GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

The next meeting of the Gloucestershire Hospitals NHS Foundation Trust Main Board will be held on **THURSDAY 24 March 2016** in the **Gallery Room, Gloucestershire Royal Hospital** commencing at 9.00 a.m. with tea and coffee. **(PLEASE NOTE DATE AND VENUE FOR THIS MEETING)**

Professor Clair Chilvers
Chair

17 March 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 26 February 2016	**PAPER**	**To approve**	09:02
4.	Matters Arising	**PAPER**	**To note**	09:03
5.	Summary of the meeting of the Finance and Performance Committee held on 23 March 2016	**PAPER (To follow)** (Mr Gordon Mitchell)	**To note**	09:05
6.	Minutes of the meeting of the Finance and Performance Committee held on 24 February 2016	**PAPER** (Mr Gordon Mitchell)	**To note**	09:07
7.	Minutes of the meeting of the Audit Committee held on 8 March 2016	**PAPER (To follow)** (Ms Anne Marie Millar)	**To note**	09:11
8.	Minutes of the meeting of the Quality Committee held on 11 March 2016	**PAPER (To follow)** (Mrs Helen Munro)	**To note**	09:14
9.	Minutes of the meeting of the Equality Committee held on 14 March 2016	**PAPER (To follow)** (Mr Clive Lewis)	**To note**	09:17
	Chief Executive's Report and Environmental Scan			
10.	March 2016	**PAPER** (Dr Frank Harsent)	**To note**	09:20
	Strategy			
11.	Draft Revenue Budget 2016/17	**PAPER** (Mrs Helen Simpson)	**To approve**	09:30
12.	Capital Programme 2016/17	**PAPER** (Mrs Helen Simpson)	**To approve**	09:45
	Governance and Operations			
13.	Integrated Performance Framework Report	**PAPER** (Mrs Helen Simpson)	**To endorse**	10:00
14.	Financial Performance Report	**PAPER** (Mrs Helen Simpson)	**To endorse**	10:15
15.	Emergency Pathway Report	**PAPER** (Mr Eric Gatling)	**To endorse**	10:30
16.	Nurse and Midwifery Staffing	**PAPER** (Mrs Maggie Arnold)	**To approve**	10:40
17.	Information Governance Toolkit Standards Final Assessment	**PAPER** (Dr Sally Pearson)	**To approve**	10:45
18.	Complaints and Concerns Q3	**PAPER** (Mrs Maggie Arnold)	**To note**	10:55

	For Information			
19.	Minutes of the meeting of the Council of Governors held on 24 February 2016	**PAPER** (Prof Clair Chilvers)	**To note**	11:05
	Next Meeting			
20.	Items for the next meeting and Any Other Business	**DISCUSSION (All)**	**To Discuss**	11:08
	Staff Questions			
21.	A period of 10 minutes will be provided to respond to questions submitted by members of staff		**To Discuss**	11:15
	Public Questions			
22.	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**	11:25 11:35
	Break			

Date of the next meeting: The next meeting of the Main Board will take place at on **Friday 29 April 2016** in the Boardroom, Alexandra House, Cheltenham General Hospital at 9.00 am.

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 BOARDROOM, 1 COLLEGE LAWN, CHELTENHAM ON FRIDAY 26 FEBRUARY 2016 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
	Mrs Maria Bond	Non-Executive Director
	Mr Tony Foster	Non-Executive Director
	Mr Clive Lewis	Non-Executive Director
	Mrs Helen Munro	Non-Executive Director
APOLOGIES	Ms Anne Marie Millar	Non-Executive Director
IN ATTENDANCE	Mr Martin Wood	Trust Secretary
	Mr Bob Pearce	Deputy Director of Service Delivery
	Mr Andrew Seaton	Director of Safety
	Mr Vinay Takwale	Chief of Service – Surgery
	Ms Rebecca Wassell	Associate Director of Transformation
PUBLIC/PRESS	Mr Rob Randles	Staff Governor
	Mrs Jenifer Harley	Patient Governor
	Mrs Laura Kleister	Contracts Manager
	Mr Matt Discombe	Citizen
	Mr Bren McInerney	Public

The Chair welcomed all to the meeting.

ACTION

034/16 DECLARATIONS OF INTEREST

The Chief Executive declared an interest in minute 049/16 below in relation to the appointment of an additional Non-Executive Director in that he was a member of the Board of the University of Gloucestershire.

035/16 MINUTES OF THE MEETING HELD ON 29 JANUARY 2016

RESOLVED: That the minutes of the meeting held on 29 January 2016 were agreed as a correct record and signed by the Chair.

036/16 MATTERS ARISING

376/15 Integrated Performance Framework Report: The Chair invited the Medical Director and the Director of Service Delivery to look at other staff groups undertaking VTE Assessments provided there is a

consistent approach. The Director of Service Delivery added that there is an expansion of day cases in line with the action plan and these cases do not require an assessment. The data are being revisited. *The Director of Service Delivery said that work continues with progress being made through the patient process. Ongoing.*

The Chair said that the situation regarding the availability of community beds should be raised with the Gloucestershire Strategic Forum. The Chair reported that this will be raised formally at the next meeting of the Forum, with the issue being continuingly raised at every opportunity. *The Chair reported that this will be raised at a meeting of the Forum taking place during the week following the Board meeting. Ongoing.*

006/16 Minutes of the meeting of the Health and Wellbeing Committee held on 5 January 2016: The Chair referred to the number of apologies recorded at the meeting and invited the Committee to consider whether deputies should attend when the appointed representative was unable to do so. *The Chair said that all Board Committees have been invited to consider using video and telephone conferencing facilities for meetings. Completed.*

The Director of Clinical Strategy commented that there is a good pathway for obese children who are admitted but the system response is not well defined. The Trust staff contribute to the County-wide group to prevent obesity. The Chair invited the Director of Clinical Strategy to take forward developing a system response to obesity. *The Director of Clinical Strategy said that this is being included as part of the corporate objectives in the Operational Plan. The Clinical Commissioning Group and Gloucestershire County Council are supportive of the approach. Completed.*

007/16 Summary and minutes of the meeting of the Quality Committee held on 15 January 2016: The draft Operational Plan is to be submitted to Monitor by 8 February 2016 and will be shared with the Board. *The Trust Secretary reported that the draft plan was circulated to the Board on 10 February 2016. Completed.*

008/16 Summary and minutes of the meeting of the Sustainability Committee held on 18 January 2016: The Chair invited Board Committee Chairs to consider the use of video and teleconferencing for their meetings. *The Trust Secretary reported that Committee Chairs and those servicing Board Committees have been invited to put this as an item on the next Committee meeting. The Chair of the Finance and Performance Committee said that the Committee, given the size and format, will keep this option under review. The Trust Secretary has made arrangements to ensure that this included on the next meeting of each Board Committee. Completed as a matter arising.*

013/16 Emergency Pathway Report: The Chair invited the Director of Service Delivery to include in future reports details of peaks in the Emergency Department which cause significant difficulties for the Trust. *This was included in the report which appeared later in the agenda. Completed.*

The Director of Service Delivery undertook to provide Mr Lewis with details of the impact of the fines and penalties on 30 and 60 days imposed by the South West Ambulance Service. *The Director of Service Delivery confirmed the information which he had provided to*

Mr Lewis, namely that the total for Q1 was £55k and for Q2 was £67k. Completed.

The Chair said that she will invite the Chief Executive to speak to the Chief Executive of the Ambulance Service to discuss the issue where GP admissions are booked with the Ambulance Service between 3 and 7pm, but due to the pressures on that Service are not picked up until the evening placing operational pressures on the Trust. *The Chair said that she had revisited this issue and raised it with the Accountable Officer at the Clinical Commissioning Group who had agreed to take this forward which is a more appropriate course of action. Completed.*

The Director of Safety said that the Academic Health Science Network had undertaken a piece of work with the Emergency Department in North Bristol Hospital to provide a checklist to mitigate risk (but does not address patient flow) during very busy periods which can be used within the Trust. *The Director of Service Delivery reported that the checklist is to be used as a pilot in Cheltenham General Hospital from 1 March 2016. Completed.*

014/16 Nursing and Midwifery Staffing: The Chair invited Mr Foster, the Nursing Director and the Director of Human Resources and Organisational Development to discuss the staff retention information. *The Director of Human Resources and Organisational Development reported that he had shared information with Mr Foster and the dialogue is continuing. Completed.* [0905]

037/16 SUMMARY OF THE MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE HELD ON 24 FEBRUARY 2016

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 24 February 2016. He reported on those matters considered by the Committee which were not included on the agenda as separate items. Firstly, the Committee had considered a revised format for the Performance Management Framework report based on the CQCs Key Lines of Enquiry (KLOEs). Whist not perfect it will link in part to the presentation of the work of other Board Committees. The revised format will provide a forward looking projection which is currently not available. Secondly, there is good performance this year in delivering the Cost Improvement Programme with approximately 80% of the £22m achieved. An outline programme for next year has been considered and in April 2016 the Committee is to consider more detail on the implications of the Carter Review. Thirdly, there is an enthusiastic approach to the challenge of delivering a theatre modernisation project over the next three years.

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

- Mr Foster reiterated that the recurrent Cost Improvement Programme schemes should be identified earlier in the financial year.
- The Chief Executive expressed his appreciation to staff for their efforts in delivering the Cost Improvement Programme which will be cascaded widely throughout the Trust.

The Chair thanked Mr Mitchell for his report.

RESOLVED: That the summary minutes be noted. [0911]

038/16 MINUTES OF THE MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE HELD ON 27 JANUARY 2016

RESOLVED: That the minutes of the meeting of the Finance and Performance Committee held on 27 January 2016 be noted. [0911]

039/16 MINUTES OF THE MEETING OF THE AUDIT COMMITTEE HELD ON 22 JANUARY 2016

RESOLVED: That the minutes of the meeting of the Audit Committee held on 22 January 2016 be noted. [0911]

040/16 CHIEF EXECUTIVE'S REPORT AND ENVIRONMENTAL SCAN

The Chief Executive presented his report stating that Emergency Department performance will be considered as part of the Emergency Pathway report in minute 043/16 below and that he had nothing further to add.

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

- The Chair enquired as to the impact upon the Trust of The Mental Health Five Year Forward View published by NHS England. In response, the Medical Director said that the Trust supported greater liaison on mental health issues but the main challenge is the recruitment of appropriate staff. The Chief Executive said that £1b from the Government's £8b has been allocated to mental health and the issue is whether staff can be provided during the course of the Five Year Forward View. The Nursing Director added that there are issues for the Trust between 10.00pm and 8.00am; however, the Trust is well placed with its focus on safeguarding and staff education as patients do not always inform Emergency Department of their experiences. Meetings are held at six-weekly intervals with liaison staff and the Trust has a good working relationship with the 2gether Trust.
- The Chair asked for reasons why the West of England Academic Health and Science Network had voted not to continue to be a company limited by guarantee but hosted by the Royal United Hospital, Bath. In response, the Chief Executive said that the decision has been taken on the grounds that the monies can be kept within the NHS rather than paying corporation tax and VAT.
- The Medical Director paid tribute to the senior doctors and nurses who had provided services during the junior doctors' strike and the Board agreed that its appreciation be recorded.

The Chair thanked the Chief Executive for his report.

RESOLVED: That the report be noted. [0917]

041/16 INTEGRATED PERFORMANCE FRAMEWORK REPORT

The Finance Director presented the report summarising the key highlights and exceptions in the Trust up until the end of January 2016 for the 2015/16 financial year. She drew attention to each of the highlights and exceptions on performance as set out in the report.

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

- The Chair suggested that the Trust should aspire to improving the target for 90% of stroke patient spending 90% (from 80%) of their time on a stroke ward and asked for an indication of any barriers to achieving this target. In response, the Director of Service Delivery supported this aspiration and said that he will undertake a detailed analysis of the data to see why this could not being achieved. **EG**
- The Chair asked for information on the background for the six cases of Clostridium Difficile post 48 hours in January 2016. The Nursing Director said, in response, that the increase was due to the high volume of patients and the samples taken on admission. The Trust is appealing against four cases which it considers to be unavoidable. The Patient Led Assessments of the Care Environment (PLACE) audits undertaken in Cheltenham General Hospital had looked particularly at the cleanliness of commodes and toilets. There is a focus on benchmarking for antibiotic prescribing.

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. [0922]

042/16 FINANCIAL PERFORMANCE REPORT

The Finance Director presented the Financial Performance Report stating that the financial position of the Trust at the end of January 2016 is a surplus of £0.5m on income and expenditure which is in line with the position reported in December 2015. Operational pressures continue and temporary staffing expenditure is £0.4m higher than the expenditure in December 2015. 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. She stressed that patient safety remains a priority for the Trust. 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 a favourable variance of £0.2m from the planned position of a £0.3m surplus of income over expenditure at the end of January 2016. The cash position has improved to £7.2m at the end of January 2016. New measures are in place to improve the position over the coming months. The Clinical Commissioning Group has recognised the Trust's over performance against plan and has paid for some of this increase. Specialised Commissioners are slower at making payments. The Capital Programme is behind plan as a result of the due diligence work undertaken by the Director of Estates and Facilities and the change in administrative process requiring an order to be placed before payment is made. Efforts are being made to get back to plan by the end of the financial year. The impact of the emergency cap cumulative to January 2016 was £1.2m. There is a concentrated focus for the remainder of the current financial year to achieve the surplus. Budgets for 2016/17 are in the course of preparation.

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

raised:-

- The Director of Human Resources and Organisational Development reported that all recruitment agencies had been advised that they will not be used by the Trust from 1 April 2016 unless they comply with the Monitor cap rules. The challenge to Divisional Nursing Directors is to check every application to use agency staff and to attract agency staff to work for the Trust and not agencies. The two Bristol Trusts, Bath and Swindon Trusts have adopted a similar approach. Mr Foster stressed the benefit of a united Trust approach to the use of agency staff. The Trust is to employ between 70 and 100 Health Care Assistants (HCAs) to cover some of the gaps in nurses. This was welcomed by Mr Foster.
- In response to a question from Mr Foster, the Finance Director undertook, in conjunction with the Medical Director, to provide details of the £7m on locum doctors. **HS/SE**
- The Director of Human Resources and Organisational Development reported that with effect from 1 April 2016 the agency rates will be the same as paid to NHS staff and there may be compliance issues for agencies.

The Chair thanked the Finance Director for the report.

RESOLVED: That:-

1. The financial position of the Trust at the end of month 10 is a surplus of £0.5m on income and expenditure be noted. This is in line with the position reported at Month 9.
2. The £0.5m surplus represents a favourable variance of £0.2m from the planned position of £0.3m surplus of income over expenditure at the end of January 2016 be.
3. 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.
4. The new Monitor risk assessment framework shows a Financial Sustainability Risk Rating of 3.
5. 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. [0933]

043/16 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 successfully met in January 2016 with Trustwide performance reported as 80.16%.
- The main issues relating to performance are the increased level of attendances and admissions where the admissions are on average 12 a day greater than the corresponding period in 2015. On three days in January 2016 there were 400 attendances. The medically fit list remains higher that the system-wide plan of no more than 40 patients. The list is between 60 and 70 patients and is nearer to 100 patients when those waiting for social services accommodation (between 10

and 20 patients) and those patients on the fast track end of life pathway are taken into account. There is more work which the Trust can do to improve patient flow. The position is not helped with 20% of the medical staff being temporary appointments. There are new site management teams which are settling into the role. A new Improvement Director, recommended by Monitor, is to commence on 1 March 2016 with a track record of sustained improvement in another large Trust.

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

- Mr Mitchell expressed disappointment with performance commenting that this pattern has been experienced for the last 12 months. He asked for the position with Monitor given the number of quarters the Trust's performance has been red risk rated. Mr Foster supported these concerns. In response, the Chief Executive said that the Trust is working hard to improve performance. In addition to the new Improvement Director, the Trust from the previous weekend has provided additional clinical staff to progress chase what are termed "simple discharges" over the weekend period. This will help the positon at the beginning of the week. The Trust continues to work with partner organisations to reduce admissions. Admissions are currently 6.8% above plan which equates to three extra wards impacting on length of stay. Work also continues with partners to reduce the medically fit list. There is no reason why the Trust's performance should not get back on track. The Medical Director supported this view but said it is not a quick process.
- The Nursing Director said that every Wednesday afternoon she is involved with partner organisations discussing the medically fir list which has been at 75 or over for the last five weeks. On one occasion it rose to 108 patients. Discussion involves moving patients to community beds which needs to happen more quickly. She said that from her recent night duty there is no evidence of harm to patients in the Emergency Department. She referred to the pressures placed on the Trust when on one occasion 11 ambulances arrived within a space of 20 minutes. A nurse is with patients when they are waiting in the Emergency Department.
- Mr Lewis observed that in October 2015 the Trust achieved the system-wide medically fit plan total of 40 patients. The Nursing Director said that at that time there were 50 reablement nursing home beds opened but that these are now full.
- The Medical Director said that seven day working is providing a benefit as is the work undertaken by Dr Kate Hellier to reduce length of stay. If length of stay can be reduced then unfunded beds can be removed easing the pressure on staff where the current pressures are difficult to sustain.

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. [0949]

044/16 NURSING AND MIDWIFERY STAFFING

The Nursing Director presented the report updating the Board on the exception report made regarding compliance with the 'Hard Truths' –

Safer Staffing Commitments for January 2016. In line with the set parameters for the safer staffing guidance there were no outlying exceptions for January 2016. The six monthly Keith Hurst benchmarking exercise has been undertaken and, in summary, there are no significant changes required at this time. The Trust continues to work hard to both retain and recruit nurses.

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

- The Chair enquired why only two of the first group of nine overseas-qualified nurses were successful in the International English Language Testing System (IELTS) examination. In response, the Nursing Director commented that the examination is challenging. The Director of Human Resources and Organisational Development added that the Trust is offering coaching in language skills to new recruits. He undertook to approach colleagues to see if they were experiencing similar test results. The Nursing Director said that she will take this up with the Nursing and Midwifery Council. **DS** **MA**

The Chair thanked the Nursing Director for the report.

RESOLVED: That the report be endorsed. [1000]

045/16 CULTURAL CHANGE PROGRAMME UPDATE

The Associate Director of Transformation presented the report providing the second review of the Culture Change Programme. She drew attention to the achievements which were not at the desired rate. There are some risks identified against the workstreams. There has been some progress in key activities particular in Women and Children's Division where there is now greater engagement with nursing and midwifery. There have been discussions relating to devolved management and accountability which sits within the Operational Workstream which has a significant interdependency with the Analytics Workstream. The Director of Finance added that the Executive Team is to consider this issue where there is a keenness for devolved decision making with a clinical lead. The Medical Director commented that Service Lines do not necessarily align in relation to improving performance and the next stage is to develop with the Chiefs of Service a pilot for a more blended approach.

During the course of the discussion, the Chair wished to see greater involvement of Non-Executive Directors in the Programme and to this end she invited the Associate Director of Transformation to contact each Non-Executive Director for ideas for greater involvement. **RW**

The Chair invited the Associate Director of Transformation to provide a further update to the Board in May 2016. **RW (MW to note for Agenda)**

The Chair thanked the Associate Director of Transformation for the report.

RESOLVED: That the report be noted. [1009]

046/16 LEGAL SERVICES REPORT

(Mrs Caroline Pennels, Head of Legal Services and Georgina Ody, Claims Manager,

attended the meeting for the discussion of this item)

The Director of Safety introduced the report providing information for the period 1 October 2014 to 31 December 2015, describing the range of work undertaken by the Legal Services Department and further detail on some of those activities. He stressed the support provided by Legal Services to patients and staff especially those attending inquests.

The Head of Legal Services explained the work of Legal Services in respect of clinical negligence claims, employer and public liability claims, complex case management, duty of candour, court cases and hearings including inquests, and other court cases and the freedom of information service provided.

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

- In response to a question from Mrs Munro about claims management, the Head of Legal Services said that she has authority to settle claims within delegated limits.
- The Medical Director echoed the support provided by Legal Services to staff in very stressful situations. This was also echoed by the Nursing Director in the support provided to junior nurses.
- The Chief Executive commented that the Trust is below the national average in the number of claims made. The work on dealing with Freedom of Information requests is time consuming with the majority received from the media.
- In response to a question from Mr Foster, the Head of Legal Services said that the bulk of her work related to inquests and that she spent approximately 70 days per year in court.
- In response to a question from Mr Foster, the Head of Legal Services said that the Duty of Candour requires the Trust to be open. The Chief Executive added that he was impressed with the reports which he signs both in terms of the level of detail and the readily understood language.
- Mr Lewis referred to the National Health Service Litigation Authority (NHSLA) mediation pilot commenting on the low take up nationally and asked if the Trust was engaged with the pilot. The Head of Legal Services responded stating that the Trust is not involved in this pilot but it does endeavour to resolve issues locally.

The Chair thanked the Director of Safety, the Head of Legal Services and the Claims Manager for the report.

RESOLVED: That the report be noted. [1025]

047/16 COMBINED ASSURANCE FRAMEWORK AND TRUST RISK REGISTER

The Director of Safety presented the report inviting the Board to approve the updated assurance framework (AF) and combined dashboard and to note the Trust Risk Register (TRR). Each year the assurance framework is refreshed so it reflects the main potential risks to the current annual plan. The top risks from the plan are added or consolidated with the previous year's assurance framework to ensure continuity and in the current year the updated Strategic Goals and

Objectives will be added. Risks from the Trust Risk Register which need to be mitigated to deliver the annual plan are also included in the assurance framework. To show themed risks from both documents, the risks have been brought together under the strategic headings so that the potential risks associated with the annual plan and the risks that are currently adversely affecting the delivery of the plan can be seen together.

The Chair invited the Board to consider each risk rating in the combined assurance framework and the following amendments were made:-

- Inability of the local health and social care system to manage demand within the current capacity – Revised risk rating of 5x4=20 approved (from 4x4=16).
- Failure to match the workforce profile with clinical/service needs of the organisation – Amend risk rating to 5x4=20 (from 4x4=16).

The Director of Clinical Strategy added that the risks will be added to the Operational Plan.

The Chair then invited the Board to consider each risk rating in the Trust Risk Register and no amendments were made. The Board noted that the risk for M1c (hospital at full capacity) has been increased to 5x5=25 (from 4x5=20).

The Chair thanked the Director of Safety for the report.

RESOLVED: That the updated assurance framework be approved and that the Trust Risk Register be noted. [1037]

048/16 2015 STAFF SURVEY RESULTS

The Director of Human Resources and Organisational Development presented the key findings from the 2015 staff survey and outlined the process by which results will be shared with staff and the 'rolling' action plan from previous years updated and amended to effect the required improvements. For the 2015 survey there were subtle changes to some of the questions involving a single word so that there is no precise comparison with 2014. The Trust scores are presented in the form of staff engagement, progress against the rolling action plans. top and bottom ranking scores, improvements and deterioration since last year and key observations by Division and Staff Group. The detail in relation to each heading was set out in the report. It is clear that the Trust continues to make progress against the overall engagement index; however, significantly improved traction has not been achieved which is very disappointing. Of the 32 key findings, only six have moved in a statistically significantly direction (three in each direction). The programme of work underpinning the Trust's vision has yet to develop and 2016 presents an opportunity to make explicit the links between the proposed actions from the staff survey and the delivery of the vision and to make the required step change.

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

- The Chair observed that there are Divisional variations in the level of engagement, the reasons for which need to be understood. She suggested that the three most important

issues should be selected for the action plan. The Trust's vision needs to be more widely articulated with staff improvement being linked to the vision.

- The Director of Service Delivery suggested that the Board needs to determine whether there is to be a radical change to the delivery of the Trust's vision or to continue by evolution which was the consensus of the Board.
- Mr Mitchell commented that there should be closer links with the cultural change programme which he thought did not align well with other services.
- The Director of Human Resources and Organisational Development said that a focus group will be established to obtain data behind KF21 relating to the percentage of staff believing the organisation provides equal opportunities for career progression/promotion.
- The Medical Director suggested that there should be pilot areas from the survey to improve engagement.
- The Director of Human Resources and Organisational Development said that the Divisional Engagement Groups are to present to the Board in April 2016 with an action plan being presented to the Board in May 2016. **DS (MW to note for Agendas)**

The Chair thanked the Director of Human Resources and Organisational Development for the report.

RESOLVED: That the report be noted and that feedback from the Divisional Engagement Groups will be presented to the Board in April 2016. [1059]

049/16 APPOINTMENT OF AN ADDITIONAL NON-EXECUTIVE DIRECTOR – PROPOSED AMENDMENT TO THE CONSTITUTION

The Trust Secretary presented the report providing an opportunity to increase the membership of the Board by the appointment of one additional Non-Executive Director from the University of Gloucestershire and that the Trust's Constitution be amended accordingly. The proposal is to establish more formally the link between the Trust and the University by the appointment of a Non-Executive Director from the University. This proposal would also provide a majority of Non-Executive Directors on the Board and more fully fulfil the Monitor requirement for the Board to comprise a majority of Non-Executive Directors rather than the current arrangement of the Chair exercising any casting vote. The proposals will also require the approval of the Council of Governors.

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

- The Chief Executive said that the University welcomed this approach. The Director of Clinical Strategy added that this approach supports the statement of intent between the two organisations for training and research.
- The Chair said that clarity be sought on filling the appointment should there be a resignation/retirement before the end of the term of office. The Trust Secretary was invited to look at the arrangement in place in other area where there are similar links with universities for inclusion in the Constitution. **MW**

The Chair thanked the Trust Secretary for the report.

RESOLVED TO RECOMMEND: That the Council of Governors amend the Constitution of the Trust so that the membership of the Board be increased by the appointment of one additional Non-Executive Director from the University of Gloucestershire and that the Constitution be amended as set out in paragraph three of the report subject to the above amendment. [1111]

050/16 ITEMS FOR THE NEXT MEETING AND ANY OTHER BUSINESS

Items for the next meeting: The draft Budget 2016/17 and draft Capital Programme for 2016/17 were identified as items for the next meeting.

Any other business: There were no further items of business. [1112]

051/16 STAFF QUESTIONS

The two staff questions submitted on behalf of the Unscheduled Care Staff Engagement Group and the responses provided at the meeting by the Chair are set out in Appendix 1 to these minutes. [1112]

052/16 PUBLIC QUESTIONS

There were none. [1113]

053/16 DATE OF NEXT MEETING

The next **Public** meeting of the **Main Board** will take place at **9am** on **Thursday 24 March 2016** in the **Gallery Room, Gloucestershire Royal Hospital**.

054/16 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 11.14 am.

Chair
24 March 2016

APPENDIX 1

QUESTIONS FROM STAFF

Questions on behalf of our Unscheduled Care Staff Engagement Group

1. What happens to the high risk assessments undertaken once they reach the top/ Trust level e.g. high risk of pressure sores to patients with fractured hips experiencing long delays on ED trollies waiting for a bed on ward?

Response

Risk assessments are plans to reduce the chance and consequence of harm, with reference to the question ED staff would be reviewing the current practice and making improvements to reduce the risk. As the risk score (high risk) increases the level of monitoring, scrutiny and any intervention is increased, so for example the Trust Tissue Viability team (as experts) would be involved in the plans, the progress would be reported at key meetings and a Director would oversee the actions. Even at this level many of the actions still need to be taken by the ED staff as the risk is still part of the care they deliver. Trust Level risks (High risks) are all added to the Trust risk register and monitored at Trust Board each month.

2. In the light of the current ED situation and poor bed capacity within the Trust could there be an exception to the rule to having a bed in ED for such patients given that , sometimes the wait for some of these elderly and frail patients can exceed 10-12 hours?

Response

Patients are continually assessed as to their condition whilst in the ED. Both of the ED departments have pressure relieving mattresses which are used as required with the patient trollies. Beds are not traditionally put in ED however if there are specific clinical needs, then the Divisional Nursing Director or the on call Nursing Director will authorise this.

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – MARCH 2016

MATTERS ARISING

CURRENT TARGETS

Target Date	Month/Minute/Item	Action with	Detail & Response
March 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. The Director of Service Delivery added that there is an expansion of day cases in line with the action plan and these cases do not require an assessment. The data are being revisited. *The Director of Service Delivery said that work continues with progress being made through the patient process. Ongoing.* The Chair said that the situation regarding the availability of community beds should be raised with the Gloucestershire Strategic Forum. The Chair reported that this will be raised formally at the next meeting of the Forum, with the issue being continuingly raised at every opportunity. *The Chair reported that this will be raised at a meeting of the Forum taking place during the week following the Board meeting. Ongoing.*
March 2016	February 2016 Minute 041/16 Integrated Performance Framework Report	**EG**	The Chair suggested that the Trust should aspire to improving the target for 90% of stroke patient spending 90% (from 80%) of their time on a stroke ward and asked for an indication of any barriers to achieving this target. In response, the Director of Service Delivery supported this aspiration and said that he will undertake a detailed analysis of the data to see why this could not being achieved. *Ongoing.*
March 2016	February 2016 Minute 042/16 Financial Performance Report	**HS/SE**	In response to a question from Mr Foster, the Finance Director undertook, in conjunction with the Medical Director, to provide details of the £7m on locum doctors. *Ongoing.*
March 2016	February 2016 Minute 044/16 Nursing and Midwifery Staffing		The Chair enquired why only two of the first group of nine overseas-qualified nurses were successful in the International English Language Testing System (IELTS) examination. In response, the Nursing Director commented that the examination is challenging. The Director of Human Resources and Organisational

		DS **MA**	Development added that the Trust is offering coaching in language skills to new recruits. He undertook to approach colleagues to see if they were experiencing similar test results. The Nursing Director said that she will take this up with the Nursing and Midwifery Council. *Ongoing.*
March 2016	February 2016 Minute 045/16 Cultural Change Programme	**RW**	The Chair wished to see greater involvement of Non-Executive Directors in the Programme and to this end she invited the Associate Director of Transformation to contact each Non-Executive Director for ideas for greater involvement. *The Associate Director of Transformation is contacting Non-Executive Directors individually*. *One suggestion being pursued is NEDs engaging in a session within PALS to get a good feel (and a direct feel) for what is happening in the Trust. Ongoing.*
March 2016	February 2016 Minute 049/16 Appointment of an Additional Non-Executive Director – proposed Amendment to the Constitution	**MW**	The Trust Secretary was invited to look at the arrangement in place in other area where there are similar links with universities for inclusion in the Constitution. *Ongoing.*

FUTURE TARGETS

Target Date	Month/Minute/Item	Action with	Detail & Response
April 2016	February 2016 Minute 048/16 2015 Staff Survey Results	**DS**	The Director of Human Resources and Organisational Development said that the Divisional Engagement Groups are to present to the Board in April 2016. *Ongoing.*
May 2016	February 2016 Minute 045/16 Cultural Change Programme	**RW**	The Chair invited the Associate Director of Transformation to provide a further update to the Board in May 2016. *Ongoing.*
May 2016	February 2016 Minute 048/16 2015 Staff Survey Results	**DS**	The Director of Human Resources and Organisational Development said that the action plan is to be presented to the Board in May 2016. *Ongoing.*

COMPLETED TARGETS

Target Date	Month/Minute/Item	Action with	Detail & Response
February 2016	January 2016 Minute 006/16 Minutes of the meeting of the Health and Wellbeing Committee held on 5 January 2016	**AF**	The Chair referred to the number of apologies recorded at the meeting and invited the Committee to consider whether deputies should attend when the appointed representative was unable to do so. *The Chair said that all Board Committees have been invited to consider using video and telephone*

			conferencing facilities for meetings. Completed.
		SP	The Director of Clinical Strategy commented that there is a good pathway for obese children who are admitted but the system response is not well defined. The Trust staff contribute to the County-wide group to prevent obesity. The Chair invited the Director of Clinical Strategy to take forward developing a system response to obesity. *The Director of Clinical Strategy said that this is being included as part of the corporate objectives in the Operational Plan. The Clinical Commissioning Group and Gloucestershire County Council are supportive of the approach. Completed.*
February 2016	January 2016 Minute 007/16 Summary and Minutes of the meeting of the Quality Committee held on 15 January 2016	**SP/MW**	The draft Operational Plan is to be submitted to Monitor by 8 February 2016 and will be shared with the Board. *The Trust Secretary reported that the draft plan was circulated to the Board on 10 February 2016. Completed.*
February 2016	January 2016 Minute 008/16 Summary and Minutes of the meeting of the Sustainability Committee held on 18 January 2016	**Committee Chairs**	The Chair invited Board Committee Chairs to consider the use of video and teleconferencing for their meetings. *The Trust Secretary reported that Committee Chairs and those servicing Board Committees have been invited to put this as an item on the next Committee meeting. The Chair of the Finance and Performance Committee said that the Committee, given the size and format, will keep this option under review. The Trust Secretary has made arrangements to ensure that this included on the next meeting of each Board Committee. Completed as a matter arising*
February 2016	January 2016 Minute 013/16 Emergency Pathway Report	**EG**	The Chair invited the Director of Service Delivery to include in future reports details of peaks in the Emergency Department which cause significant difficulties for the Trust. *This was included in the report which appeared later in the agenda. Completed.*
		EG	The Director of Service Delivery undertook to provide Mr Lewis with details of the impact of the fines and penalties on 30 and 60 days imposed by the South West Ambulance Service. *The Director of Service Delivery confirmed the information which he had*

			provided to Mr Lewis, namely that the total for Q1 was £55k and for Q2 was £67k. Completed.
		CC	The Chair said that she will invite the Chief Executive to speak to the Chief Executive of the Ambulance Service to discuss the issue where GP admissions are booked with the Ambulance Service between 3 and 7pm, but due to the pressures on that Service are not picked up until the evening placing operational pressures on the Trust. *The Chair said that she had revisited this issue and raised it with the Accountable Officer at the Clinical Commissioning Group who had agreed to take this forward which is a more appropriate course of action. Completed.*
		EG	The Director of Safety said that the Academic Health Science Network had undertaken a piece of work with the Emergency Department in North Bristol Hospital to provide a checklist to mitigate risk (but does not address patient flow) during very busy periods which can be used within the Trust. *The Director of Service Delivery reported that the checklist is to be used as a pilot in Cheltenham General Hospital from 1 March 2016. Completed.*
February 2016	January 2016 Minute 014/16 Nursing and Midwifery Staffing	**MA/DS**	The Chair invited Mr Foster, the Nursing Director and the Director of Human Resources and Organisational Development to discuss the staff retention information. *The Director of Human Resources and Organisational Development reported that he had shared information with Mr Foster and the dialogue is continuing. Completed.*

ITEM 5

SUMMARY OF THE MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE TO BE HELD ON 23 MARCH 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 24 FEBRUARY 2016 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
	Mrs M Bond	Non-Executive Director
	Mr T Foster	Non-Executive Director
	Mrs H Simpson	Finance Director and Deputy Chief Executive
APOLOGIES	Mr E Gatling	Director of Service Delivery
IN ATTENDANCE	Mr M Wood	Trust Secretary

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

(Mr Foster in the Chair)

ACTION

017/16 DECLARATIONS OF INTEREST

There were none.

018/16 MINUTES OF THE FINANCE AND PERFORMANCE COMMITTEE HELD ON 27 JANUARY 2016

RESOLVED: That the minutes of the Finance and Performance Committee held on 27 January 2016 were agreed as a correct record and signed by the Chair.

019/16 MATTERS ARISING

009/16 Cancelled Operations Update: Mr Foster suggested that the whole system of theatre efficiency should be considered and it was agreed that this should be at the next meeting in February 2016. *This item appeared later in the agenda. Completed.*

020/16 FINANCIAL PERFORMANCE REPORT

The Finance Director presented the Financial Performance Report stating that the financial position of the Trust at the end of January 2016 is a surplus of £0.5m on income and expenditure which is in line with the position reported in December 2015. Operational pressures continue and temporary staffing expenditure is £0.4m higher than the expenditure in December 2015. The Trust needs 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. She stressed that although there are controls patient safety clearly remains the priority for the Trust. The Monitor Risk Assessment under the framework shows a Financial Sustainability Risk Rating of 3. The surplus of £0.5m on the income and expenditure position represents a favourable variance of £0.2m from the planned position of a £0.3m surplus of income over expenditure at the end of January 2016.

Although not a concern the plan to date was behind as higher levels of surplus should have been achieved earlier in the year. The cash position has improved to £7.2m at the end of January 2016. New measures are in place to improve the position over the coming months. Agency costs are required to decrease during February and March 2016. The Capital Programme is behind plan partly as a result of the due diligence work undertaken by the Director of Estates and Facilities and the change in administrative process earlier in the year requiring a purchase order to be placed before payment is made. Efforts are being made to get back to plan by the end of the financial year. The impact of the emergency cap cumulative to January 2016 was £1.2m. There is a concentrated focus for the remainder of the current financial year to achieve the surplus. Budgets for 2016/17 are in the course of preparation.

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

- The Chief Executive commented that our Trust is one of a small number of Trusts in financial surplus. He paid tribute to staff efforts across the Trust in achieving this position.

(Mr Mitchell joins the meeting)

- In response to a question from Mrs Bond about the anticipated year-end financial position, the Finance Director said that the anticipated position is a surplus with a Divisional forecast of £2m; however, there are significant risks. The position will become clearer in March 2016. She stressed that the Trust is doing everything it can to achieve the best possible financial position. Mr Foster asked about the impact of late payments from Specialised Commissioners on the year-end financial position. In response, the Finance Director said that it will depend if there are any late challenges from Specialised Commissioners. If not, she anticipated that there will be minimal impact on the year-end financial position. There are significant risks relating to agency costs and operational pressures and therefore she could not guarantee the year-end position.

The Chair thanked the Finance Director for the report.

RESOLVED: That:-

1. The financial position of the Trust at the end of month 10 is a surplus of £0.5m on income and expenditure be noted. This is in line with the position reported at Month 9.
2. The £0.5m surplus represents a favourable variance of £0.2m from the planned position of £0.3m surplus of income over expenditure at the end of January 2016 be noted.
3. 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.
4. The Monitor risk assessment framework continues to show a Financial Sustainability Risk Rating of 3.
5. 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.

(Mr Mitchell in the Chair)

021/16 INTEGRATED PERFORMANCE MANAGEMENT FRAMEWORK

The Finance Director presented the report summarising the key highlights and exceptions in the Trust up until the end of January 2016 for the 2015/16 financial year. She drew attention to each of the highlights and exceptions on performance as set out in the report.

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

- The Chair invited the Finance Director to outline what she viewed as the main concerns to performance. In response, the Finance Director said that after Emergency Department performance the main concern is the high number of patients on the medically fit list in excess of the system-wide plan total of 40 leading to the equivalent of two additional wards. There is a lack of demand management in the health system leading to financial and operational pressures.
- The Chief Executive stressed that the only issue which Monitor has with the Trust is Emergency Department performance.

The Finance Director tabled a reformatted Integrated Performance Management Framework report linking to the CQC's Key Lines of Enquiry (KLOEs). The new style provided the measure, performance in the last 12 months, quarter and monthly actual performance, the forecast, standards, an indication of who set the target, how often performance is reported and the date of the data.

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

- Mrs Bond said that the duplication of data between the performance and finance reports should be avoided wherever possible and that there should be clarity of where the data is contained.
- The Chief Executive said that this approach could be adopted by the Quality Committee so that a similar report format is presented to the Board to assist in their deliberations.
- The Committee supported the revised format which will be introduced for the beginning of the next financial year.

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.

022/16 EMERGENCY PATHWAY REPORT

The Chief Executive presented the Emergency Pathway Report and highlighted the following:-

- The 95% four hour target for Emergency Department

performance was not successfully met in January 2016 with Trust-wide performance reported as 80.16%

- Partner organisations do not agree what the issue is to improve performance. Exit blocking is not seen as an issue by some partners and the majority of breaches arose due to the lack of available beds.
- NHS England has demanded that our Trust attends a Quality Summit but they have no concerns about quality issues. This is taking place in Swindon on 29 February 2016. On 1 March 2016 the bottom 30 performing Trusts (including our Trust) have been summoned to a workshop in London arranged by Monitor. The Trust's year to date position was 115 out of 136 acute trusts, but the week selected by Monitor the Trust's position was in the bottom 30. The issue is a system-wide issue, but Monitor only gets involved with the Trust as a Foundation Trust. Monitor may decide to take formal action against the Trust. There remain a high number of patients on the medically fit list above the system-wide plan total of 40. There are high numbers of patients waiting for social care packages and community placements. In total there are now approximately 100 patients on the medically fit list. The focus is to improve performance to above 80% and then continue to improve.

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

- Mrs Bond asked what measures our Trust is taking to make a difference. In response, the Chief Executive said that an Improvement Director will commence duties on 1 March 2016 reporting to the Chief Executive. She has a successful track record in improving and sustaining Emergency Department performance in a large Trust. She will focus on a small number of issues. This will enable the Director of Service Delivery to focus on other issues and is no reflection on that post holder. From the weekend preceding the meeting additional nurses are progress chasing what are termed simple discharges with patients returning to their own homes. This will help the position for the beginning of the week. The Director of Service Delivery and the Medical Director are to work with Medicine Division to understand why patients are not being discharged to their own homes and if they need other services before discharge to arrange that they are provided speedily.
- In response to a question from the Chair, the Chair Executive said that there is no evidence that patient safety had been affected.

The Chair thanked the Chief Executive for the report.

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

023/16 READMISSION ANALYSIS

This item was deferred to the meeting in March 2016.

EG
(MW to note for Agenda)

024/16 THEATRE EFFICIENCY

On behalf of the Director of Service Delivery the Finance Director gave a presentation setting out the programme for theatre modernisation over the next three years. She covered the background to the programme which had been identified as part of the high level Cost Improvement schemes for the Trust with the potential for savings in the region of £26m. Key areas for delivery are included in Surgery Division's Cost Improvement Plan for 2016/17. The main elements for the delivery plan for the next three years were set out together with a summary of the responses to the identified opportunity.

