that safety management is properly financially resourced. The Executive has board responsibility for Security Management / Violence and Aggression

- **Director of Service Delivery -** Has day to day responsibility for the site including any arising safety issues and has board responsibility for water management. They are the lead for co-ordinating emergency planning and ensuring business continuity.

- **Director of Nursing/ Medical Director -** Have executive responsibility for the quality of care including the safety of patients and specific profession related safety issues such as "infection control, sharps management and working time directives". They are the designated leads for assuring on clinical governance processes for the organisation with the Director of Clinical Strategy

- **Director of Human Resource and Organisational Development -** Has executive responsibility for the management of human resources and organisational development including mandatory training, staff health and welfare, with specific responsibility for the management of workplace stress. Has responsibility for developing a library of human resource related policies and procedures reflecting sound human resource management

- **Director of Clinical Strategy -** Has executive responsibility for the strategic planning for the Trust and will ensure that safety issues are considered for patients and staff as part of any new developments and that the Annual Plan has a health and safety component describing the issues to be managed. Has executive responsibility for Information Governance

4.15 **The Director of Safety** has particular responsibility for leading the Safety programmes and risk management for both staff and patients. He liaises closely with the Divisional teams to support their activities, co-ordinating and monitoring the safety programmes, ensuring provision of reports on the appropriate metrics.

- Contributing to the development and monitoring of the annual safety objectives through consultation and review.
- Responsible for the establishing of an open and fair system for the investigation of incidents and accidents, including a confidential reporting process and Duty of Candour.
- Coordination of the Executive visits to all areas in the organisation ensuring wide understanding of safety issues and concerns from all staff
- Delivery of agreed Safety objectives

This person is required to complete the NEBOSH (certificate level) training on risk management/ Health and Safety and will attend the Quality Committee, Health and Safety Committee and Patient Safety Forum.

4.16 **The Chief of Service** is accountable for the safety activities in their areas of responsibility and ensure their organisational structure is able to discharge the requirements of staff and patient safety (appendix 3). Each division will identify forums for the planning, delivery, action and checking of patient and staff health and safety facilitated by NEBOSH certificate trained Risk Manager, with competent advice from specialist staff as required. This person is required to complete the IOSH Safety for Senior Executives training on risk management/ Health and Safety

4.17 **Trust/ Divisional Risk Managers -** staff who are expected to provide Health and Safety advice will have a minimum of NEBOSH certificate. The Trust lead for providing Health and Safety advice will have a minimum of post graduate degree on occupational safety and health with associated membership of a professional organisation at a senior level. This person will provide advice to the Director of Safety on Health and Safety process and policy. Trust Risk Managers attend Patient Safety Forum / Health and Safety Committee. Divisional Risk Managers attend equivalent divisional meetings.

4.18 **Specialist Safety Advisory Roles**. Staff in specialist roles such as Security Advisors, who are required to provide competent advice on policy, will have their role and qualification identified in the appropriate related policy.

4.19 **Local Managers** (as defined by Divisional management teams) are responsible for identifying, assessing and managing safety risks. They must ensure that safety management is integrated into their planning and delivery of services with appropriate levels of monitoring to ensure compliance within their area and must participate in wider governance, quality and risk management issues within their division. These managers will be required to undertake the “Managing Safely” course (IOSH).

4.20 **Delegated responsibility for risk assessment, investigation and inspection.** Staff that have these responsibilities delegated to them, must attend the in-house workshops on these topics, their training requirement will be identified as part of their appraisal.

4.21 **Staff Side Health and Safety Representatives; Representatives of Employee Safety (RoES).** Designated/ elected representatives will engage with staff groups or union members (dependant on role) and consult, communicate and provide feedback to and from health and safety meetings. They will advise (within their competence) on effective health and safety management and engage in safety improvement work, safety inspections, including investigation and risk assessment activity in partnership with the Trust Safety team. Staff side representatives would be expected to attain level 2-3 of the union based health and safety qualification. RoES would be expected to complete the "Managing Safely'' IOSH course. Both roles have to complete the in-house investigation and risk assessment workshop.

4.22 **All staff** have a responsibility to follow health and safety instructions and report any patient and staff safety incident/ accident immediately, co-operating with any subsequent investigation (Procedure for Managing, Reporting and Investigating Incident and Accidents to include Serious Incidents). Their safety training needs will be identified during annual appraisals as part of the training matrix for professional groups as well as specific needs. For those staff identified by their professional body as having additional Health and Safety responsibilities a recognised qualification will be gained. Staff are encouraged to participate in improvement programmes promoting patient and staff safety and opportunities to participate in setting the safety agenda for the organisation are encouraged.

5. PLANNING

5.1 The Trust Board will lead the implementation of effective risk management through formal planning throughout the organisation and significant risks. Improvement programmes and targets will be further developed in conjunction with the Staff and Patients Safety Strategies.

5.2 The Annual Plan will identify key objectives / performance indicators reflecting significant risk issues identified by staff and patients through local and national safety programmes and initiatives. A risk based approach will be utilised to assist in the prioritising and setting of these objectives and improvement programmes.

5.3 Senior managers/ Board Directors will engage with staff members to learn of the risks to the organisation/ staff and patients through recognised forums e.g. Quality Committee, Trust Management Team, Health and Safety Committee, Patient Safety Forum as well as at divisional forums. They will also participate in visits to individual areas to observe and hear of good practice and learn of areas for improvement through meeting with staff and patients. The issues raised will feed into operational business planning schedules and the annual planning process for the Trust aiming to promote safety and reduce harm.

5.4 Each Division will develop an annual Health and Safety management plan that supports the implementation of the Trust plan and take into consideration local priorities. This must include:

- Plans and targets for improvement based on risk assessment of local issues
- A schedule of workplace inspections involving staff Health and Safety representatives based on the Health and Safety Manual (Risk assessment and controls compliance monitoring).
- A Health and Safety training/ competence plan

5.5 Managers must ensure they have appropriate local risk assessments in place, investigate, follow up and feedback incidents and ensure there is a programme of inspection as indicated in the Health and Safety Manual (see Health and Safety Policy).

5.6 Staff involvement will be integrated into the work of all safety programmes so that improvements includes the staff members interpretation of what is important and improves their work experience within the Trust.

5.7 Key safety metrics/ dashboards will be continually developed and reported through the Performance Management and Quality Frameworks informing on the success of the Safety Strategies through the introduction of safer systems of working. These will be a mix of performance monitoring and targets for improvement.

5.8 The Trust will undertake to provide staff with training to meet the requirements of their role and also to provide training on aspects of risk and safety management necessary to undertake that aspect of their role – this may be provided through different platforms and led by the Trust Learning and Development Department / Safety Department. (See section on Competencies/ Training)

6. DELIVERING / IMPLEMENTATION

6.1 The Trust will actively engage and participate in initiatives in the organisation that plan to promote the safety cultures demonstrating their commitment to the Risk Management and control programme. The organisation will ensure that there is an adequate resource to support risk management activities through availability of competent advice, training programmes, information services etc.

6.2 The Trust will implement the annual plan, risk assessments, incidents and accidents investigations, health and safety inspections and staff training to ensure the appropriate delivery of health and safety systems.

6.3 The Trust Risk Register will be reviewed and challenged on progressing entries at each Trust Management Team and by the Trust Board. At Division and Speciality level this process will be replicated to ensure relevant risks with appropriate mitigation is in place throughout the organisation (see Risk Assessment and Procedure for Managing Risk Registers).

6.4 The Trust promotes the adoption of recognised methodologies testing the effect of changes in reducing risk and measuring the effect of controls, demonstrating the efficacy of action taken. Examples include ‘plan-do-study-act cycles’, using of SMART objectives (specific, measurable, agreed, realistic, time framed) or the ‘policy, organising, planning and implementing, measuring performance, review and audit’ used as a framework for designing risk control systems

6.5 The Trust will identify key roles responsible for the delivery of the risk management processes and designated safety topics ensuring the postholders are competent through recognised training and experience. This will include ensuring board members, both executive and non executive, have an understanding of sound safety management principals.

6.6 The Trust’s Management Team will pro-actively engage with staff members and patients in identifying concerns and issues for improving safety for all through conducting patient and staff surveys, scheduling workplace visits as well as participating in unexpected reviews and encouraging involvement of staff in safety improvement projects, audits and inspections.

6.7 The Trust will promote the involvement of employees / representatives in improvement projects through active engagement with staff Health and Safety Representatives, clinical champions/ key workers etc ensuring stakeholder involvement as well as management leadership. Staff involved with these activities will be given the facilities to participate within working hours if outside of normal working practices.

7. MEASURING PERFORMANCE

7.1 The Trust Performance Management Framework process will monitor performance against the in year safety objectives and therefore the Trust Board, Quality Committee and Trust Management Team will receive updates of both proactive (Safety plans and Inspections) and reactive (incidents and accidents) regularly dependant on the type of data as part of the corporate Quality Report and safety performance dashboard.

7.2 The Divisional Health and Safety Committees will receive updates of both active (Health and Safety plans and inspections) and reactive (incidents and accidents) for their areas and will report performance to the Trust Health and Safety Committee

7.3 The emphasis will be to provide initial benchmarking, target setting, then monitoring and assurance of improvement of performance throughout the Trust. Metrics will be aligned with external monitoring e.g. NHS England via the NRLS (National Reporting and Learning System) and HSE (RIDDOR) reporting, National Staff Survey, other national or local sources where available. The information management processes must be supported by effective data collection and robust organisational information arrangements.

7.4 All risk management improvement programmes will adopt a methodology that enables the measuring of performance against actions taken which can be translated into serial measurements for demonstrating ongoing improvements over time. This measurement can be proactive as well as reactive in its approach or a combination of the both.

8. REVIEW AND AUDIT

8.1 The Quality Committee, sub committee of the board, will receive regular reports of progress with the Patient and Staff Safety strategies as well as being informed of breaches in patients and staff safety through the incident and accident reporting system (specifically serious incidents). The Trust Health and Safety committee and Patient Safety Forum act as custodians for the review of progress for projects and also to ensure wide dissemination of project plans and achievements.

8.2 The Trust Board will receive an annual report on Health and Safety management/ achievement and continuing issues for patient and staff safety management and risk control and agree components to take forward to the next financial year to be monitored at board level. Divisions will provide reports and assurance to trust safety focussed committees on achievements in improving safety for staff and patients.