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

- The Finance Director said that the Chief of Service for Surgery Division is overseeing the move to seven day services.
- In response to a comment form Mr Foster about the timeframe for the programme, the Chief Executive said that there are cultural challenges to bring changes to working arrangements.
- The Chair asked if the opening of the theatre in Cirencester will be an issue for the Trust. In response, the Chief Executive said that discussions are taking place with Gloucestershire Care Services about the Trust employing consultants at Cirencester and then back filling posts. This arrangement will assist the Trust in increasing activity.
- The Chair enquired about the support available to the Chief of Service to deliver the programme. In response, the Chief Executive said that the Chief of Service is already involved in the programme and an internal project manager has been appointed supported by the Divisional Operations Director.

The Chair thanked the Finance Director for the presentation.

RESOLVED: That the presentation be noted.

025/16 COST IMPROVEMENT PROGRAMME UPDATE

The Finance Director gave a presentation providing an update on the Cost Improvement Programme. She covered the tracker position as at January 2016, the monthly movement, the current position, a comparison against the 2014/15 Cost Improvement Programme, the Cost Improvement Programme split by recurrence, the opportunities presented by and the requirements of the Carter review, opportunities presented by project themes, the draft Cost Improvement Plan for 2016/17 and the challenges in delivering the Programme.

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

- The Chief Executive said that the Committee should receive a briefing on the Carter review and it was agreed that this be presented to the Committee in April 2016. **HS (MW to note for Agenda)**
- Mrs Bond stressed that arrangements should be in place to ensure that the project themes deliver quickly.
- The Finance Director said that the Cost Improvement Programme target for 2016/17 is 4.8%. The Chair said that there should be no slippage in the Programme early in the

financial year and that income should be managed. He invited the Finance Director to include in the finance report in June/July 2016 an indication of progress in meeting the Cost Improvement Programme. **HS**

- Mrs Bond said that the Committee should see the risk status for the 2016/17 Cost Improvement Programme before the start of the financial year. **HS**
-

The Chair thanked the Finance Director for the presentation.

RESOLVED: That the presentation be noted.

026/16 PROGRESS UPDATE ON 2015/16 CONTRACTING PROCESS

The Finance Director presented the report updating the Committee on the key points associated with the 2015/2016 Contracting Process stating that a greater commercial approach is being adopted to the contract negotiations, The financial gap between the Trust and the Clinical Commissioning Group has reduced to £1m. There is a focus on resolving issues with Specialised Services and with Gloucestershire Care Services. The whole of the NHS is facing an increasingly challenging cash position and the Trust has put in place additional measures to improve cash flow. Escalation continues to be necessary in addition to further investment in internal credit control. Negotiations have commenced with the Clinical Commissioning Group on the 2016/17 contract with high level intentions issued and the Monitor plan for 2016/17 submitted. This contract round will be challenging and in response to the Clinical Commissioning Group the Trust has been clear on our position in relation to QIPP proposals and the reality of Commissioner plans compared with the operational pressures experienced across unscheduled and planned care pathways. Growth rates have largely been agreed.

The Chair thanked the Finance Director for the report.

RESOLVED: That progress made in managing the 2015/2016 contracts and that negotiations have commenced in relation to 2016/17 be noted.

027/16 NOTES OF THE EFFICIENCY AND SERVICE IMPROVEMENT BOARD MEETING HELD ON 10 FEBRUARY 2016

The Finance Director presented the notes of the meeting of the Efficiency and Service Improvement Board held on 10 February 2016.

The Chair thanked the Finance Director for the notes.

RESOLVED: That the notes be noted.

028/16 FINANCE AND PERFORMANCE COMMITTEE WORK PLAN

The Trust Secretary was invited to amend the work plan as follows: **MW**

- March 2016 – defer form February 2016 Readmission Analysis
- April 2016 – add Overview of Lord Carter Review
- June 2015 – add theatre efficiency update

029/16 CONSIDERATION FOR THE USE OF VIDEO AND TELEPHONE CONFERENCING FOR COMMITTEE MEETINGS

The Committee considered the benefits of using video and telephone conferencing facilities for its meetings and concluded that, given the size and format, this option be kept under review.

030/16 ANY OTHER BUSINESS

There were no further items of business.

031/16 DATE OF NEXT MEETING

The next meeting of the Gloucestershire Hospitals NHS Foundation Trust Finance and Performance Committee will be held on **Wednesday 23 March 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 **Friday 11 March 2016**.

The meeting ended at 12.07 pm.

Chair
23 March 2016

HOSPITALS NHS FOUNDATION TRUST GLOUCESTERSHIRE

MINUTES OF THE AUDIT COMMITTEE
MEETING HELD ON 8 MARCH 2016 AT 8.00AM
IN THE BOARDROOM, NO 1 COLLEGE LAWN, CHELTENHAM

PRESENT

Mrs Anne Marie Millar	(AM)	Non-Executive Director Chair
Mr Clive Lewis	(CL)	Non-Executive Director

IN ATTENDANCE (by invitation)

Mrs Helen Simpson	(HS)	Finance Director & Deputy CEO
Mr Alan Thomas	(AT)	Lead Governor
Mr John Golding	(JG)	Partner, Grant Thornton (GT), External Audit
Mr Kevin Henderson	(KH)	Grant Thornton (GT), External Audit
Mr Sam Elwell	(SE)	Price Waterhouse Coopers (PWC), Internal Audit
Mr Andrew Seaton	(AS)	Director of Safety
Mr Lee Sheridan (part)	(LS)	Head of Counter
Mrs Alex Gent (part)	(AG)	Head of Shared Services
Mr Martin Wood	(MW)	Trust Secretary
Mrs Lynn Pamment	(LP)	Partner, Price Waterhouse Coopers (PWC), Internal Audit
Mr Sean Ceres	(SC)	Interim Director of Operational Finance
Ms Geraldine Daly	(GD)	Grant Thornton (GT), External Audit
Mrs Sarah Smith	(SS)	PA to Finance Director

APOLOGIES

Mr Peter Stephenson	(PS)	Price Waterhouse Coopers (PWC), Internal Audit
Mrs Helen Munro	(HM)	Non-Executive Director

ACTION

019/16 DECLARATIONS OF INTEREST

None.

020/16 MINUTES OF MEETING HELD ON 22 JANUARY 2016

The minutes are to be amended to reflect Mr Elwell and Mr Stephenson left the meeting once during the meeting before the discussion on Internal Auditors Performance.

RESOLVED: with the agreed amendment the minutes of the meeting held on the 22nd January 2016 were agreed as a correct record and would be signed by the Chair at the May meeting.

021/16 MATTERS ARISING

003/16 Shared Record Project Review

The review has not yet been finalised and therefore will be presented at a later date to the Audit Committee.

003/16 Internal Audit Agency Nursing

Mr Elwell reported that some updates had been received towards findings but not enough to close the item. Members noted that this is a complex issue and the Committee will require assurance that agency costs are mitigated. Mr Elwell agreed to confirm a date for completion to the Committee. **SE**

003/16 Shared Services Operational Activity

Item Complete.

004/16 Review of the Audit Committee Terms Of Reference
To be discussed as part of item 10 - **Item Complete.**

004/16 Draft Terms of Reference for Shared Services Committee
Item 10 on the agenda - **Item Complete.**

009/16 Performance Monitoring
The Finance Director confirmed that the recommendation tracker has been updated accordingly - **Item Completed.**

009/16 Completion of Business Cases
The Finance Director confirmed that there are clear pathways for business cases which are now approved by the Efficiency and Service Improvement Board rather than the Business Development Group. **Item Complete.**

010/16 Progress Report, emerging issues and developments
Mr Golding and the Finance Director confirmed that they have discussed asset disposal. **Item Complete.**

010/16 Key Financial Indicators
Item 6 on the agenda. **Item Complete.**

013/16 Review of the Audit Committee Self-Assessment Checklist
Item 14 on the agenda. **Item Complete.**

RESOLVED: That the report be noted and revisited on the 17 May 2016.

022/16 COUNTER FRAUD UPDATE

PROGRESS REPORT
It was agreed to move this item to earlier on the agenda. Mr Sheridan summarised ongoing Counter Fraud investigations. Mr Sheridan reported that on Tuesday 8 March 2016, he had attended a Nursing and Midwifery Council conduct hearing involving a former Trust employee. The hearing was due to conclude on 14 March 2016. Mr Sheridan reported a further investigation involving a former Trust employee and enquiries would continue.

The Chair asked if Counter Fraud had enough resources or whether additional resources were needed. Mr Sheridan confirmed there were appropriate resources in place and external support had been engaged to provide support.

It was agreed that management would need to consider whether there were any material issues regarding counter fraud that would need to be referred to in the annual accounts. The Finance Director agreed to discuss with the chair and external auditors in advance of the May meeting. **HS**

COMPLETED ACTION PLAN 2015/2016

Members noted the report.

ACTION PLAN 2016 /2017
Mr Sheridan advised members that he would be revisiting the Action Plan as the substantive Head of Counter Fraud.

DRAFT ANNUAL REPORT
Members considered the report agreeing that it was important to include

recovery costs within the report. **LS**

RESOLVED: That the reports be noted.

LS left the meeting.

023/16 REPORTS FROM THE FINANCE DIRECTOR

LOSSES AND COMPENSATIONS

Members noted that the largest invoice written off related to a deceased Norwegian resident where there was no agreement to pay and the family cannot be held liable. The Chair expressed her concern about the process and asked for assurance that processes are in place. The Finance Director reassured members that a detailed internal review had taken place, Counter Fraud had also reviewed process and PwC would also look at this area. During discussion members also considered how money was recovered from Trust employees. The Finance Directors advised members that she was satisfied internal measure are working and Mr Golding gave assurance that this is an area which has improved.

SINGLE TENDER ACTION

The Chair accepted a tabled waiver. Mrs Gent brought to members attention a waiver for an onsite scanning service for medical records and legal files needed to comply with statutory deadlines. A tender exercise will be undertaken; members noted the value of the waiver at £45k.

RESOLVED: That the reports be noted.

024/16 EXTERNAL AUDIT UPDATE

Mr Golding introduced Ms Daley as the new engagement lead to members. He advised he would also be attending the Audit Committee with Ms Daley and Mr Henderson. Mr Golding would be the client liaison lead with the Finance Director.

AUDIT PLANS

Ms Daley presented the report to members, key points were noted as :

- Developments and other requirements
    - Financial Reporting - further testing will be undertaken to understand a new accounting standard.
    - Corporate Governance - external auditors will provide a view on the Trusts Annual Report.
    - An audit will be carried out of the Quality Report and Charitable Funds. Members noted that there is a new criteria around Dementia to be reviewed within the Quality Accounts. Mr Henderson is to confirm to the Director of Clinical Strategy that the criteria is auditable. **KH**

- Materiality - the overall materiality for the purpose of the audit has been determined to be £9.67m.
- Significant risks identified were:
    - Revenue cycle – members noted work undertaken and work completed
    - Management over-ride of controls – members noted work to be undertaken.
    - Valuation of property and equipment – members noted worked planned and the sale of 1 and 2 College Lawn will be accounted for appropriately re surplus assets.
    - Employee remuneration – members asked for clarity around the approach to annual leave accrual, the Finance

Director confirmed that annual leave accrual forms part of the final accounts working papers.

- Operating expenses

- Members noted the focus of value for money work. Mr Henderson updated that he would discuss information required with the Director of Service Delivery and follow up any outstanding information with the Director of Finance. Mr Henderson agreed to produce a list of required documents to share with the Finance Director. Mr Seaton asked what level of documentation was required for the CQC inspection review agreeing to meeting with PwC and Grant Thornton (GT) to share findings. **GT**
- The Chair highlighted the understanding business section of the report commenting that the classification of the Capital and Revenue would need careful review. The Chair also asked that income recognition would be key in view of the small surplus currently forecast.
- GT agreed to report back at the May meeting.
- Members noted the results of interim audit work including the attendance of GT at the Pharmacy stocktake.
- The Trust Audit Fee was noted as £55k.

THE AUDIT PLAN FOR GHNHSFT CHARITABLE FUNDS

Members noted the developments and other requirements which included the Department of Health published guidance for NHS charities considering converting to independent status although not urgent the Trust will need to take a view. The Charitable Fund audit fee was noted as £3k. The Chair asked where the Audit plan would be discussed, agreeing the plan would be presented first to the Charitable Funds Committee and then feedback to the May Audit Committee.

KEY FINANCIAL INDICATORS 2015

The report compares the Trusts performance with other Acute Foundation Trusts and identifies areas for further investigation and trends for the trust over the last 3 years, members noted that the report uses Monitor ratings and discussed the better payments practice code requirement .The Finance Director updated the Committee that steps had been taken to improve the percentage of invoices paid within 30 days and the position is improving.

PROGRESS REPORT AND EMERGING ISSUES AND DEVELOPMENTS

Members noted progress at of 23rd February 2016 and the Accounts workshops key finance staff were invited to and had attended.

RESOLVED: That the reports be noted.

025/16 INTERNAL AUDIT UPDATE

PROGRESS REPORT

Members noted progress and publications for member's information. (PwC) are currently reviewing the SmartCare report agreeing to circulate the report to members for early visibility as the system will go live before the date of the next Audit Committee meeting in May . **PwC**

Nursing Rostering - work ongoing with onsite visits, members noted that it is important that assurance is provided that the plan has been implemented as expected, the Committee asked for early feedback and concerns to be shared with members. **PwC**

DRAFT ANNUAL REPORT 2015/2016

Members noted Internal Audit work to date with a number of days to finalise. The opinion is subject to outcomes of ongoing reviews but is likely to be 'Generally satisfactory with some improvements required 'this is the second highest category in terms of opinion. Very few Trusts received the highest category.

Follow up work conducted

The following areas were discussed

- Patient Property was noted as a high risk report. The Finance Director commented that this would need to be reviewed to understand why agreed actions are ongoing adding that significant work had taken place. The Finance Director agreed to follow up with the legal team. Ms Pamment advised the work could be revisited before the report is finalised.
- Consultant Job Planning - members noted that a number of job plans were not due at the time of the report.

FINANCIAL RESILIENCE WORKFORCE PLANNING

The reported was noted as a medium risk with four medium risks identified which related to clarification on budgetary impact and lack of details available on the Permission to Fill Forms (PTFs) . Mr Ceres advised members that there were lots of discussion around PTFs but there is a need to insure that discussions were documented. The Finance Director added that there is a balance needed between holding up recruitment and ensuring documentation is in place assuring members that there are controls in place.

INFORMATION GOVERNANCE

Mrs Pamment advised that there were number of areas where insufficient evidence was available on the portal, this was due to the timing of the audit but members were assured that the evidence is now available and up to date. The report classification was noted as low risk .

RISK ASSESSMENT AND INTERNAL AUDIT PLAN 2016/17

Members noted the report, the final version will be presented at the May meeting of the Committee.

RESOLVED: That the reports be noted.

026/16 APPOINTMENT OF EXTERNAL AUDIT RECRUITMENT UPDATE

Internal and External Auditors left the meeting.

Mrs Gent updated that the Trust had received bids which were invited to present to a panel. The award will be communicated on the 9th March.

RESOLVED: That the verbal update be noted.

Internal and External Auditors re-joined the meeting.

027/16 UPDATE ON ANNUAL ACCOUNTS PLANNING PROCESS

Members noted the key deadlines for the production of the 2015/2016 Annual Report and Accounts and assurance was provided that the accounting policies had been considered. The Finance Director reported that additional resources with relevant experience had been secured for the completion of the accounts process.

RESOLVED: That the report be considered.

028/16 DRAFT TERMS OF REFERENCE FOR SHARED SERVICES COMMITTEE

Members noted that the 2gether Audit Committee had considered the terms of reference and had not seen the value in the development of a Shared Service Audit Committee. During discussion members agreed to a formal meeting of Trust members to review the Core Financial reviews undertaken by the Internal Auditor's. Mrs Pamment suggested that Trust confirm with 2gether that they wish to have sight of the core financial reviews. The plan would be to hold three meetings during 2016-17. Mr Wood agreed to review the Terms of Reference for Audit Committee for the May meeting the Committee. **MW**

RESOLVED: That the report be noted

Mrs Alex Gent left the meeting.

029/16 COST IMPROVEMENT PROGRAMME UPDATE

The Finance Director gave a presentation providing an update on the Cost Improvement Programme highlighting that the programme was scrutinised in detail by the Finance and Performance Committee. She covered the reporting process, tracker, the opportunities presented by and the requirements of the Carter review, opportunities presented by project themes and the challenges in delivering the Programme. In course of discussion key pointed noted were:

- Service Reconfiguration key, there is a limited period to make change before the next election cycle.
- The target for next year will be 4.5%, with the transformational fund the target is likely to increase. The Finance Director added although the target would be challenging to a greater extent than the challenges experience in the current financial year.
- The unscheduled care pathway has a significant pressure on the financial position, the Finance Director added that operational grip is the only way to deliver the CIP programme.
- The Chair asked how the Trust differentiated between lower spend and CIP, Mr Ceres reassured the Chair that the Finance team take a very forensic view in terms of classification.

RESOLVED: That the report be noted.

030/16 REVIEW OF TRUST RISK REGISTER & ASSURANCE FRAMEWORK

Mr Seaton highlighted the key risk around the Emergency Care Plan, the focus on 4 hours waits and the Monitor Action plan. Members sought reassurance and Mr Seaton agreed to rise at the Quality committee. **AS**

Mr Seaton highlighted the SmartCare programme as one of the key risks for the Trust and during discussion members agreed that the Main Board would benefit from assurance and sight of the proposed criteria that will be used to determine the decision to go or not live with the programme in May. Members also agreed that a formal update would be useful. The Finance Director agreed to raise this request with the Chief Executive. **HS**

RESOLVED: That the report be noted.

032/16 REVIEW OF THE AUDIT SELF-ASSESSMENT CHECKLIST

There was brief discussion of feedback received and the Finance

Director agreed to summarise the responses and report back at the May meeting of the Committee. **HS**

RESOLVED: That the report be noted.

033/16 AUDIT COMMITTEE WORKPLAN 2016

Mr Wood and the Finance Director proposed to review the work plan and to include Audit Specific work.

Members to agree the date and firm up the approach of the Audit Committee Seminar Session at the May meeting. **MW/HS**

RESOLVED: That the report be noted

034/16 COMMITTEE REFLECTION & DEVELOPMENT

The Chair agreed to discuss the earlier start time of 8.00am for future meeting with Mrs Munro. Members found the extended length of the meeting and break useful adding that the inclusion of an 'end time' on the agenda was beneficial. PwC highlighted the pressures of attending two Audit Committee and asked whether future dates for the Audit Committee could be coordinated with the Clinical Commissioning Group , Mr Wood agreed to review future dates. **MW**

RESOLVED: That the report be noted

035/16 VIDEO AND TELEPHONE CONFERENCING

Members considered the use of video conferencing and agreed not to pursue at this time.

RESOLVED: That the report be noted

036/16 ANY OTHER BUSINESS

None.

037/16 DATE OF THE NEXT MEETING

Tuesday 17 May in the Boardroom at 1 College Lawn. Time to be confirmed.

THE MEETING ENDED AT 11.05AM

CHAIR

ITEM 8

SUMMARY OF THE MEETING OF THE QUALITY COMMITTEE HELD ON 11 MARCH 2016

PAPER (To follow)

Mrs Helen Munro
Chair

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE TRUST QUALITY COMMITTEE HELD IN THE BOARDROOM, 1 COLLEGE LAWN, CHELTENHAM ON FRIDAY 11 MARCH 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)
	Prof C Chilvers	Chair of the Trust
	Dr F Harsent	Chief Executive
	Mr T Foster	Non-Executive Director
	Dr S Pearson	Director of Clinical Strategy
	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
	Mrs Arnold	Nursing Director
IN ATTENDANCE	Mrs S Smith	PA to Finance Director
	Ms R Wassell	Associate Director of Transformation

APOLOGIES

The Chair welcomed all to the meeting.

ACTION

020/16 DECLARATIONS OF INTEREST

There were none.

021/16 MINUTES OF THE QUALITY COMMITTEE MEETING HELD ON 15 JANUARY 2016

RESOLVED: That the minutes of the meeting of the Quality Committee held on 15 January 2016 were agreed as a correct record and signed by the Chair.

022/16 MATTERS ARISING

113/15 Divisional Attendance – Medicine: In response to a question from the Chair of the Trust, the Chief of Service said that a review of every patient has been undertaken for those waiting follow up appointments in Neurology and Rheumatology. *This will form part of the Division's next presentation to the Committee. Ongoing.*

008/16 Serious Untoward Incidents: The Chair invited the Director of Safety to consider adjusting his Board Report so that the Board received updates on open serious incidents. *The adjusted report was presented to the January 2016 Board meeting where it was agreed that such reports would be presented on a six monthly basis. Completed.*

018/16 Committee Reflection and Development: The Chair and the Trust Secretary to design a feedback form to be completed after Divisional attendances. *The form is to be amended to reflect that the form it will be used to feedback on the whole meeting.* **MW**

023/16 DIRECTORS' STATEMENT TO THE QUALITY COMMITTEE

The Director of Clinical Strategy presented the report setting out the key issues relating to the quality of care delivered in the Trust from the perspective of the Nursing and Medical Directors and the Director of Clinical Strategy. Key points of discussion were noted as:

- A more detailed analysis of (AKI) Acute Kidney Injury had been received but was not yet reflected in the report.
- Sepsis screening increased to 95%, the Director of Safety explained that it was the second part of the screening to give antibiotics within one hour which is problematic. Adding that the bulk of patients come through the Emergency Department with a range of issue and the assessment needed to be completed as early as possible to see the results..
- The Director of Safety updated that AKI is improving monthly and that there are four elements to be included in the Discharge letter. Mr Seaton highlighted the systematic failure where doctors discharge after three or four weeks and the AKI may have happened in week 1 which results in data having to be worked back through.
- Royal College of Physicians National Hip Fracture Database mortality supplement which show Gloucestershire Royal Hospital as an outlier with 30 day mortality rates. Attendees noted that there is an extensive action plan of which fractured Neck Of Femur is a substantive item. **MW**
- League table for adverse incidents , paper submitted ahead of publication
- Essence of Care Champions - Mrs Lewis asked for assurance around how champions address issues and Mrs Arnold explained that there are 11 standards discussed at each Essence of Care Board which are then discussed at ward level.
- The key facts elements of the NHS Choices website show the Trust amongst the worst in terms of infection control and cleanliness at GRH. The Director of Nursing updated that PLACE did not look at infection Control but general cleanliness and the Domestic Manager is currently trying to identified the reason for the results. The Trusts will need to focus on the elements that make up the measure.
- Review of Nursing Metrics – Safer Staffing – The Director of Nursing commented that the metric doesn't give a full picture as agency nurse are being used to achieve green.

RESOLVED: That the reports be noted.

024/16 DRAFT QUALITY REPORT

The Director of Clinical Strategy presented the early draft of the Quality Report , attendees noted that the National CQUINs had now been received which include 62 day Cancer waits , Sepsis and Improving Health and Well Being of NHS Staff which will be reflected in the reports and are required as part of the template. The report will be shared with stakeholders and responses on statements and any further comments are to be received by 23 March.

Number of admission by month – the Chair suggested that it would be useful to see comparators.

Number of admission by hours – Mrs Adams commented that is not good practice to discharge frail patients in the late hours. The Nursing Director reassured members that patients discharged after 10.00pm is monitored.

RESOLVED: That the report be noted.

025/16 QUALITY FRAMEWORK 2016

The Director of Safety presented the updated Quality Framework to the Committee. Members noted that Duty of Candour is a new element in the report and there will be further revisions as works develops with the Academy. The Chair of the Trust asked that the values of the Trust were reviewed and it was noted this would need to progress through the Cultural Change Programme.

The Director of Safety agreed to provide more explanation around the specific duties of the Trust Board, strengthen the section on Mortality monitoring and to amend the Chief Executive from the Accountable Office to the Accounting Officer. **AS**

RESOLVED: That the reports be noted.

026/16 CLINICAL CODING UPDATE

Mr Hopwood Interim Information Project Consultant attended the meeting for the discussion of this item)

Mr Hopwood presented a clinical coding update , key points noted:

- The Trust currently has 24 coders led by a coding manager; there are 10 coders at GRH and 14 at CGH.
- Completeness - the focus has been on a quality improvement plan to ensure activity is captured in a complete way and specific awareness activities have been implemented.
- Workforce - there is strong contract coder market and a 6 month lead time to train a new coder leading to a high turnover of staff, members noted that a national qualification is required, coders are then buddied with an experienced coder. GHNHSFT has recruited two permanent coders and there are reward and recognition arrangements to improve retention and colocation is currently being considered to improve efficiency. Members noted that Coders could work agilely with the implementation of Trac
- Next Steps will be to deliver remaining planned improvements and move to a business as usual position.
- The Chair of the Trust commented that people need to be reminded to complete notes. With the implementation of SmartCare it will be easier to automatically prompt people and Trak will also have prompts to guide documentation

The Chair thanked Mr Hopwood for his presentation.

RESOLVED: That the reports be noted.

027/16 DIVISIONAL ATTENDANCE – DIAGNOSTIC AND SPECIALTIES

(Mr Dr Frank Jewell, Chief of Service attended the meeting for the discussion at this time.)

Radiology continues to be an area of concern mainly to insufficient capacity in machine time and workforce issues. There have been some improvements and there is a pending introduction of a new MRI scanner at Gloucestershire Royal. Members noted that MRI are starting to breach to point the Trust may be fined; additional capacity with the new scanner will help to resolve this. Other areas of the division have sustained increase activity which includes dietetics and palliative care. There is a plan in place for dietetics and attendees also noted the summary of good work. A risk assessment around the Palliative care service will be presented at the next Quality Committee; mitigation is in place.

Fentanyl patches – staff have reported several adverse clinical incidents on the DATIX system and were likely to be treat as untoward incidents.

Pharmacy has lost two senior Pharmacists to the National Pharmacy in the Community programme.

The Chair commented that there is the expectation that complaints responses will move to green, it was noted that part of difficulty in responding is delays in other divisions.

Members noted the Divisional Dashboard and discussed Histology in red, it was noted that a change in work practices has accrued that had improved the process which will make the target difficult and it was agree that a review of the metrics should be undertaken to ensure that they are meaningful. The Director of Safety commented that there should be a ' should do' action plan from Diagnostic and Specialties for the next Quality Committee meeting and agreed to discuss further with Dr Jewell .

The Chair of the Trust was reassured that the action plan relating to the incident where a patient had died from heart failure had been completed.

The Chair thanked Dr Frank Jewell for the comprehensive report.

RESOLVED: That the report be noted.

028/16 DIVISIONAL ATTENDANCE – MEDICINE

(Dr Kate Hellier , Speciality Director and Mr Gordon , Interim Divisional Operations Director attended the meeting for discussion at this time)

Significant Events - there have been significant improvement in Endoscopy and Echocardiography wait with zero breeches. The redesign of stroke units have reduce Length of stay and there are is further work to be undertaken. There have been further changes to General Manager posts and significant staff changes within the division including the trial of a Patient flow manager.

CQC 'Must Dos' - Minutes of Morbidity and Mortality meetings within the division are now being kept and actions take and recorded . There is also a Morbidity and Mortality template in use and a SharePoint has

been created. Attendees noted that an Acute Pain Managements Quality Improvement Project is underway to ensure patients have an assessment of their pain and prompt pain relief. The ED level 3 safeguarding training log is up to date.

CQC ' Should Dos' – The Ambulatory Emergency Care Unit is sited in an appropriate equipped area that ensure dignity and comfort for patients , the relocation of AEC is still under discussion and improvements to the area are currently with the Estates department . A new end of life document is in place and working well.

The Division highlighted a number of achievements including Endoscopy where there had been nil breeches on both sites and the JAG accreditation had been successful. There has been a significant improvement in the reduction in follow up pending list for Rheumatology. Members noted that Non-Medical Endoscsopist capacity needs to be increased to meet future demands.

Stroke SSNAP Data – now moving in the right direction, there have however been significant TIA breeches and there has been a concerted piece of work to resolve.

Pressure Ulcer Management - there has been a reduction in total numbers grade 2/3s. There is currently a focus on pressure ulcers with a scanner pilot which will help to improve management.

Patient Flow Manager - crossed site role supported by B7 nurses tasked with driving SAFER processes within the Medical Division Wards and ensuring nurse led discharges are delivered by everyone.

ED Performance - Achievements of 4 hour standards remains a challenge , Monitor have visited and provided guidance and an action plan. The focus is on demand management and 'front door' efficiency and flow throughout the hospitals and community services.

Follow up appointments Neurology - A Rapid Improvements Event had taken place and a action plan agreed, breeches are reducing, a recovery of backlog is underway and a locum consultant is in place.

Infection Prevention Control - hand hygiene results are disappointing, prevention controls need to be addressed and Dr Hellier agreed to take back to the division.

The Chair thanked Dr Hellier and Mr Gordon for the comprehensive report.

RESOLVED: That the report be noted.

029/16 BOARD ROUNDS

Dr Hellier shared her learning from the IHI Quality Improvement Advisor Programme and learnt skills to provide quality improvements. This included the patient flow bundle SAFER initiative to improve patient care and is made up of five parts
Senior Review - board rounds , ward rounds
All patients have an Expected Discharge Date
Flow early from assessment units to IP WARDS
Early discharge

Review long lengths of stay

Members noted the SORT criteria poster which will help staff understand the functions and output of a Board round, the Data collection sheet for SAFER weeks and the SAFER briefings roll out plan across medicine wards. This is a cultural change programme linked to analytics and will need a coordinated approach to embed the programme across the hospital.

The Chair thanks Dr Kate Hellier for her presentation.

030/16 SERIOUS UNTOWARD INCIDENTS

The Director of Safety briefed the Committee on current serious untoward incident (SUIs), Never events, High Level reviews and RIDDOR reportable incidents. Four new incidents were reported, three of the incidents were potential Never Events

- Serious Incident status has been confirmed for the occasion where a patient received a unit of blood intended for another patient.
- Pain Control administered to the wrong region of the back during a shoulder manipulation is currently under review as a (SUIs).
- Wrong site surgery currently under review as a (SUIs).
- These incidents are currently under review to see if it meets the criteria for a Never Event.
- The final new incident reported involved the Delivery of a compromised baby, update of the action plan is scheduled for April 2016.

RESOLVED : That the report be noted

031/16 INTERNAL INCIDENT JANUARY 2016 – ROOT CAUSE ANALYSIS

The Chief Executive presented the report which reviews the patient's safety during the period of increased operational pressures in the Emergency Departments and examines the route cause which led to Trust calling an internal incident. The Chief Executive highlighted that during this period here was a rise in attendance of 378 and the number of beds which were in use when they should not have been. Although this period impacted on patient experience the report has not identified any serious patient safety issues or significant incidents.

RESOLVED: That the report be noted.

032/16 Q3 COMPLAINTS AND CONCERNS

The Director of Safety presented the report on information on the complaints and concerns reported to the Trust during Quarter 3.

- A proposition of the increase in the Medicine Division relates to the time to see a doctor in the Emergency Department and Acute Assessment Unit.
- Attendees considered the responses rates and internal Trust standard noting that longer timescales can be appropriate where agreed with the patient. There are also some delays with responses due to system issues which will be resolved with an electronic system.
- HB should consider whether it is possible to report against patient

agreed timescales

RESOLVED: That the report be noted.

033/16 MINUTES OF THE HEALTH AND SAFETY COMMITTEE MEETING HELD ON 25 FEBRUARY 2016

The Director of Safety presented the minutes of the meeting of the Health and Safety Committee held on 25 February 2016.

The Director of Safety highlighted that there has been an increase in the use of latex products and a review will be undertaken.

The Chair thanked the Director of Safety for the minutes.

RESOLVED: That the minutes be noted.

034/16 MINUTES OF THE PATIENT SAFETY FORUM MEETING HELD ON 20 JANUARY 2016

The Director of Safety presented the minutes of the meeting of the Patient Safety Forum held on 20 January 2016.

Members noted progress with the Medicines Safety Thermometer .

The Chair thanked the Director of Safety for the minutes.

RESOLVED: That the minutes be noted.

035/16 MINUTES OF THE PATIENT EXPERIENCE STRATEGIC GROUP MEETING HELD ON 27 JANUARY 2016

The Head of Patient Experience presented the minutes of the meeting of the Patient Experience Strategic Group held on 27 January 2016.

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

RESOLVED: That the minutes be noted.

036/16 MINUTES OF THE HOSPITAL MORTALITY INDICATORS GROUP MEETING HELD ON 2 DECEMBER 2015

The Medical Director presented the minutes of the meeting of the Hospital Mortality Indicators Group held on 2 December 2015.

The Chair thanked the Medical Director for the minutes.

RESOLVED: That the minutes be noted.

037/16 MINUTES OF THE SCREENING PROGRAMMES GOVERNANCE COMMITTEE MEETING HELD ON 16 DECEMBER 2015

The Director of Clinical Strategy presented the minutes of the meeting of the Screening Programmes Governance Committee held on 16 December 2015.

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

RESOLVED: That the minutes be noted.

038/16 MINUTES OF THE SAFEGUARDING ADULTS STRATEGIC BOARD MEETING HELD ON 21 DECEMBER 2015

The Nursing Director presented the minutes of the meeting of the Safeguarding Adults Strategic Board held on 21 December 2015.

The Chair thanked the Nursing Director for the minutes.

RESOLVED: That the minutes be noted.

039/16 MINUTES OF THE SAFEGUARDING CHILDREN STRATEGIC BOARD MEETING HELD ON 21 DECEMBER 2015

The Nursing Director presented the minutes of the meeting of the Safeguarding Children Strategic Board held on 21 December 2015.

The Chair thanked the Nursing Director for the minutes.

RESOLVED: That the minutes be noted.

040/16 ANY OTHER BUSINESS

None.

041/16 QUALITY COMMITTEE WORK PLAN

Members updated the Committees workplan as follows :

- The Committee would receive one divisional presentation instead of two divisional presentations at each meeting. **MW**
- The Infection Control Annual Report will be presented to the June meeting of the Quality Committee.
- The Acute Trust Dashboard is no longer available so will be removed from the workplan

RESOLVED: That the report be noted.

042/16 USE OF VIDEO AND TELEPHONE CONFERENCING FOR COMMITTEE MEETINGS

Members considered the use video and telephone conferencing and were receptive to the principle. The Chair will discuss further with the Trust Secretary. **MW**

044/16 COMMITTEE REFLECTION

The Chair invited the attendees to reflect on the meeting and the following observations were made:

- The Chair of the Trust asked that large documents being presented to the Committee are bound separately to the papers.
- Attendees found the feedback forms useful and felt it would also be useful to feedback to presenters.
- Divisions to use a set format for formal presentation.
- The overview of the Trust is not clearly reported ,reports are often divisional and should be benchmarked against other Trusts.
- SmartCare implementation – The Chief Executive reassured attendees that the decision to proceed will be made against a clear

set of criteria.

045/16 DATE OF NEXT MEETING

The next meeting of the **Quality Committee** will be held on **Friday 15 April 2016** in the **Boardroom, 1 College Lawn, Cheltenham** commencing at **9.30am**.

The meeting ended at 1:10pm

Chair
15 April 2016

ITEM 9

SUMMARY OF THE MEETING OF THE EQUALITY COMMITTEE HELD ON 14 MARCH 2016

PAPER (To follow)

Mr Clive Lewis
Chair

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – MARCH 2016

REPORT OF THE CHIEF EXECUTIVE

1. National

1.1 Our Trust accepted the proposed financial control total for 2016/17 set by Monitor. However it would appear that a significant number of providers have not. At this time is unclear how this will be resolved nationally and whether there is an impact on our organisation.

2. Regional

2.1 The West of England Academic Health Science Network (AHSN) held its quarterly Board meeting earlier this month. It was reported that the AHSN had been selected as one of only two national innovation test beds. The chosen topic is diabetic self-management and is described at Annex A.

2.2 One of the key strands of activity is the creation of new products to address healthcare issues. The AHSN is proposing creative ways of achieving this aim and at Annex B is an example of co-design between patients and companies.

2.3 The minutes of the latest Board meeting are at Annex C.

3. Regulators

3.1 Monitor have issued their analysis of Quarter 3 performance. Our Trust has been given a rating of 3 for financial sustainability. With regard to Governance they have decided to open an investigation because of the ongoing poor performance on the 4 hour A&E target.

4. Our Trust

4.1 The Junior Doctors section of the Bristol Medical Association have decided to pursue further industrial action over March/April. Plans have been put in place to maintain safe services.

4.2 Progress on the implementation of Phase 1 of SmartCare has been reviewed. The key elements of Patients Administration, Emergency Department, Maternity and Operating Theatres remain on track but a formal Go/No for decision will be taken at the beginning of April. Pathology and Pharmacy Stock Control will no longer be part of Phase 1 but will be scheduled for later in 2016. There is no change to Phase 2 timing in November.

4.3 The following consultants have been appointed

Ophthalmology	-	Mr Paul Tomlins
	-	Mr Fadi Alkerdahji
Elderly Medicine	-	Mr Nooeleen Nandi

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

You Said	We Did
Difficulties contacting paediatric department via LUCY telephone system	System has been updated to improve paediatric contact details.
Issues with waiting time information in Phlebotomy outpatients	Changes to the waiting time information display system have been made to ensure it reads more clearly
Patient's GP did not receive letter regarding medication in timely manner	In future letters to faxed to GP's to ensure timely sharing of information.

4.4 The Risk Register is at Annex D.

Dr Frank Harsent
Chief Executive

March 2016

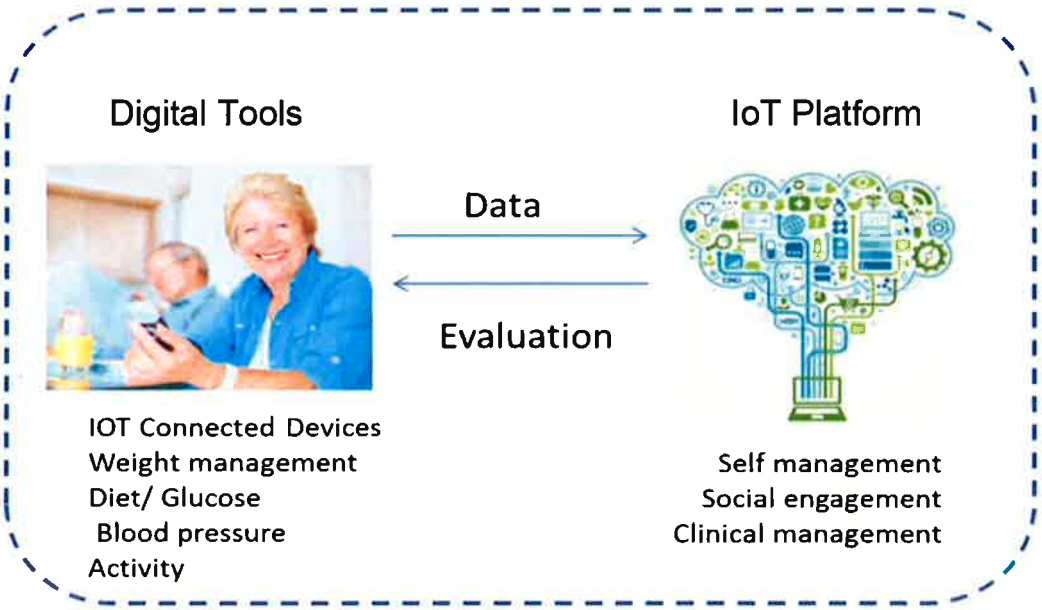
Diabetes Digital Coach

NHS Test Bed for the West of England

The West of England region has been selected as an innovation test bed to help people with diabetes self-manage their condition in the future using remote monitoring and coaching technology. It is one of seven test beds that have been announced by the NHS around the country as part of a major new drive to modernise the delivery of healthcare.

What will the programme do?

The Diabetes Digital Coach programme is led by the West of England Academic Health Science Network, with a range of technology & evaluation partners. It will bring together digital health self-management tools (such as wearable sensors and supporting software) with the latest developments in connecting monitoring devices – the Internet of Things (IoT). The Test Bed will enable people with Type 1 or Type 2 diabetes to 'do the right thing at the right time' to self-manage their condition, and will encourage more timely and appropriate interventions from peers, healthcare professionals, carers and social networks.



Jacqui Ferguson, Senior Vice President & General Manager for Enterprise Services UK & Ireland at Hewlett Packard Enterprise, said: "Digital innovation and collaboration are at the heart of how HPE brings value and as such, we look forward to working with partners in the West of England on the application of this Test Bed to achieve effective diabetes self-management."

Mary Hutton, Executive Sponsor of the Diabetes Digital Coach Test Bed and Accountable Officer at NHS Gloucestershire Clinical Commissioning Group (CCG) said: "This exciting technology offers the NHS an opportunity to test out innovative and new ways of working that will inform and empower patients to take control of their diabetes. NHS Gloucestershire CCG is pleased to be an active partner in this programme over the next few years."

What does it mean for people with diabetes?

Over two years, the project will be looking for 12,000 people with diabetes across the West to come forward and participate in the Test Bed. 'Diabetes Digital Coach' will involve using and evaluating a range of technologies that can support self-management, from wearable sensors to online apps that can monitor insulin levels. It aims to deliver a range of benefits for those with diabetes, including providing a real time view of their own data to enable them to take prompt actions to prevent their condition deteriorating. They can also share their information with others including healthcare professionals.

Sandra Tweddell from Bristol has lived with Type 1 diabetes since 1961 and has been involved in the design of the Diabetes Digital Coach programme said: "I am so excited by the Diabetes Digital Coach Test Bed. In the absence of a cure for diabetes, technology offers a way of giving immediate information about your diabetes control so you can manage it better and prevent or delay the complications that can go with the condition.

"Technology can be used to enable true partnership between the GP, consultant or practice nurse and the person with diabetes. Diabetes Digital Coach is a really exciting initiative as, if successful, it will enable more people to better manage their diabetes, hopefully reducing the awful complications that go with the condition."

Claire Gordon, South West Regional Manager for the charity Diabetes UK, said: "This is a great project because it will provide patients with joined-up information, allowing them to take control of their diabetes and manage it more appropriately to live well with their diabetes."