8.3 Health and Safety Staff representatives are encouraged to identify subjects for audit to contribute to a Trust annual audit programme reviewing the effectiveness of the Health and Safety arrangements for the organisation. The results will be reported at the Trust Health and Safety Committee and inform the annual plan

8.4 The Trust Risk Register will be reviewed and challenged on progressing entries at each Trust Management Team and Trust Board. The operational review of the

Divisional Risk Register is described in divisional procedures with annual challenge described in the Risk Assessment and Procedure for Managing Risk Registers.

8.5 The Board will review key strategies/ policies associated with Risk Management and in accordance with the Trust How To Write a Procedural Document Guidance.

8.6 The organisation will acknowledge achievement of implementation of Safety objectives through recognised forums e.g. Celebrating Success Awards and other human resource promotional initiatives e.g. Rewards, Outline newsletter.

Monitoring compliance and effectiveness of the RISK MANAGEMENT FRAMEWORK				
Element/activity being monitored	**Reference**	**Methodology to be used for monitoring**	**Frequency of monitoring and reporting arrangements**	**Lead/ role**
Organisations risk management structure, detailing committees and groups with responsibility for risk	Section 4, para 4.3 – 4.10, Appendix 1, Appendix 2 Section 8, para 8.2	Annual report demonstrating Compliance with Appendix 1 to Board/ Sub committees of the Board Annual Health and Safety Report to Board	Annual Annual	Director of Safety Director of Safety
How the board or high level risk committees review the organisation wide risk register	Section 4, para 4.1.1 Section 4, para 4.5 Section 6 para 6.3, Section 8, 8.4 Appendix 1	Annual report demonstrating Compliance with Appendix 1 specific to Risk Register Audit committee review of risk	Annual	Director of Safety
How risk is managed locally	Section 4, para 4.10, 4.18 Divisional Action Cards 1-3 Section 5 para 5.4 Section 7 para 7.2	Divisional Annual report confirming compliance with local processes for risk issues	Annual	Chief of Services
Duties of key individuals for risks management activities	Section 4 para 4.12 – 4.18 Section 8, para 8.2	Annual review/ Update of Risk Management Framework to include • Annual report demonstrating Compliance with Appendix 1 • Annual Health and Safety Report to Board	Annually as part review process	Director of Safety

Monitoring compliance and effectiveness of the RISK MANAGEMENT FRAMEWORK				
Element/activity being monitored	**Reference**	**Methodology to be used for monitoring**	**Frequency of monitoring and reporting arrangements**	**Lead/ role**
How risk management awareness training is delivered to board members and senior managers (for others see risk management training document) to include monitoring of attendance	Section 9, related documents Training needs analysis	Compliance with TNA included in Trust/ Divisional annual reports	Annual reports	Director of Safety/ Chief of Service/ Learning and Development

9 COMPETENCY / TRAINING

9.1 The Trust as part of the recruitment process ensures that training and competency of staff for the key roles identified by the Risk Management Framework and also specialist Safety Advisors to ensure the provision of effective competent health and safety management advice. (See Related Documents - Training).

9.2 The Trust aims to ensure that staff are provided with training and awareness of key safety messages as part of the annual mandatory updates. This enables staff to participate in safe systems of practice in the workplace and progress through the Knowledge Skills Framework (KSF) as part of their development.

9.3 The Trust will provide specialist training to staff to enable them to undertake their role, this includes

- Accident / incident investigations (root cause analysis)
- Risk assessment training
- Risk register process

9.4 Specialist training will be provided for safety issues by competent trained trainers – with updates as recommended by national and local requirements. Where practice is competency based this will be recorded on the Trust training software and reviewed as part of the appraisal process.

9.5 Training programmes for risk management will be regularly reviewed and updated to ensure inclusion of current topics and practice and feedback from experiential learning.

9.6 All risk management training will be recorded on the Trust electronic staff record software management system with quarterly reports (minimum) provided to divisional boards'/ key committee of attendance at training. Non attendance at sessions is monitored by divisions through the process described in the Document used for Risk management Training/ Training needs analysis standard.

Related document - Training Needs Analysis -

Subject and Date: Risk Management Training					
Staff Group/s	**Division / Department / Specialty**	**Content**	**Frequency of training / update**	**Method of training delivery**	**Lead and department responsible for provision of training**
CEO, executive and non executive director responsible for H&S, Director of Safety and divisional H&S leads	All divisions	**IOSH accredited Safety for Senior Executives** one day training programme	Once *(then complete mandatory updates provided by the Trust)*	Face to face	External Provider – 'on site' or public course depending on numbers
Departmental Managers (including Matrons)	All Divisions	**IOSH accredited - Managing Safely** 8 half day modules as follows: • General approach • Accident and injury causes • Management of safety • Human factors affecting safety • Health and Safety Law • Communicating health and safety effectively • Common hazards • Specialised hazards.	Once	Face to face	External/ Local Provider – 'on site' or public course depending on numbers
Delegated staff (ward managers, supervisors etc specified by Divisional leads)	All Divisions	**In house investigation course to include (half day workshop)** • Risk assessment theory and practical exercise • Process for risk registers • Accident Incident Investigation methodologies to include Root Cause Analysis	Once	Face to Face	Trust Risk Managers

Staff Group/s	**Division / Department / Specialty**	**Content**	**Frequency of training / update**	**Method of training delivery**	**Lead and department responsible for provision of training**
All Staff	All Divisions	**Mandatory Training** required for role as indicated in the Trust Training Matrix http://glosnhs.brinkster.net/	On induction and updates as indicated in training matrix	Face to Face or E learning	Learning and Development
Staff Side Health and Safety Representatives	All Divisions	Trust Mandatory Training requirements relevant to role (Risk Assessment/ Accident investigation) Union based course or IOSH 'Managing Safely'	According to training Matrix Once on appointment as rep	Various	various
Divisional Risk Managers / Trust Risk Managers/ Director of Safety	All Divisions	**NEBOSH Certificate** (minimum) appropriate to area of responsibility as a minimum Root Cause Analysis Training	Once	Various	Various external Providers
Specialist Safety advisors e.g. security, manual handling	Trustwide	**Specialist qualification** as indicated by professional body **–** see individual specialist policy documents Root Cause analysis training	Once with updates required by professional body/CPD	Various	
Trust Risk Manager with a lead for Health and Safety	Corporate Division	**Membership of IOSH at post-graduate level**	Once and annual re- registration and CPD	Various	Various external providers

10 DISSEMINATION

10.1 The Risk Management Framework will be shared with all as a result of widespread consultation with managers/ staff through the following communication.

- Divisional Quality Assurance / Health and Safety groups
- Trust Board, Quality Committee, Patient Safety Forum, Trust Health and Safety Committee
- Joint Staff Side Committee

10.2 On agreement it will be accessible to all via the Trust Policy website with related documents and linked to relevant risk management procedural documents as listed in paragraph 3.3 and 3.4.

11 REVIEW OF FRAMEWORK

11.1 The Risk Management Framework will be reviewed on an annual basis to ensure it reflects current risk control and management methodologies as well as informing the Annual Plan.

12 RECOMMENDATION

12.1 The Board is invited to approve the Risk Management Framework.

Author and Presenting Director: Andrew Seaton, Director of Safety

Date: January 2016

Related documents

- **Roles and responsibilities for key members of staff** for specific Risk Management procedures
- **Roles and responsibilities for key trust/ divisional committees/ group** for specific Risk Management procedures
- **Training Needs Analysis**

References

- Leading health and safety at work 2008, Institute of Directors/ Health and Safety Commission, http://www.hse.gov.uk/pubns/indg417.pdf
- Successful Health and Safety Management - HSG65
- 7 steps to Patient Safety, NPSA
- Management of Health and Safety at Work Regulations 1999

Appendix 1

Safety Reporting to the Board/ Board Sub Committees

Report	Reporting Director	Frequency
Trust Risk Register – topics include • Health and Safety • Patient Safety • Business Planning/ Service Delivery • Finance	Director of Safety	Monthly to **Board** At each **Trust Management Team**
Assurance Framework	Director of Safety	Three times a year **Board/ Audit Committee**
Performance Management Framework – progress against agreed Trust objectives .e.g CQuINs	Director of Finance Director of Safety	Monthly to **Trust Management Team / Board**
Serious incidents • Health and Safety • Patient Safety • Business continuity • Information Governance	Chief Executive Director of Safety	New incidents - monthly to **Board** Progress report to each **Quality Committee and TMT**
External regulatory bodies • HSE- improvement notices/ action plans • Monitor/CQC • Others	Director of Safety Chief Executive As appropriate	As occurring with updates to **Board** Progress - quarterly to **Quality Committee**
Audit Committee reports on Trust selected processes e.g. • Clinical Governance / risk management • Risk register process • Business continuity	Chair of Audit Committee	Monthly minutes to **Board.** updates of reports annually

Quality Dashboard – includes key safety metrics for staff and patients e.g.
• Patient Safety incidents
• Staff Accident rates
  o Falls
  o Sharps
  o Manual handling
  o Violence and aggression
  o RIDDOR
• Infection control rates
  o C diff/ MRSA
  o Handwashing
	Director of Nursing
	Director of Safety
		Quarterly to **Quality Committee**

Safety Alert Process • Alerts issued through the Central Alert System (CAS) • NICE publications • Confidential enquiries	Director of Safety	Monthly exception reporting on non – compliance to **Trust Management Team** Progress reports quarterly to **Quality Committee**
Divisional Quarterly reports to include based on agreed template	Chief of Services	Twice a year to **Trust Management Team** and

and parameters		**Quality Committee**
Divisional Risk register - all entries graded as 8+ (moderate 0- or where the outcome is tragic (5) - topics include • Health and Safety • Patient Safety • Business Planning/ Service Delivery • Finance	Chief of Services	Annually to **Trust Management Team**

TRUST MANAGEMENT TEAM

TERMS OF REFERENCE

Policy	✓
Review of Policy	✓
Review of Trust Area of Activity	✓
Operations	✓
Resource Management	✓

The Trust Management Team is advisory to the Executive Team and is responsible for the following main functions:

1. Delivery of safe high quality care
2. Planning and implementation of improvements to the patients' experience.
3. Delivery of the business and OD strategies of the Trust.
4. Delivery of the performance objectives of the organisation.
5. Delivery of the corporate objectives for the year.
6. Monitoring and performance management of major capital schemes.
7. Provision of advice to the Trust Board on both annual and strategic plans.
8. Identification, planning and implementation of development opportunities.
9. Monitoring of the Trust Risk Register.