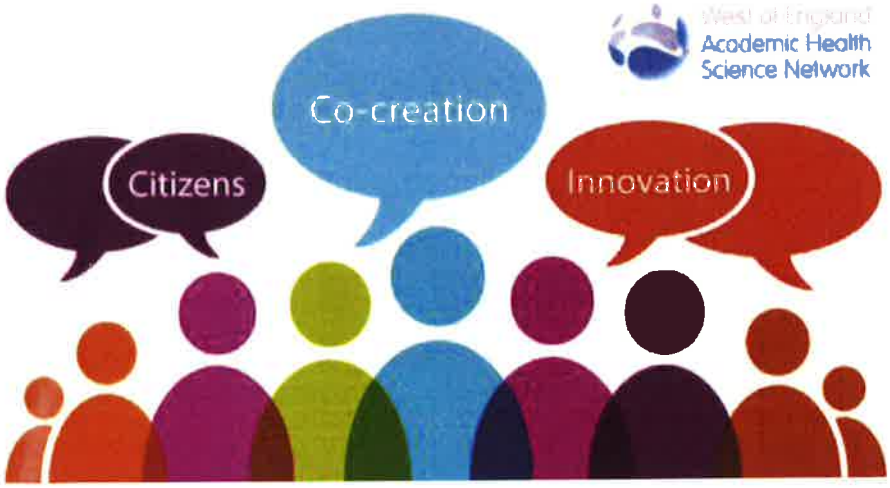
What healthcare organisations are involved?

- All seven Clinical Commissioning Groups (CCGs) in the West of England (Bath & North East Somerset, Bristol, Gloucestershire, North Somerset, South Gloucestershire, Swindon, Wiltshire)
- Royal United Hospital Bath NHS Trust
- North Bristol NHS Trust
- SEQOL
- Sirona Care and Health
- Bristol Community Health

How can I find out more?

Contact the Diabetes Digital Coach Team at enterprise@weahsn.net

ANNEX B



West of England Academic Health Science Network

The Wisdom of the Crowd

19 April 2016 09:30 - 16:00

Hilton Swindon, SN5 8UZ

Register now

This meeting focuses on the increasing role that patients play in the **co-design** and **co-production** of new products. Clearly people living with health conditions are in a great place to see what design features are needed in new products. This implies developing a new dialogue between **patients** and **companies** and new ways of gathering user input.

We will be exploring the role that **digital platforms** and **structured ideation** design methodology plays in gathering **user input** and **beta testing** of new products. We will also be exploring case studies of patients who have decided take their ideas forward to market themselves and some of the issues they have faced on this journey.

The West of England AHSN will also be launching its new **Citizen Innovation Platform** and you are invited to come and help us co-design it at the event.

This event's of interest to:

- Healthcare innovators & businesses
- Healthcare professionals & academics
- Patients, carers, family & friends
- The voluntary community

Confirmed speakers:

- Michael Seres - Founder, 11Health
- Kevin Mashford - CEO, Mi Heart
- Lars Sundstrom - Director of Enterprise, West of England AHSN

Contact us:
Email: events@weahsn.net
Tel: 0117 900 2543

ANNEX C

Report from West of England Academic Health Science Network Board,

2 March 2016

1. Purpose

This is the eleventh quarterly report for the Boards of the member organisations of the West of England Academic Health Science Network.

Board papers are posted on our website www.weahsn.net for information.

2. Business Plan 2016/17

We won't know our financial allocation for 2016/17 before the end of March, but are working on the basis that most of the work will be a continuation of our current, well supported programmes.

At this stage it seems that new projects will include:

- A second phase of our popular crowd sourcing project "DesignTogether, Live Better" – this time with a distinctly digital flavour. The kick-off event "The Wisdom of the Crowd" on 19 April 2016 is filling up fast. Contact Nada for more information – nada.khalil@weahsn.net
- Avoidable mortality - our Acute Trusts are keen to work together on mortality reviews, sharing good practice. We will support this and bring patient contributors and primary care colleagues into the collaboration.
- Health Education South West are funding us to coordinate their new, grassroots approach to developing new models of care and addressing workforce issues in GP practice and wider primary, community and social care. This helps us to build on our primary care support to commissioners and our QI /patient safety work in this setting
- Improving wound care – bringing expertise and innovation from the Welsh Wound Improvement Centre we will be working across district nursing and community nursing in Swindon to support better wound care through quality improvement and skills development.

A couple of strategic developments in this year's Business Plan discussions are:

- We have had some good discussions with chairs, CEOs and clinical leaders about how we might support West of England organisations to develop a combined approach to rapid implementation of product innovation and service improvement. Two angles on the same process we think.
- How the AHSN can best support effective Sustainability and Transformation Plans – we've had lots of feedback that people value what we do now, would like more signposting towards best practice and would like further conversation about how far to change our approach towards community wide working. It was good to hear that senior leaders are happy with how we're doing things now.

3. Highlights and next steps from our work streams

We continue to report very high levels of momentum in our work and this is because we have huge levels of engagement from commissioners, providers, our Universities and wider partners:

- Diabetes Digital Coach Test Bed: after the celebrations at winning this high profile national competition we are now getting to grips with governance and making clear arrangements for this 27 month experiment with our member organisations and the companies. We will report progress quarterly and have learning events so everyone can join in.
- Health Innovators programme – the second programme is running in the first and second weeks of March with 16 participants who want to learn how to turn their entrepreneurial ideas into viable business cases.

- ‘Don’t Wait to Anti Coagulate,’ our stroke prevention programme was scored by the other 14 AHSNs as the top adoption and spread project and one that they would be willing to adopt. We now have baseline results from 18 GP practices in Gloucestershire and are on track to save 90 people from having a stroke. People in Bristol will be the next to benefit as Bristol CCG takes this on in 2016/17.
- The Health Foundation have accredited us as the third Flow Academy in England joining Sheffield and South Warwickshire in being able to train flow coaches. RUH are working on 3 pathways and will share their learning.
- All 7 CCGs are inviting GP practices to volunteer for a primary care patient safety collaborative which will work initially on incident reporting.
- The Emergency Department safety checklist is in great demand and has impressive results. We are supporting all the EDs in the West of England to implement it through a collaborative approach. Colleagues from all over the country have asked to use it and we are running a masterclass on 25 April 2016 for all comers.
- March is the first birthday for our project to spot and treat deteriorating patients quickly. Every commissioner and provider in the West of England is active in this work to use the National/Early Warning Score across every single interface of care and SWAST are at the heart of this work.
- We held a very successful informatics event on 23 February 2016 which included a meeting of the Chief Clinical Information Officers network. The AHSN is supporting health community Digital Road Map events.
- Our Evidence and Evaluation Toolkits will be published on their own websites on 22 March 2016 and we warmly encourage you to use them and give us feedback. We will also offer a free two hour workshop on each of “Finding the Evidence” and “Getting started with Service Evaluation” to complement the toolkits in every CCG over the next 3 months.
- We continue to support the implementation of the West of England Genomics Medical Centre by leading the Public and Patient Involvement Steering Group and contributing to other work streams such as the education and training Steering Group. We supported the UWE bid to run the Genomics MSc which has now been awarded to Exeter University.

4. Find out more

Our e-newsletter is out click on:
http://us8.campaignarchive1.com/?u=f0307060daac60c96aab19b07&id=457348f4c7&e=57daf01a1b

Deborah Evans, March 2016

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

TRUST RISK REGISTER –March 2016 **ANNEX D**

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 o Addressing three main areas of concern ▪ Demand ▪ Staffing (Medical & Nursing) ▪ Beds and capacity • Monthly Emergency Care Board report • Delivery of relevant QIPP plans & CQuINs • 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	5 (4)	5	25 (20)
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 .	• 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	3	5	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 • Performance notice issued by CCG to ARRIVA • Increased scrutiny of Stretcher bookings and Same day bookings of Anbulances	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

Risk	Controls	Responsible Director	Assurance Committee	Review date	Likelihood score	Impact score	Risk rating score
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
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 completed and action agreed • Divisional Governance Monitoring	Medical Director	Quality committee Mortality Review Group	Monthly	4	4	16
N 2276 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

Risk	Controls	Responsible Director	Assurance Committee	Review date	Likelihood score	Impact score	Risk rating score
IT-2246 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
New Risk Due to acute staffing shortages and increased activity the Palliative care team are unable to provide the necessary responsive and comprehensive service .Short term measures are in place for essential elements of the service.	• Locum cover for consultant staff • Business case to address o IDT cover for Oncology o Increased staffing for palliative care	Medical Director CoS D&S	TMT	Monthly	4	4	16

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD

OPERATIONAL PLAN 2016/17

1. Background

1.1 As part of the national planning guidance, every NHS provider trust is required to submit an operational plan by 11th April 2016 covering activity, capacity and finance for 2016/17 and setting out all the relationship to the emerging system-wide Sustainability and Transformation Plan.

Although there is no template for the Narrative Plan it is expected that it addresses:

- Approach to activity planning
- Approach to quality planning including approach to quality improvement, seven day services, quality impact assessment, triangulation of indicators
- Approach to workforce planning
- Approach to financial planning
- Link to the emerging Sustainability and Transformation Plan
- Membership and Elections

Monitor will publish all Operational Plans on their website.

2. Our Operational Plan

2.1 The plan is composed of a 20-page narrative plan and a series of templates. The structure of the narrative plan builds on our Strategic Plan, our 2015/16 Operational Plan and the emerging Sustainability and Transformation Plan.

2.2 A draft narrative Operational Plan was shared with the Board in February prior to submission to Monitor. There are no material changes from the draft in this version of the plan. The plan is being considered by the Finance and Performance Committee prior to the Main Board. The figures in the plan may change following review by the Committee. The final version of this plan will be published on our website.

The presentation of our objectives for 2016/17 now include 6-month and 12-month milestones to facilitate a more robust approach to tracking progress as identified in our recent Board Governance Review.

3. Recommendations

3.1 The Board is asked to note the plan and identify any amendments to be made prior to submission to Monitor.

Author: **Dr Sally Pearson**
Director of Clinical Strategy

Date: **March 2016**

Gloucestershire Hospitals NHS
NHS Foundation Trust

Operational Plan Document for 2016/17

Gloucestershire Hospitals NHS Foundation Trust

Operational Plan for y/e 31 March 2016

This document completed by (and Monitor queries to be directed to):

Name	Dr Sally Pearson
Job Title	**Director of Clinical Strategy**
e-mail address	**sally.pearson@glos.nhs.uk**
Tel. no. for contact	**300422860**
Date	**1 April 2016**

In signing below, the Trust is confirming that:

- **The Operational Plan is an accurate reflection of the current shared vision of the Trust Board having had regard to the views of the Council of Governors and is underpinned by the strategic plan;**
- **The Operational Plan has been subject to at least the same level of Trust Board scrutiny as any of the Trust's other internal business and strategy plans;**
- **The Operational Plan is consistent with the Trust's internal operational plans and provides a comprehensive overview of all key factors relevant to the delivery of these plans; and**
- **All plans discussed and any numbers quoted in the Operational Plan directly relate to the Trust's financial template submission.**

Approved on behalf of the Board of Directors by:

Name *(Chair)*	Prof Clair Chilvers

Signature

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	Dr Frank Harsent

Signature

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	Mrs Helen Simpson

Signature

GLOUCESTERSHIRE HOSPITALS NHSFT
OUR PLAN FOR 2016/17

BACKGROUND

Gloucestershire Hospitals NHS Foundation Trust is one of the largest hospital trusts in the country and provides high quality acute elective and specialist health care for a population of more than 612,000 people. Our hospitals are district general hospitals with a great tradition of providing high quality hospital services; some specialist departments are concentrated at either Cheltenham General or Gloucestershire Royal hospitals, so that we can make the best use of the expertise and specialist equipment needed.

During 2015/16 we reviewed how we wanted to express our ambitions for our services (our vision). Our **Framework for the Future** is now made up of:

Our Mission:
"Improving health by putting patients at the centre of excellent specialist health care"

Our Vision:
"Best Care for Everyone"

Our Goals:
Our goals are described in 4 core areas:

Our Services: to improve year on year the safety of our organisation for patients, visitors and staff and the outcomes for our patients

Our Patients: to improve year on year the experience of our patients

Our Staff: to develop further a highly skilled and motivated and engaged workforce which continually strives to improve patient care and trust performance

Our Business: to ensure our organisation is stable and viable with the resources to deliver its vision

Our Values:
Our Values underpin everything we do and describe, in single words, the way we expect our staff to behave towards our patients and their families and carers, and colleagues. After listening to patients and staff the Trust has identified six core values, described here in the words of patients. These are:

Listening
Patients said: "Please acknowledge me, even if you can't help me right now. Show me that you know that I'm here."

Helping
Patients said: "Please ask me if everything is alright and if it isn't, be willing to help me."

Excelling
Patients said: "Don't just do what you have to, take the next step and go the extra mile."

Improving
Patients said: "I expect you to know what you're doing and be good at it."

Uniting
Patients said: "Be proud of each other and the care you all provide."

Caring
Patients said: "Show me that you care about me as an individual. Talk to me, not about me. Look at me when you talk to me."

Our Strategic Plan

Our Strategic Plan, published in June 2014 and refreshed in April 2015, sets out our approach to meet our vision, by identifying the following strategic initiatives aligned to our goals

Goal	Strategic Objective
Our Services	
To improve year on year the safety of our organisation for patients, visitors and staff and the outcomes for our patients	To continue to improve the quality of care we deliver to our patients and reduce variation
	To continue to align our services between our sites
	To future proof our services through clinical collaboration
	To improve the health and wellbeing of our staff, patients and the wider community
Our Patients	
To improve year on year the experience of our patients	To continue to treat our patients with care and compassion
	To provide care closer to home where safe and appropriate
Our Business	
To ensure our organisation is stable and viable with the resources to deliver its vision	To improve our internal efficiency
	To improve our clinical estate
	Harnessing the benefits of information technology
	Exploiting the opportunities for new markets
Our staff	
To further develop a highly skilled, motivated and engaged workforce which continually strives to improve patient care and Trust performance	To develop leadership both within our organisation and across the health and social care system
	To redesign our workforce

THE NATIONAL CONTEXT

The Comprehensive Spending Review in November included an £8.4 billion real terms increase in funding by 2020/21. With this funding the NHS in England is expected to implement the Five Year Forward View, restore and maintain financial balance and deliver core access and quality standards. These expectations are reflected in the Government's Mandate to NHS England, setting out overall goals for 2020 and deliverable objectives for 2016/17. https://www.england.nhs.uk/wp-content/uploads/2015/12/05.PB .17.12.15-Annex-A-Mandate-to-NHS-England.pdf

All elements of the NHs are required to demonstrate how they will play their part in achieving these goals through two separate but connected plans:

- A place based five year Sustainability and Transoformation Plan (STP)
- A one year organization based Operational Plan

THE LOCAL CONTEXT

The size of **the population we serve** is continuing to grow and is ageing. The risk of all major causes of early death and serious illness increases with age. This means that the number of people living longer with a long-term illness will rise much more quickly than the growth in the population. Care for people with multiple long term conditions is often very complex.

The **vision for Gloucestershire**, agreed across the health and social care system is:
"to improve health and wellbeing, we believe that by all working better together – in a more joined up way – and using the strengths of individuals, carers and local communities, we will transform the quality of care and support we provide to all local people".

How we intend to achieve this vision is set out in the Joining Up Your Care Strategy. Work on this strategy in 2015/16 has allowed the health and social care organisations in Gloucestershire to estimate that, if nothing changes, the sector in Gloucestershire would be facing a combined deficit of in the order of £250m by 2025. Securing sustainable services in response to this challenge will require transformational change in the way in which we deliver our services. This scale of change is only achievable through organisations working together.

This commitment to collaboration is reflected in the Gloucestershire devolution bid.
We are Gloucestershire sets out our devolution 'asks' of government and 'offers' from Gloucestershire, so we can drive economic growth and public sector reform.
Devolution would not replace existing organisations, but would have representation from them. It would however build on the close working relationships we already have, removing red-tape, making it easier to work together helping remove duplication, and making it easier to share resources and expertise.
We are Gloucestershire is endorsed by the county council, the six district councils, the the Local Enterprise Partnership (LEP), the Gloucestershire Constabulary, the Office of Police and Crime Commissioner and Gloucestershire NHS Clinical Commissioning Group, who commission the majority of our services. They have indicated their priorities for 2016/17 as:

- Deliver the **Enabling Active Communities** strategy, improve **Health and Well-Being** through prevention and self care
- Focus on **Primary Care and Locality Development** to ensure the future sustainability of this critical part of our system
- Work with system partners through **Clinical Programmes Approach** to improve pathways for people in Gloucestershire
- The CCG will ensure a continued focus on achieving **Parity for Mental Health and Learning Disabilities** for our population
- **One Place, One Budget, One System** to develop a place based approach to service delivery, New Models of Care and delivery of ongoing integration of our health and care system

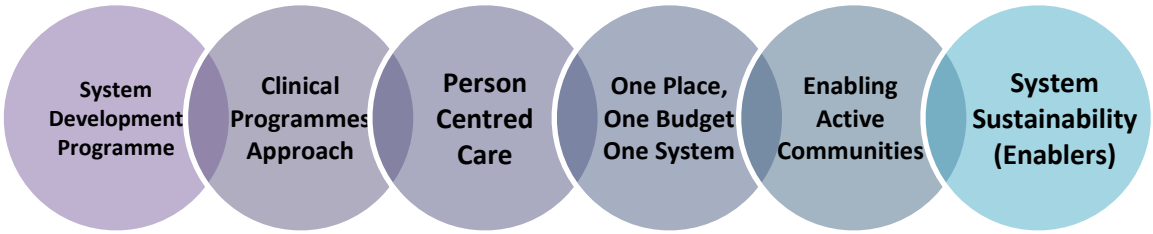
- Develop our approach to delivering **Person Centred Care**
- Work with health and social care partners on our shared **System Development Programme**
- Continuous focus on **System Sustainability**

OUR SUSTAINABILITY AND TRANSFORMATION PLAN

All health and social care organisations in Gloucestershire, have been working together to develop a Sustainability and Transformation Plan which will set out our ambitious blueprint across the health and social care system for addressing the three pressing gaps identified in the 5 Year Forward View

- the health and wellbeing gap, requiring a radical upgrade in prevention
- the funding gap, requiring efficiency coupled with investment
- the care and quality gap requiring major system changes and new models of care

The following headline priorities have been identified for a system wide Sustainability and Transformation Plan



We are confident that our Strategic Plan is consistent with these priorities.
However, as a system we recognize that the footprint of Gloucestershire may be too small to enable us to drive change at sufficient scale or to secure the longer term sustainability of some of our more specialized services.

Over the coming months we will be working with partners both in Gloucestershire and in neighbouring health and social care systems to develop shared objectives that both support the transformational change required and ensure that each organisation can meet the expectations of them as legal entities.

The outcome of these deliberations will be reflected in a Sustainability and Transformation Plan to be published in June.

OUR OPERATIONAL PLAN FOR 2016/17

This Operational Plan builds on our 5 year Strategic Plan published in June 2014.
http://www.gloshospitals.nhs.uk/SharePoint3/Communications%20Web%20Documents/CorpDocs/GHNHSFT-Strategic-Plan-2014.pdf

It sets out how we are going to respond to changes in our context, both national and local, to enable us to have the flexibility and capacity to overcome short term difficulties (resilience) and make progress towards our 5 year strategy (sustainability).

OUR APPROACH TO QUALITY

Delivering high quality healthcare is at the heart of our mission and vision. For this reason our Chief Executive is the lead executive for quality, supported by the Medical Director, the Nursing Director, the Director of Clinical Strategy, the Director of Safety and the Head of Patient Experience.

Our Quality Committee, with representation from Non executives, executives, governors and commissioners leads our quality agenda. The committee meets monthly.

We have three trust wide priority quality programmes

Our SAFER Programme

This national programme is based around the SAFER patient flow bundle which is similar to a clinical care bundle. It is a combined set of simple rules for adult inpatient wards to improve patient flow and prevent unnecessary waiting for patients.
If we routinely undertake all the elements of the SAFER patient flow bundle we will improve the journey our patient's experience when they are admitted to our hospital.

S - Senior Review. All patients will have a Consultant Review before midday.
A - All patients will have an Expected Discharge Date (that patients are made aware of) based on the medically suitable for discharge status agreed by clinical teams.
F - Flow of patients will commence at the earlier opportunity (by 10am) from assessment units to inpatient wards. Wards (that routinely have patients transferred from assessment units) are expected to 'pull' the first (and correct) patient to their ward before 10am.
E – Early discharge, 33% of our patients will be discharged from base inpatient wards before midday. TTO's (medication to take home) for planned discharges should be prescribed and with pharmacy by 3pm the day prior to discharge wherever possible to do so.
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 clinical leaders supported by operational managers who will help remove constraints that lead to unnecessary patient delays.
During 2016/17 we will implement a plan that is designed to improve our performance over all elements of the bundle

Our Seven Day Services Programme.

The implementation of consistent care irrespective of the time or day is a cornerstone of improving the quality of our services. During 2015/16 we appointed a Programme Director to provide leadership for this important area of work, appointed more consultants, and extended ward clerk cover to 7 days, to free clinicians to care. Our plan for 2016/17 has been informed by an analysis of where we have gaps against the 10 national standards for a seven day service and a pilot project in our respiratory services. It will focus on:

- presence of senior decision makers supported by multi disciplinary teams focused on rapid identification and implementation of care plans for older people
- realignment of some of our services to reduce duplication
- Enhanced availability of diagnostic and support services
- Roll out of criteria based discharge

The Trust also leads a countywide steering group on behalf of the Clinical Commissioning Group with all other providers across the health and care systems represented. The Group has a single 7 Day Services vision and cross-provider working groups explore areas where working closer together can improve the overall service. Our system wide plan to achieve compliance across all four clinical standards by 2020 will be set out in the Sustainability and Transformation Plan
(DN link to investment table)

Our **Smartcare Programme**

This will deliver an information system which is innovative, efficient, effective, safe, accessible and reliable, helping us improve patient care and save money. It will enable our staff to be able to access the information they need about a patient, when they need it, wherever they are. At its core will be an Electronic Patient Record that:

- Is kept constantly up to date and available to key staff involved in each patient's care
- Improves patient safety by, for example, highlighting special needs, allergies and past
- medication doses
- Supports clinicians in taking decisions on treatment, with prompts to take action or to carry
- out tests
- Speeds up the ordering and turnaround of tests, such as blood and tissue analysis
- Puts an end to the difficulties posed by missing notes

- Reduces medication errors
- Means patients shouldn't need to repeat the same information to different staff
- Reduces or eliminates the use of paper

The Countywide "Joining Up Your Care" project will allow clinical teams across organisations to share information, improving safety and continuity of care for patients.

In addition to these corporate quality improvement programmes, the Quality Committee have agreed specific quality objectives for 2016/17 that reflect:

- the national priorities
- our learning from our recent Care Quality Commission inspection
- our performance
- input from staff, governors, commissioners, and patient representatives, including Healthwatch and our Health Overview and Scrutiny Committee.
- The Government's three-year **Sign up to Safety campaign** which is designed to help realise the ambition of making the NHS the safest healthcare system in the world by creating a system devoted to continuous learning and improvement. Plans are should be built around the following five core pledges:
    - Put safety first
    - Continually learn
    - Honesty
    - Collaborate
    - Support

Our quality objectives for 2016/17 are included in our corporate objectives for 2016/17 set out in section x, and covered in detail in our Quality Report for 2015/16 published in June.

Our Safety and Quality Improvement Academy

The Gloucestershire Safety & Quality Improvement Academy was established at Gloucestershire Hospitals NHS Foundation Trust in June 2015.

Through our courses, our students are provided with the knowledge, the skills, the opportunity and the support to contribute to patient safety and to make practical improvements to the way we provide care in our hospitals.

Our aim is that our structured programmes will contribute to the development of a culture of continuous quality improvement within our Trust, where staff at all levels have the confidence to highlight areas for improvement and then have the skills, knowledge and support to be able to implement improvements.

Our Quality Impact Assessment Process

Every provider should have an effective process to assess the impact of any cost improvement programme to guard against any unintended adverse impacts on the quality of care we provide.
Cost improvement initiatives are generated through a variety of mechanisms including ideas from teams themselves, benchmarking activities and input from external bodies. All proposals, whether for investment or disinvestment are supported by business cases which include a requirement for an impact assessment. Cases are reviewed within the relevant division and then at our monthly Efficiency and Service Improvement Board, which has representation from all divisions and all Executives, including the Medical Director and the Nursing Director. This provides a mechanism to check there are no unintended consequences on the quality of care. Only cases that have the support of this group progress. With closer collaboration between us and other providers we hope to extend this process across organisations to ensure that a cost improvement proposal in one organisation does not have an adverse impact on the care provided elsewhere.

The Quality Impact Assessment provides assurance relating to the impact of quality before a proposal is implemented, but it is equally important that we regularly check to ensure that we are maintaining the balance between quality and efficiency. Each month the Board receives the Integrated Performance Report. This report contains 77 carefully selected measures which align with our 4 goal areas, including measures of quality, workforce and finance. An example is available through the following link:

http://www.gloshospitals.nhs.uk/SharePoint2/Board%20Papers/2016/January%202016/Item%2012%20-%20PMF%20-%20Complete.pdf

In addition our Quality Committee reviews an extensive range of quality measures and our nursing metrics, which relate staffing levels on the ward to measures of harm.

The environment within which we are operating remains highly challenging. The top three risks to us being able to maintain quality services and our plans for mitigation are included in the table below.

Risk	**Mitigation**
Inability of the local health and social care system to manage demand within the current capacity	This is a priority area for the whole health system. Arrangements are in place to monitor demand and trigger escalation policies This will be a priority for our sustainability and transformation plan
Failure to match the workforce profile with the clinical / service needs of the organisation	See "Our Approach to Workforce Planning" (below)
Failure to maintain our physical estate to meet the requirements for high quality health care	Our capital programme includes investments to replace essential equipment and maintain our existing estate. We have plans for the development of both of our sites and limited resources have been identified in our capital programme to allow us to make some progress. Alternative funding sources will be required if we are to fully realise these plans

OUR APPROACH TO WORKFORCE PLANNING

We recognise that the development of our staff is critical to our ability to deliver our Vision of **Best Care for Everyone**. At the heart of our plan is our organisational development programme which seeks to embed this vision by reflecting it in everything we do.
In 2016-2017, we will continue to invest in the ongoing recruitment, retention and support of an appropriately skilled, qualified and experienced workforce to meet the challenging demands with which we are faced. However, we also acknowledge that transformation of the workforce presents a significant opportunity in terms of the delivery of financial balance and the improvement of operational efficiency. As at month 7 of 2015-2016, substantive workforce costs represented 62% of our total Trust spend, and all workforce costs (including agency and locum) represented 66% of our total Trust spend. Whilst these figures suggest we are already a relatively lean Trust, we believe there is further scope for the delivery of workforce-related improvement and efficiency savings particularly through compliance with the Monitor agency regulations and the reduction of agency spend.
Our approach to both long and short term workforce planning is now well-embedded as part of the overall planning cycle. The process is clinically-driven, with plans developed and owned at Speciality level, allowing staff the autonomy to develop plans which are meaningful and achievable. As part of the planning process, Clinicians and Managers work together to identify risks and issues in terms of their current and future workforce, and to develop associated plans to address these concerns. The Trust workforce planning framework highlights considerations such as succession, training and development, encouraging the formation of a plan which is holistic and wide-ranging, whilst also explicitly linked to the Speciality's specific ambitions in terms of service delivery. These plans are maintained within Clinical Divisions, but also aggregated into a Trust-wide plan, which is approved at Board level through discussion with the Executive Director of HR and OD. This plan is then used to inform internal planning and workforce development, as well as external engagement with our local and regional partners and colleagues. Specifically, this Trust-wide plan drives much of our engagement at regional level, informing the discussions with the Local Education and Training Board around education commissioning and securing appropriate pipelines of future workforce supply.
2015-2016 has also seen the establishment of a County-wide workforce planning group within Gloucestershire, of which our Trust is a member, with the goal of developing robust strategic and operational workforce plans for the County (based on our local priorities and commissioning objectives), and taking collective responsibility for securing our future workforce supply. Given the criticality of workforce planning for the future, we have recognised the need to build our internal knowledge and skills base within the Trust; in 2015-2016 we supported a number of individuals in undertaking both professional qualifications and short courses on workforce planning, with the aim of developing an internal network of workforce planning experts who can share expertise and encourage best practice in this important arena.

Workforce transformation

Looking ahead, we have a number of **Workforce initiatives** in place to address the workforce redesign and transformation elements of our Trust objectives. We know that ongoing challenges in medical workforce supply, combined with expected shortages at Junior and Middle grade Doctor level and the national imperative to deliver 7 day services, have the potential to create an unsustainable fragility in our medical workforce, and therefore in the delivery of clinical services. In response to this, we are exploring a range of possible solutions that focus on **Sustaining Clinical Services**, and will continue with the scoping and delivery of these as appropriate, including:

- The expansion of the Advanced Nurse Practitioner role to complement, and in some cases replace, Medical staff.
- The development of the Pharmacy Prescriber role, exploring ways in which prescribers could work in teams with non-prescribing clinical colleagues so as to release clinical time.
- The continued development of the Therapy services within the Trust to ensure that all opportunities for the provision of these services are maximized.

- The identification of opportunities to streamline administration as far as possible, and ensure that Clinical time is not being spent unnecessarily on administrative tasks.

Leadership development will continue to be a priority for us, recognising the emphasis placed on high quality leadership in both the 5 Year Forward View and Lord Rose's recent review. We will continue to support staff at all levels both internally (through coaching and development programmes) and externally (through the provision of opportunities to participate in the Leadership Academy's range of Development activities). A strategic approach to Talent Management and Succession planning is being developed and embedded to ensure we have a resilient and secure Leadership infrastructure in the future.

The development and promotion of the **Wider workforce** (Bands 1 – 4, including Apprentices) has been a significant growth area for the Trust in recent years and this will continue with widespread support and investment dedicated to developing this cadre of staff, and extending our already significant number of Apprentices. This will become increasingly important in the context of ensuring that the Apprenticeship levy does not impact detrimentally on our financial position.

Within nursing, recognising the national landscape and challenging issues around workforce supply, we are continuing with the implementation of a comprehensive **Nurse Recruitment Strategy**. The principal focus of our Nurse Recruitment strategy for 2016-2017 will be to recruit nurses continually through a range of different supply sources as follows:

- **Newly qualified Nurses**; we intend to raise our employer profile and promote our "Extraordinary Everyday" brand such that we are able to attract large numbers of newly qualified Nurses from our traditional "feeder" University and beyond.
- **Filipino Nurses;** progress with Non-European recruitment was severely inhibited during 2015 due to the significant restrictions on visas and the requirement for Non EU candidates to hold an International English Language Qualification (IELTS). The (temporary) placement in November 2015 of Nursing on the Shortage Occupation List enabled us to progress with recruitment in the Philippines with great success. On this basis, continued recruitment activity from this country will be a significant component of our 2016-2017 Nurse recruitment strategy. Having invested in developing our in-house recruitment team to the extent that we have been able to cease using UK-based agencies for this recruitment activity, we are delivering a saving (cost avoidance) to our Trust, whilst continuing to provide a high level of activity in this area.
- **UK-based overseas qualified Nurses**.
- **UK based experienced Nurses.**

Given the challenged position in which we find ourselves, we expect our Nursing deficit to remain throughout 2016-2017, but towards the end of the year we should begin to see progress in terms of bringing about an improved level of Nursing staffing. We do not view this as an acceptable position, and will continue to work to improve the supply of Nurses into our Trust, with the goal of bringing about this projected improvement as quickly as possible, but we are operating in an extremely competitive marketplace and it is likely that supply issues relating to the Nursing workforce are likely to be a significant feature of our workforce activity for the whole of 2016-2017.

Workforce efficiency and the delivery of CIP

2016-2017 will see a continued focus on the development and delivery of robust and effective plans to deliver greater workforce efficiency and workforce-related CIP. This process will be managed through our Delivery Board, meeting on a fortnightly basis and reporting to our Efficiency and Service Improvement Board (a sub-committee of the Trust Board). Through these groups, all workforce (and other) CIP schemes will be subject to rigorous evaluation prior to approval, and then to ongoing monitoring to ensure appropriate delivery without any negative impact on quality. It is anticipated that these schemes will be Divisional in nature, and will include both transformational and tactical change.

It is anticipated that the Workforce CIP contribution for 2016-2017 will be derived from a range of different projects and programmes, including:

- Reduction in temporary staffing expenditure in medical, nursing and other staff categories (see below).
- Increased efficiency across Trust support functions, leading to a reduction in the number of Admin and Clerical staff employed by the Trust (through natural attrition and redeployment where appropriate, not redundancy or MARs).
- Improved workforce efficiency in senior level staffing and across supervisory grades.

Agency engagement and reliance

A critical workforce priority for 2016-2017 will be reducing our reliance on temporary staff, particularly nursing agency. This will provide a significant contribution to the delivery of Workforce CIP, but will also support the delivery of our Vision through ensuring high quality care and better continuity of staffing. The recruitment challenges identified above are a significant contributory factor in our use of agency staff, and on this basis our projected nursing shortfall will continue to mean some temporary staffing use is inevitable, given that our priority to is to maintain safe and high quality service provision. However, our goal for 2016-2017 is to reduce that agency use to an absolute minimum, and to address the need for additional staffing through the use of our own bank (which we plan to grow) wherever possible. The issues around agency engagement and utilisation are varied and complex, however in addition to our recruitment agenda, we are taking a number of other steps to minimise our use of, and expenditure on, agency staffing:

- We recognise and welcome the opportunity afforded by the recent introduction of rules relating to agency engagement. Our plan for 2016-2017 is to ensure full compliance with all of these, as follows:
    - Annual ceiling for spend – at present we are working to bring our agency spend in line with the agreed trajectory level of 6% (agency spend, as a % of total nursing pay spend), ready to decrease further throughout 2016-2017 to reach the agreed end goal of no more than 3% of all nursing pay spend being agency costs. Whilst in percentage terms these are relatively small margins, the scope for delivering material reduction in spend is significant.
    - Mandatory use of frameworks for nursing agency staff – we will be working towards full compliance with this requirement during 2016-2017, with a move to using a small number of preferred suppliers through approved frameworks.
    - Hourly cap on rates for nursing, medical and other staff groups – since the introduction of these caps our compliance has steadily increased week-on-week, and we expect this trend to continue throughout 2016-2017.
- Utilisation of existing resource: In recognition of the challenges of external recruitment, we are working hard to ensure we increase our retention rates as far as possible, and use our existing resource as effectively as we can; this will continue to be a key focus for 2016-2017. In line with this, and in light of the fact that our participation rate within Nursing is relatively low (at around 84%), we will seek to incentivise our existing staff working additional hours to contract, on the basis that offering enhanced pay arrangements to substantive staff is still significantly cheaper than engaging agency staff.
- Effective use of E-rostering: This is a key focus of the Carter review and we recognise the opportunity that effective use of e-rostering offers in terms of workforce efficiency. With our e-rostering system now fully implemented, the focus for 2016-2017 will be on benefits realisation, and on ensuring good rostering practice throughout the Trust.

OUR APPROACH TO ACTIVITY PLANNING

Activity planning for 2016/17 started in autumn 2015 with the four Clinical Service Divisions planning for the forthcoming coming year. Activity information was produced indicating trends over the last three years. Adjustments were made to reflect non-recurring additional levels of activity. This was followed by review meetings between each of the four Clinical Service Divisions with the commissioning team from Gloucestershire Clinical Commissioning Group at which the plans including activity levels and growth assumptions were shared. As a result we have been able to reach an agreement with the CCG on activity levels influenced by a shared agreement on growth rates.

The key uplifts are:

- Electives 2.4% (6 additional patients a working day)
- First outpatients 1.5% (15 additional patients a working day)
- Follow up outpatients 2% (27 additional patients a working day)
- Cancer 2 week wait referrals 12% (8.5 additional patients a working day)
- Cancer 62 day treatments 4.7% (0.3 additional patients a working day)
- Emergency department attendances 1.2% (2 additional patients a calendar day)
- Non elective admissions 2.5% (3.5 additional patients per calendar day)

The activity uplift for 2016/17 is assessed to be achievable within our existing capacity. Further analytical modelling of capacity is being undertaken to ensure that there is sufficient capacity for the variation in the peaks and troughs of activity rather than just planning on averages.

Elective Care and Cancer

There are no plans to increase bed or theatre capacity and the agreed marginal additional activity will be delivered through internal efficiencies from the existing programmes on patient flow; theatre modernisation and outpatient improvement. As we are already achieving the 18 week referral to treatment standard for incomplete pathways there are no additional plans to use the independent sector over and above the existing schemes in urology, general surgery and gynaecology. This position will remain under review and if there are risks to sustaining this position then discussions will take place with the two private hospitals in Gloucestershire to secure additional capacity. We will continue to work with our commissioners to manage demand within the agreed referral levels through a range of QIPP schemes.

Activity will profiled throughout the year taking into account two factors:

- The Smartcare programme - elective activity will be re-profiled and reduced immediately after the go live dates to minimize any potential impact on patient activity whilst staff familarise themselves with the new system.
- Impact of the Christmas and New Year period – to create bed capacity for the increased length of stay experienced by medical patients over end of December and early January.

Good progress is being made on improving the cancer pathways and the Trust is aiming to deliver and sustain all cancer performance targets. The accommodation of increased demand will be met by increased efficiencies and balancing with routine referrals.

Emergency Care

There has been considerable work within the Trust and across the system to tackle the current performance issues in emergency care. The focus internally through our SAFER Programme has been on;

- Improving patient flow,
- Addressing issues within the emergency departments,
- Establishing schemes to avoid admissions.

Across the system the plans and investments have focused on

- Pre hospital care – to reduce the need for patients to attend the emergency departments and provide alternatives for admissions
- In hospital – the three areas of focus in the Trust
- Post hospital – focusing on improving discharge arrangements.

The intention is for the existing schemes to continue subject to a review of their effectiveness against the agreed business cases and plans.

The achievement of all this work is critical to us being able to deliver high quality emergency care and achieve the improvement trajectory for the 4 hour emergency department standard.

To meet the anticipated bed pressures over the winter period we will be re-profiling elective capacity and re-allocating some surgery beds temporarily to medicine. Modelling work is underway to assess the scale of this change so the appropriate ward area can be identified.

Additionally the intention is to use in the region of 50 beds in nursing homes over the winter period as part of the discharge to assess model. This number is consistent with the numbers used in 2014/15 and in 2015/16 and can be safely delivered by the nursing home sector in the county.

OUR APPROACH TO FINANCIAL PLANNING

Financial Forecasts & Modelling

Our financial plan is based on the assumption that the Trust will accept the Sustainability & Transformation funding subject to agreeing improvement trajectories and milestones. In developing our financial plan the following assumptions have been used, in line with Monitor guidance.

	%age
Pay, incl pension changes	2.2
HCHS Drugs	0.4
Non Pay, non drugs	0.3
CNST	0.7
Revenue Costs of Capital	0.1
Uplift	**3.8**
Efficiency	-2.0
Net prices uplift	**1.8**

Our financial plan for 2016/17

The economic and financial environment will continue to remain challenging during 2016/17 and beyond with a 2% national efficiency challenge resulting in a net price uplift of 1.8%. In establishing the financial plan for 2016/17 we have adopted the following principles:

- We plan to achieve a £5.3m operational surplus which will increase to £18.2m upon receipt of the Sustainability & Transformation (S&T) funding allocation
- We plan to maintain a Continuity of Service rating of 3 under the risk assessment framework rising to a 4 as a result of the S&T funding.
- In agreeing contracts with our main commissioners the contracted levels of activity must be both affordable and deliverable for the Trust.
- To deliver the £5.3m operational surplus, the CIP target has been set at 4.8% of expenditure budgets. The overall savings programme will be managed and delivered at Service Line level supported centrally through both an operational Delivery Board and Efficiency and Service Improvement Board.

The Trust financial plan is summarised below, having applied the key financial assumptions detailed above:

	2015/16 FOT (£m)	2016/17 Draft Plan (£m)
Income	497.3	523.7
Pay Expenditure	-307.3	-313.7
Non Pay Expenditure	-187.8	-191.8
Operational surplus	2.2	18.2
Capital expenditure	13.3	10.0
Year-end cash position	6.4	17.5

Income
Our income plan is built on the recurrent positon from 2015/16 and has been adjusted for the full year effect of developments and recognised chargeable activity actioned in 2015/16. The inflationary uplift is in line with the tariff uplift and the growth reflects the rates agreed by the divisions and are currently being agreed with commissioners; the income plan thus reflects the current position of negotiations with our commissioners. The plan includes £12.9m of S&T funding notified to the Trust; this facilitates the delivery of the control target of £18.2m surplus.

Pay Expenditure
The largest single area of expenditure for the Trust is on its workforce. This increased during 2015/16 due to an increase in the numbers of permanent staff employed and an increase in the use of temporary staff to ensure we could continue to deliver safe services as demand for our beds increase and we opened up areas of additional capacity.

Temporary staffing costs will need to be reduced through recruitment initiatives, rostering systems and management of sickness. Our plans include a £3m net saving expected from temporary staffing spend as we fill vacant post and reduce our reliance on temporary staffing, as highlighted in the workforce planning section. We will continue with both local and overseas recruitment campaigns to address the challenges faced in recruiting both Nursing and Medical staff throughout the year, but particularly during the winter period in order to minimise temporary staffing expenditure.

Non Pay Expenditure
Non pay plans include additional allocations for the expected increased cost of CNST and other non pay areas such as drugs and clinical supplies. Additional cost pressures, such as the marginal costs of the delivering additional growth and the revenue consequences of capital expenditure, have been recognised. CIPs of £15.6m have been allocated against the various categories of expenditure that will be targeted during 2016/17.