Membership & Responsibilities

Chair
Chief Executive

Vice Chair
Chief Operating Officer / Deputy Chief Executive

Members
Executive Directors
Divisional Chiefs of Service
Director of Safety
Head of Patient Experience
Estates and Facilities Director

Officer
PA to CEO

Quorum
The Committee shall be quorate when at least two Executive Directors and at least two Divisional Chiefs of Service are present

Frequency of Meetings
Monthly – 2nd Wed / month am

Reporting Line
Executive Team

Sub-Committees
Trust Operational Performance Team

Submission/Availability of Minutes
Minutes are held by the Assistant Trust Secretary

QUALITY COMMITTEE

TERMS OF REFERENCE

Policy	√
Review of Policy	√
Review of Trust Area of Activity	√
Operations	**X**
Resource Management	**X**

The Quality Committee is responsible to the Trust Main Board for the following main functions:

1. To provide leadership and assurance to the Board on the effectiveness of the Trust's arrangements for quality, ensuring there is a consistent approach throughout the Trust, specifically in the areas of:

   - Safety (Patient & Health & Safety)
   - Effectiveness
   - Patient Experience

2. To oversee the development and publication of an annual Quality Report, that identifies the improvement priorities for the coming year appropriately influenced by key stakeholders

3. To scrutinise the Divisions on their performance against the Quality Framework that includes the relevant Strategic Objectives, and the priorities set out in the Quality Report.

4. To examine in-depth key quality issues and thereby contribute to the development of a quality culture

5. To receive regular reports from specialist committees providing assurance of compliance to specialist systems as set down in the Quality Framework through the process of annual reports.

6. To initiate and monitor investigation of areas of serious concern as necessary and ensure resulting action plans are implemented.

Membership & Responsibilities

Chair
Non-Executive Director

Vice Chair
Non-Executive Director

Members
One further Non-Executive Director
Chief Executive
Nursing Director
Medical Director
Director of Clinical Strategy
Governors representatives (4)
CCG representative
Director of Safety
Head of Patient Experience
Invited representatives as appropriate

Officer
Trust Secretary

Quorum
The Committee shall be quorate when at least 1 Non-Executive Director (which could be the Chair of the Trust), 2 Executive Directors (one of whom should have a clinical background) attend.

Frequency of Meetings
Eight times per year

Reporting Line
Trust Main Board

7. Through the quarterly summary reports receive assurance reports from the Quality Standards Review Group of compliance with CQC's standards

8. To review reports from external bodies to assure itself, and the Board, that the necessary steps are being taken to deal with any issues raised and that action plans are being implemented and reviewed.

9. To monitor the key performance indicators relevant to areas of quality.

Sub-Committees
Patient Safety Forum
Health & Safety Committee
Patient Experience Strategic Group
Hospital Medicines Management Committee
Other Specialist Committees
Quality Standards Review Group

Submission/Availability of Minutes
Minutes reported to the next Board meeting

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

PATIENT SAFETY FORUM

TERMS OF REFERENCE

Policy	X
Review of Policy	X
Review of Activity	√
Operations	√
Resource Management	X

The group is responsible to the Trust for the following functions:

1. To develop the Patient Safety Strategy and performance manage the safety programmes

2. To monitor and promote the implementation of national guidance and alerts, specifically: CAS generated alerts, Confidential Enquiries, High level enquiries from external sources.

3. To receive assurance from the Safety and Experience Review Group (SERG) that SUI's are being managed effectively

4. To monitor the achievement of the Trust's Patient Safety Projects including CQUINS

5. To receive reports/ updates from specialist safety committees at an agreed frequency, specifically: Blood Transfusion Committee, Medication Safety Group, Resuscitation Committee

6. To act as a forum for divisions to present and disseminate patient safety themes and actions for shared learning

7. To review new and updated patient safety policies

8. To provide regular reports to the Quality Committee.

Membership & Responsibilities

Chair
Associate Medical Director

Vice Chair
Director of Safety

Members
Corporate
Trust Risk Managers
Head of Patient Experience
Clinical Audit Manager
Standards Performance Manager
Specialist
Infection and Prevention Control Representative
Pharmacy Representative
Blood Transfusion Representative
Resuscitation Representative
Divisional
Lead divisional clinician
Lead divisional manager

Quorum
The forum shall be quorate when the chair or vice chair are present, 2 Corporate members, 1 specialist members and divisional representative from each division.

Members must send deputies if they are unable to attend the meeting

Frequency of Meetings
6 weekly

Reporting Line
To the Quality Committee

Submission/availability of notes
Papers and agenda items to be submitted one week before the meeting

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

SAFETY AND EXPERIENCE REVIEW GROUP

TERMS OF REFERENCE

Policy	X
Review of Policy	X
Review of Trust Area of Activity	✓
Operations	X
Resource Management	X

The Committee is responsible to the Patient Safety Forum/ Quality Committee for the following main functions:

1.To review issues arising from the Governance quality feeder systems:
- Complaints /PALS
- Claims
- Inquests
- Incidents/ Accidents

2. To identify learning arising from specific concerns or thematic analysis, identify and monitor the implementation of changes in practice

3. To monitor the progress of serious complaints and untoward incidents, formally closing investigations and action plans.

4. To ensure a seamless approach to parallel investigations involving Risk, Complaints, Claims and Inquests

5.To further develop the process for organisational learning

6. To identify opportunities to share the learning of a wider spectrum in the healthcare community

7. To identify training opportunities for the organisation promoting patient and staff safety and risk reduction

8. To promote progress with improving patient and staff safety within the organisation as well as with the local population

Membership & Responsibilities
Chair
Director of Safety

Vice Chair
Head of Patient Experience

Members
Head of Legal Services
Claims Manager
Trust Risk Managers
Head Complaints/PALS
Divisional Risk Managers
CCG representative
Nursing Director

Quorum
The Committee shall be quorate when either the Chair or Vice-Chair and two other members are present.

Frequency of Meetings
The Committee will meet monthly

Reporting Line
Patient Safety Forum

Submission/Availability of Minutes
Minutes are made available from the Trust Risk Manager

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

TRUST HEALTH AND SAFETY COMMITTEE

TERMS OF REFERENCE

Policy	✓
Review of Policy	✓
Review of Trust Area of Activity	✓
Operations	X
Resource Management	X

The Committee is responsible to the Trust for the following main functions:

1. **Policy** - To agree Health and Safety Policies and Procedures in the Trust ensuring compliance with Health and Safety legislation

2. **Plan -** To support the implementation of the Risk Management Framework and the Staff, Contractors and Visitors Safety Strategy

3. **Plan/ Review** - To agree an annual health and safety plan to include local/ trustwide inspection/ audit and review action pans arising from inspections

4. **Plan/ Deliver** - To agree and monitor training progammes for Health and Safety related topics for trust members arising from training needs analysis demonstrating competency of staff

5. **Deliver** - To engage with staff representatives in the promotion of Health and Safety on Trust property

6. **Deliver** - To monitor and promote the implementation of national guidance and alerts, specifically Health and Safety Executive, Environment Agency and other enforcing agencies, Central Alert Systems and other High Level Enquiries from external sources

7. Deliver – To critically review themed accident/ incident reports and, and where applicable and appropriate, identify recommendations for corrective action

Membership and Responsibilities

Chair
Chief Executive Officer

Vice Chair
Director of Human Resources / Organisational Development

Members
Director of Safety
Trust Risk Managers
Divisional Health and Safety leads (5)
Manual Handling Team Representative
Infection Control Team Representative
Occupational Health Department Representative
Trust Security Advisor
Fire Team Representative
Staff Side Health and Safety Representatives / Representatives of Employee Safety (Health and Safety)

Co-opted members
Specialty advisors as indicated by agenda

Quorum
The Committee shall be quorate when either the Chair or Vice-Chair and representation from both staff side and management.

Frequency of Meetings
Alternate months.

Reporting Line
Quality Committee

8. **Deliver** - Receive divisional reports on Health and Safety inspections/ concerns informing the Trust annual / business plan for Health and Safety at Work

9. **Review and Monitor** -To review and monitor the annual Safety Improvement Programme.

10. **Review** – To review key trust risks register entries as part of the annual plan

11. **Review and deliver** – to recommend consideration of key risks to divisional risk registers as part of trust procedure based on risk assessments

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – JANUARY 2016

7 DAY SERVICES PROJECT UPDATE

1 Background

1.1 The Main Board was last updated on the 7 Day Services project in October 2015 and is updated quarterly. This report will provide comment on the pilot in Respiratory and the roll out plan for the remainder of the Trust.

1.2 This note will also provide an update on the County-wide activity.

1.3 The Board is requested to note this update.

2 Update on Pilot

2.1 The pilot in Respiratory continues to be the focus for the transformation of delivery and the service has introduced a new model of working in Cheltenham General Hospital (CGH) with the employment of the locum consultant. The Service has also changed its way of working in Cheltenham where the two wards now start the day with a Board Round using the format devised by Dr Kate Hellier as part of her Board Round project. This model will be monitored and assessed to determine the best configuration of the service for the future.