Activity in 2016/17
The 2016/17 activity plans have used the 2015/16 outturn as a start point and has been supplemented by our assessment of likely growth in demand over the coming

Activity category	2015/16 Forecast outturn	2016/17 plan
Elective spells	63,041	65,679
Non-elective spells	49,956	51,965
A&E Attendances	125,899	127,138
Out-patients	580,386	592,008

Cost Improvement Programme
Our Cost Improvement Programme will support our ability to maintain and improve the quality of services we deliver and achieve the control target set in order to access the S&T funding. The Trust will be utilising external expertise (CIP Director) to support the delivery of the overall programme and specific initiatives where necessary. The CIP director will report directly to the Director of Finance and will work with the Divisions to develop and implementing schemes to create headroom to mitigate any additional risks that may materialize. The key workstreams of our Cost Improvement Plan include:

- Operational effectiveness and efficiency
  - Improved efficiency in theatres
  - Careful targeting of community-based services to balance outcomes with resources
  - Reduction in unnecessary scans and tests
  - Consolidation and improved operational efficiency of administration of out-patient clinics
  - Consolidation of diagnostic and support services across hospital sites
  - Consolidation of asset management and maintenance of specialist equipment both within divisions and across hospital sites
  - Smartcare revenue savings
- Workforce utilisation and efficiency
  - Increased efficiency across Trust support functions
  - Reduction in temporary staffing levels in medical, nursing and other staff categories
  - Improved workforce efficiency in senior level staffing and across supervisory grades
  - Promotion of evidence-based workforce savings across corporate departments and medical divisions
- Supplier engagement in procurement and supply chain effectiveness
  - Savings in drugs procurement and Gain Share through joint-working arrangements with local health economy stakeholders and specialist commissioners
  - Further development of procurement catalogues to most items purchased, then develop a category management platform approach to procurement and supply chain
  - Increased savings through better buying efficiency
  - Development of innovative and cash-saving approaches to procurement of expensive equipment and specialist services
- Business Development

- Develop a range of services tailored to private patients and commercially leverage the new dedicated facilities at Cheltenham General Hospital
- Seek savings in PFI financing at the Gloucester site

The table below shows how our cost improvement programme aligns with our strategic objectives. Quality impact assessments will ensure that as we progress these transformational programmes we continue to make progress towards our strategic goals.

	Operational effectiveness & efficiency	Workforce	Procurement and supply chain	Business development
Improving quality		•	•	•
Aligning services	•	•	•	
Clinical collaboration	•	•	•	•
Harnessing technology	•		•	•
Improving health		•	•	
Care and compassion		•		
Care closer to home	•	•		•
Workforce redesign	•	•	•	•
System leadership	•		•	•
Improving the estate	•			•
New markets	•		•	•

A summary of 2016/17 Cost Improvement Plan by themes is shown in the table below:

CIP theme	**£m**
Operational effectiveness & efficiency	10.0
Workforce efficiency	3.0
Procurement & supply chain	5.6
Business development	0.2
Total:	**18.8**

Our Capital Programme

The capital plan addresses the key Trust strategic priorities for the Trust, namely completing the implementation of the Smartcare clinical information system, replacement of medical equipment and key strategic service reconfiguration/infrastructure maintenance schemes.
A summary of our capital programme allocations is shown below

	2016/17 £m
Building and Infrastructure schemes	4.5
Medical Equipment Fund	3.3
Information Management & Technology	2.2
Total planned spend	**10.0**

Our Priorities for 2016/17

In determining our priorities for next year we have taken into account:

- Feedback from a wide range of stakeholders
- The need to make progress towards our strategic objectives to be sustainable into the future
- The need to ensure we are operationally and financially resilient

Our priorities for 2016/17 are detailed in the table below, aligned to our strategic objectives.

(D/N all milestones to be confirmed following feedback on draft plan and negotiation with commissioners around CQUINs, and prior to submission of final plan in April)

Strategic Objective	Priorities for 2016/17	By 30/09/16 we will have……	By 31/03/17 we will have…..
Our Services			
To continue to improve the quality of care we deliver to our patients and reduce variation	To improve the care of emergency patients through the implementation of the SAFER Programme (Q)	improved the accuracy of our Estimated Date of Discharge by 20% from April 2016 baseline Improved 'day before' booking of Transport from 10% to 30% of all bookings. Improved discharges before 1200hrs to 15% of daily discharges.	Improved EDD accuracy by further 10% from September baseline. Improved 'day before' booking of transport to 40% of overall bookings. Improved before1200hrs discharges to 25% of daily discharge
	To reduce the likelihood of missed fractures in ED (Q)		
	To reduce the number of lower limb amputations in patients with diabetes (Q)	introduced diabetic footcare checks on 6 wards	introduced diabetic footcare checks on all wards

	To implement the National Safety standards for Invasive procedures (Q)		
	To ensure antibiotics are prescribed in accordance with local formularies (Q)	*to be confirmed as part of CQUIN agreement in contract*	*to be confirmed as part of CQUIN agreement in contract*
	To improve care for people with dementia and delirium (Q)		
To continue to align our services between our sites	To improve the management of patients requiring emergency abdominal surgery (Q)	*to be confirmed as part of CQUIN agreement in contract*	*to be confirmed as part of CQUIN agreement in contract*
	To improve the management of patients with fractured neck of femur (Q)		
To future proof our services through clinical collaboration	To contribute to the development of an emergency care network (Q)	Provided Input to the stock-take of existing services (to improve the Directory of Services). Contributed to the Network's vision and priorities for 2016/17 for the Delivery Plan	Shared 'best practice' across the region for improving Emergency Care processes. Supported the development of a combined clinical hub across 999/111/OOH services.
To improve the health and wellbeing of our staff, patients and the wider community	To implement the patient health and wellbeing strategy	published our patient health and wellbeing strategy	increased the number of staff trained to deliver "making every contact counts"

	To contribute to the countywide obesity strategy	completed a gap analysis of our services against the childhood obesity strategy	published our own plan of actions to reduce childhood obesity
Our Patients			
To continue to treat our patients with care and compassion	To improve our discharge processes (Q)		
	To improve the transition from children to adult services (Q)	*to be confirmed as part of CQUIN agreement in contract*	*to be confirmed as part of CQUIN agreement in contract*
	To implement the Living with and Beyond Cancer Programme (Q)	started risk stratifying patients with colorectal, prostate and breast cancer	offered all patients with colorectal, prostate and breast cancer an Holistic Needs Assessments at least twice on their care pathway Introduced Treatment Summaries for all patients to ensure GP's have relevant information about the care received
	To improve our End of Life care (Q)		
	To meet all waiting time standards		
	To improve our services based on what we learn from those who use them (Q)		

To provide care closer to home where safe and appropriate	To contribute to the countywide service transformation programme	*To be confirmed as part of Sustainability and Transformation Plan*	*To be confirmed as part of Sustainability and Transformation Plan*
Our Business			
To improve our internal efficiency	To deliver the Cost Improvement Programme		
To improve our clinical estate	To implement approved schemes from capital programme		
	To progress our site development programme	endorsed the outline business case for the preferred site development plan	identified a funding strategy to implement the plan
Harnessing the benefits of information technology	To implement SmartCare (Q)	implemented the patient administration, maternity, emergency department and theatre modules of the Trakcare product	implemented the , pathology, pharmacy and prescribing modules of the Trakcare system
	To contribute to the countywide information sharing project	*To be confirmed when Implementation plan agreed*	*To be confirmed when Implementation plan agreed*
Exploiting the opportunities for new markets	To develop capacity and capability to identify new markets and technologies and promote commercialisation	identified a route to exploitation for at least one innovation	secured funding for the exploitation of at least one innovation
	To develop a clear private patient offer		

Our staff			
To develop leadership both within our organisation and across the health and social care system	To progress our organisational development programme		
	To ensure all staff in the leadership roles are trained in service improvement methodology (Q)		
To redesign our workforce	To progress our Seven Day Services Programme (Q)		

(Q) denotes Quality priorities

STATEMENT ON MEMBERSHIP AND ELECTIONS

Governor Elections

In 2015/16 elections were held to fill vacancies caused by resignations in two of the four staff constituencies. There were no Public Governor elections during the year. For 2016/17 there are Governor elections planned in each of the six public constituencies with seven of the 12 Governors coming to the end of their term of office. Six of those Governors are eligible to seek re-election. Elections are also planned in two of the four staff constituencies with the term of office of two staff Governors coming to an end. The three appointing organisations will be invited to appoint/re-appoint a Governor.

Governor Recruitment and Training

During the year Governors have had the opportunity to be involved in development sessions focussed on, engaging with and representing members and patient feedback and one, in conjunction with NHS Providers, about holding Non-Executive Directors to account.
Governors have been provided with business cards which they can give to members to help enable two-way dialogue. In addition the 'Contact your Governor' form on the Trust's website has been in use for the past year and so far 27 enquires have been made using this form.
A feature 'Meet your Governor' has been included in the Involve newsletter which is helping to inform members as to who their Governors are and providing members with some information about each Governor.

Membership Strategy

Our Membership Strategy was agreed in 2014 with 4 objectives:

- Provide more opportunities for member engagement
- Enhance and diversify membership communication channels with emphasis on enabling two way dialogue
- Maintain existing membership base/develop support systems
- Develop a more representative membership

http://www.gloshospitals.nhs.uk/SharePoint3/Communications%20Web%20Documents/CorpDocs/Membership-Strategy-A4.pdf

Our membership within the public constituency is broadly reflective of the eligible population with an increase or stability in the number of members within all ethnic groups with the exception of the 'White' category.
Our membership continues to be under represented in the lower age groups and this is where our recruitment will be focussed during 2016-2017. A number of actions are provided within the strategy action update report.

During 2016/17 we will continue to progress the strategy to develop a more representative membership, with particular emphasis on initiatives to communicate and recruit young people under 16, and in the 17 to 21 age group. These include involvement with secondary schools, Voice of the Child, Gloucestershire Young Carers and a Careers Science event associated with our 2016 AGM. Initiaves to increase the representation from black and minority ethic groups include development of cross-county CCG-led Diversity & Inclusion group and associated planned work with BME communities as route.

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD - MARCH 2016

REPORT OF THE FINANCE DIRECTOR
DRAFT REVENUE BUDGETS & MONITOR ANNUAL FINANCIAL PLAN UPDATE FOR 2016/17

1 INTRODUCTION

The purpose of this paper is to update the Board on the key points of the budget setting process and agreement of revenue budgets for the 2016/17 financial year. This information is a key feature of the Monitor Annual Plan. The content of this document will be updated as necessary to ensure it synchronises with the Monitor templates and is coherent with other Trust strategies and policies.

2 BACKGROUND

As the Board are aware, a draft one year plan for 2016/17 was submitted to Monitor in February and the final draft will be submitted in April. During the financial year briefing papers on the budget setting and contracting processes have been presented to the Finance and Performance Committee.

3 STATUS OF CONTRACT NEGOTIATIONS WITH MAIN COMMISSIONER

We are currently in the process of negotiating the 2016/17 contract with Gloucestershire CCG and at the time of writing this report discussions have commenced. The expectation remains that contract signing should be achieved with Gloucestershire CCG by the end March 2016. When negotiations are concluded the budgets will be updated to reflect the agreed contract settlement.

The budget as proposed takes account of:-

- Current status of negotiations with all our main commissioners.
- The national tariff changes introduced for 2016/17.
- Budget review meetings with divisions where there has been a review of cost pressures, service development, capacity planning and cost improvement plans.
- Current assessment of our asset base, this may change dependent on the outcome of the annual asset revaluation which is carried out at the end of each financial year.

4 PLANS FOR 2016/17

Against this background, the main focus of this plan is the provision of quality, safe services including the delivery of key targets as part of the sustainability and transformation plans. Mindful of increasing demand for services and as part of the negotiations with Gloucestershire CCG, the Trust is seeking to agree the development of initiatives to support transformation of services, including 7-day working. Development of our workforce, recruitment of front line staff with less reliance on agency staff, and engagement of all staff in the drive to improve patient experience is integral to our plans.

Our financial plan is based on the assumption that the Trust will accept the Sustainability & Transformation funding (£12.9m) made available to Trusts, subject to agreeing improvement trajectories and milestones. This funding cannot be used to fund routine expenditure and therefore net impact of the sustainability and transformation fund has therefore increased the planned surplus of the trust accordingly.

	2015/16 Plan	2015/16 Outturn*	2016/17 Plan
Operating Revenue within EBITDA	482,783	497,321	523,728
Operating Expenses within EBITDA	(454,887)	(472,012)	(480,495)
EBITDA	**27,896**	**25,309**	**43,233**
Interest Revenue	92	48	48
Interest Expense	(4,584)	(4,593)	(4,471)
Depreciation and Amortisation	(12,392)	(11,281)	(13,281)
PDC Dividend Expense	(7,028)	(7,315)	(7,315)
Surplus (Deficit) before impairments	**3,984**	**2,168**	**18,214**
Impairment (Losses)/Gains net	0	0	0
Surplus (Deficit) after exceptional items	**3,984**	**2,168**	**18,214**
EBITDA Margin %	*5.8%*	*5.1%*	*8.3%*

**Based on M10 forecast outturn*

5 OVERVIEW OF PLAN SHORT-TERM CHALLENGE

The Trust faces a range of short term challenges over the next 12 months. These include:-

Managing capacity – the Trust continues to experience referrals significantly higher than planned over recent years. Additional beds and capacity has been opened at financial risk to mitigate this pressure.

Improving quality – continuing focus on quality, clinical outcomes and patient experience are driving investment in front line services.

Targets – Delivering performance targets across all key areas including A & E waits; bed capacity and care pathways are key factors in managing flow through the system.

Financial Performance – the Trust is required to deliver annual surpluses in order to maintain investments in its asset base and retain cash balances to avoid regulatory action. The Trust plan is based on delivery of relatively small surpluses in comparison with the overall revenue budget. This is increasingly challenging with increasing numbers of acute Foundation Trusts in deficits at Q4 2015/16. The main financial challenges facing the Trust over the next year includes:-

Annual Efficiency Requirement - this is currently set at 4.8%, taking into account an average national tariff inflator of up to 1.8% for 2016/17.

Recruitment of Nurses and Middle Grade Doctors - Trust plans are reviewed against workforce supply both locally and nationally in order to identify key risk areas. Action to mitigate workforce risks includes:

- Targeted recruitment events
- Overseas recruitments events
- The up-skilling of existing staff through education and development programmes and a continued focus on staff retention, return to practice opportunities and leadership development.

6 FINANCIAL PLANNING PROCESS

In developing the draft financial plan for 2016/17 there has been extensive consultation with Divisions to ensure the key issues they face are reflected in the plan. This has been achieved through a series of individual divisional meetings which helped to consolidate the current position and provided a greater understanding of the pressures

that are either in the current baseline or unavoidable for the 2016/17 financial year. This has included reviewing CCG activity demand proposals to ensure the final plans can be delivered.

For each Division a budget proposal is being developed that covers the following key headings:

- Recurrent budgets
- Additional funding to reflect outturn
- Inflation/Incremental drift impact
- Full year effect of current developments
- New Trust agreed developments
- New cost pressures
- Impact of savings delivered non-recurrently during 2015/16
- Impact of Cost Improvement Savings target for 2016/17

The detailed expenditure and income plans for divisions will be finalised and formally signed off following the completion of the contract negotiations with the primary CCG's and other partners. The financial and activity plans will be supported by accountability agreements for each Division ensuring financial targets are managed along with quality, safety and other Trusts targets.

7 INCOME

7.1 Tariff Related Changes

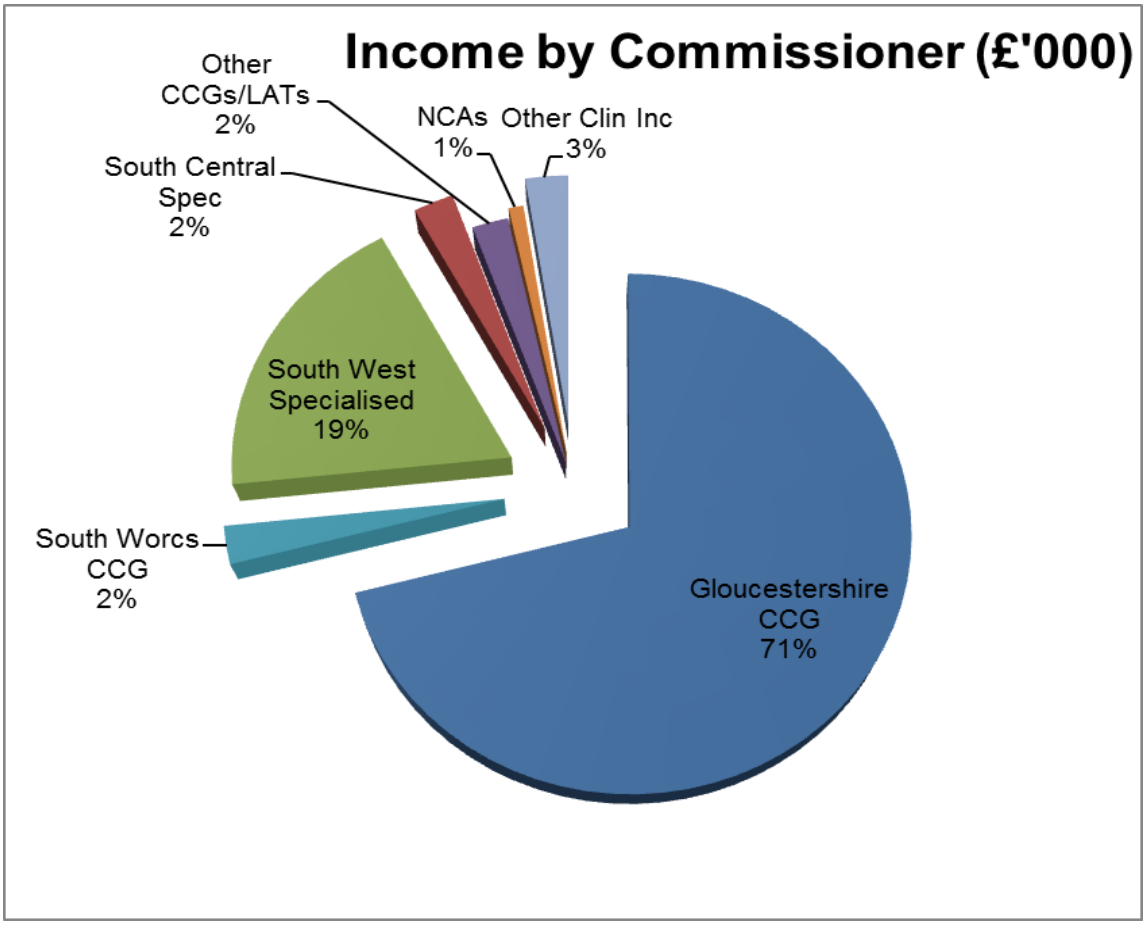
The national guidance on tariffs has been issued alongside draft national prices for 2016/17.

The following are the key headline issues affecting the tariff:

- The general inflation is up to +1.8% for the national tariff reflecting a cost inflation uplift of 3.1% and a CNST uplift of 0.7% covered by an assumption of cash releasing efficiency savings of 2.0% giving an overall change up to +1.8%.
- There remains additional income that the Trust can earn for Clinical quality improvements (CQUINs) which remains at 2.5% of contract income.
- The marginal rate for emergency admissions over the 2008/09 baseline remains at 70% for all commissioners.
- For specialised services the marginal payment of 70% over an agreed baseline from 2014/15 that was in place for 2015/16 has been removed. From 2016/17, with the exception of the emergency cap, the Trust should receive all income on specialised services work.

7.2 Commissioning Income

In addition to Gloucestershire CCG, Specialised Commissioning is a significant source of income with £84.7m planned for 2016/17, South Worcestershire CCG £10.6m and other English CCGs. We also continue to provide some services to Health Boards in Wales. The chart below shows income by commissioner in our first draft Monitor plan for 2016/17.



7.3 Other Operating Income

This includes income from Research and Development, Education and Training, Overseas visitors and other miscellaneous income. The Budget plan included changes in accordance with guidance for each of these income categories.

7.4 Hosted Services

The Trusts Hosts GP trainees and although the amount varies based on the actual number of trainees the income is £27m per annum. Cash flow relating to this service will require careful monitoring due to the contractual arrangements and number of organisations involved.

7.5 Shared Services

The Trust provides various elements of shared services to local Trusts and Gloucestershire CCG. Discussions have started on the contract values for 2016/17.

8 EXPENDITURE BUDGETS

The key elements of planned changes in expenditure budgets are highlighted below:

8.1 Inflationary Cost Pressures

The main element of the inflationary increases relates to pay. Currently the plan assumes the actual pay cost across all staff groups for the twelve months from November 2015 to October 2016. An adjustment will be made in budget setting to reflect the national pay awards.

In relation to non-pay the Trust is taking a robust stance with suppliers to ensure value for money for the Trust.

8.2 Contingency Reserve

The current plan includes a small contingency reserve of £4m to cover risk. Mindful of the environment the Trusts operates in, the risks will continue to be monitored closely and further action taken to cover risk.

8.3 Temporary Staffing Costs

During 2015/16 temporary staffing costs did not reduce as expenditure on permanent staff continued to rise. The reasons for this are understood, however temporary staffing costs will need to be reduced if the financial targets are to be achieved. Recruitment initiatives and rostering systems will be used to reduce costs without compromising on the quality of care.

The Trust continues to strive to recruit trained nurses and doctors particularly for hard pressed posts, and a number of initiatives will continue in order to improve this position.

9. LIQUIDITY

The Trust cash balances are forecasted to be between the levels required to maintain COSR of 3. The main drivers for this assumption are as follows:

- Phasing of capital expenditure and this has been agreed as part of the approvals process for setting the capital plan.
- Negotiation of contractual terms which do not adversely penalise the Trust liquidity position.
- It is anticipated that cash balances should improve in the financial year 2016/17 due to the improved management of debtors, tighter grip on financial control and delivery of cash releasing savings.

10. CONTINUITY OF SERVICE RATINGS

During 2015/16 the COSR remains at 3 (with 1 being the lowest and 4 being the highest). The plan for 2016/17 is to maintain this rating. Although the current and planned rating is good the Trust should not be complacent due to the uncertainty and financial risk in the environment, in particular for acute hospitals.

11. COST IMPROVEMENT PLANS

The savings plan for 2016/17 will again be devolved and agreed with Divisions and Corporate functions. The target is currently set at £18.2m. This figure has been derived using the internal efficiency requirement of 4.8% to reflect the additional funding that needs to be generated to support the capital programme and deliver on the control total linked to the Sustainability & Transformation funding.

The process of identifying cost improvements for 2016/17 is ongoing and divisions have presented initial plans to the Trust Delivery Board. The focus will continue to be delivering efficiency savings without compromising quality. All savings schemes are subject to a robust Quality Impact Assessment process to provide the assurance that patient safety and quality is maintained. This includes a governance process covering the identification of new schemes and the development of Cost Improvement Scheme Proposals (CISPs) to ensure the appropriate processes have been followed.

A summary of the 2016/17 Cost Improvement Plans by themes is shown in the table on the next page:

CIP theme	**£m**
Operational effectiveness & efficiency	10.0
Workforce efficiency	3.0
Procurement & supply chain	5.6
Business development	0.2
Total:	**18.8**

The Efficiency and Service Improvement Board and Delivery Board will continue to meet to review progress against the achievement of savings schemes. This work will be particularly focused on converting those savings schemes currently within the pipeline category into cash releasing savings that have a material impact on the expenditure and income run rate for the Trust.

The summary savings plans by Divisions are shown in the table below:

DIVISION	**2016/17 SAVINGS TARGET**	**%AGE OF DIVISIONAL BUDGET**
Surgical	5,124	4.8%
Medicine	4,474	4.8%
Diagnostics & Specialties	4,406	4.8%
Women's & Children's	1,514	4.8%
Estates & Facilities	1,616	4.8%
Corporate	1,045	4.8%
TOTAL	**18,178**	

The Trust has a good track record in delivery of savings, however delivery of workforce savings is challenging mindful of the need to invest in front line services and provide additional capacity to meet demand, hence the requirement for transformation in addition to transactional savings. In addition to the above the Trust will also be reviewing the 2015/16 schemes that were delivered non-recurrently and the impact this will have on budgets in 2016/17. Currently these total around £9.6m and the treatment of the outstanding amount will also be dependent on the outcome of negotiations with CCG's. A key factor within our plans is the requirement to continue to strive to recruit trained nurses and doctors and hard to fill posts and to reduce the reliance on agency expenditure.

The table below illustrates how the key themes within the Cost Improvement Programme aligns with the Trust strategy.

	Operational effectiveness & efficiency	Workforce	Procurement and supply chain	Business development
Improving quality		•	•	•
Aligning services	•	•	•	
Clinical collaboration	•	•	•	•
Harnessing technology	•		•	•
Improving health		•	•	
Care and compassion		•		
Care closer to home	•	•		•
Workforce redesign	•	•	•	•
System leadership	•		•	•
Improving the estate	•			•
New markets	•		•	•

12. SUMMARY OF FINANCIAL RISKS

The Trust is facing several financial risks going into 2016/17 including but not exclusive to:

- Finalisation of contract values
- QIPP Scheme risk share
- Delivery of cost improvement schemes
- Delivery of CQUIN schemes
- Contract penalties
- Seasonal pressures
- Specialised Commissioning
- Additional costs of agency and locum staff

The impact of these risks continues to be reviewed as the Trust progresses through the contract negotiations.

13. CONCLUSION

The Trust is currently in the process of negotiating contracts with its primary Commissioners. Robust governance processes will continue to be required to ensure focussed management of the financial risk that the Trust is facing in 2016/17. The aim is to ensure that expenditure budgets are signed off and financial agreement reached on the main commissioning contracts by the end of March.

The budget booklet is currently being produced within the overall budget strategy as outlined in this paper. And the booklet will be circulated early next week to synchronise with the national contracting timetable.

14. RECOMMENDATION

The Board is asked to note the current contracting position and to approve budgets and the annual financial plan described within this report. The budgets, pending contract agreement with our main commissioner reflects:

- Revenue surplus of £18.2m to support investment of our capital programme, COSR of 3 and delivery of Sustainability & Transformation funding control total
- Delivery of cost improvement programme of £18.2m, as well as any unachieved CIP from 2015/16

Author: **Sean Ceres, Interim Director of Operational Finance**

Presenting Director: **Helen Simpson, Deputy CEO and Executive Director of Finance**

March 2016

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

REPORT OF THE FINANCE DIRECTOR

MAIN BOARD - MARCH 2016

CAPITAL PROGRAMME

1 Purpose

To inform the Finance & Performance Committee of the Trust's outline Capital plan for 2016/17.

2 Background

2.1 The funds available for capital investment during 2016/17 will be less than previously planned. The indicative programme below therefore comprises the priority schemes that the Trust is committed to from each category.

Funding sources for Capital Programme

The funds available for the capital programme is developed through funding from a variety of sources and these are highlighted in the table below

Capital Funding 2016/17	£000
Funding from Depreciation	12.8
Contribution from I&E	2.0
Loan repayments	-2.6
Capital receipts	2.0
Contribution to Working Capital	-3.0
2015/16 slippage risk (depreciation)	-0.5
Charitable Funds	0.3
Funding available	**11.0**

Capital Programme

From the funding sources identified above the indicative programme is as outlined below. More discussion is still required within the Trust before the final allocations are agreed:

Priority Schemes 2016/17	£000
IM&T	
SmartCare	2.4
Network replacement	1.0
Telephony	1.0
SmartCare devices	0.8
Building and Infrastructure schemes	3.5
Medical Equipment Fund	2.3
Total	**11.0**

3 Key Points

3.1 This indicative programme is consistent with the draft Monitor plan submitted in February 2016 and reflects priorities from divisions and will be closely monitored to ensure safety is not compromised

3.2 The medical equipment fund was introduced on the 1st April 2015 and has been considered a successful mechanism to prioritise and purchase equipment, involving senior clinical leaders and clinical directors. The medical equipment fund will continue for 2016/17.

3.3 The capital programme is focused on essential maintenance and equipment replacement along with the major IT developments of Smartcare implementation, Network replacement and telephony.

3.4 There is an assumption that asset sales will deliver £2m during 2016/17, which is included as part of the source of funding.

3.5 The current assumptions about use of leasing will require business cases to ensure the revenue case is affordable within the current budgets. This is being pursued with the relevant divisions.

3.6 There is an assumed level of funding from charitable sources, which is in line with previous levels of funding, this supported by Director of Fund Raising.

4 Recommendations

The F&P Committee is asked to **APPROVE** the Trust's capital programme for 2016/17

Author **Sean Ceres, Interim Director of Operational Finance**

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

March 2016

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

INTEGRATED PERFORMANCE MANAGEMENT FRAMEWORK

EXECUTIVE SUMMARY

TRUST BOARD – MARCH 2016

1. INTRODUCTION

This report summarises the key highlights and exceptions in Trust performance up until the end of February 2016 for the financial year 2015/16. As the Main Board meeting is earlier in March due to Easter, the report is as complete as possible at the time of writing.

2. KEY HIGHLIGHTS ON PERFORMANCE

- GP referrals have run all this financial year at higher levels than last year and were 4.0% over last year at the end of February. Despite these rising referrals the Trust has met the 18 Week RTT standard overall at Trust level for incomplete pathways as it has done each month this financial year.

- The Trust met the standard for a maximum 14 day wait for patients referred with non cancer breast symptoms to be seen in outpatients.

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

- There were no breaches of the mixed sex accommodation standard during February.

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

- The Trust continues to see benefits from its carbon energy reduction programme which is achieving its target to date.

3. AREAS OF EXCEPTION ON PERFORMANCE

- Emergency admissions continue to run at levels over the plan for the year, ending as 6.9% over plan at the end of February. The percentage of patients spending less than 4 hours in the Emergency Department was 76.4% compared to the target of 95%. A recovery plan is in place with Monitor support. Year to date the number of ambulance handovers delayed over 30 and 60 minutes continues to run below the total for last year.

- There were six cases of Clostridium Difficile (C-Diff) infections - post 48 hours in February, which is above the monthly trajectory and takes the Trust to 7 cases above the year to date trajectory. Year to date 9 cases are deemed unavoidable and will be appealed with the Commissioners. The target for 2015-16 is challenging and reflects the good performance in 2014-15. There was one MRSA case during February.

- The number of patients waiting over six weeks for a key diagnostic test is predicted to remain over target with capacity issues in MRI and neurophysiology. Action plans have been agreed with our Clinical Divisions.

- The Trust did not meet the recovery trajectory for the 62 day cancer standard in January. The trajectory is under review due to ongoing capacity issues in Urology.

- 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 was a rise in the number of operations cancelled on the day for a non-medical reason and such patients not being re booked within 28 days as a consequence of both the number of medically fit patients remaining in a hospital bed and the level of emergency admissions.

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: **March 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 4.

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	Jan	Feb	Monitor weighting	Current position for 4
C-Diff Toxin Detection (post 48 hour annual target)		37/yr	9	6	8	13	8	10	10	6	6	1.0	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%	92.2%	1.0	
A&E 4 Hour Wait		95%	93.3%	94.3%	89.5%	82.7%	93.4%	89.7%	85.6%	80.2%	76.4%	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%	99.5%	94.1%			
	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%	95.6%	84.0%		1.0	1.0
	62 Days to Treatment (excluding rare cancers)	85%	88.1%	86.1%	78.4%	77.1%	73.9%	75.6%	79.5%	77.4%			
	14 Days to First Appt	93%	90.5%	94.1%	94.3%	88.8%	91.5%	90.9%	92.4%	88.0%		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%	93.4%	94.1%			
	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	4.0				4.0

KEY: Actual Provisional

Gloucestershire Hospitals NHS
NHS Foundation Trust

PERFORMANCE MANAGEMENT FRAMEWORK 2015-16

March 2016

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TRUST PERFORMANCE - as at end February 2016

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	Jan	Feb	Year end position	Basis of year / quarter end assessment
Monitor Financial Risk Rating	level 3	Monitor	M	Feb	3	3	3	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	-£1.6m	£0.1m	£0m	-£1.4m	-£3.1m	-£1.5m	-£1.6m	-£2.1m	-£2.1m	-£1.6m	£238k	-£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	Jan	6.3%	6.4%	6.2%	5.8%	6.4%	6.4%	6.1%	6.5%	6.5%	6.3%	6.3%	6.5%	6.5%	6.4%	5.9%	6.1%	6.5%			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%	3.0%	4.0%		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%	5.2%	7.7%	7.4%		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%	4.1%	5.1%	6.0%	6.9%	7.0%	6.9%		year end cumulative
LOS for general and acute non elective spells	Q1 /Q2 <5.4days, Q3 /Q4 <5.8days	Trust	M	Feb	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	6.1	6.2		year end cumulative
LOS for general and acute elective IP spells	≤ 3.4 days	Trust	M	Feb	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	3.4	3.6		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%	0.8%	0.8%	0.7%	0.7%	0.7%	0.3%		year end cumulative
% records submitted nationally with valid GP code	≥ 99%	Trust	M *	Dec	99.9%	100%	99.8%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%				year end cumulative
% records submitted nationally with valid NHS number	≥ 99%	Trust	M *	Dec	99.6%	99.7%	99.8%	99.8%	99.8%	99.7%	99.7%	99.8%	99.8%	99.8%	99.8%	99.6%	99.7%	99.5%	99.5%	99.8%				year end cumulative
Carbon Utilisation **	-1.5%	Trust	M in arrears	Jan	-2.6%	-11.6%	-14.0%	-4.9%	-8.9%	-9.4%	-4.9%	-10.1%	-10.7%	-5.8%	-12.7%	-11.7%	-3.9%	-4.3%	-4.7%	-5.7%	-5.5%			current quarter end

* in arrears/national timetable

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

TRUST PERFORMANCE - as at end February 2016

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	Jan	Feb	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	Feb	9	6	8	13	8	10	10	4	4	0	4	4	2	3	4	3	6	6		year end cumulative
Number of Methicillin-Resistant Staphylococcus Aureus (MRSA) infections - post 48 hours	0	GCCG	M	Feb	0	0	1	1	0	0	2	0	0	0	0	0	0	0	1*	1	0	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	Feb	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%	1.2%	1.6%		year end cumulative
SAFETY																								
Number of Never Events	0	GCCG	M	Feb	0	1	0	2	0	1	1	0	0	0	1	0	0	0	0	1	0	0		year end cumulative
% women seen by midwife by 12 weeks	90%	GCCG	M	Feb	90.3%	91.6%	90.8%	90.5%	90.3%	90.0%	90.0%	89.7%	88.7%	92.5%	90.5%	89.8%	89.1%	90.3%	90.1%	89.4%	90.2%	88.6%		year end cumulative
% stroke patients spending 90% of time on stroke ward	80%	GCCG	M	Jan	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%	81.8%			year end cumulative
% of eligible patients with VTE risk assessment	95%	GCCG	M	Feb	93.1%	93.2%	93.0%	93.8%	94.5%	94.6%	94.2%	94.3%	93.9%	95.4%	94.9%	94.4%	94.4%	95.1%	94.5%	93.0%	93.6%	93.4%		year end cumulative
ED																								
% patients spending 4 hours or less in ED	≥ 95%	Monitor	M	Feb	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%	80.9%	76.4%		current quarter end
Number of ambulance handovers delayed over 30 minutes	< previous year	GCCG	M	Fe b	283	184	248	324	192	191	213	52	88	52	37	87	67	66	68	79	93	105		year end cumulative
Number of ambulance handovers delayed over 60 minutes	< previous year	GCCG	M	Feb	37	26	27	51	13	21	28	3	7	3	3	11	7	6	2	20	5	16		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 February 2016

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	Jan	Feb	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	Q4	5%	19%	29%	0%	3%	12%	25%	20%	11%	14%	29%	44%	47%	52%	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	Q4	69%	83%	96%	69%	54%	84%	82%	**83%**	**83%**	**100**	**95**	**93**	**92**		Q4 Target
Sepsis Antibiotic Administration 2b			M	Q	Q4	N/A	32%	43%	N/A	N/A	N/A	33%	36%	32.0%	46.0%	36.0%	50.0%	39.0%		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		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		Report	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		Report	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		Report	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		Report	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%	90.0%	89.20%	86.80%	
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%	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%	100.0%	100.0%	100.0%	
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	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	Jan	Feb	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	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	Jan	Feb	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			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	Report			Q4 target

TRUST PERFORMANCE - as at end February 2016

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	Jan	Feb	Year end position	Basis of year / quarter end assessment
18 WEEKS																								
Incomplete pathways - % waited under 18 weeks	≥ 92%	Monitor	M	Feb	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%	92.2%	92.2%		current quarter end
15 key Diagnostic tests : numbers waiting over 6 weeks at month end	<1% of nos waiting at month end	GCCG	M	Feb	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%	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	Feb	60	138	2	79	400	206	142	219	353	400	455	505	206	83	79	142	190	184		year end snapshot
CANCER																								
Max 2 week wait for patients urgently referred by GP	≥ 93%	Monitor	M	Jan	90.5%	94.1%	94.3%	88.8%	91.5%	90.9%	92.4%	90.1%	94.0%	90.5%	88.9%	90.0%	94.2%	94.6%	93.2%	89.7%	88.0%			current quarter end
Max 2 week wait for patients referred with non cancer breast symptoms	≥ 93%	Monitor	M	Jan	66.1%	93.6%	96.6%	94.9%	95.2%	91.8%	93.4%	93.6%	97.6%	95.1%	90.9%	92.3%	93.0%	91.3%	94.6%	94.4%	94.1%			current quarter end
Max wait 31 days decision to treat to treatment	≥ 96%	Monitor	M	Jan	99.6%	99.8%	99.5%	100%	99.5%	99.7%	100%	100.0%	99.5%	99.6%	99.7%	99.6%	99.7%	100%	100%	100%	100%			current quarter end
Max wait 31 days decision to treat to subsequent treatment : surgery	≥ 94%	Monitor	M	Jan	99.0%	100%	100%	98.8%	100%	100%	99.5%	100%	100%	100%	100%	100%	100%	98.8%	100%	100%	94.1%			current quarter end
Max wait 31 days decision to treat to subsequent treatment : drugs	≥ 98%	Monitor	M	Jan	100%	100%	100%	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	Jan	100%	98.6%	99.8%	100%	100%	100%	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	Jan	88.1%	86.1%	78.4%	77.1%	73.9%	75.6%	79.5%	74.4%	72.0%	72.9%	70.8%	85.1%	72.9%	78.7%	81.8%	79.4%	77.4%			current quarter end
Max wait 62 days from national screening programme to 1st treatment ***	≥ 90%	Monitor	M	Jan	91.4%	97.1%	92.4%	91.3%	97.3%	94.0%	95.6%	98.3%	93.8%	98.1%	95.1%	92.6%	93.3%	97.1%	92.3%	96.8%	84.0%			current quarter end
Max wait 62 days from consultant upgrade to 1st treatment	≥ 90%	GCCG	M	Jan	85.7%	100%	94.1%	100%	60%	92.9%	100%	50%	100%	60.0%	100%	88.9%	100%	100%	100%	100%	100%			current quarter end
DELAYED DISCHARGES																								
Number of delayed discharges at month end (DTOCs)	<14	Trust	M	Feb	9	5	14	13	11	13	19	8	8	11	11	16	13	8	26	19	16	16		year end snapshot
No. of medically fit patients - over/day	≤ 40	Trust	M	Feb	55	60	57	66	40	56	51	67	55	52	64	51	56	40	54	51	54	63		Total days
Bed days occupied by medically fit patients		Trust	M	Feb	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	1,354	1,584		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%	88.6%	88.3%	89.2%	87.3%	90.0%	89.6%	88.7%	89.2%	88.7%	88.6%	88.4%			current quarter end
Number of Breaches of Mixed sex accommodation	0	GCCG	M	Feb	0	0	0	0	0	0	17	0	0	0	0	0	0	9	0	8	11	0		year end snapshot
CANCELLATIONS																								
Elective Patients cancelled on day of surgery for a non medical reason	≤ 0.8%	Trust	M	Feb	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%	1.9%	1.6%		year end cumulative
Patients cancelled and not rebooked in 28 days	0	GCCG	M	Feb	9	9	19	41	17	18	15	6	6	5	2	8	8	8	4	3	1	11		year end cumulative

NO LONGER A NATIONAL TARGET - UNVALIDATED INFORMATION

18 WEEKS																								
Admitted pathways - % treated in 18 weeks *	≥ 90%	Trust	M	Feb	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%	84.5%			current quarter end
Non-admitted pathways - % treated in 18 weeks *	≥ 95%	Trust	M	Feb	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%	90.0%			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 February 2016

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	Jan	Feb	Year end position	Basis of year / quarter end assessment
Total PayBill spend £'000	target + 0.5%	Trust	M	Jan	£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	£24,335			year end cumulative
Total worked FTE	target + 0.5%	Trust	M	Jan	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	6,675.0			year end cumulative
Annual sickness absence rate *	<3.5	Trust	M in arrears	Dec	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%	3.76%				year end cumulative
Staff who have annual appraisal	90%	Trust	M	Jan	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%	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%##	38%##			
Staff who completed mandatory training	90%	Trust	M	Jan	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%	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##	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%##	35.0%##	35.0%##		annual
Turnover rate (FTE)	7.5 -9.5%	Trust	M in arrears	Dec	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%	11.18%				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 February 2016

RISK ASSESSMENT - FORWARD LOOK

Measure	Standard	Target Set By	Comments
OUR BUSINESS			
GP referrals year to date - within 2.5% of previous year	range +2.5% to -2.5%	Trust	GP referrals have run above last year's levels all year.
Emergency Spells year to date - within 2.5% of plan	range ≤2.5% over plan	Trust	Emergency admissions have increased 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%	Jan-16	6.5%	R

What is driving the reported overperformance

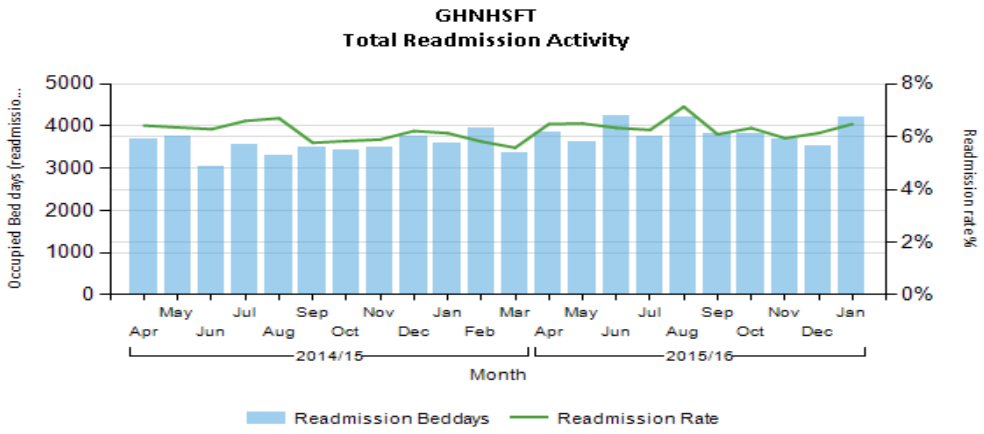
The emergency re-admission rate has been relatively constant this financial year.

Actions taken to improve performance

This is being scrutinised by the Emergency Care Board. Specific actions have been agreed with Divisions as part of an overall improvement plan.

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 have increased in the winter months. The average/day is as follows;

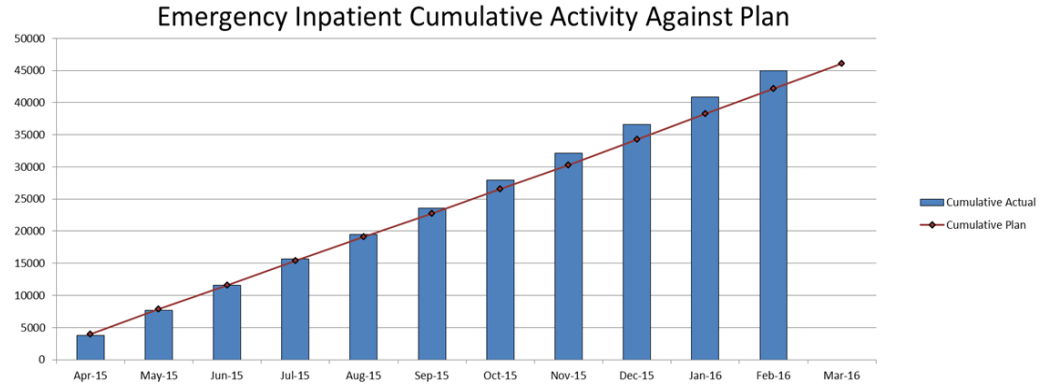
April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb
128	127	129	130	124	139	138	139	145	139	141

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	32088	36583	40896	44981	
Cumulative Plan	3933	7883	11561	15392	19141	22729	26580	30308	34286	38264	42124	46041

LENGTH OF STAY FOR GENERAL & ACUTE NON ELECTIVE SPELLS

Trust Standard

Bed days used by General and Acute Non Elective patients discharged in month; excludes Paediatrics, Maternity and private patients

Standard	Month	Actual	RAG for current month
≤ 5.8	Feb-16	6.2	R

What is driving the reported overperformance

Length of stay has increased in the winter months.

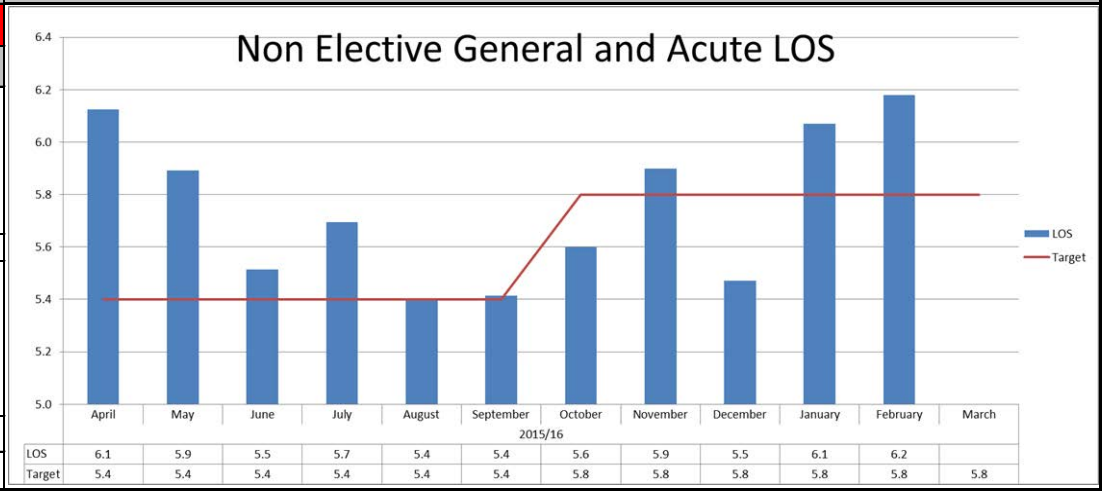
Actions taken to improve performance

Length of stay remains an issue. The Gloucestershire wide action plan has been reviewed across the health community to reflect the urgent requirement to improve performance. Increases in the numbers of medically fit patients has exacerbated the length of stay.

A specific project is in place to review patients with a length of stay over 14 days.

Expected date to meet standard	TBA
Lead Director	Director of Service Delivery

Activity



	April	May	June	July	August	September	October	November	December	January	February	March
	2015/16											
LOS	6.1	5.9	5.5	5.7	5.4	5.4	5.6	5.9	5.5	6.1	6.2	
Target	5.4	5.4	5.4	5.4	5.4	5.4	5.8	5.8	5.8	5.8	5.8	5.8

LENGTH OF STAY FOR GENERAL & ACUTE ELECTIVE SPELLS

Trust Standard

Bed days used by General & Acute elective IP patients discharged in month

Standard	Month	Actual	RAG for current month
≤ 3.4	Feb-16	3.6	R

What is driving the reported over performance

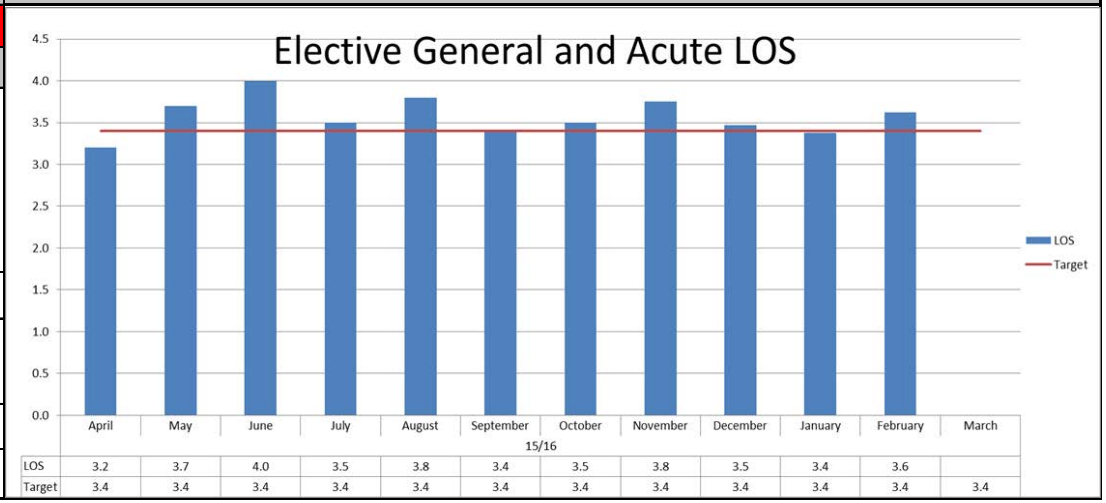
Elective length of stay has fluctuated close to the Trust's target in 2015-16

Actions taken to improve performance

A specific project is in place to review patients with a length of stay over 14 days.

Expected date to meet standard	TBA
Lead Director	Director of Service Delivery

Activity



	April	May	June	July	August	September	October	November	December	January	February	March
	15/16											
LOS	3.2	3.7	4.0	3.5	3.8	3.4	3.5	3.8	3.5	3.4	3.6	
Target	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4

CLOSTRIDIUM DIFFICILE

Monitor Standard : quarterly
GCCG Financial Penalty

Number of Clostridium Difficile cases - post 48 hours admissions

Standard	Month	Actual	RAG for current month
37 / year	Feb-16	6	R

What is driving the reported underperformance

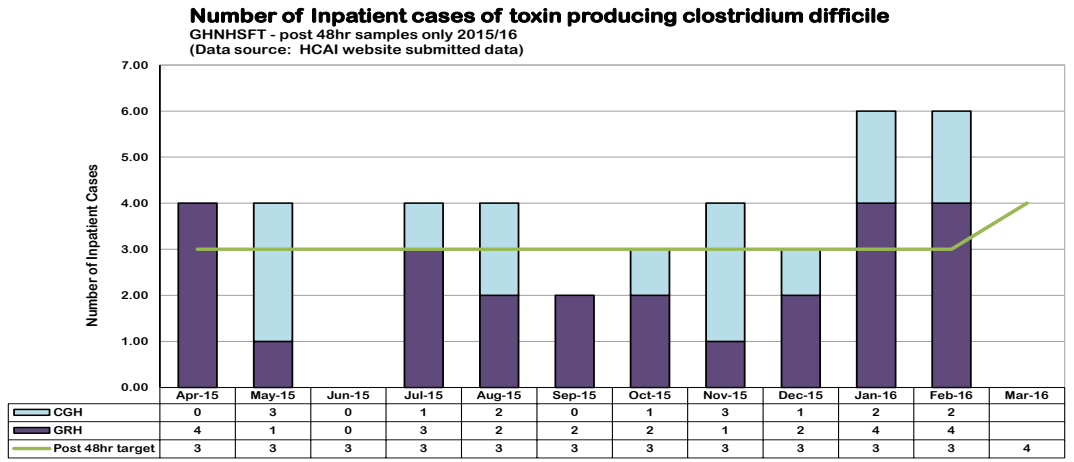
The monthly trajectory was 3 cases of post 48 hour cases and the actual number was 6. 2 Cases were deemed unavoidable and will be appealed with the commissioners. The total cases that have been unavoidable in 2015/16 and will be appealed are 9.

Actions taken to improve performance

All cases have been revewied by root cause analysis to establish if cases are avoidable or unavoidable. All periods of increased incidence are investigated and ribotyped and action plans put in place. A summary of avoidable and unavoidable cases is discused monthly at the Infection Control Committee. All cases are being ribotyped in March.

Expected date to meet standard	Yearly target
Lead Director	Director of Nursing

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
CGH	0	3	0	1	2	0	1	3	1	2	2	
GRH	4	1	0	3	2	2	2	1	2	4	4	
Post 48hr target	3	3	3	3	3	3	3	3	3	3	3	4

MRSA

GCCG Standard
Financial Penalty

Number of MRSA cases - post 48 hours attributable to GHNHSFT

Standard	Month	Actual	RAG for current month
0	Feb-16	1	R

What is driving the reported underperformance

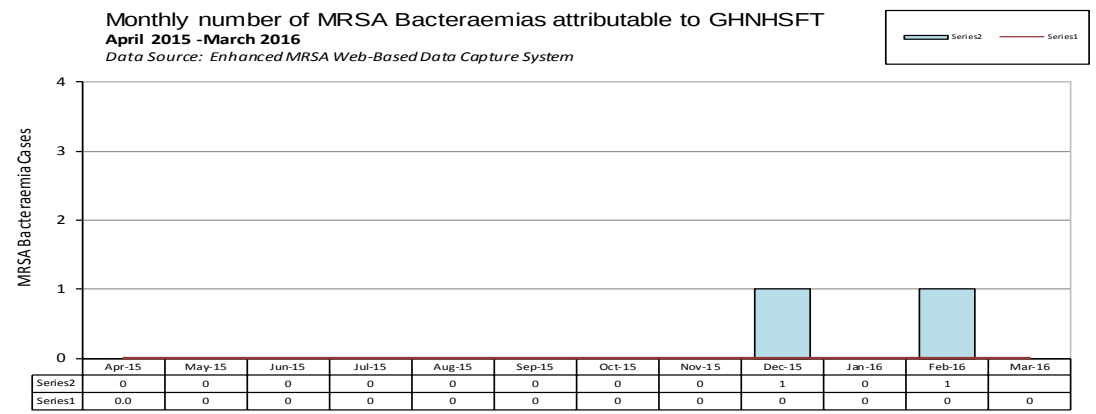
From root cause analysis the cause was thought to be a colo vaginal fistula due to the patients longterm condition. No lapses in care were found and the patient is waiting for elective surgery to correct the problem but is not yet fit for anaesthetic. Under the PIR process NHS England have been asked to consider assigning to a third party.

Actions taken to improve performance

No actions identified as this was unavoidable

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

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
Series2	0	0	0	0	0	0	0	0	1	0	1	
Series1	0.0	0	0	0	0	0	0	0	0	0	0	0

% 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%	Feb-16	93.4%	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.

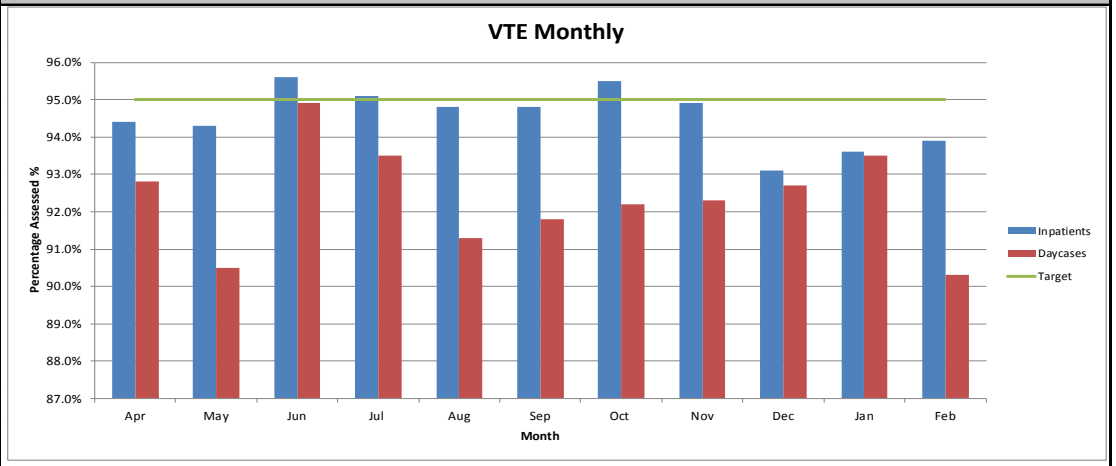
Actions taken to improve performance

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.

In addition the VTE committee will initiate a ward by ward review of performance and visit areas to identify improvement.

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%	Feb-16	76.4%	R

What is driving the reported underperformance

Please refer to Emergency Pathway Report

Actions taken to improve performance

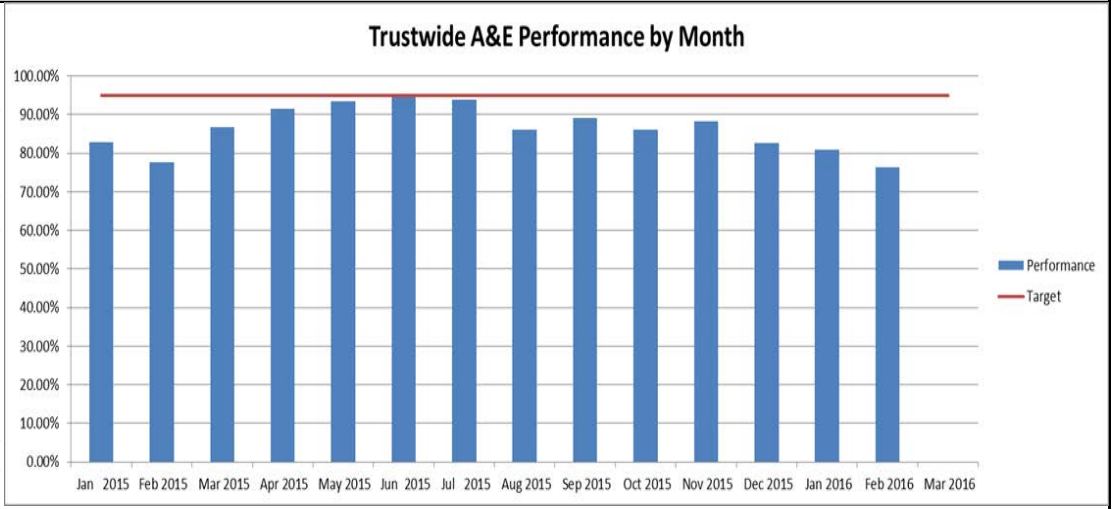
Recovery plan in with Monitor support focusing on: internal flow ; ED Department ; Admission avoidance.

The trajectory for ED has been reviewed in conjunction with the Monitor sustainablity and transformation requirements. The trajectory for 2016/17 is:

Q1	Q2	Q3	Q4
85%	87%	90%	90%

Expected date to meet standard	As above
Lead Director	Director of Service Delivery

Activity



OUR SERVICES – CQUIN

ACUTE KIDNEY INFECTION (AKI)

National CQUIN Standard

AKI Diagnosis, treatment and planned care after discharge.

Standard	Month	Actual	RAG for current month
>90% of 4 key items in discharge summaries Q4	Feb-16	52%	R

What is driving the reported underperformance

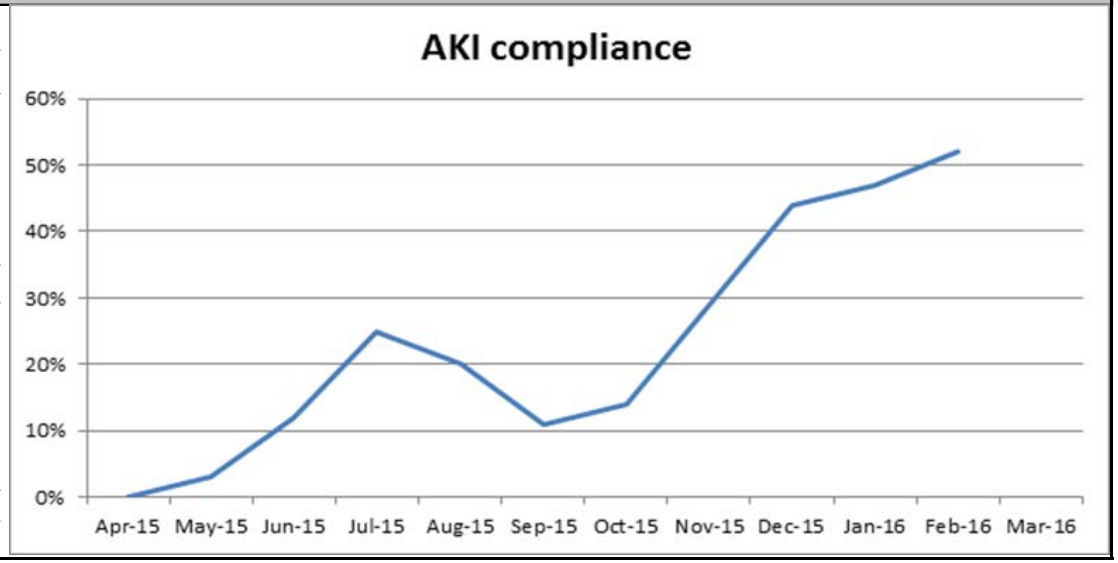
The project required us to create a new electronic recording process associated with the electronic discharge summary. This was launched on July 1st with supporting briefings and education, through testing several changes have been made through the 2nd quarter. It was predicted that the results would 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

The F2 Improvement Group supported by the academy and the clincal lead contiue to evaluate and modify the systems in place. 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 most recent action includes launch of "Ned the Nephron" which will help the campaign and also be used as a visual reminder to complete the AKI discharge boxes. 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 40%.

Expected date to meet standard	2016-17
Lead Director	Director of Safety

Activity



SEPSIS 2B

National CQUIN Standard

Eligible patients receiving antibiotics

Standard	Month	Actual	RAG for current month
>90% eligible patients	Jan-16	39%	R

What is driving the reported underperformance

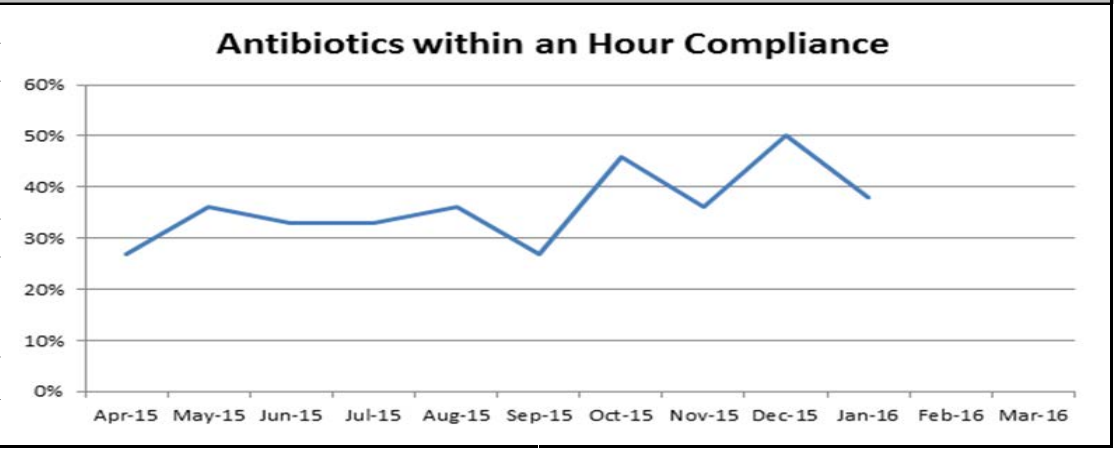
The target for Q3 was an average of 50%, this wasn't achived due to low compliance in November. The target for Q4 is 90% so it will be very difficult to make significant changes to the performance. Although the screening for sepsis (2a) is performing above 95% the time to antibiotics suffers from a range of problems, the clock starts from booking into ED (the old standard was from diagnosis or within 3 hrs of ED admission). This means that when ED is busy the time to antibiotics increases.

Actions taken to improve performance

To improve the performance a new ED sepsis team are looking at local practice. The Trust has also commneced the ED checklist programme which was succesfully tested at North Bristol, the project is being funded by the WEAHSN. This tool will allow earlier sepsis identification and is designed specifically for when the ED is at its busiest.

Expected date to meet standard	2016-17
Lead Director	Director of Safety

Activity



OUR PATIENTS

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	Feb-16	184	R

What is driving the reported underperformance

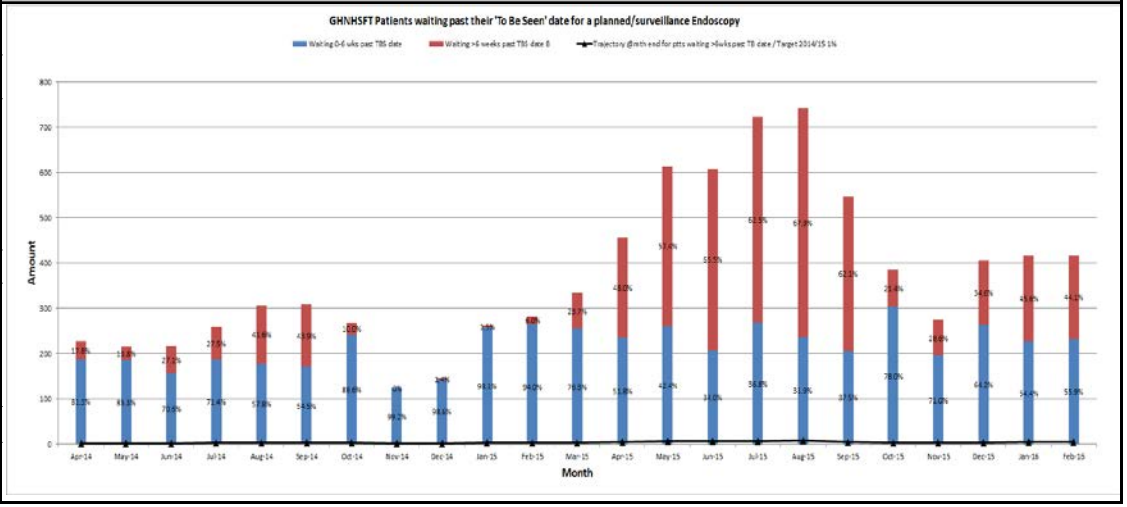
Demand has increased, particularly for 2ww Endoscopy, which has impacted on capacity available.

Actions taken to improve performance

Additional activity is being undertaken.

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

Activity



TWO WEEK WAIT FOR PATIENTS URGENTLY REFERRED

Monitor Standard
GCCG Financial Penalty

This relates to patients referred urgently by their GP for suspected cancer seen in 14 days

Standard	Month	Actual	RAG for current month
≥ 93%	Jan-16	88.0%	R

What is driving the reported underperformance

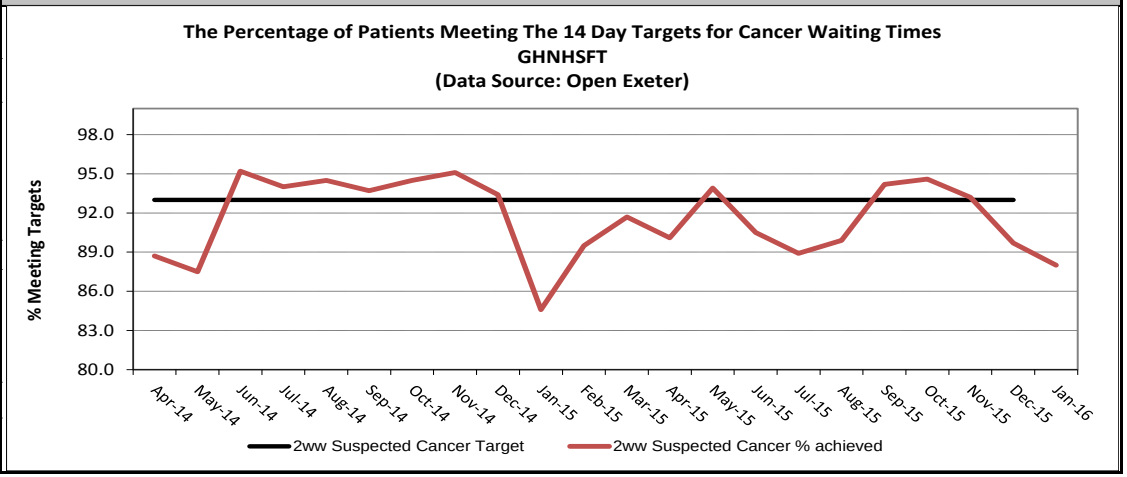
Referrals remain high in January and are currently 13% higher than the same time last year.

Actions taken to improve performance

Action plans are in place.

Expected date to meet standard	Feb-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%	Jan-16	77.4%	R

What is driving the reported underperformance

The position by tumour site for January is as follows. The position below is the Recovery Trajectory for January at 80.4%.

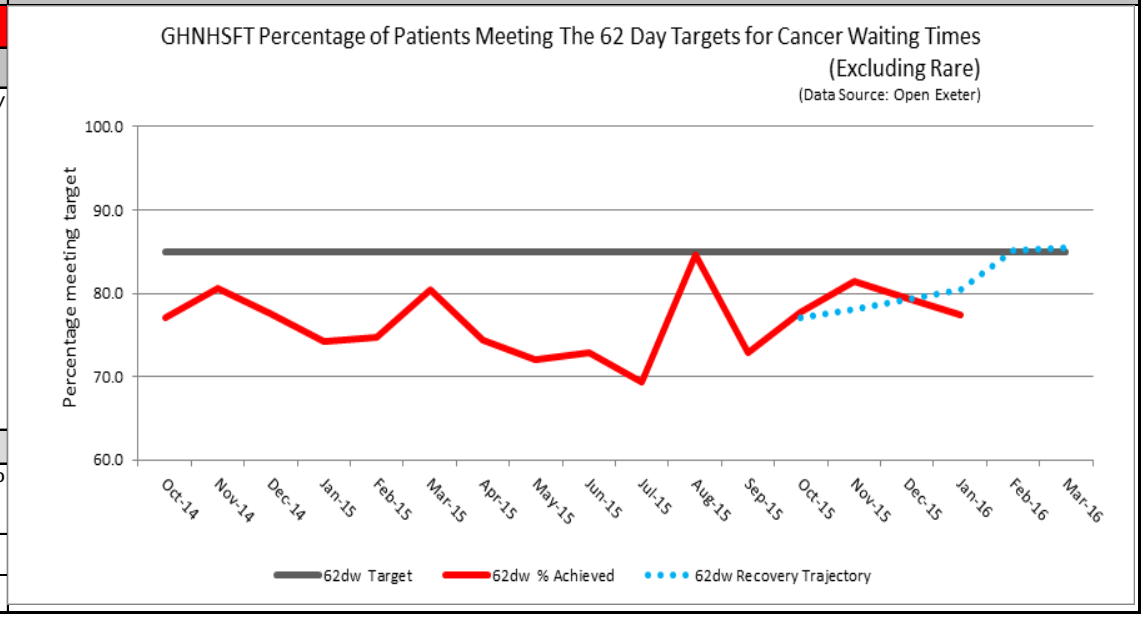
Tumour Site	Total	Breaches	%
Breast	18.5	2	89.2
Gynae	6.5	1.5	76.9
Haematology	4	1	75.0
Head & Neck	6	2	66.7
Lower GI	26	8.5	67.3
Lung	11.5	0.5	95.7
Sarcoma	1.5	0.5	66.7
Skin	31	0	100.0
Upper GI	10.5	3.5	66.7
Urology	24	12	50.0
Total	**139.5**	**31.5**	**77.4**

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 Management Group.

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

Activity



MAXIMUM 62 DAYS FROM NATIONAL SCREENING PROGRAMME TO 1ST TREATMENT

GCCG Standard

Standard	Month	Actual	RAG for current month
≥ 90%	Jan-15	84.0%	R

What is driving the reported underperformance

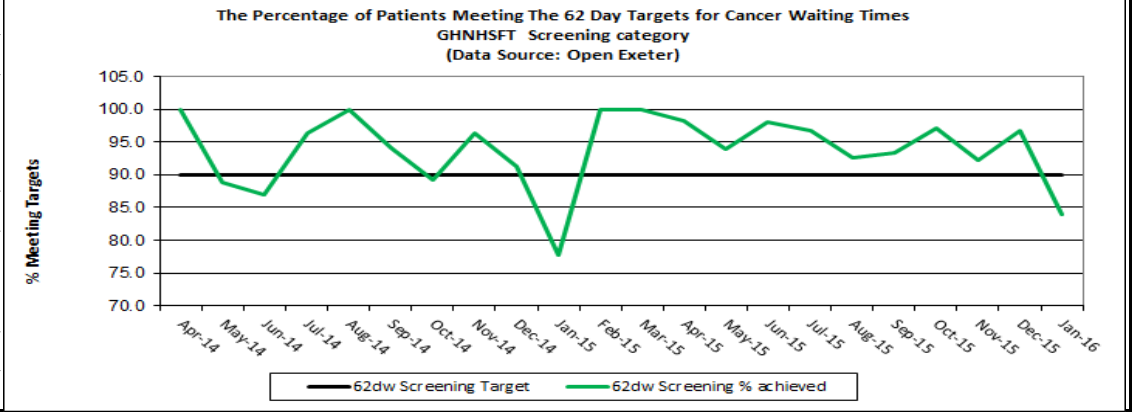
Of the 25 total number of treatments, there were 4 breaches, 1 relating to Breast and 3 Lower GI.

Actions taken to improve performance

The standard is predicted to be achieved in February.

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

Activity



OUR PATIENTS

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	Feb-16	16	R

What is driving the reported underperformance

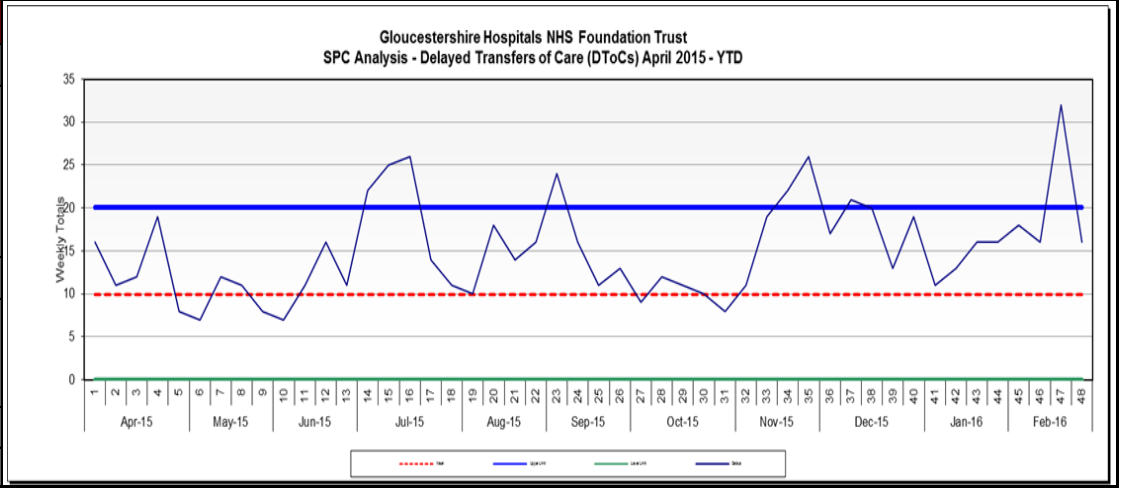
Please refer to Emergency Care Report

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	Feb-16	63	R

What is driving the reported underperformance

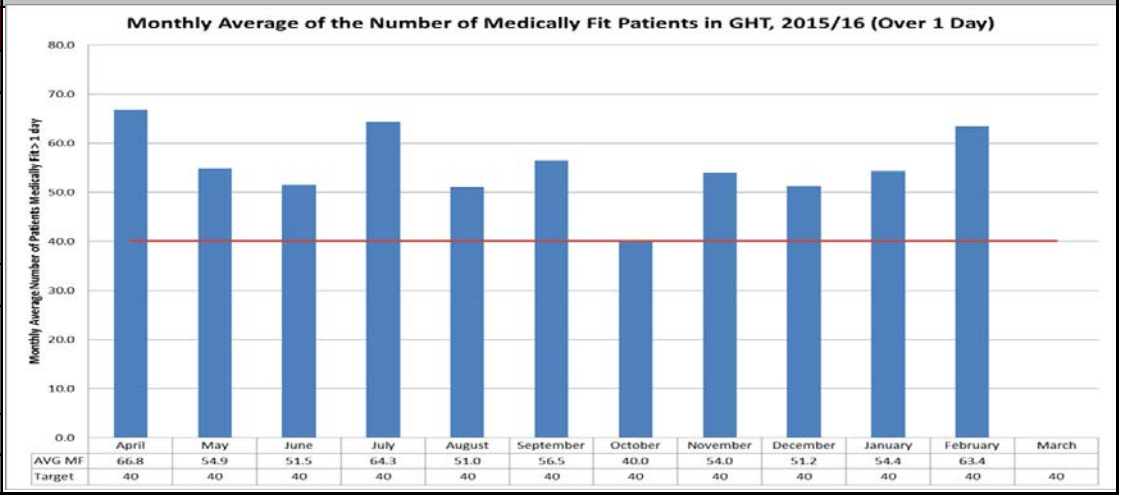
Please refer to Emergency Care Report

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



OUR PATIENTS

ELECTIVE PATIENTS CANCELLED ON DAY OF SURGERY

Trust Standard

Number of elective patients cancelled by hospital on the day for a non clinical reason as a % of elective admissions

Standard	Month	Actual	RAG for current month
≤ 0.8%	Feb-16	1.6%	R

What is driving the reported underperformance

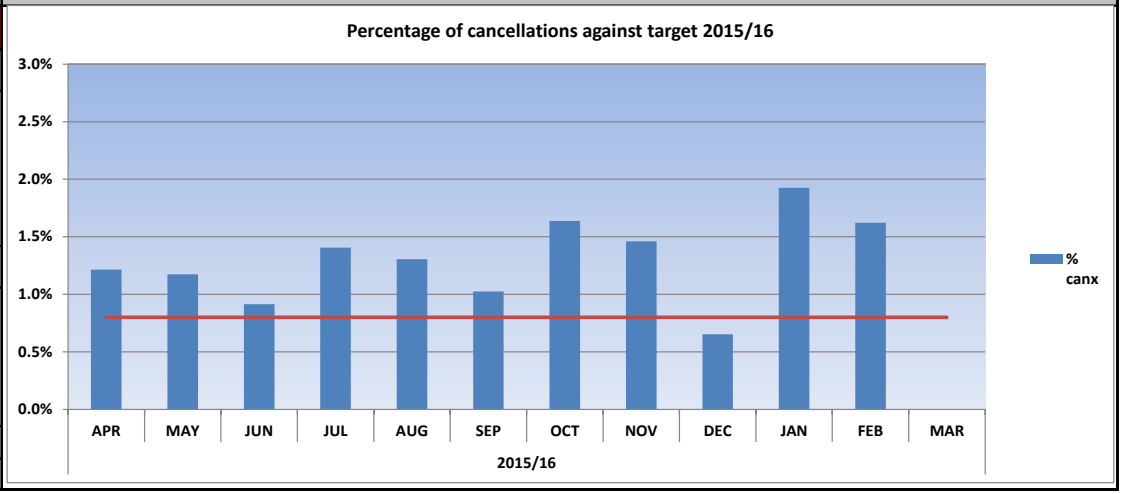
The increase in the numnber of medically fit patients and level of emergency admissions inpacted on this measure.

Actions taken to improve performance

Refocus by Surgical Division to reduce the number of cancellations on the day. Process establsihed in Surgical Division to review all elective activity daily

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

Activity



PATIENTS CANCELLED AND NOT REBOOKED IN 28 DAYS

GCCG Standard
Financial Penalty

Standard	Month	Actual	RAG for current month
0	Feb-16	11	R

What is driving the reported underperformance

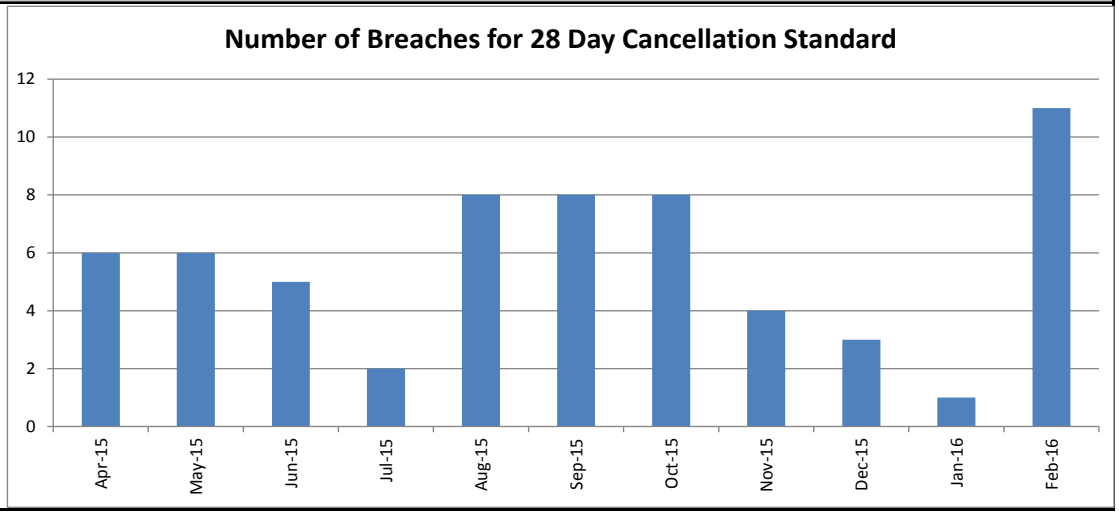
The increase in the numnber of medically fit patients and level of emergency admissions inpacted on our ability to rebook patients in 28 days.

Actions taken to improve performance

Focus by Surgical Division.

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

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 29TH FEBRUARY 2016

1. Executive Summary

The table below summarises the performance for the year to 29 February 2016 against key elements of the Trust's plan and financial duties.

	Month 11 YTD actual	Month 11 YTD plan	Variance	Full Year Plan
Delivering planned surplus	£0.7m	£2.3m	(£1.6m)	£4.0m
Monitor Financial Sustainability Risk Rating	3	3	(0)	3
Better Payment Practice Code (by value)	67%	95%	(28%)	95%
Capital expenditure	£10.8m	£12.6m	£1.8m	£16.5m

Key Issues:

- The financial position of the Trust at the end of month 11 is a surplus of £0.7m on income and expenditure. This is £0.2m higher than the position reported in Month 10.

- Operational pressures continue and temporary staffing expenditure is £0.4m higher than in Month 10. If agency pay expenditure in months 6 to 11 had been contained at the month 2 level the reported overall surplus would have improved to £5.1m.

- 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 £0.7m on the income and expenditure position represents an adverse variance of £1.6m from the planned position of £2.3m surplus of income over expenditure at the end of month 11.

- The cash position has improved to £8.2m at the end of the month (£7.2m in Month 10). New measures are in place to improve this position over the coming months.