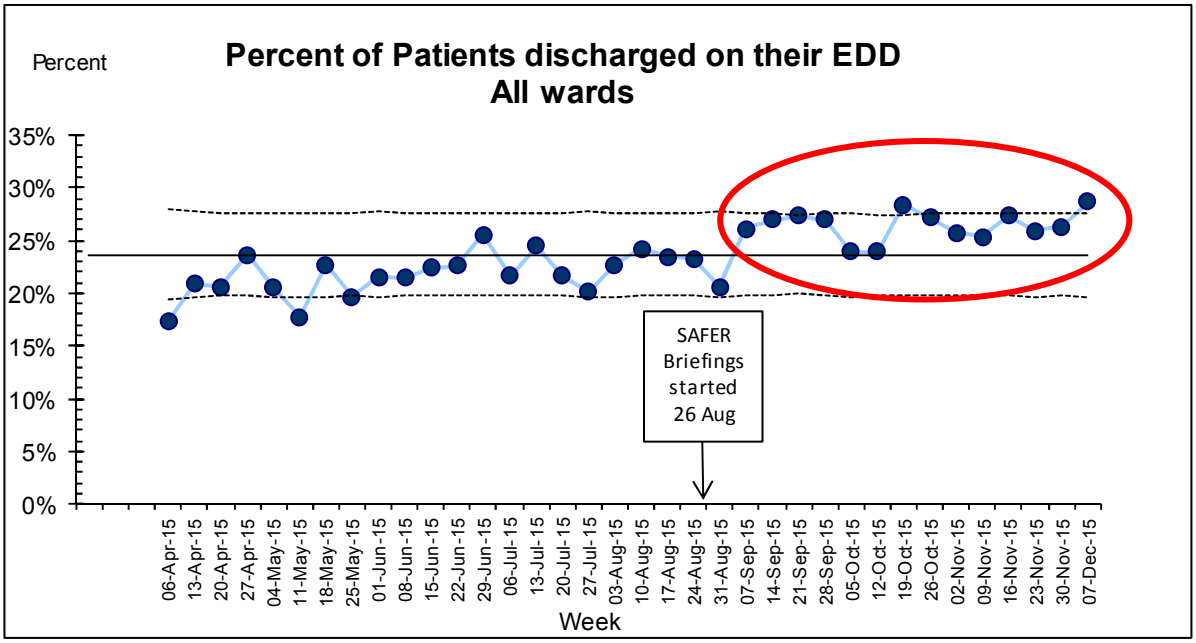
2.2 The Gloucestershire Respiratory Team continues to explore integrated working with Gloucestershire Care Services (GCS) and is currently looking at the challenge of providing access to patient data held on the GCS patient record system to improve efficiency.

3 Whole Trust Plan

3.1 The second round of gap analysis continues in order to define the specific requirements for service improvement and provide a baseline for costing the whole project. Divisions will present their priority areas at Project Boards held monthly from December 2015 to March 2016. This will determine the focus areas for development over the next year.

3.2 Ward Clerks. Twelve additional wards now have weekend ward clerks. Interviews for the Ward Clerk Manager and two Supervisors were conducted in December with a start date of late January. Once in post the Manager will ensure standardised processes are used across all wards and provide training for new and existing staff. A second round of recruitment will be coordinated to expand the weekend ward coverage.

3.3 Board Rounds. The improvement of Board Rounds (standard 3) has been combined with Dr Kate Hellier's work and the roll out of the National SAFER programme. SAFER weeks have been held each month since October, providing a focus for improvement. The initial focus was on process and the graph below shows the impact on the accuracy of the Estimated Date of discharge (EDD). Subsequent work is addressing the detail of how the EDD is determined and benchmarking against national figures in order to measure improvements within the Trust. Other SAFER weeks have looked at the time that prescriptions are sent to pharmacy in order to improve the processes to allow more patients to be discharged earlier in the day.



4 County-wide Activity

4.1 The County-wide Steering Group met on 18 January and examined the National Planning Guidance direction on the introduction of 7 Day Services. The approach being taken within the Trust was reinforced with the need to deliver against the 4 National Priority Standards (2 – time to first consultant, 5 - Access to Diagnostic Services, 6 - Consultant Directed Interventions (Critical care, radiology, endoscopy) and 8 – Every patient seen every day). By working towards all 10 Standards and concentrating on the greatest need identified through gap analysis, the Trust has ensured that the focus is on the appropriate areas.

4.2 NHS England Project update. In September all Acute Trusts were required to submit an on-line assessment against the National priority standards. On 10 November a meeting was held with NHS England (South West) and the Clinical Commissioning Group (CCG) to discuss progress on the implementation of the project following the on-line submission. A brief overview of our approach was given at the meeting together with an explanation of the next steps with regard to the Trust's Divisional priorities for 2016. A 6 month update to the on-line submission is likely to be called for in March 2016.

5 Risks

5.1 The risks to the Whole Trust Plan are being reviewed to focus on the delivery against the priority areas rather than the Respiratory Pilot.

6 Recommendation

6.1 The Board is requested to note this update on progress towards the introduction of 7 Day Services into the Trust.

Author: **Bob Pearce**

Presenting Director: **Dr Sean Elyan**

Date January 2016

ITEM 19

ITEMS FOR THE NEXT MEETING AND ANY OTHER BUSINESS

DISCUSSION

ITEM 20

STAFF QUESTIONS

(One question attached)

Prof Clair Chilvers
Chair

QUESTIONS FROM STAFF

Question from Mrs Pam Adams

I am aware of the issues with “no smoking” from both Sally Pearson and the Health and Wellbeing side. I think we have previously approached the local authority to send out a stronger public message. I think there may be an issue in that there was a recent request to charitable funds committee to provide new signage which had to be turned down due to lack of funds.