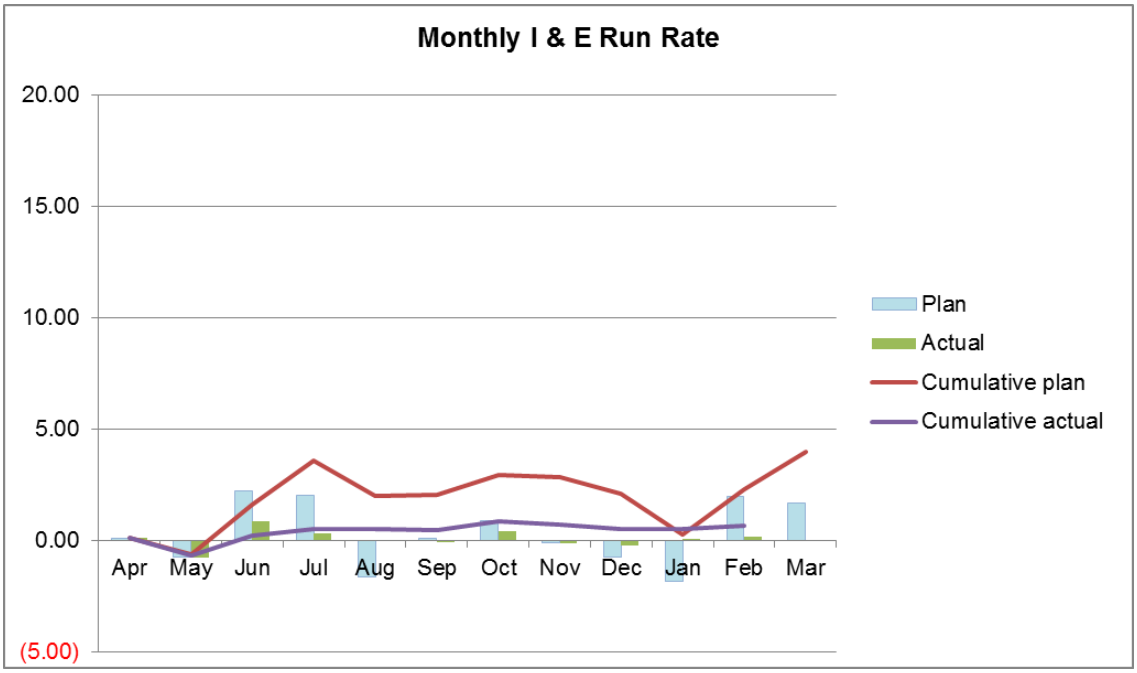
- The impact of the emergency cap cumulative to Month 11 was £1.3m.

2. Financial Position to 28 February 2016

The position at month 11 of the 2015/16 financial year is a surplus of £0.7m 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	379,299	388,452	9,152
PP, Overseas and RTA Income	5,557	5,094	5,082	(12)
Operating Income	62,785	57,467	56,890	(577)
Total Income	**482,783**	441,861	**450,424**	**8,563**
Pay	294,713	269,513	284,488	(14,974)
Non-Pay	160,180	148,151	144,940	3,211
Total Expenditure	**454,893**	**417,664**	**429,427**	**(11,763)**
EBITDA	**27,890**	**24,197**	**20,997**	**(3,200)**
EBITDA %age	**5.8%**	**5.5%**	**4.7%**	**-0.8%**
Depreciation	12,391	11,358	10,076	1,283
Public Dividend Capital Payable	7,028	6,442	6,772	(329)
Interest Receivable / Payable	4,491	4,117	3,478	639
Funds Available for Investment	**3,980**	**2,279**	**671**	**(1,608)**

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



The income and expenditure position at the end of February has improved by £0.2m in the month to £0.7m surplus.

Income from contracts is £9.2m 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 eleven months of the 2015/16 financial year was £8.6m above the planned level. This is due to an over performance of income from contracts of £9.2m and an under performance in other income of £0.6m.

The table below shows the commissioner income position to the end of Month 11 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	11,208	10,539	(669)	36,343	35,631	(711)
Daycase Spells	43,143	47,855	4,712	33,096	35,747	2,651
Non-elective Spells	1,305	1,225	(80)	2,292	2,003	(289)
Emergency Spells	42,126	44,968	2,842	78,470	82,835	4,365
Outpatient Attendances	417,897	413,632	(4,265)	46,574	47,170	597
Outpatient Procedures	110,518	116,452	5,934	16,325	16,580	255
A&E Attendances	115,361	115,871	510	13,799	14,143	344
Radiology Direct Access	37,258	34,865	(2,393)	2,558	2,173	(386)
Radiology Unbundled	13,878	17,687	3,809	1,559	1,850	291
Renal Dialysis	44,183	55,233	11,050	5,423	6,272	849
Excluded Drugs				39,844	42,906	3,062
Other Non-PbR				103,018	101,141	(1,877)
Grand Total				**379,299**	**388,452**	**9,152**

Key issues to note include:

- **Referrals**
  Referrals are 3.7% higher than the first 11 months of 2014/15 (+2.6% to month 10). Within this GP referrals are 4.0% 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 7.4% above plan on activity and 2.8% above plan on income. When separated out, elective activity is 6.0% below plan on activity and 2.0% below plan on income whilst daycase activity is 7.3% above plan with income 4.8% above plan on the same comparative basis as last month.

- **Emergency Activity**
  The Emergency spells position is 6.8% above plan in activity terms, and income is above plan by 5.5%.

  The impact on income of the Emergency Cap at month 11 was £1.3m, which is £200k in excess of the planned level of £1.1m and is a further reduction to the total income for the Trust.

- **Emergency Department**
  Emergency Department activity is broadly in line with plan, with income 2.5% above 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 0.3% and 1.3% respectively.

- **Radiology Direct Access**
  Radiology Direct Access activity and income are below plan by 6.4% and 15.1% respectively.

- **Unbundled Radiology**
  Activity and income levels are above plan by 27% and 19% respectively.

- **Excluded Drugs**
  Excluded drugs remain is 7.7% ahead of plan after the first eleven months of 2015/16.

4. Expenditure

Expenditure against plan for the first eleven months of the 2015/16 financial year represents an overspending of £11.8m against approved budgets.

Pay Expenditure

At Trust level for the eleven months ending February 2016 pay expenditure was above plan by £15.0m.

At a Divisional level the main contributory factor to the overspend was the impact of operational pressures within the health system and agency costs.

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	45,185	46,919	(1,734)	-3.84%
Junior Medical	28,229	25,719	29,350	(3,631)	-14.12%
Nursing	100,067	91,516	97,185	(5,669)	-6.19%
Admin & Clerical and Management	32,383	29,631	31,760	(2,128)	-7.18%
Clinical Support Services	42,631	39,010	40,124	(1,114)	-2.86%
Other Non Clinical	9,518	8,711	9,013	(302)	-3.46%
Other staff (includes CIP target)	866	779	519	259	33.26%
Divisional Pay sub total	**263,118**	**240,552**	**254,870**	**(14,319)**	-5.95%
Hosted Services Pay	25,974	23,810	24,412	(602)	-2.53%
Shared Services and Other Pay	5,620	5,152	5,205	(53)	-1.03%
Total	**294,713**	**269,513**	**284,488**	**(14,974)**	-5.56%

Key issues to note for the month include:

- Total Pay expenditure for February was just over £26.1m, which is £0.5m lower than January.
- Total temporary staffing expenditure during the month was £2.8m, which was £0.4m higher than previous month and £1.0m above the monthly average for 2014/15.
- The level of Pay expenditure over plan of 5.6% is not in line with the total income recovery over plan of 1.9%.
- Cumulative Divisional pay overspends were most significant within Medicine/USC (£8.6m overspent, an increase of £1.0m in the month) and Surgery (£6.5m overspent) which relates to both Nursing and Medical staff.
- Whilst Nursing is still showing the highest financial variance against plan at £5.7m (6.19%), the largest variance in terms of percentage from plan is Junior Medical staffing at 14.12% (£3.6m).
- 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 below 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 February expenditure at £0.4m higher than January's expenditure, which in turn was £0.4m higher than December. February's expenditure on temporary staffing was £1.0m above the monthly average of 2014/15.

Temporary Staffing Expenditure – Analysis by Staff Group	**Expenditure to date £000's**
Medical Agency & Locum	8,475
Nursing Agency	6,397
Nursing Bank	6,054
Other Clinical staff	1,095
Non Clinical staff	3,950
Total	**25,971**

Monitor continues to scrutinise the level of nursing agency expenditure at each Trust. We anticipate that this level of interest will intensify over the coming months.

Non Pay Expenditure

During February non-pay expenditure was above plan by £0.3m and is now cumulatively below plan by £3.2m for the year to date. Within this total non-pay position, the Divisional non-pay underspend has decreased to £0.9m in Month 11 with Hosted Services and Shared Services Non Pay underspend increasing to £2.3m in Month 11 against plan.

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	47,393	48,000	(607)	-1.28%
Medical and Surgical Equipment (MSE)	40,527	37,338	36,779	559	1.5%
Contract Services and Service received	20,126	18,549	20,084	(1,535)	-8.27%
Energy / Utilities	5,602	5,146	5,197	(51)	-0.98%
Building and other Estate expenses	5,916	5,441	5,439	2	0.0%
Establishment expenses	11,618	10,745	10,259	486	4.53%
Other Non-Pay (includes CIP target)	23,032	22,156	20,070	2,087	9.42%
Total Divisional Non Pay	158,671	146,768	145,826	942	0.64%
Hosted Services Non Pay	344	315	465	(150)	-47.66%
Shared Services & Other Non Pay	1,165	1,068	(1,352)	2,420	226.54%
Total	160,180	148,151	144,940	3,211	2.17%

Key issues to note for the month include

- Overall Non-pay expenditure overspent in comparison to plan by £0.3m.
- Drug expenditure underspent in comparison with plan in month 11 by £0.3m with a year to date position showing a £0.6m overspending.
- Medical & Surgical Equipment expenditure in month 11 underspent in comparison to plan by £0.2m and stands at £0.6m below plan for the year to date.

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	7,065	71	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	866	0	815
Trustwide		200	0	0
Total (£'000)	**24,003**	**18,992**	**589**	**4,599**
Total (%)		**79%**	**2%**	**19%**

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 further improvement in the final month 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 forecast surplus. Work continues to improve the position in the remaining weeks of the year. The main risks are outlined in the following table, together with a brief summary of the plans for mitigation:

Risk		Mitigation
	£m	
Payment from commissioners less than anticipated	2.0	Negotiations on finalising settlements ongoing
Pay expenditure run rate does not reduce, risk related to agency	2.1	Fortnightly Divisional meetings
There are potential financial penalties for missing contractual targets	0.5	Improvement plan to mitigate risks,
Total	**4.6**	

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 eleven months of the year totalled £10.8m. Details can be found in the table below.

Capital Programme 2015-16	Annual Plan £'000s	Mth 11 YTD Plan £000s	Mth 11 YTD Expenditure £'000s	Mth 11 Variance £'000s
Building schemes	1,595	1,508	1,054	453
Infrastructure maintenance	2,438	2,702	2,287	415
Other estates	440	340	302	37
Service reconfigurations	1,180	1,082	248	833
Sub Total	**5,653**	**5,631**	**3,892**	**1,739**
Major equipment infrastructure works	1,336	977	905	72
Medical Equipment	3,006	1,545	1,518	27
IM&T*	6,500	4,500	4,522	(22)
Total Expenditure	**16,495**	**12,653**	**10,837**	**1,816**

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 February 2016 (month 11) the BPPC performance was 67% by value and 39% 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 11		Cumulative for Financial Year 2014/15 Month 11	
	£'000	Number	£'000	Number
Total Bills Paid Within period	300,819	111,405	301,779	102,761
Total Bill paid within Target	200,512	43,004	250,050	75,220
Percentage of Bills paid within target	67%	39%	83%	73%

Although the BPPC remains similar to month 10, the number of invoices paid has increased in comparison to the same period last year, with payments being targeted at small companies to ensure they are paid more promptly.

Measures have been taken to improve the actual bills paid within the target. This includes a review of the 'No Purchase Order, No Pay' system and improvements to receipting of orders in a more timely fashion. The trust is working with our commissioners to improve receipt of cash within the month and within contract terms.

Debtors

The Trusts aged debt analysis at the end of February 2016 is shown in the table overleaf. 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	180	3,145	1,567	349	888	6,130
Other English NHS	3,197	1,212	368	1,172	5,048	10,998
Other Territory NHS	847	32	19	22	358	1,277
Overseas Patients	15	38	25	5	304	387
Private Patients	205	82	22	18	345	672
Other Non-NHS	539	109	70	47	274	1,040
	4,983	**4,619**	**2,071**	**1,613**	**7,217**	**20,503**

Within 'Other English NHS', the single largest debtor in the 120+ days will be Gloucestershire Care Services. We have recently settled a dispute with GCS and we expect this balance to be cleared shortly.

Cash Balances

The Trust cash balance at the end of February 2016 stands at £8.2m which is an improvement of £1.0m since last month. The position is illustrated in the table below.

Trust Cashflow Statement Feb-16	February £'000
Opening Bank Balance	7,214
Receipts	
Main CCG SLAs	38,838
All other NHS Organisations	5,630
Other Receipts	2,151
Total Receipts	46,619
Payments	
Payroll	(25,141)
Creditor(including capital)payments	(20,463)
Other Payments	0
Total Payments	(45,604)
Closing Bank Balance	8,229

8. Recommendation

The Board are asked to note:

- The financial position of the Trust at the end of month 11 is a surplus of £0.7m on income and expenditure. This is £0.2m higher than the position reported at Month 10.
- The Trust needs to improve its controls on the use of agency staff and discretionary expenditure to bring the overall position back in to line with plan as soon as possible.
- The Monitor risk assessment framework shows a Financial Sustainability Risk Rating of 3.
- Actions to address the issues identified in this report will continue and progress will continue to be reported monthly to the Finance and Performance Committee and the Foundation Trust Board.

Author: **Sean Ceres, Interim Director of Operational Finance**

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

Date: **March 2016**

Appendices

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

DIVISIONAL POSITION AS AT THE END OF MONTH 11 - FEBRUARY 2016

	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	379,299	388,452	9,152	3,658	2,524	1,751	1,667	2,872	0	(3,321)
Operating income	62,561	61,972	(589)	(2,131)	(3,312)	(346)	(294)	162	(832)	6,163
Pay expenditure	269,513	284,488	(14,974)	(8,593)	(6,502)	(1,059)	(817)	(479)	(774)	3,249
Non pay expenditure	148,151	144,940	3,211	(2,853)	(57)	(741)	(518)	324	1,585	5,471
Non Operating Costs	21,918	20,325	1,592	0	0	0	0	0	0	1,592
Total	**2,279**	**671**	**(1,608)**	**(9,919)**	**(7,346)**	**(394)**	**39**	**2,879**	**(21)**	**13,155**
Last Month Variance	**284**	**522**	**238**	**(8,600)**	**(6,525)**	**(633)**	**124**	**2,239**	**(87)**	**13,719**
Movement	**1,995**	**149**	**(1,846)**	**(1,319)**	**(821)**	**239**	**(85)**	**640**	**66**	**(564)**

HEALTHCARE CONTRACT INCOME POSITION AS AT MONTH 11

2015/16 Healthcare contracts position as at Month 11	2015/16 Full year plan £000	Month 11 Plan £000	Month 11 Actuals £000	Variance £000
NHS Gloucestershire CCG	292,592	267,623	275,898	8,275
Worcestershire Health Community	10,828	9,900	9,885	(16)
NHS Hereford CCG	3,748	3,429	3,797	368
Wiltshire Health Community	2,979	2,724	2,413	(311)
NHS South Warwickshire CCG	250	229	181	(48)
Oxfordshire CCG	386	353	454	100
Specialist Commissioning Group	74,180	67,903	71,093	3,190
Welsh Commissioners	3,435	3,143	3,702	559
Other Commissioner Income	22,026	20,322	17,425	(2,897)
Non Contractual Agreements (NCAs)	4,017	3,673	3,604	(69)
NHS CLINICAL REVENUE	**414,441**	**379,299**	**388,452**	**9,152**

Monitor Financial Sustainability Risk Rating calculation February 2016

Continuity of Services	Balance Sheet Sustainability		**Feb-16**	
		Capital Service		
		Revenue Available for Capital Service	21,723	
		Capital Service	(12,293)	
		Sum = (calc above x no. of days)	**1.77**	**Key to scoring - Liquidity (25% weighting)**
		Rating	**3**	**4**: >2.5 / **3**: 1.75-2.5 / **2**: 1.25-1.75 / **1**: <1.25
	Liquidity	**Liquidity**	**Current month**	
		Working capital balance	(14,162)	
		Operating expenses within EBITDA	(429,428)	
		Sum = (calc above x no. of days)	(10.9)	**Key to scoring - Debt Service Cover (25%weighting)**
		Rating	**2**	**4**: <0 days / **3**: (7) - 0 days / **2**: (14) - (7) days / **1**: >(14) days
Financial efficiency	Underlying performance	**I & E Margin**		
		Normalised Surplus (deficit)	670	
		Total Income	451,151	
		I&E Margin	**0.15%**	**Key to scoring - I & E Margin (25% weighting)**
		Rating	**3**	**4**: >1% / **3**: 0 - 1% / **2**: (1) - 0% / **1**: <(1)%
	Variance from plan	**I & E Margin Variance From Plan**		
		I & E Margin	0.15%	
		I & E Margin Variance from Plan	-0.61%	**Key to scoring - Variance in I& E Margin(25%weighting)**
		Rating	**3**	**4**: >0% / **3**: (1) - 0% / **2**: (2) - (1)% / **1**: <(2)%
		OVERALL RATING	**3**	

Gloucestershire Hospitals NHS Foundation Trust
Statement of Financial Position

Trust Financial Position as at 29 February 2016	**Opening Balance £000**	**Closing Balance £000**
Non-Current Assests	303,840	304,697
Current Assets		
Inventories	7,926	7,915
Trade and Other Receivables	41,136	33,926
Cash and Cash Equivalents	7,214	8,229
Total Current Assets	56,276	50,070
Current Liabilities	(61,312)	(56,317)
Net Current Assets	(5,036)	(6,247)
Non-Current Liabilities	(70,314)	(69,810)
Total Assets Employed	228,490	228,640
Financed by Taxpayers Equity		
Public Dividend Capital	166,519	166,519
Reserves	66,828	66,828
Retained Earnings	(4,857)	(4,707)
Total Taxpayers' Equity	228,490	228,640

EMERGENCY PATHWAY REPORT
MONTHLY PERFORMANCE REPORT: FEBRUARY 2016
FOR MAIN BOARD IN MARCH 2016

1. Executive Summary

Key Messages

- The 95% 4 hour target for Emergency Department performance was not successfully met in February 2016, with Trustwide performance reported as 76.43%. Neither site achieved the 95% standard in February.

- The daily average number of Emergency Department attendances in February 2016 was 366 patients (10,603 for the month), compared to February 2015 (315 per day) and January 2016 (346 per day). The work of the GP in the Gloucestershire Royal Hospital Emergency Department and direct attendances to the Ambulatory Emergency Care units are not included in the 2015/16 attendances.

- The daily average number of admissions from the Emergency Department in February 2016 was 119 patients (3,447 for the month), compared to February 2015 (108 per day) and January 2016 (120 per day).

- General and Acute average length of stay for non-elective admissions in February 2016 was 6.18 days compared to 6.07 days in January 2016. The internal target for Quarter 4 is 5.8 days.

- The number of patients on the medically fit list for one day and over has been at an average of 63 throughout February 2016. This is 9 patients more than the previous month, and remains above the system-wide plan of no more than 40 patients.

New Services Commenced in February 2016

- From February 2016, the Gloucestershire healthcare system has established the Six Week Improvement to Flow and Transfer (SWIFT) action plan.

- Primary Care pilot in Gloucestershire Royal Hospital Emergency Department accepting some minor injury cases from 29th February 2016, to ease pressure on the Emergency Department.

- Additional Senior Nursing cover at weekends commenced mid-February, to increase simple discharges and embed criteria-led discharge.

Key Risks

- Demand exceeding both the contractual plan and historical levels. As at the end of February 2016, admissions were 6.4% higher than last year.

- 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 29th February 2016.

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

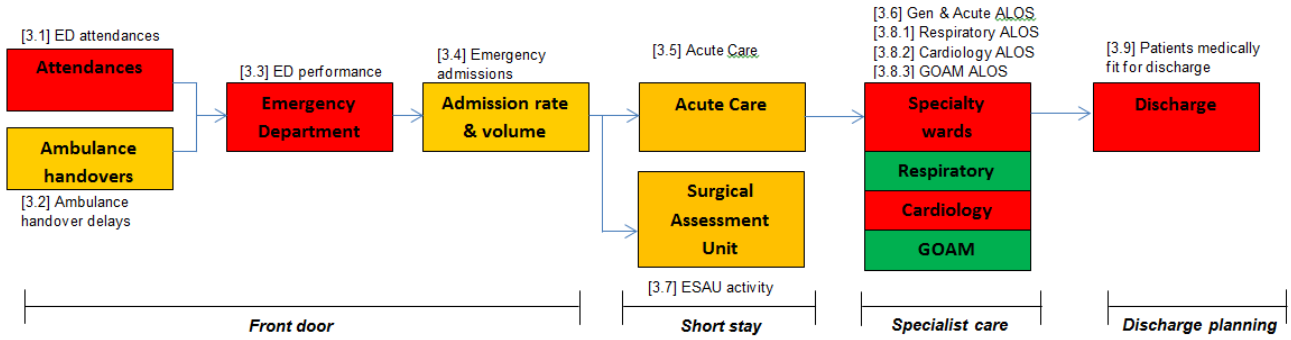
The diagram below shows the key processes within the emergency pathway.

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

The Trust appointed an Improvement Director in February 2016 to support in the delivery of the plan, they commenced in March 2016.

3.1 Emergency Department Attendances

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

How: Work with:-

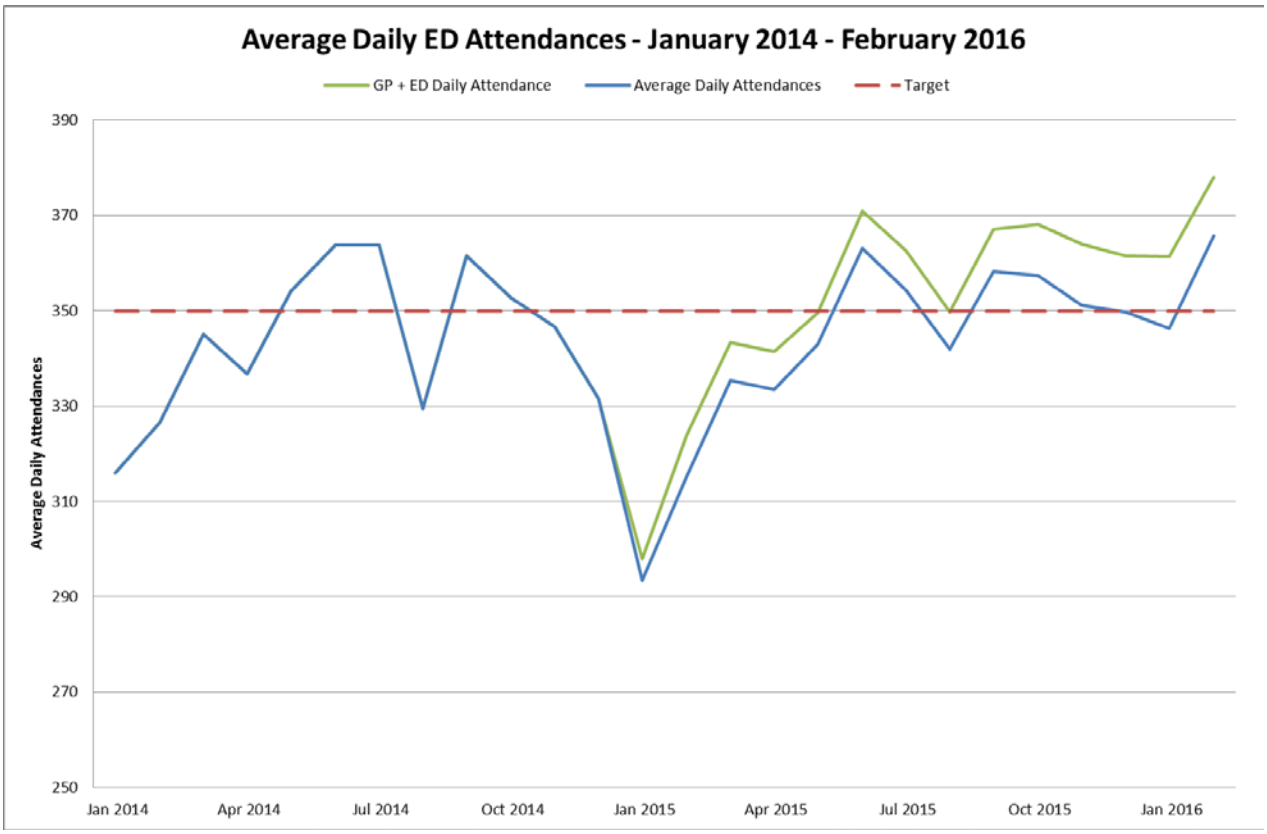
- South Western Ambulance Service NHS Foundation Trust (SWAST) to 'Smooth' emergency demand in the system;
- Integrated Discharge Team (IDT) within Emergency Department to increase direct admissions to community hospitals from Emergency Department;
- Develop the Older Person's Assessment and Liaison (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).

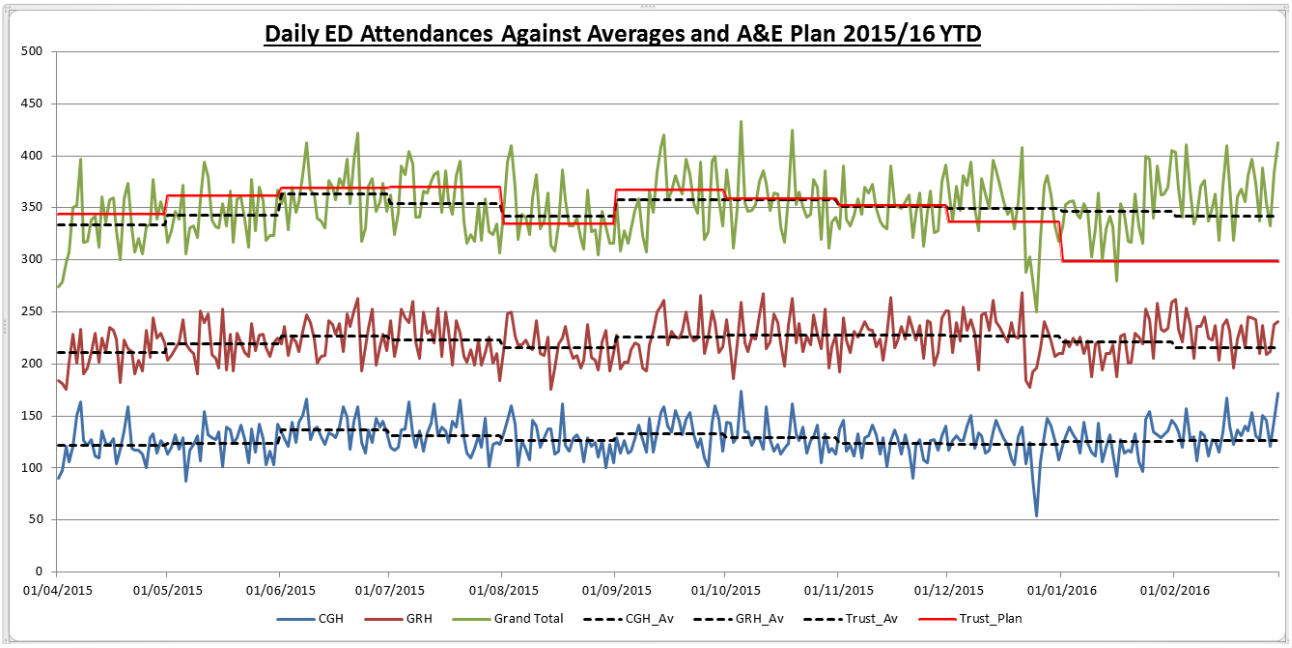
Narrative: There were 10,603 attendances in February 2016 (average of 366 per day) which is 20 higher than January 2016 and 16 above the plan of 350 per day.

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.

Emergency Department Attendances Chart



Emergency Department Daily Attendances against Plan



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
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%
January 2016	10734	2130	80.16%	468	80.99%
February 2016	10603	2499	76.43%	361	77.21%

Actions to be taken

- Continue with Primary Care in Emergency Department pilot (now extended to April 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;

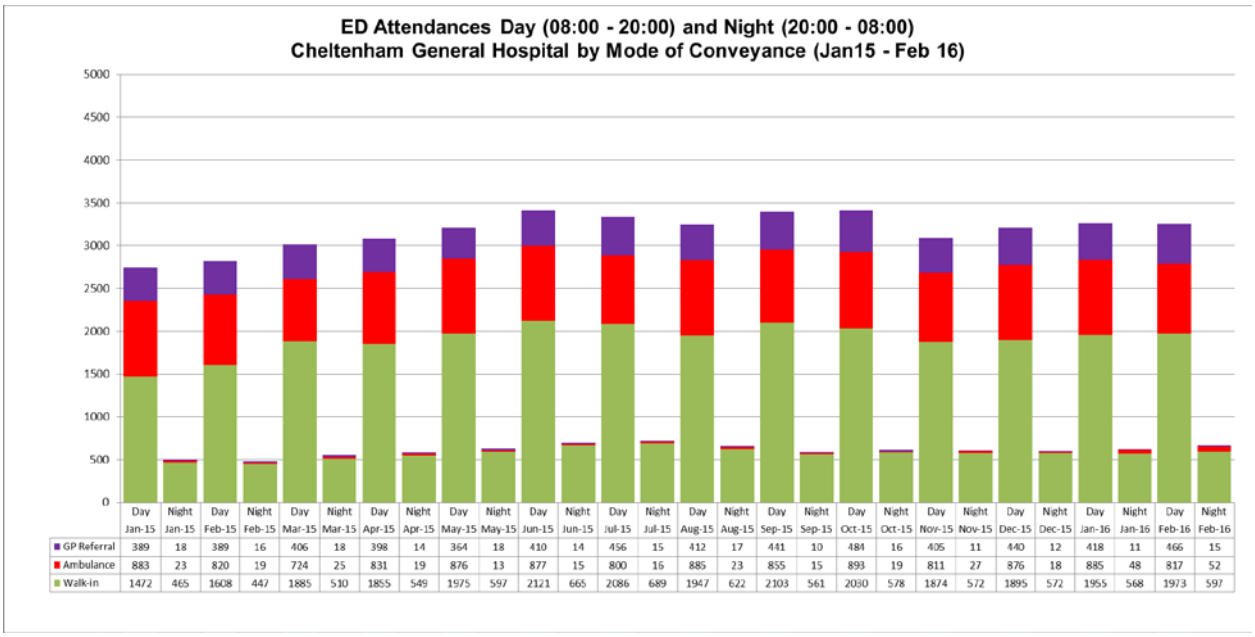
- Streamlining Urgent Care Programme: the 'Streaming' function and pathways have been revised, and a pilot that tested the role of a Clinical Navigator took place over two days w/c 12th October. This proved successful and Gloucestershire Clinical Commissioning Group has agreed to fund the post until the end of April 2016, with a view to extend further into 2016/17. The Clinical Navigator is now in post and a comprehensive Memorandum of Understanding has been agreed between the Trust and the Ambulance Service. To increase the numbers into Primary Care, the service will now accept some minor injury cases. This went live 29th February 2016.

- Continued use of the Ambulatory Emergency Care service on both sites. The Clinical Navigator is also able to refer suitable patients presenting to the Emergency Department directly into the Ambulatory Emergency Care service.

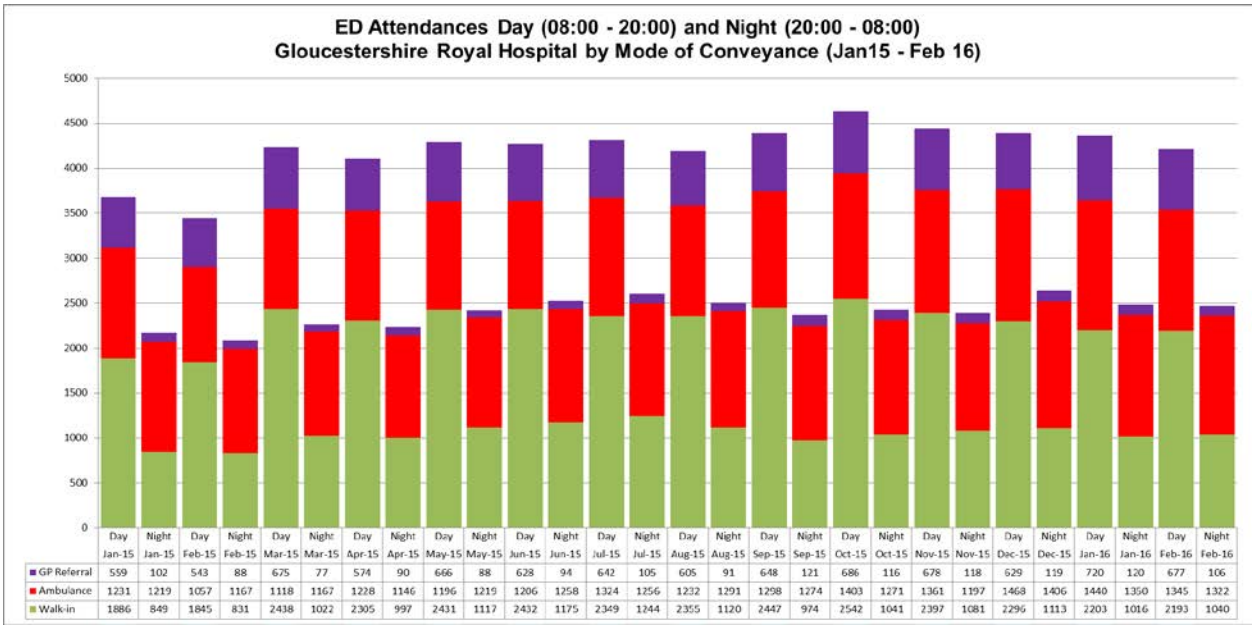
- System-wide performance management of Unscheduled Care QIPP schemes.

- From February 2016, the Gloucestershire healthcare system has established the Six Week Improvement to Flow and Transfer (SWIFT) action plan.

Emergency Department Attendances by Mode of Conveyance Charts



	Day Jan-15	Night Jan-15	Day Feb-15	Night Feb-15	Day Mar-15	Night Mar-15	Day Apr-15	Night Apr-15	Day May-15	Night May-15	Day Jun-15	Night Jun-15	Day Jul-15	Night Jul-15	Day Aug-15	Night Aug-15	Day Sep-15	Night Sep-15	Day Oct-15	Night Oct-15	Day Nov-15	Night Nov-15	Day Dec-15	Night Dec-15	Day Jan-16	Night Jan-16	Day Feb-16	Night Feb-16
GP Referral	389	18	389	16	406	18	398	14	364	18	410	14	456	15	412	17	441	10	484	16	405	11	440	12	418	11	466	15
Ambulance	883	23	820	19	724	25	831	19	876	13	877	15	800	16	885	23	855	15	893	19	811	27	876	18	885	48	817	52
Walk-in	1472	465	1608	447	1885	510	1855	549	1975	597	2121	665	2086	689	1947	622	2103	561	2030	578	1874	572	1895	572	1955	568	1973	597



	Day Jan-15	Night Jan-15	Day Feb-15	Night Feb-15	Day Mar-15	Night Mar-15	Day Apr-15	Night Apr-15	Day May-15	Night May-15	Day Jun-15	Night Jun-15	Day Jul-15	Night Jul-15	Day Aug-15	Night Aug-15	Day Sep-15	Night Sep-15	Day Oct-15	Night Oct-15	Day Nov-15	Night Nov-15	Day Dec-15	Night Dec-15	Day Jan-16	Night Jan-16	Day Feb-16	Night Feb-16
GP Referral	559	102	543	88	675	77	574	90	666	88	628	94	642	105	605	91	648	121	686	116	678	118	629	119	720	120	677	106
Ambulance	1231	1219	1057	1167	1118	1167	1228	1146	1196	1219	1206	1258	1324	1256	1232	1291	1298	1274	1403	1271	1361	1197	1468	1406	1440	1350	1345	1322
Walk-in	1886	849	1845	831	2438	1022	2305	997	2431	1117	2432	1175	2349	1244	2355	1120	2447	974	2542	1041	2397	1081	2296	1113	2203	1016	2193	1040

Narrative: In February 2016 there were 3,536 ambulance arrivals across both sites (average 122 per day). This is an increase of 15% on the same period last year, when there were 3,063 ambulance arrivals (average 109 per day). However, it is in line with the daily average in January 2016 of 120 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.

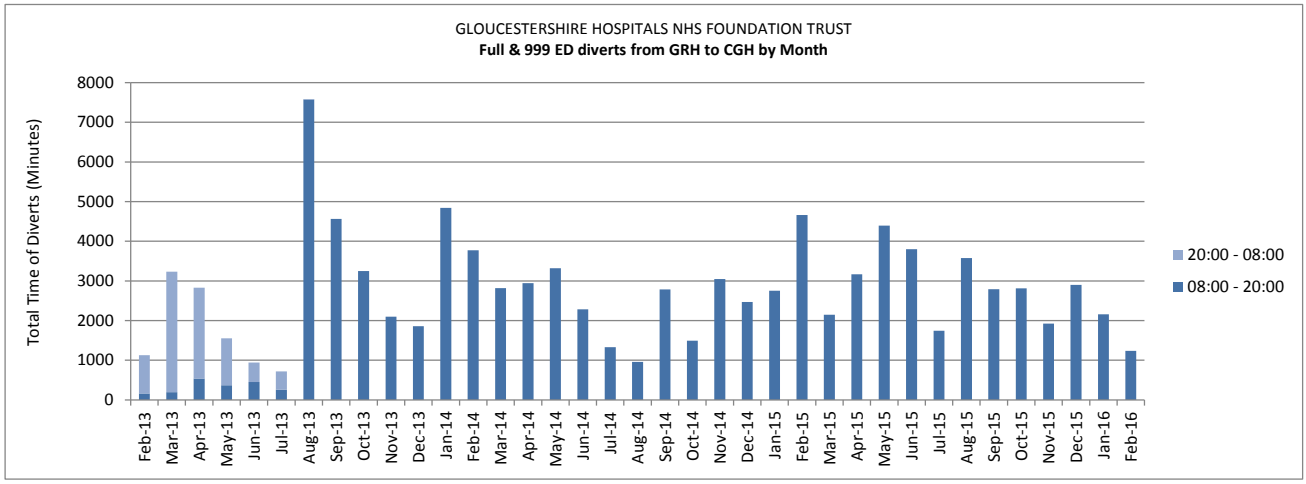
Diverts Between Gloucestershire Royal Hospital & Cheltenham General Hospital

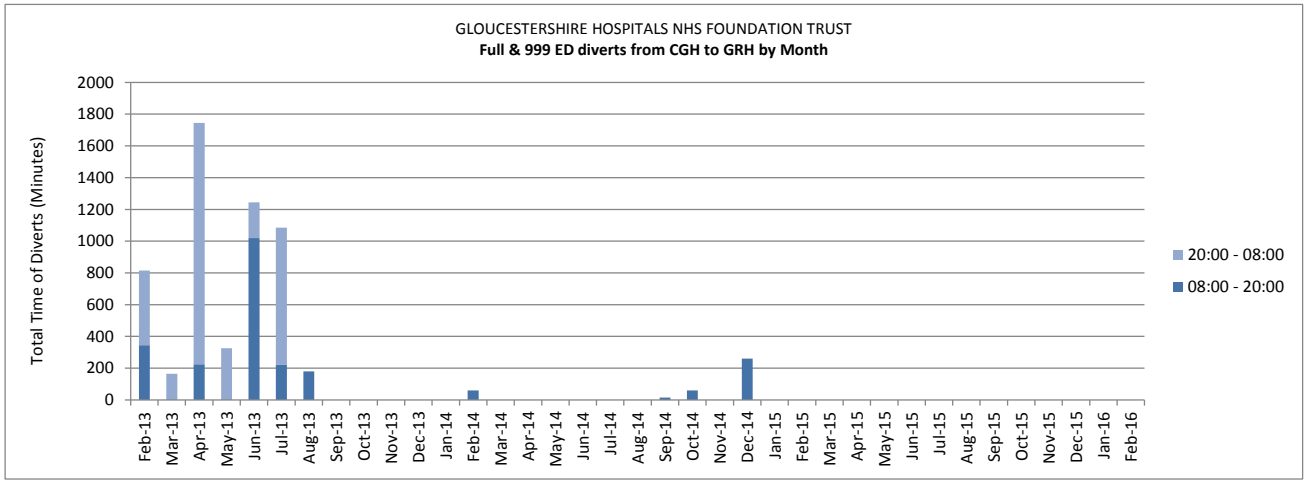
Aim: To reduce the number of across site diverts.

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. Evidence suggests that there has been no significant change so far.

There were 6 occasions when a Full/999 divert took place in February 2016 compared to 10 last month. The total duration reduced from 36 hours to 20.6 hours, but the average number of hours per divert remained similar at 3.4 hours in February, compared to 3.6 hours in January.





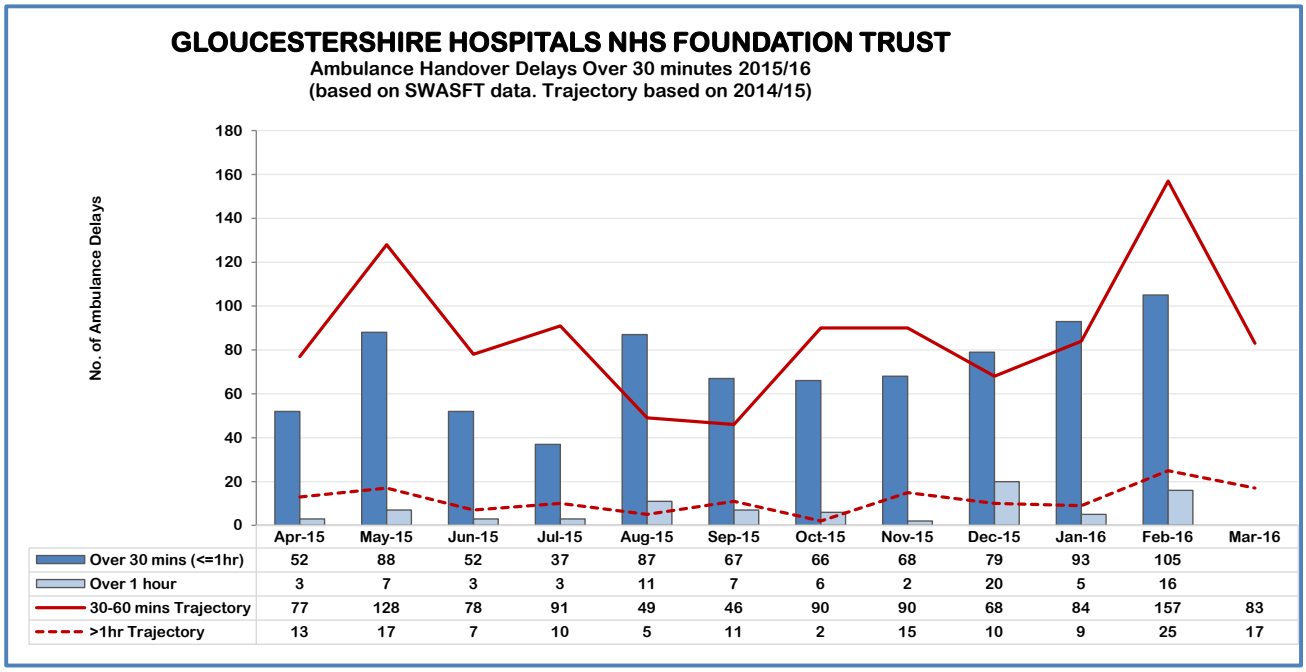
3.2 Ambulance Handover Delays

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

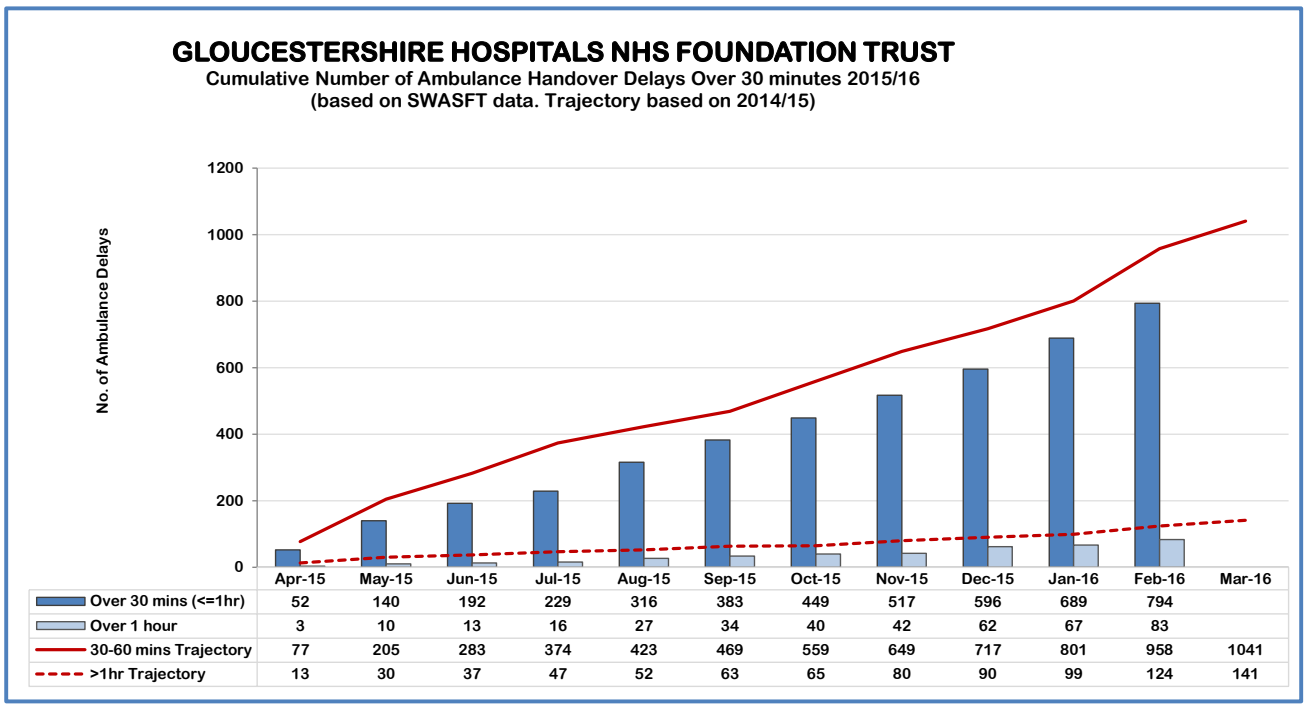
How: Doctor and nurse rotas better aligned to demand, revised handover process, improved reporting, trialling new 'flow coordinator' post, implementing capacity and escalation action cards and use of Rapid Assessment and Treatment (RAT) model.

Narrative: There were 121 ambulance handover delays in February 2016; of which 16 were over one hour. This is an increase from last month in which there were 98 handover delays and 5 over one hour.

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	93	105	
Over 1 hour	3	7	3	3	11	7	6	2	20	5	16	
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	689	794	
Over 1 hour	3	10	13	16	27	34	40	42	62	67	83	
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. February 2016 data shows that neither site successfully met the 95% standard. The overall Trust performance in February was 76.43%, which is the lowest since February 2015.

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%	87.34%	88.88%	
GRH actual	89.50%	92.27%	93.70%	92.41%	82.40%	85.61%	83.27%	85.86%	79.06%	76.08%	69.13%	
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%	80.16%	76.43%	

NHS England (Type 1) Emergency Department performance for Quarter 3 2015/16 was 87.4%. The Trust's performance for the same period 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 February 2016 is outlined in the following table:

January 2016						
	Total Breached	**Breach due to Awaiting Assessment**	**Breach due to Awaiting Bed**	**Breach due to Undergoing Treatment**	**Breach due to ED Capacity**	**Others***
CGH	436	45	209	42	28	112
GRH	2063	270	963	148	396	286
Total	2499	315	1172	190	424	398
%		12.60%	46.90%	7.60%	16.97%	15.93%

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

3.3.3 Quality

Aim: To consistently deliver national Emergency Department quality standards.

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

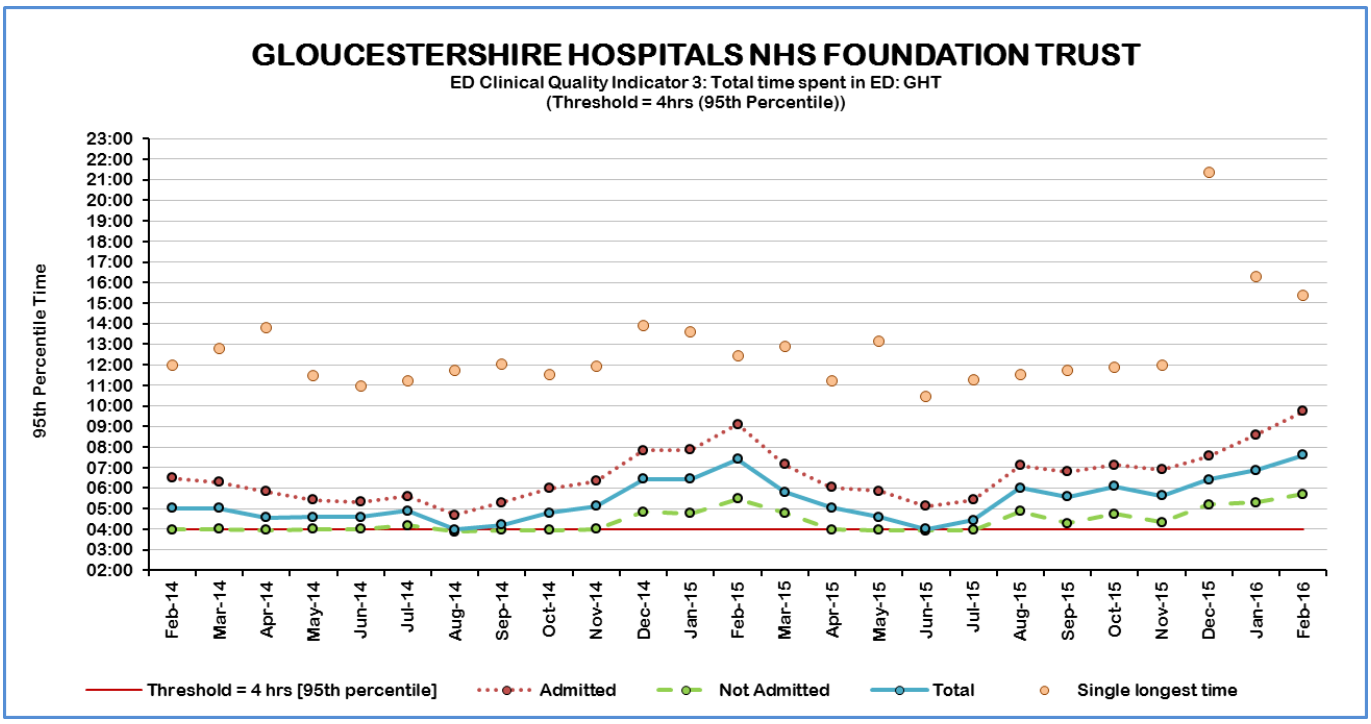
National Quality Indicators

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

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	Jan-16	Feb-16
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%	1.40%	1.70%
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	06:53	07:37
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%	1.40%	1.80%
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	01:02	01:13

To better understand the distribution of total 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.

The 95th percentile time (for all patients) in February was 7 hours 37 minutes, compared to 7 hours 25 minutes the previous year. The single longest wait was circa 15 hours within the department.



Safety & Experience Quality Metrics:

Narrative: The Director of Safety, Head of Patient Experience and Executive Directors are working to improve visibility of the quality of care being delivered, particularly when there are long waits, or the Emergency Departments are crowded. Metrics will include:

Safety Metrics:	*Experience Metrics:*
• Number of incidents, plus themes and actions; • Number of Serious Incidents; • Current improvement and audit projects; • National audits; • Morbidity and Mortality outputs; • Risk register and actions	• Friends & Family Test – Emergency Department response rate and positive score; • Number of complaints, plus themes; • Number of concerns, plus themes; • Number of compliments; • "You said, we did" – lessons learned

In addition, a project commenced on the 1st February 2016, to introduce an Emergency Department Checklist. This has been previously tested at North Bristol Trust and is being rolled-out as part of the West of England Academic Health Science Network. The checklist is designed to help staff in the department manage in times of extremis and ensure patient safety is maintained. The initial roll-out and three month evaluation will commence on 1st March 2016.

A Root Cause Analysis which addressed the question of patient safety during the period of increased operational pressures in the Emergency Departments, for the period 24th December 2015 to 6th January 2016, was submitted to Gloucestershire Clinical Commissioning Group in February and will be discussed at the Quality Committee.

3.4 Emergency Admissions

3.4.1 Emergency Admission Rate

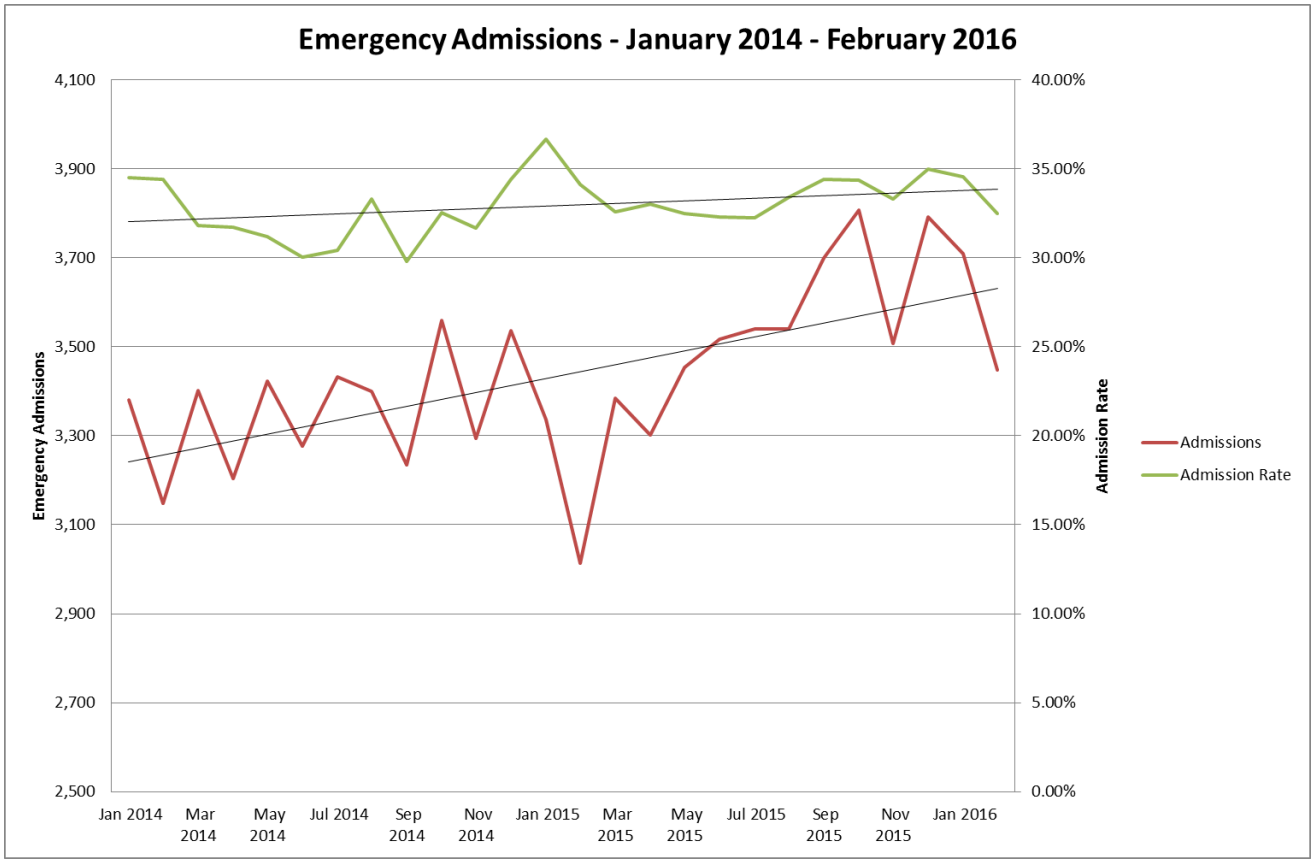
Aim: To ensure the admission rate from the Emergency Department remains in control.

How: By avoiding admissions through alternatives as appropriate.

Narrative: The Emergency admission rate in February 2016 was 32.51% compared to February 2015, when the admission rate was 34.14%. In February 2016 there were 10,603 Emergency Department attendances and 3,447 patients were admitted (average 119 per day), compared to February 2015 when there were 8,829 attendances but 3,014 patients were admitted (average 108 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.

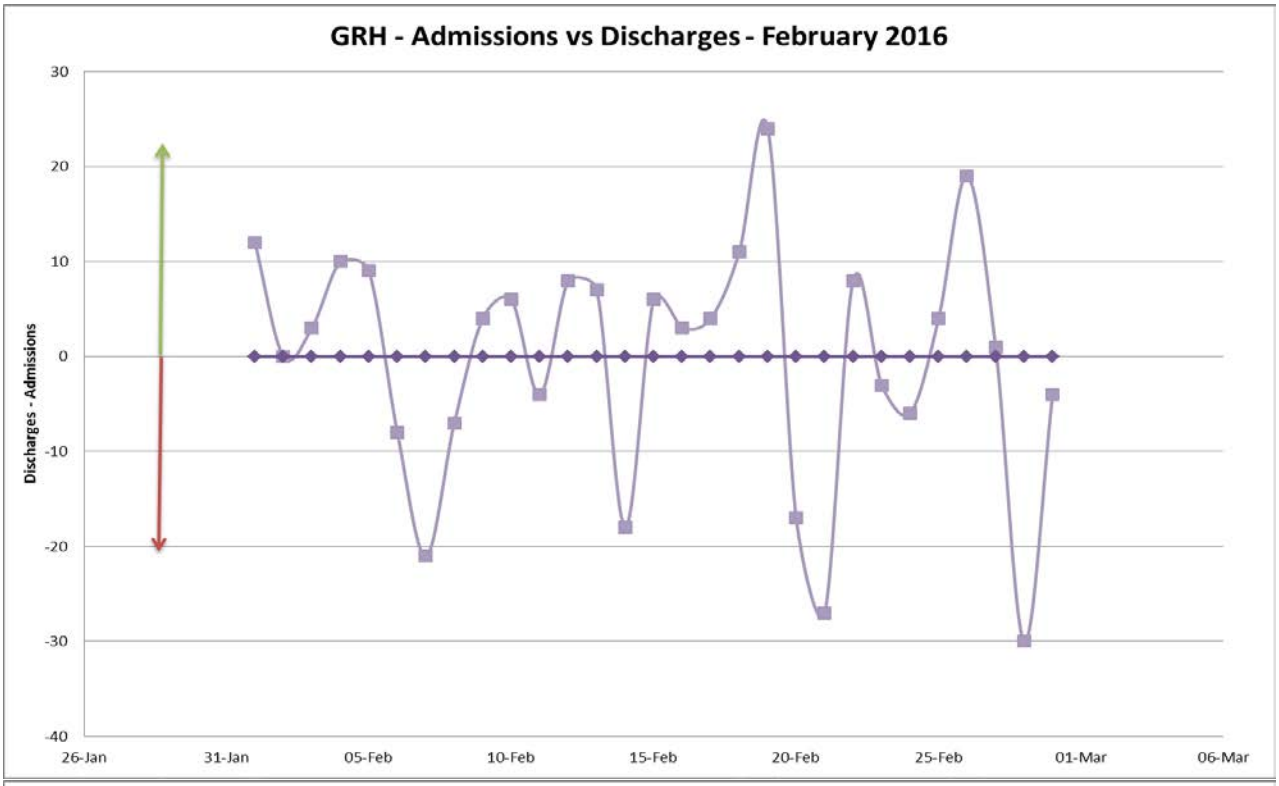


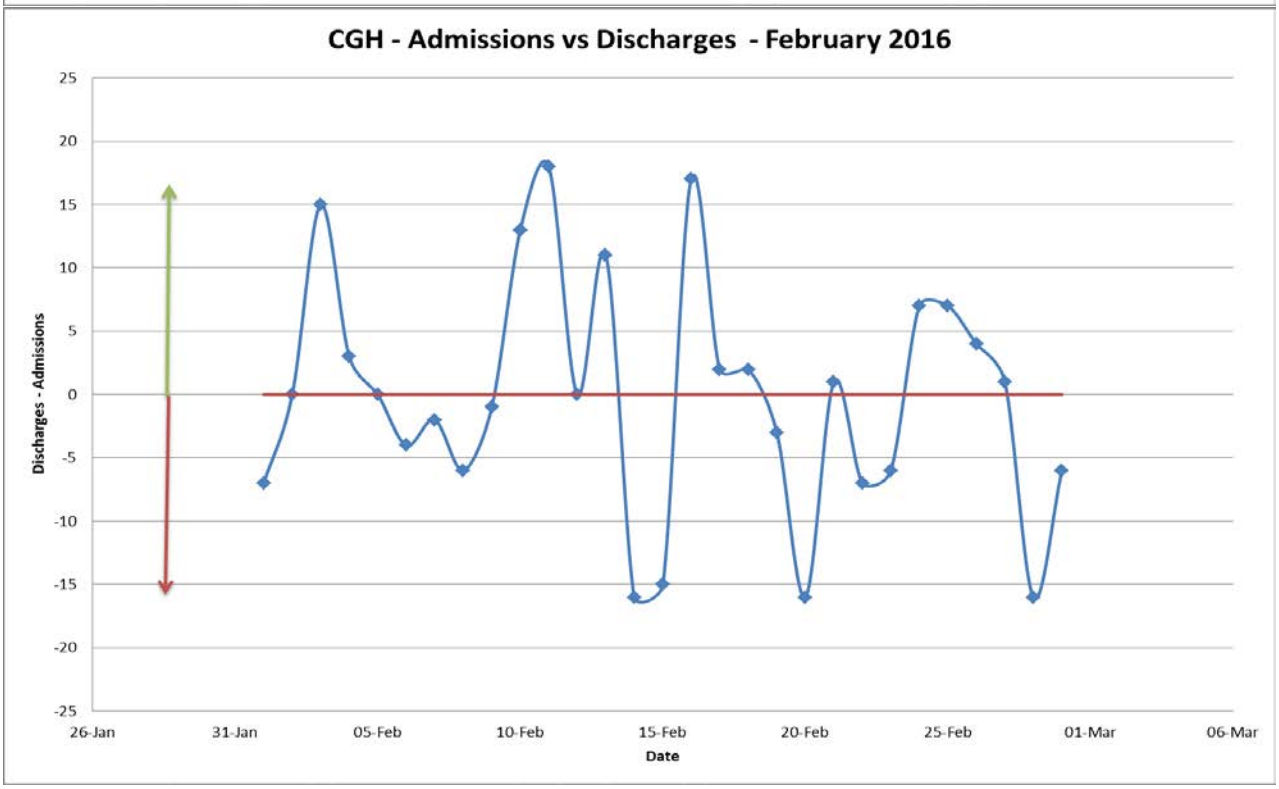
3.4.2 Admissions vs Discharges

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.





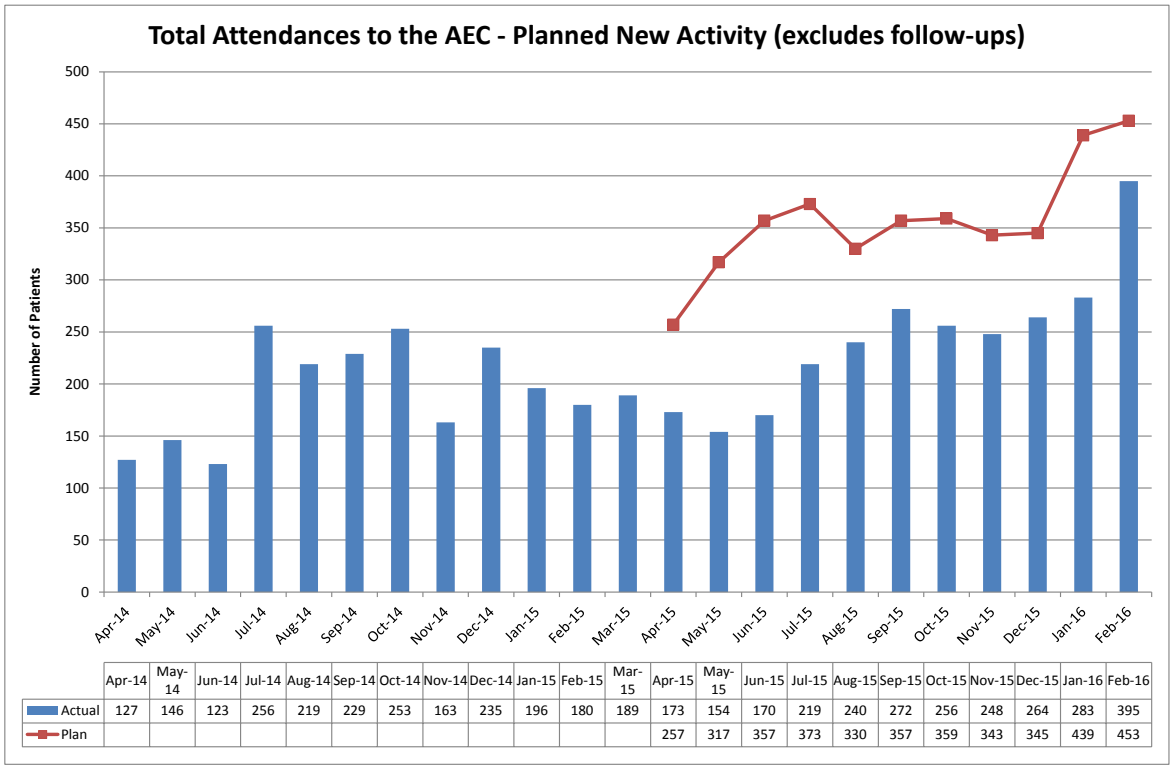
3.5 Ambulatory Emergency Care Attendances

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.

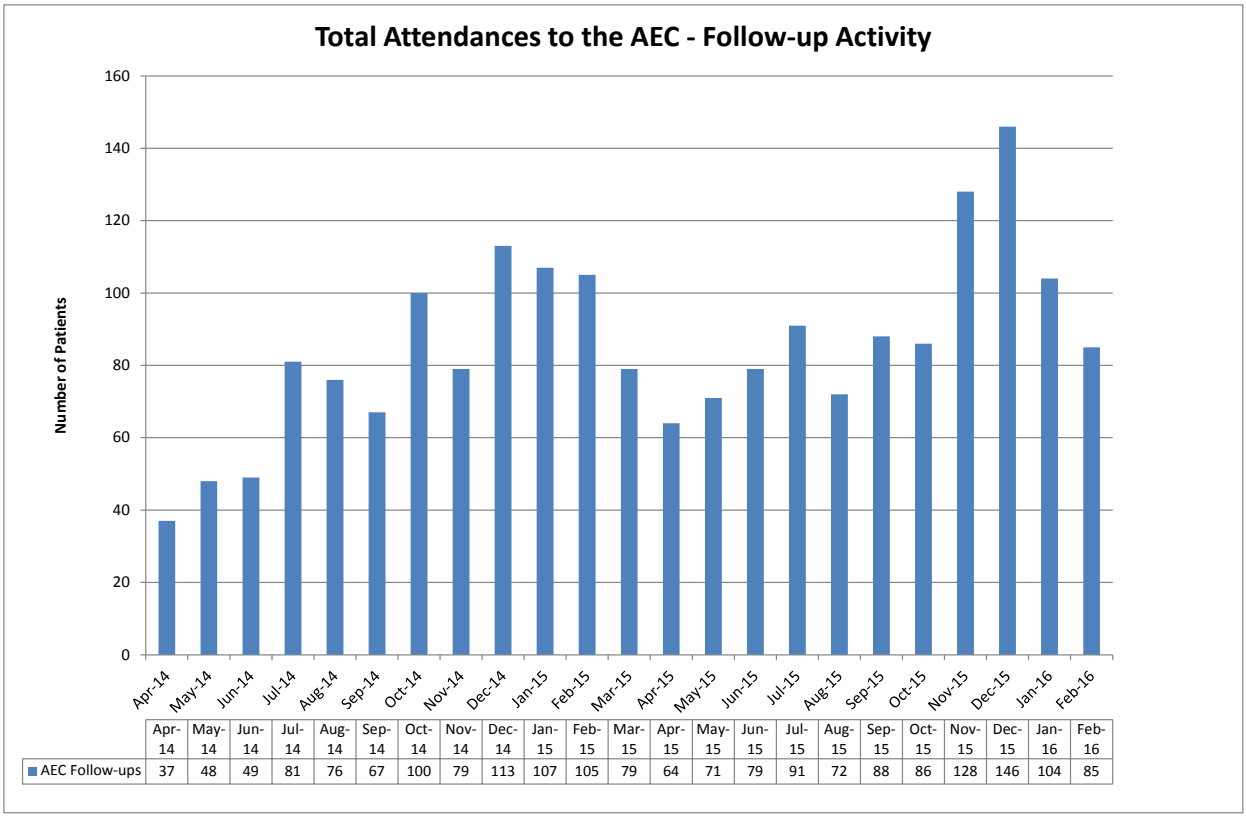
The chart below shows the actual number of new Ambulatory Emergency Care patients (excluding Follow ups) from April 2014. The plan for 2015/16 is based on actuals from 2014/15 plus the impact of the planned pathway developments. For Quarter 4 2015/16, it was projected that 22 new patients would be seen per day, across both sites. The actual average for February 2016 was 19 compared to an average of 14 last month.



	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	Jan-16	Feb-16
Actual	127	146	123	256	219	229	253	163	235	196	180	189	173	154	170	219	240	272	256	248	264	283	395
Plan													257	317	357	373	330	357	359	343	345	439	453

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, and activity in February 2016 was much improved.

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.



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.

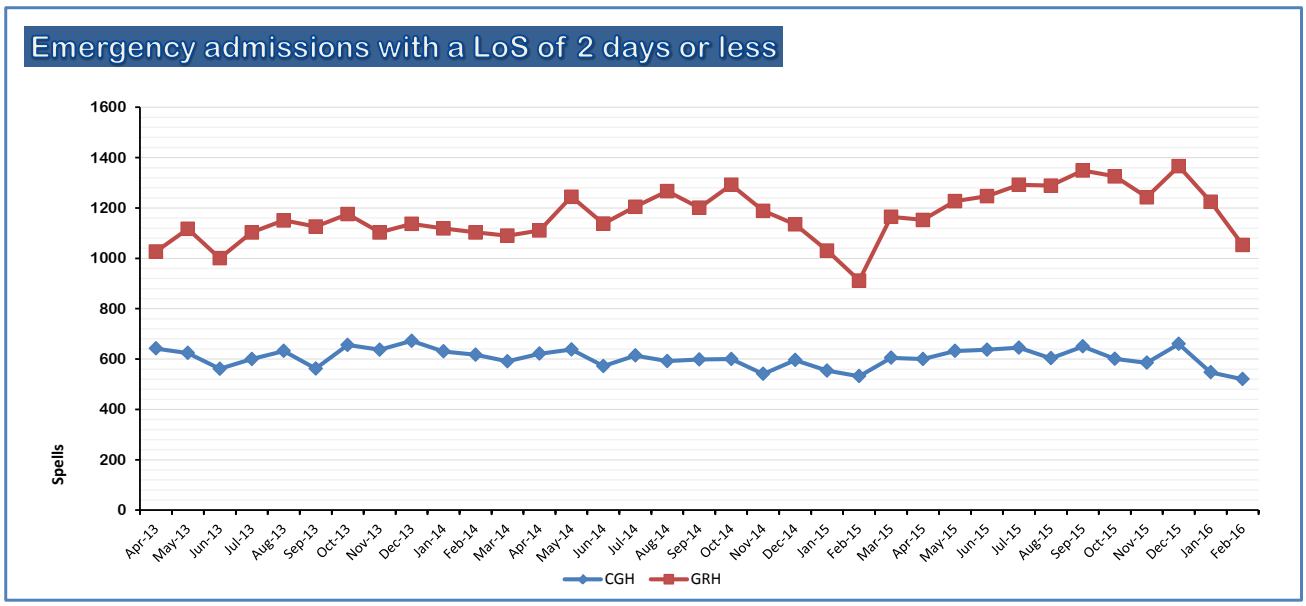
Ambulatory Emergency Care is a key strand of the High-Level Priorities Plan agreed with Monitor. During February 2016, the short-stay Surgical Abdominal Pain and Low Risk Chest Pain pathways were assessed, with a view to managing these high volume patients through an ambulatory pathway, potentially avoiding an Emergency Department attendance and an admission.

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).

Narratives February 2016 showed 1,573 patients with a length of stay of 2 days or less Trustwide (average 54 discharges per day); compared to January which showed 1,772 patients (average 57 per day).



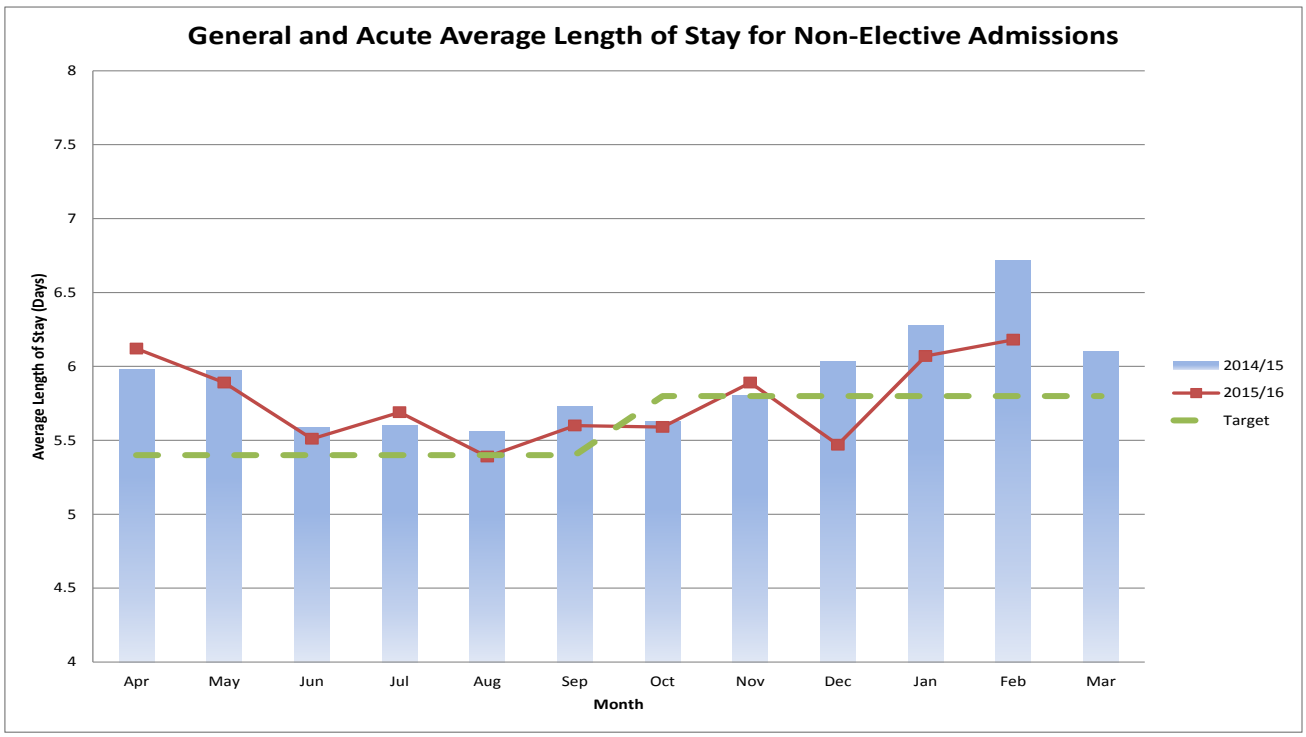
3.6 General & Acute Emergency Admissions Average Length of Stay

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. February 2016 shows an Average Length of Stay of 6.18 days which is an increase from January and exceeds the Q4 target of 5.8 days (by 0.38 days). However, it is a reduction compared to February 2015.

Renewed focus from March 2016 to ensure that all patients who have been in hospital 14 days or more (typically 200 patients), have a clear treatment and discharge plan.



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.

In order to embed these processes throughout the Trust, there is a CQUIN (Commissioning for Quality & Innovation) associated with the SAFER bundle this financial year, which will be continued into 2016/17.

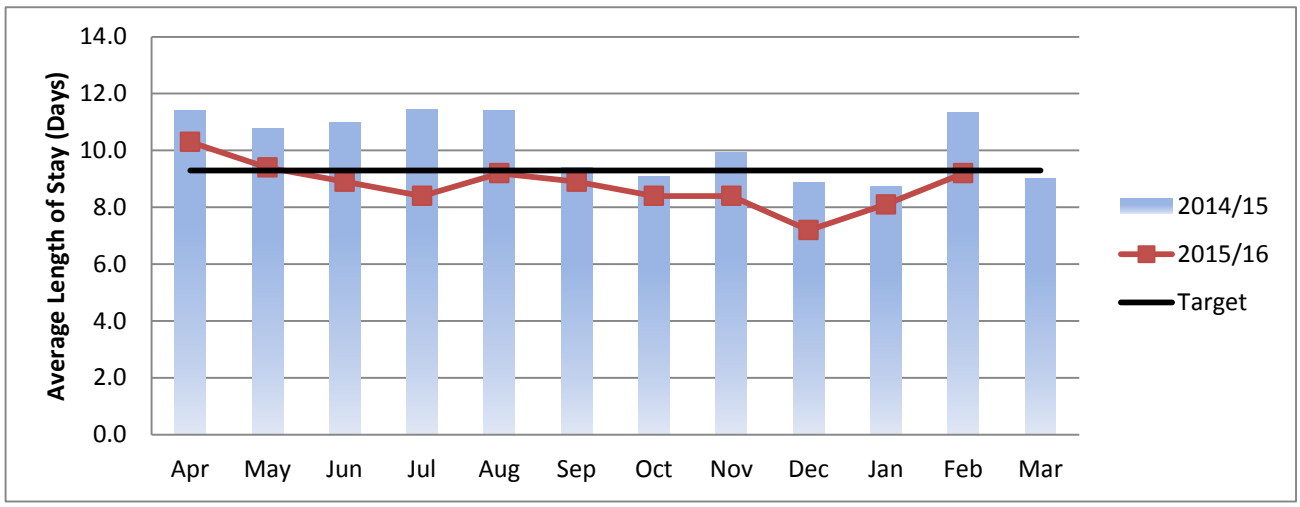
3.7 Average Length of Stay of Targeted Specialties

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.

3.8.1 Respiratory Medicine - Average Length of Stay

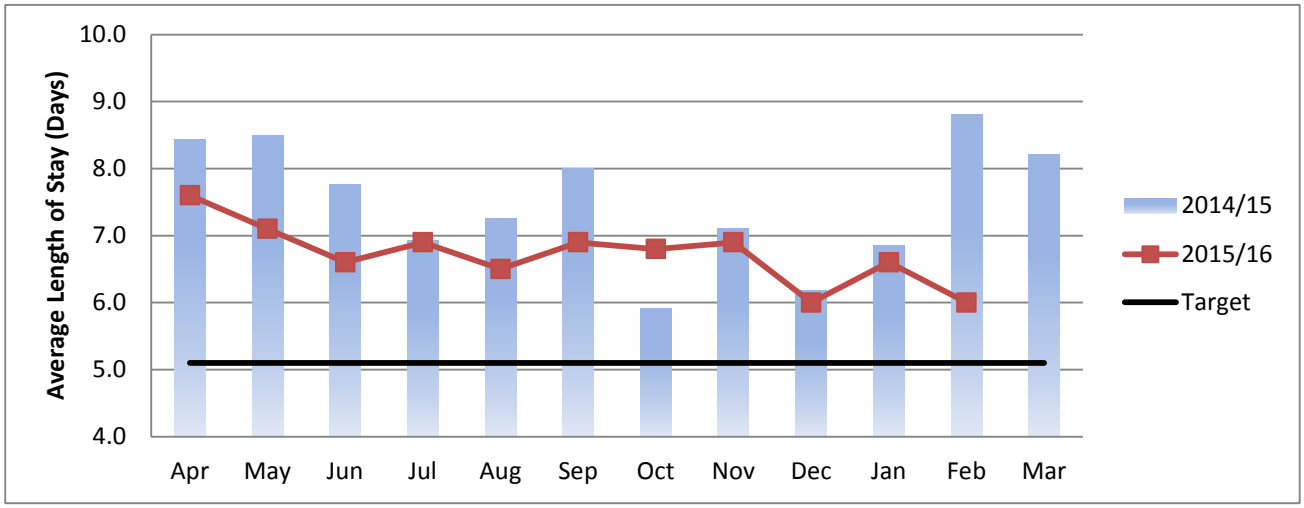
Narrative: The internal target is set at 9.3 days for 2015/16**.** The Average Length of Stay increased to 9.2 days in February 2016 and is just within the target.



3.8.2 Cardiology - Average Length of Stay

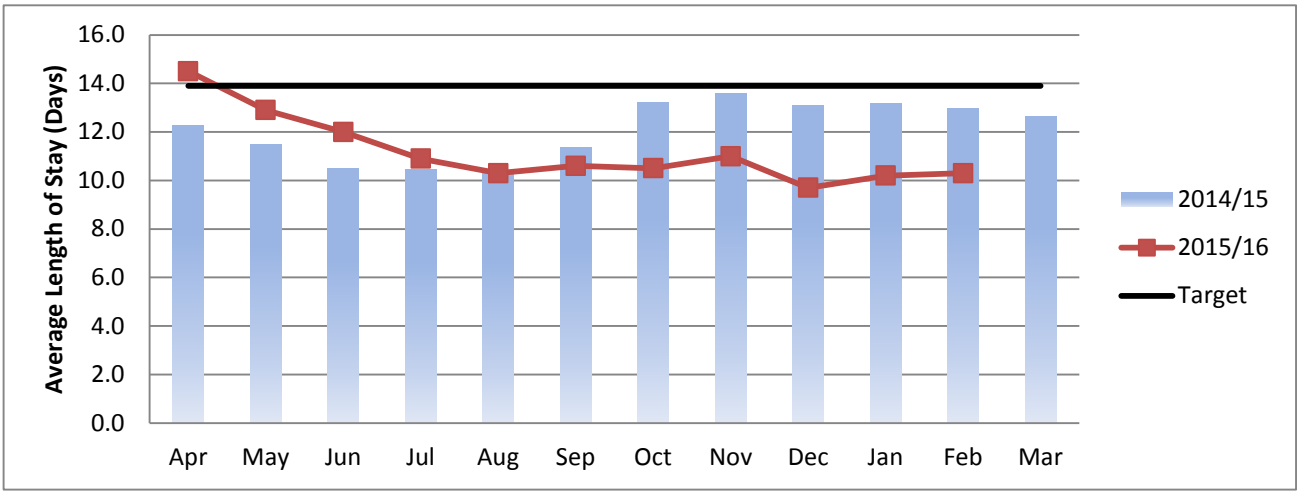
Narrative: The internal target is set at 5.1 days for 2015/16. The Average Length of Stay for non-elective Cardiology discharges was 6.0 days in February 2016.

Although Cardiology has not met the internal target for the whole of 2015/16, there has been a general reduction compared to 2014/15 and most significantly in February 2016, compared to the same period last year.



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 10.3 days in February and was comparable to last month. The Average Length of Stay 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.