ITEM 21

PUBLIC QUESTIONS

(Procedure attached)

(One question attached)

Prof Clair Chilvers
Chair

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

PROCEDURE FOR PUBLIC QUESTIONS AT BOARD MEETINGS

The Trust welcomes feedback from members of the public. We are committed to delivering the best care and constantly looking at ways to improve the services we provide at out hospitals. There are a variety of ways in which you can give your feedback. These are:-

- As a patient or visitor to the hospital by completing a comment card which is available on wards and departments.
- By contacting the Patient and Liaison Service (PALS) who offer confidential, impartial help, advice or support to any aspect of a patient's care. The team aim to help resolve issues and concerns speedily by liaising with appropriate staff on your behalf. PALS can be contacted by phone on 0800 019 3282; by text on 07827 281 266; by e-mail pals@gloucestershirehospitals@glos.nhs.uk or by writing to the PALS Office, Gloucestershire Royal Hospital, Great Western Road, Gloucester GL1 3NN. Complaints can be made to the Complaints Team by phoning 0300 422 5777, by e-mail complaints.team@glos.nhs.uk of by writing to the Complaints Team at Gloucestershire Royal Hospital/at the above address.
- By asking a question at our Board meeting by following the procedure below. Board meetings are open to the public and are normally held on the last Friday of the month at Trust HQ, 1 College Lawn, Cheltenham. Meetings normally start at 9.00am

All feedback is taken seriously and is used to either praise staff for the excellent care or service they have provided or used to make improvements where needed.

Written questions for the Board Meeting

People who live or work in the county or are affected by the work of the Trust (including members of the Trust who live outside of the County) may ask the Chair of the Trust Board a question on any matter which is within the powers and duties of the Trust.

Ten minutes will be allocated at the end of the public section of each Board meeting for written questions from the public to be answered. Where it is not possible for all written questions to be dealt with within this timeframe a written response will be provided to the questioner and copied to all Board members within 7 working days of the meeting. In exceptional circumstances, the Chair may extend the time period for public questions.

Notice of questions

A question may only be asked if it has been submitted in writing to the Trust Secretary by 12.00 noon 3 clear working days before the date of the Board meeting. Each question must give the name and address of the questioner. If a question is being asked on behalf of an organization then the name of the organization must be stated. Written questions are to be submitted to the Trust Secretary, 1 College Lawn, Cheltenham, GL53 7AT or by e-mail to martin.wood@glos.nhs.uk No more than 3 written questions may be submitted by each questioner.

Procedure

At the Board meeting the questioner, if present, will be invited to read out the question. If absent, the Chair may read out the question. A written answer will be provided to a written question and will be given to the questioner and to members of the Trust Board before being read out at the meeting by the Chair. Copies of the questions and the responses will be recorded in the minutes.

Additional Questions

A questioner who has submitted a written question may, with the consent of the Chair, ask an additional oral question arising directly out of the original question or the reply.

An answer to an oral question will take the form of either:

- a direct oral answer; or
- if the information required is not easily available a written answer will be sent to the questioner and circulated to all members of the Trust Board.

Unless the Chair decides otherwise there will not be discussion on any public question.

Written questions may be rejected and oral questions need not be answered when the Chair considers that they:

- are not on any matter that is within the powers and duties of the Trust;
- are defamatory, frivolous or offensive;
- are substantially the same as a question that has been put to a meeting of the Trust Board and been answered in the past six months; or
- would require the disclosure of confidential or exempt information.

For further information, please contact Martin Wood, Trust Secretary on 0300 422 2932 by e-mail martin.wood@glos.nhs.uk

QUESTIONS FROM THE PUBLIC

Question from Mr Bren McInerney

"I would like to formally record an open question at the January 2016 Gloucestershire Hospitals NHS Foundation Trust Board meeting. The open questions is for a response to the recently published book (December 2015) by James Titcombe, titled Joshua's Story. I don't wish to be prescriptive about what the response is, or should include, I would simply welcome a response to the content of this book.

It isn't just the sadness of a family fighting the system at a time they should otherwise be experiencing great joy, it is the ability to be totally honest when mistakes have been made."

Response from the Director of Safety and the Head of Patient Experience

As a Trust we are committed to open and transparent communication with our patients and partners. We believe this approach, however difficult, brings true accountability and creates a learning culture within our organisation.

We have for some time presented real patient and staff stories to the Trust Board and other key meetings to connect the reality of our hospital to our leaders and this includes situations where we may have caused harm or distress. Our Board visit wards and departments on a regular basis to discuss safety and patient experience issues.

To facilitate openness we invite our Commissioners and Governors to key Quality meetings so they can see the information and hear the discussion and responses to questions and in addition we share our key risks at every public Trust Board meeting.

With particular reference to cases where there has been harm caused (serious incidents) we have always followed the NHS "Being Open" guidance and we are currently introducing the "Duty of Candour" requirements to inform patients and their families about the findings of investigation. We will always offer to meet with patients and families to discuss with them the findings of any investigation and to give them an opportunity to ask questions in an open and honest forum. The Trust internal serious incident investigation reports are frequently shared with the Coroner and introduced as evidence into her inquiry. In fact in the past 6 months we have proactively shared reports with the Coroner that have identified new concerns and led to further inquiries.

For complaints and concerns we hold frequent face to face local resolution meetings which provide a route for transparent discussion and we have also recently developed specialised training for trust staff who chair local resolution meetings so that they are equipped with the necessary skills to run these important meetings that can be complex and difficult for both complainants and staff.