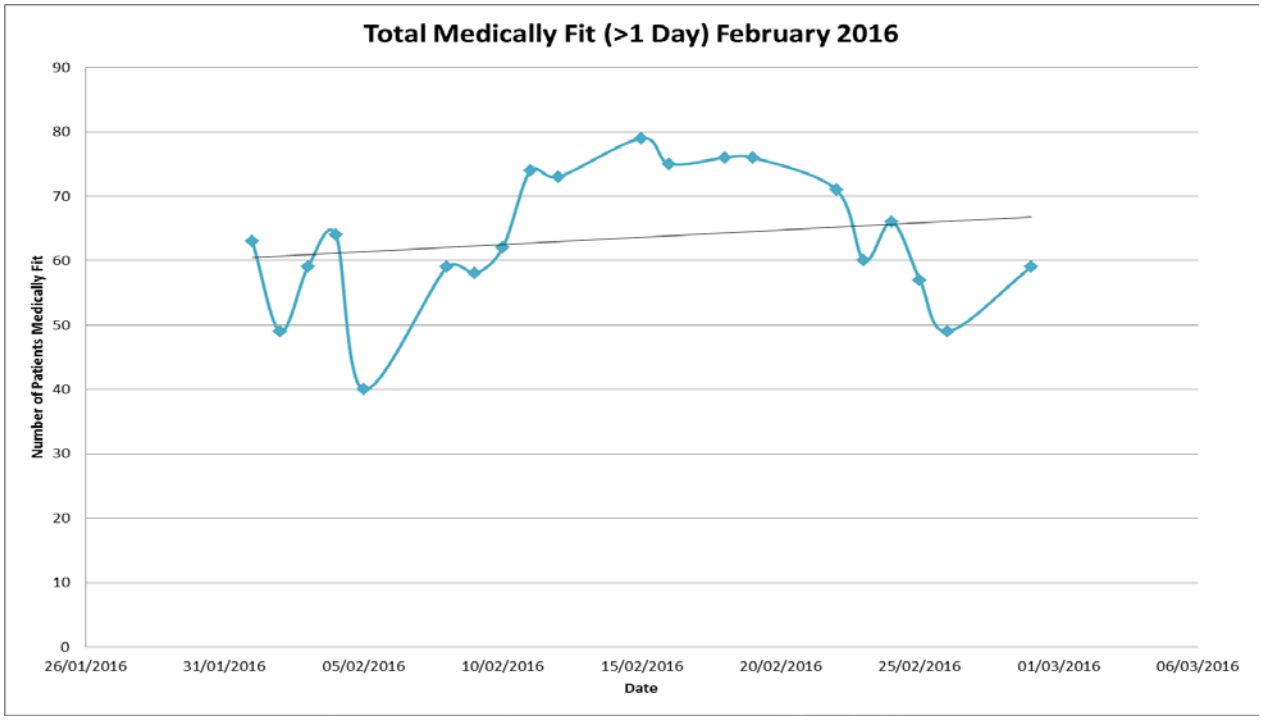
How: Focussing on a range of actions on safe and effective discharge processes. For the Trust and whole heath care system this is one of the key activities to manage.

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 February 2016:

Week 1	55	**Week 2**	65
Week 3	75	**Week 4**	58

In February, there was an average of 35 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 63 for the month, with the number of medically fit patients peaking in February to 75 in week 3. This is on average an increase of 9 medically fit patients, compared to January 2016.

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.

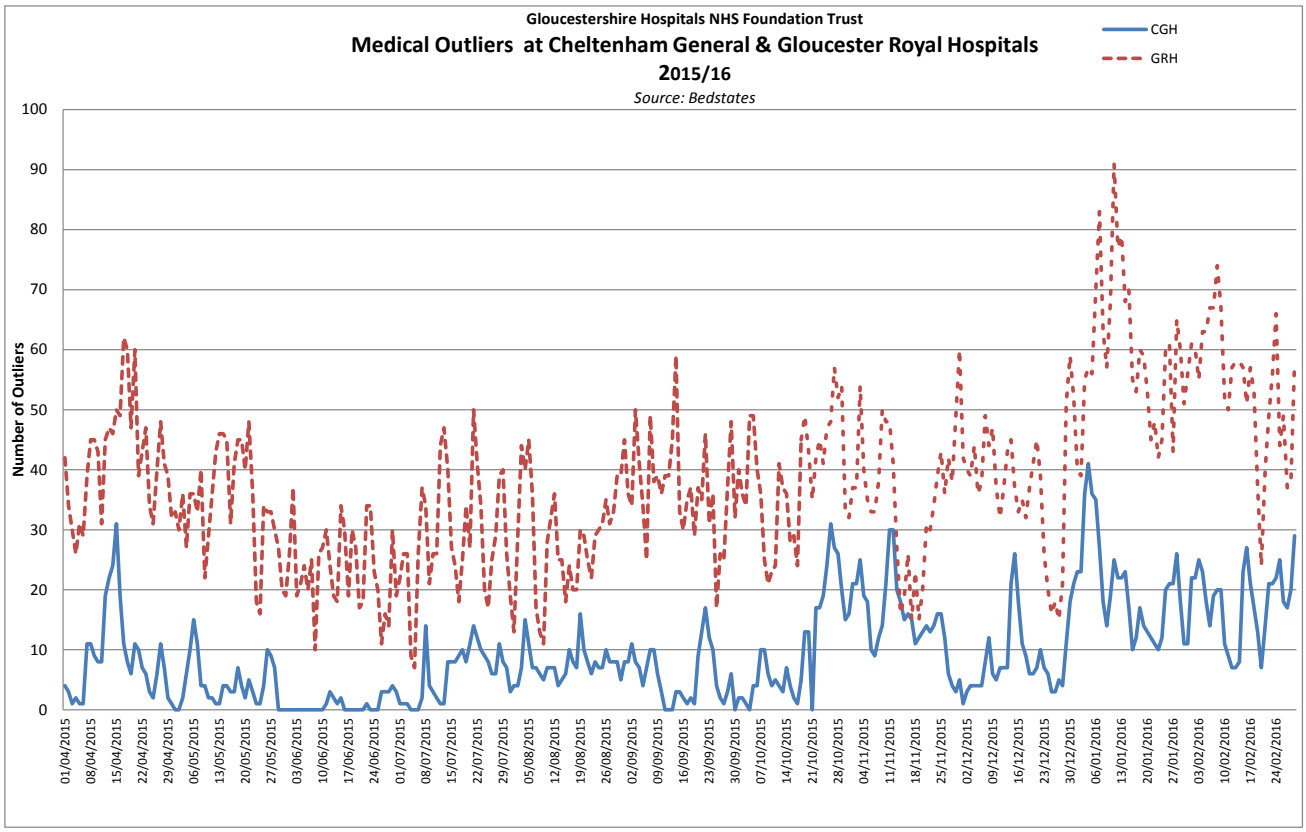
From September 2015, a weekly Senior Executive review of all Medically Fit patients takes place. This is being led by Mrs Arnold, Director of Nursing with her peers from across the system.

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 54 at Gloucestershire Royal and 18 at Cheltenham General in February; a slight reduction from last month where there were 59 and 20 respectively.

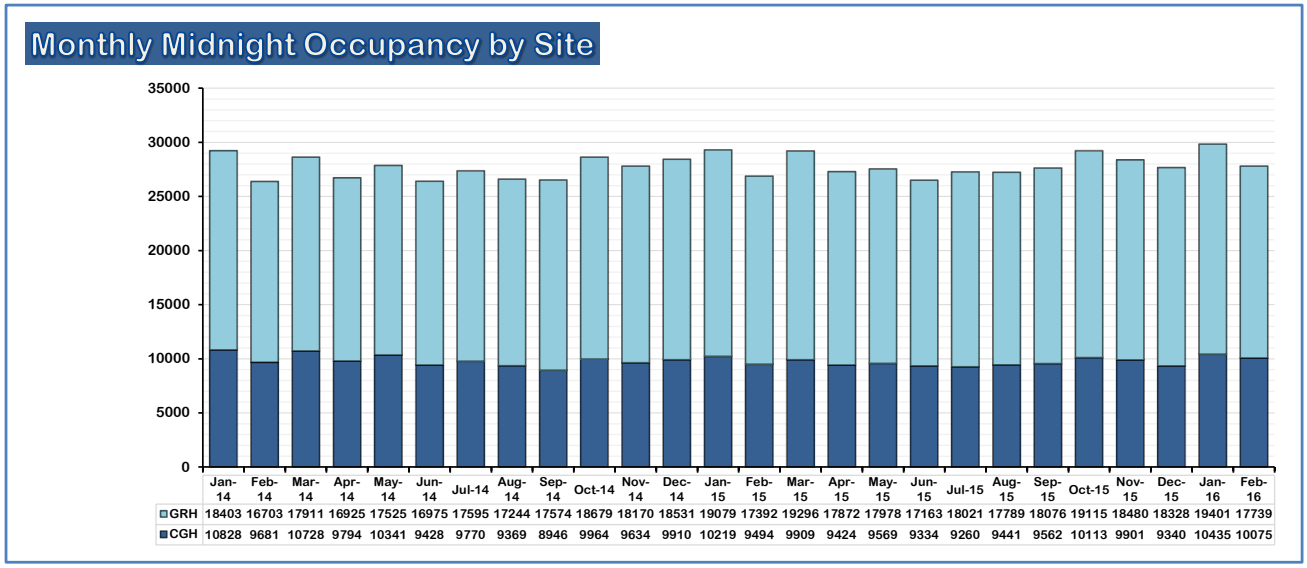


3.9.3 Midnight Bed Occupancy

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 February 2016 were 27,814 (average 959 per day). In the same month last year bed occupancies were 26,886 (average 960 per day).



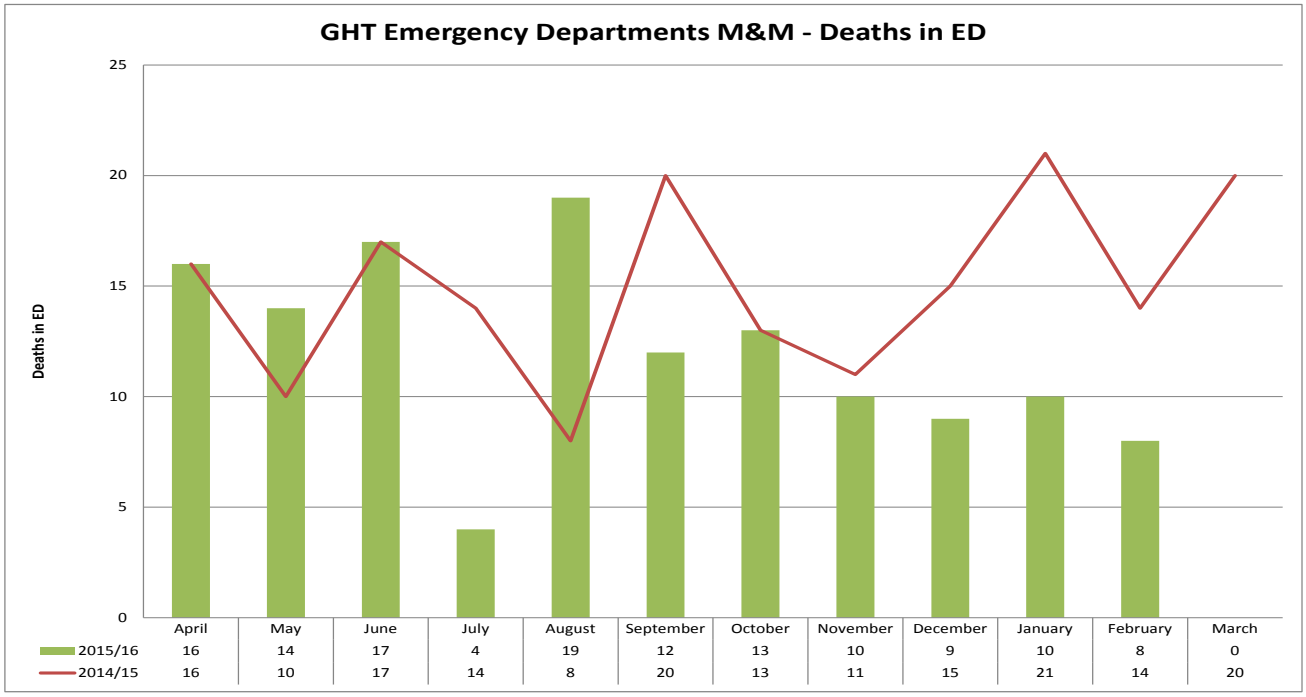
% Bed Occupancy (as at Thursday snapshot)

Week ending:	CGH	GRH	Total
07/02/2016	94.1%	100.0%	**97.6%**
14/02/2016	94.5%	98.6%	**96.9%**
21/02/2016	95.2%	97.8%	**96.8%**
28/02/2016	97.1%	97.6%	**97.4%**

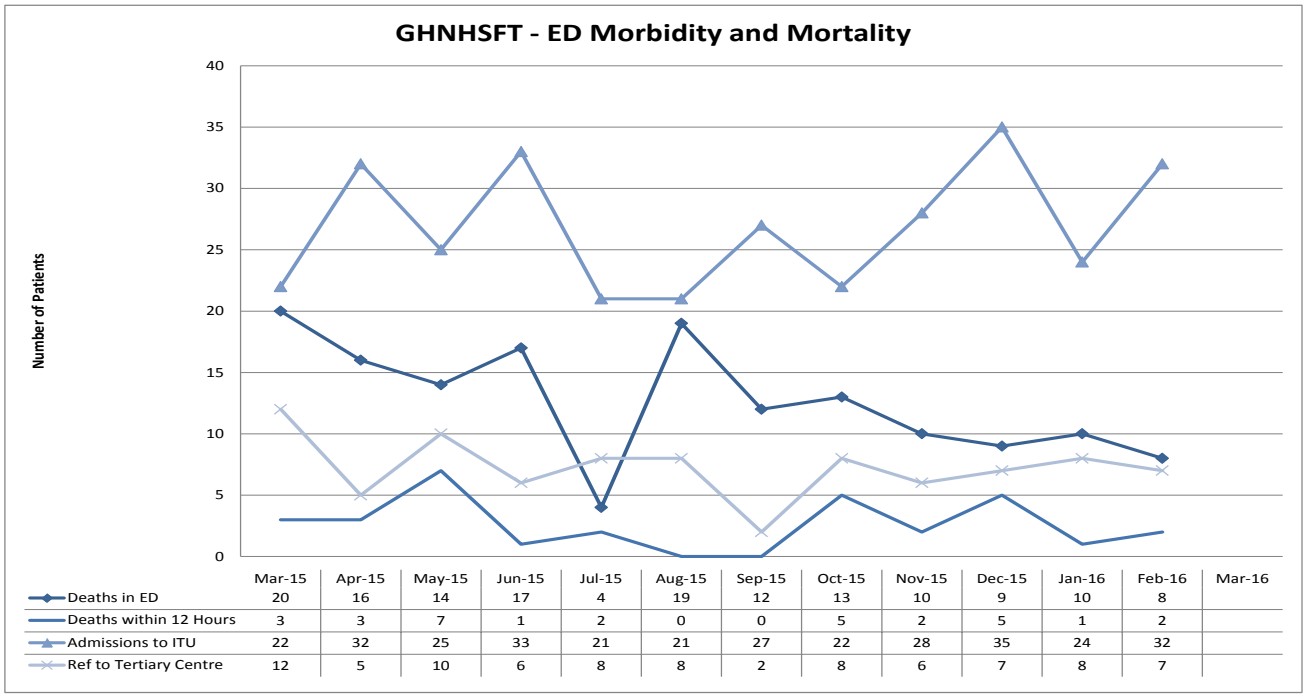
3.10 ED Morbidity and Mortality

Aim: To review the Morbidity and Mortality trend.

Narrative: During February 2016 there were 8 deaths in the Emergency Department, which is lower than February last year (-6). There were 32 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.



	April	May	June	July	August	September	October	November	December	January	February	March
2015/16	16	14	17	4	19	12	13	10	9	10	8	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	10	8	
Deaths within 12 Hours	3	3	7	1	2	0	0	5	2	5	1	2	
Admissions to ITU	22	32	25	33	21	21	27	22	28	35	24	32	
Ref to Tertiary Centre	12	5	10	6	8	8	2	8	6	7	8	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 February (wte)	Variance In Post vs. Establishment	Variance vs. in Post in January
Emergency Department	Consultants	18.70	19.60	+0.90	+1.0
	Trainee Doctors	33.52	30.10	-3.42	0
Acute Medicine	Consultants	11.03	8.33	-2.70	0
	Trainee Doctors	86.25	67.40	-18.85	-0.20

As part of the 2015/16 contract negotiations, the Trust secured funding for three 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. Plans have been developed for alternative ways of covering the middle grade rota, which are currently under review by the Director of Service Delivery and the Medical Director.

Key Actions Going Forward

- A focus on the management of the daily site meetings at 10:00 and 15:00, with all Divisions and Wards to be represented.
- Continue to embed SAFER across the Trust and improving the delivery / effectiveness of Board Rounds.
- Increased use of the Discharge Waiting Areas.
- Increasing the number of weekend discharges. Additional Senior Nursing cover working every day over the weekend, focussing on discharge of patients.
- Improvement Director to review and re-focus Emergency Care Plan, to include the 'Top 3 Short-term Priorities: ED non-admitted performance, Bed Management, and reducing the number of patients with a Length of Stay of 14 days or more.

NURSE AND MIDWIFERY STAFFING
MARCH 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 February 2016.

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 March.

3 Findings

3.1 In line with the set parameters for the Safer Staffing guidance there are no outlying exceptions for December. The Departments of Critical Care have a set shift cover. However the two units 'flex' their staff on and off to help in times of low occupancy, and high occupancy. This explains why there are times when the staffing appears to be below the target, but actually reflects low patient occupancy

4 Revalidation of Nurses and Midwives

4.1 As of April 2016 the Declaration of Fitness to Practice made by all nurses and midwives will change. In November 2015 our Trust Board was informed of the new regulations. The purpose of revalidation is to improve public protection by making sure that NMC registrants continue to remain fit to practise throughout their career. Nurses and Midwives are required to pay their registration fee every year (currently £120 per annum), and every three years all nurses and midwives are also required to *renew* their registration, showing evidence of fitness to practice, competence, Post Registration Education & Practice (PREP) requirements etc. One of the main strengths of the new revalidation processes is that it will reinforce the Code by enabling nurses and midwives to use it as a focal point for all the requirements, including written reflective accounts and reflective discussions.

4.2 It is expected that this will also enhance employer engagement by increasing their awareness of the NMC regulatory standards, so as to provide reassurances that nurses and midwives meet those regulatory standards to practice safely, encouraging early discussion about practice concerns before they escalate or require referral to the NMC, and increase access to and participation in, appraisals and professional development.

4.3 Annex A indicates the work undertaken to ensure our preparedness as an organisation to meet this national agenda. The work has been led by our Trust lead Di Thomas, Assistant Director for Professional Education.

5 Recruitment Update

5.1 UK Pipeline

- There are currently 24 UK-based nurses in the recruitment process due to commence employment in March/April 2016. We are prioritising these candidates to ensure there are sufficient resources to process the successful newly-qualifying nurses in April/May.

- A selection event for the newly-qualifying nurses completing their studies in Summer 2016 was held on Saturday 27 February. A total of 65 candidates were offered employment following this event, and a further three candidates have been interviewed outside of the selection event.

5.2 Overseas-Qualified Nurses

- A national advertising campaign started in mid-February to recruit the next cohort of Overseas-Qualified Nurses, which garnered attention in the national and local press, including Gloucestershire Echo, Gloucester Citizen, BBC Radio Gloucestershire, NHS Employers, and Nursing Times.
- A total of 660 applications were received over the three week period, and approximately 200 candidates were shortlisted for testing and interview.
- Support from Professional Education has allowed the Trust to increase the number of positions on the programme from 40 to 100.
- The first round of testing and interviews will occur on Saturday 19 March 2016.

5.3 EU Recruitment

- Two further EU nurses arrived at the Trust on 10 March, and a further six candidates are being processed to start shortly.
- We are working with our international recruitment partners to facilitate a streamlined approach to interviewing newly-qualified EU nurses that are likely to achieve the IELTS requirement set by the NMC. It is expected that we will target Belgium and the Netherlands throughout 2016.
- A tripartite recruitment event with representatives from Nurse Recruitment, Medical Staffing, and the Allied Health Professions has been approved for Thessaloniki and Athens in June 2016. Matron Liz Bruce will be representing the nursing workforce.

5.4 Philippines Recruitment

- 2014 Campaign: The final nurse planning to join the organisation has withdrawn his application after being unable to finance the pre-employment checks in The Philippines. The total number of nurses recruited through this campaign is 24 (see below).

Situation	Numbers
Staff Nurse with PIN, Band 5	12
Undertaking Overseas Nursing Programme (Awaiting PIN – likely to be autumn 2016)	3
Undertaking OSCE training (Awaiting PIN – likely to be summer 2016)	9
Total	**24**

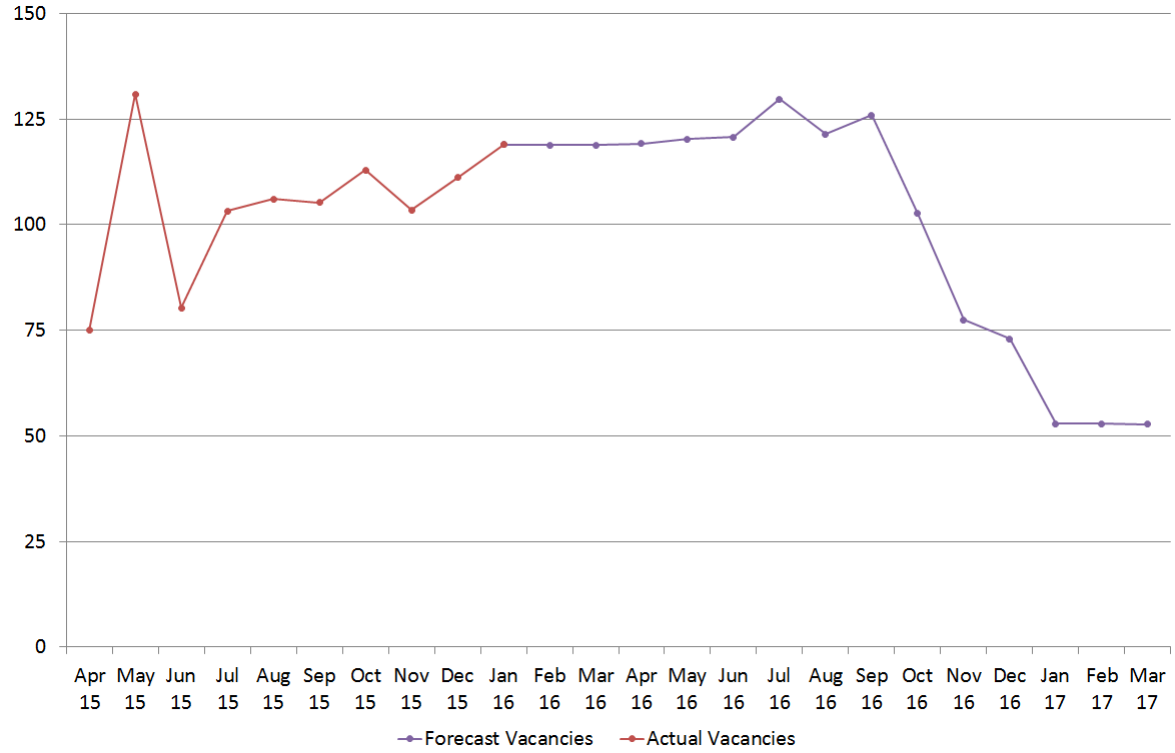
- 2015 Campaign: It is still expected that the first nurses from the November 2015 campaign will join the Trust in March/April 2016. A number of candidates have withdrawn from the process after failing their English language (IELTS) assessment on multiple occasions.

- 2016 Campaign: A further recruitment campaign in the Philippines has been scheduled from w/c 16 May 2016. The nurses attending this event will be Matron Fran Wilson, Matron Sue McShane, Matron Judith Muir, and Senior Charge Nurse Jerome Ibarra. Our Filipino recruitment partner has currently received 108 applications.

5.5 Vacancy Forecast

Based on data received from April 2015 to date, the number of starters is expected to equal the number of leavers between now and Summer 2016. Despite a high number of new starters during January (predominantly newly-qualified nurses), there was an increased number of nurses leaving the organisation. However, the forecast is more

positive than last month due to the increased number of nurses currently awaiting PIN and forecasted to gain registration in the coming weeks. There is expected to be no fundamental change in the number of vacancies until September 2016 when the Trust will benefit from the arrival of the newly-qualified nurses. Vacancies should then begin to decrease due to an increased number of overseas-qualified nurses and nurses recruited directly from The Philippines.



6 Next Steps and Communication

- Continue with proactive recruitment.
- Publish data as required.

7 Recommendations

The Board is invited to endorse this report.

Authors: **Maggie Arnold, Director of Nursing & Midwifery**
Adam Kirton, Nurse Recruitment Manager

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

Update on Nursing & Midwifery Revalidation
Gloucestershire Hospitals NHS Foundation Trust
March 2016

Activities So Far:

- Revalidation Working Group established April 2015. Monthly meetings and group membership consists of Nursing & Midwifery representation (all Directorates), Human Resources, HR systems (ESR), Allied Health Professionals. Strategy, policy, terms of reference and communication plan in place
- Six weekly newsletters written and circulated to all clinical and non-clinical nursing & midwifery teams
- Nursing & Midwifery Revalidation webpages on Professional Education Intranet page. Top tips pages, links to NMC/RCN, Unison etc
- Bi-monthly article in Outline. Most recent article (February 2016) included an interview with the Revalidation Project Lead and also an interview with one of our April Revalidators (OPAL Advanced Nurse Practitioner, Teresa Clift)
- Regular global round up emails to staff highlighting Revalidation
- Professional Education team have been facilitating ward based "micro" teaches since October 2015. Over 800 staff have participated in the micro teaches so far. We have also been offering 1.5 hour long information sessions for all staff across our organisation since summer of 2015
- Half day Revalidation workshops were launched February 2016. Extremely well attended and extremely well evaluated. Dates booked and advertised until December 2016, and these sessions will continue 2017
- Newly registered nurses and midwives on our Preceptorship programme have been targeted to highlight the process
- Board paper written and discussed in November 2015. Risk assessment completed and monitored
- Bank Nurse team fully engaged in process and a robust framework has been established to monitor and support Bank registrants
- Engagement with our Agency suppliers to gain assurances of their Revalidation processes
- All nursing and midwifery staff have been contacted across our organisation and key information sent to them
- Over 55 colleagues targeted and support offered (risk identified to Board regards failure to Revalidate)
- Ongoing data collection of Confirmers – targeted to attend half day workshops etc
- Band 4 Revalidation Officer funded for a 12 month period. Interviews week commencing 7th March 2016. Role will support Project Lead and monitor Revalidation activities etc
- Pod-casts and an interactive DVD written and planned to launch ASAP, for training purposes
- Engagement with partner universities regards Revalidation information for undergraduate students
- Strong links established summer 2015 with our Communications Department and relationship is extremely supportive regards communicating key messages etc.
- Overseas nurses identified and supported
- Engagement with HR and Leadership & Organisational Development regards strategy and purpose of Revalidation

MAIN BOARD – MARCH 2016
INFORMATION GOVERNANCE TOOLKIT STANDARDS
FINAL ASSESSMENT

1.0 Aims

1.1 The purpose of this report is to inform members of the Board of the proposed final scores for our Trust's 2015/16 Information Governance (IG) Toolkit assessment.

1.2 The final scores will be published on the Health and Social Care Information Centre (HSCIC) IG Toolkit website and will then be in the public domain.

1.3 The Board is therefore asked to approve the proposed scores prior to their formal submission and publication.

2.0 Background

2.1 Version 13 of the Information Governance Toolkit (IGT) was released in its current form on 29/05/2015. There have been significant changes to 26 of the 45 standards applicable to our Trust. These have been changes made in line with the Government response to the Caldicott 2 report and changes in the NHS England Standard Contract. This includes changes to certain requirement statements, descriptions, attainment level criteria and evidence required.

2.2 Each standard has to be rated on a scale of 0 to 3, with Level 0 representing non-compliance and Level 3 representing full compliance.

2.3 The NHS Operating Framework requires trusts to achieve level 2 in the IG Toolkit. Level 2 is equivalent to substantial compliance.

2.4 The IG Toolkit requirements are related to the ISO27001 standard which defines a systematic approach to the management of information security risks.

2.5 Monitor does not formally consider our Trust's performance against the Information Governance toolkit, but instead considers this to be a contractual matter for our commissioners and, by extension, the HSCIC and the Information Commissioner.

2.6 Our Trust's submission is available to the Care Quality Commission (CQC). The IG Toolkit score is fed into CQC Quality and Risk Profiles and Key lines of enquiry:

S1: What is the track record on safety?

S3: Are there reliable systems, processes and practices in place to keep people safe and safeguarded from abuse?
Specifically: 11. Are people's individual care records written and managed in a way that keeps people safe? (This includes ensuring people's records are accurate, complete, legible, up to date and stored securely).

S4: How are risks to people who use services assessed, and their safety monitored and maintained?
Specifically: 6. How do arrangements for handovers and shift changes ensure people are safe?

E2 How are people's care and treatment outcomes monitored and how do they compare with other services?

E5 Do staff have all the information they need to deliver effective care and treatment to people who use services?

C1 Are people treated with kindness, dignity, respect and compassion while they receive care and treatment?
Specifically: 7. Do staff respect confidentiality at all times?

W2 Does the governance framework ensure that responsibilities are clear and that quality, performance and risks are understood and managed?

3.0 Performance Overview

3.1 Each standard is led by a member of the Trust's Information Governance and Health Records Specialist Group. In addition, each standard is attributed to an executive director for monitoring and accountability.

3.2 The Information Governance and Health Records Committee oversees Information Governance strategy. The committee's approach this year has been to maintain last year's attainment levels where possible acknowledging that a slight fall in attainment will occur due to the new requirements and evidence required.

3.3 Looking forward to 2016 /2017 and version 14 of the IG Toolkit; SmartCare should enable future IG improvements by delivering enhanced security and audit functionality in a Trust-wide EPR.

3.4 A summary of the results for each standard is available to members of the Board in Appendix 1.

3.5 Appendix 2 provides a comparison based on last year's published scores with other Southwest acute trusts and local NHS bodies.

3.6 Our Trust's final score is expected to be 75% green. This is a 2% reduction on last year resulting from the in-year review of standards previously graded at Level 3 and the new requirements resulting from the Caldicott 2 report.

4.0 Recommendation

It is recommended that the Board:

4.1 Approves for publication the final IGT assessment described under item 3 and detailed in Appendix 1.

4.2 Gives delegated authority to Dr Sally Pearson, Director of Clinical Strategy, in her capacity as Senior Information Risk Owner (SIRO) to give final approval to the improvement plans resulting from the assessment and audit which will be overseen within the terms of reference of the Trust's Information Governance and Health Records Committee.

4.3 Accepts the Information Governance Assurance Statement. This is required by all organisations submitting an IGT assessment and happens at the point of publication. The full statement can be viewed in Appendix 2.

5.0 Next Steps and Communication

5.1 Following Board approval the IG and Health Records Manager will publish the electronic IGT assessment by 31st March 2016.

6.0 Monitoring and Review

6.1 Performance has been reviewed by the Trust's internal auditors in January 2016. Their findings have been reflected in this year's submission and will be incorporated, where applicable, in next year's action plans.

6.2 Progress against the action plans will be monitored and reviewed by members of the Information Governance and Health Records Committee and the Director accountable for each standard.

Author:

Thelma Turner

Lead for Information Governance

Presenting Director:

Dr Sally Pearson

Director of Clinical Strategy

March 2016

Appendix 1

Information Governance Toolkit Version 13 – Final Assessment Report

March 2016

Version 13 No.	Description	Position at end Feb 2016	Target for end Mar 2016	Lead	Director
Information Governance Management					
13-101	There is an adequate Information Governance Management Framework to support the current and evolving Information Governance agenda	3	3	Thelma Turner	Sally Pearson
13-105	There are approved and comprehensive Information Governance Policies with associated strategies and/or improvement plans	2	2	Thelma Turner	Sally Pearson
13-110	Formal contractual arrangements that include compliance with information governance requirements, are in place with all contractors and support organisations	2	2	Fraser Pike	Helen Simpson
13-111	Employment contracts which include compliance with information governance standards are in place for all individuals carrying out work on behalf of the organisation	2	2	Emma Mudie	Dave Smith
13-112	Information Governance awareness and mandatory training procedures are in place and all staff are appropriately trained	3	3	Julie Connell	Dave Smith
Confidentiality and Data Protection Assurance					
13-200	The Information Governance agenda is supported by adequate confidentiality and data protection skills, knowledge and experience which meet the organisation's assessed needs	2	2	Caroline Pennels and Thelma Turner	Sean Elyan
13-201	Staff are provided with clear guidance on keeping personal information secure and on respecting the confidentiality of service users The organisation ensures that arrangements are in place to support and promote information sharing for coordinated and integrated care, and staff are provided with clear guidance on sharing information for care in an effective, secure and safe manner	2	2	Thelma Turner	Sally Pearson

13-202	Consent is appropriately sought before personal information is used in ways that do not directly contribute to the delivery of care services and objections to the disclosure of confidential personal information are appropriately respected Confidential personal information is only shared and used in a lawful manner and objections to the disclosure or use of this information are appropriately respected	2	2	Lynne McEwan and Caroline Pennels	Sean Elyan
13-203	Individuals are informed about the proposed uses of their personal information Patients, service users and the public understand how personal information is used and shared for both direct and non-direct care, and are fully informed of their rights in relation to such use	2	2	Heather Beer	Sally Pearson
13-205	There are appropriate procedures for recognising and responding to individuals' requests for access to their personal data	2	2	Caroline Pennels	Sean Elyan
13-206	There are appropriate confidentiality audit procedures to monitor access to confidential personal information Staff access to confidential personal information is monitored and audited. Where care records are held electronically, audit trail details about access to a record can be made available to the individual concerned on request	2	2	Debbie Windle Thelma Turner	Sally Pearson
13-207	Where required, protocols governing the routine sharing of personal information have been agreed with other organisations	2	2	Thelma Turner Caroline Pennels	Sally Pearson
13-209	All person identifiable data processed outside of the UK complies with the Data Protection Act 1998 and Department of Health guidelines	2	3	Caroline Pennels	Sean Elyan
13-210	All new processes, services, information systems, and other relevant information assets are developed and implemented in a secure and structured manner, and comply with IG security accreditation, information quality and confidentiality and data protection requirements	2	2	Rob Holmes	Sally Pearson
Information Security Assurance					
13-300	The Information Governance agenda is supported by adequate information security skills, knowledge and experience which meet the organisation's assessed needs	3	3	Thelma Turner	Sally Pearson
13-301	A formal information security risk assessment and management programme for key Information Assets has been documented, implemented and reviewed	2	2	Thelma Turner	Sally Pearson

13-302	There are documented information security incident / event reporting and management procedures that are accessible to all staff	2	2	Thelma Turner	Sally Pearson
13-303	There are established business processes and procedures that satisfy the organisation's obligations as a Registration Authority	2	2	Mandy Newbould	Dave Smith
13-304	Monitoring and enforcement processes are in place to ensure NHS national application Smartcard users comply with the terms and conditions of use	2	2	Mandy Newbould	Dave Smith
13-305	Operating and application information systems (under the organisation's control) support appropriate access control functionality and documented and managed access rights are in place for all users of these systems	2	2	Rob HolmesDebbie Windle	Dave Smith
13-307	An effectively supported Senior Information Risk Owner takes ownership of the organisation's information risk policy and information risk management strategy	2	2	Thelma Turner	Sally Pearson
13-308	All transfers of hardcopy and digital person identifiable and sensitive information have been identified, mapped and risk assessed; technical and organisational measures adequately secure these transfers	2	2	Thelma Turner	Sally Pearson
13-309	Business continuity plans are up to date and tested for all critical information assets (data processing facilities, communications services and data) and service - specific measures are in place	2	2	Thelma Turner	Sally Pearson
13-310	Procedures are in place to prevent information processing being interrupted or disrupted through equipment failure, environmental hazard or human error	2	2	Rob Holmes	Sally Pearson
13-311	Information Assets with computer components are capable of the rapid detection, isolation and removal of malicious code and unauthorised mobile code	2	3	Rob Holmes	Sally Pearson
13-313	Policy and procedures are in place to ensure that Information Communication Technology (ICT) networks operate securely	2	2	Rob Holmes	Sally Pearson
13-314	Policy and procedures ensure that mobile computing and teleworking are secure	2	2	Rob Holmes	Sally Pearson
13-323	All information assets that hold, or are, personal data are protected by appropriate organisational and technical measures	2	2	Thelma Turner	Sally Pearson
12-324	The confidentiality of service user information is protected through use of pseudonymisation and anonymisation techniques where appropriate	2	2	Thelma Turner Elaine McWhinnie	Sally Pearson

Clinical Information Assurance					
13-400	The Information Governance agenda is supported by adequate information quality and records management skills, knowledge and experience	2	2	Caroline Pennels (Anna)	Sally Pearson
13-401	There is consistent and comprehensive use of the NHS Number in line with National Patient Safety Agency requirements	2	2	Debbie Windle	Helen Simpson
13-402	Procedures are in place to ensure the accuracy of service user information on all systems and /or records that support the provision of care	2	3	Debbie WindleElaine McWhinnie	Helen Simpson
13-404	A multi-professional audit of clinical records across all specialties has been undertaken	2	2	Jan Joseph Thelma Turner	Eric Gatling
13-406	Procedures are in place for monitoring the availability of paper health/care records and tracing missing records	2	2	Thelma Turner	Eric Gatling
Secondary Use Assurance					
13-501	National data definitions, standards, values and validation programmes are incorporated within key systems and local documentation is updated as standards develop	2	2	Elaine McWhinnie	Helen Simpson
13-502	External data quality reports are used for monitoring and improving data quality	3	3	Elaine McWhinnie	Helen Simpson
13-504	Documented procedures are in place for using both local and national benchmarking to identify data quality issues and analyse trends in information over time, ensuring that large changes are investigated and explained	3	3	Elaine McWhinnie	Helen Simpson
13-505	A robust programme of internal and external data quality/clinical coding audit in line with the requirements of the Audit Commission and NHS Connecting for Health is in place	2	2	Elaine McWhinnie	Helen Simpson
13-506	A documented procedure and a regular audit cycle for accuracy checks on service user data is in place	3	3	Elaine McWhinnie	Helen Simpson
13-507	The Completeness and Validity check for data has been completed and passed	3	3	Elaine McWhinnie	Helen Simpson
13-508	Clinical/care staff are involved in validating information derived from the recording of clinical/care activity	2	2	Elaine McWhinnie	Helen Simpson
13-510	Training programmes for clinical coding staff entering coded clinical data are comprehensive and conform to national standards	3	3	Elaine McWhinnie	Helen Simpson

Corporate Information Assurance					
13-601	Documented and implemented procedures are in place for the effective management of corporate records	2	2	Caroline Pennels (Anna)	Sally Pearson
13-603	Documented and publicly available procedures are in place to ensure compliance with the Freedom of Information Act 2000	2	3	Caroline Pennels	Andrew Seaton
13-604	As part of the information lifecycle management strategy, an audit of corporate records has been undertaken	2	2	Caroline Pennels (Anna)	Sally Pearson

Total Percentage Score	**72%**	**75%**

Appendix 2

Information Governance Toolkit Version 12 (2014 – 15)

Southwest Acute Trusts and Gloucestershire Final Score Comparison

This section is provided to enable members of the Board to compare our Trust's performance with similar organisations in the Southwest and with other NHS bodies in Gloucestershire. The table makes use of last year's published scores which are now in the public domain.

The red (unsatisfactory) and green (satisfactory) ratings are based on the IG Toolkit requirement for all 45 standards to be graded at level 2 or higher.

Information Governance Toolkit Version 12 (previous year) – Southwest Acute Trust Final Scores

This information is publicly available at www.igt.hscic.nhs.uk

NACS Code	Organisation	2014	2015
	South West Acute	**v11**	**v12**
RD1	Royal United Hospital Bath NHS Trust	91%	89%
RVJ	North Bristol NHS Trust	90%	67%
RA9	South Devon Healthcare NHS Foundation Trust	88%	90%
RBA	Taunton And Somerset NHS Foundation Trust	88%	88%
RA7	University Hospitals Bristol NHS Foundation Trust	85%	66%
RA4	Yeovil District Hospital NHS Foundation Trust	84%	81%
RBD	Dorset County Hospitals NHS Foundation Trust	84%	89%
RNZ	Salisbury NHS Foundation Trust	81%	85%
RN3	Great Western Hospitals NHS Foundation Trust	77%	77%
RTE	**Gloucestershire Hospitals NHS Foundation Trust**	**77%**	**77%**
RK9	Plymouth Hospitals NHS Trust	75%	75%
RDZ	The Royal Bournemouth And Christchurch Hospitals NHS Foundation Trust	74%	37%
REF	Royal Cornwall Hospitals NHS Trust	72%	73%
RA3	Weston Area Health NHS Trust	71%	73%
RH8	Royal Devon And Exeter NHS Foundation Trust	71%	75%
RBZ	Northern Devon Healthcare NHS Trust	70%	68%
RD3	Poole Hospitals NHS Trust	41%	73%

Information Governance Toolkit Version 12 (previous year) – Gloucestershire Organisations Final Scores

This information is publicly available at www.igt.hscic.nhs.uk

NACS Code	Organisation	2014	2015
	Gloucestershire		
RTQ	2gether NHS Foundation Trust	83%	84%
RTE	**Gloucestershire Hospitals NHS Foundation Trust**	**77%**	**77%**
V118	Gloucestershire County Council	76%	79%
0AE	Central Southern Commissioning Support Unit	72%	77%
R1J	Gloucestershire Care Services NHS Trust	59%	74%
11M	NHS Gloucestershire CCG	58%	68%
12A	NHS South Gloucestershire CCG		74%
AAH	Tetbury Hospital Trust Limited		66%
	Organisation achieved level 2 or higher in all 45 standards		
	Organisation with one or more standards at level 1 or lower		

INFORMATION GOVERNANCE ASSURANCE STATEMENT

Version 4, 10/06/2014

1. All organisations that have either direct or indirect access to HSCIC services[1], including N3, must complete an annual Information Governance Toolkit Assessment and agree to the following additional terms and conditions. Where the Information Governance Toolkit requirements are not met to an appropriate standard (minimum level 2), an action plan for making the necessary improvements must be agreed with the HSCIC External Information Governance team or with an alternative body designated by the Department of Health (e.g. a commissioning organisation).

2. All organisations providing indirect access[2] to HSCIC services for other organisations (approved N3 link recipients), are required to provide the Department of Health, on request, with details of all organisations that have been permitted access, the business justification and the controls applied, and must maintain a local log of organisations to which they have allowed access to N3. This log should be reviewed regularly by the organisation and unnecessary access rights removed. The Department of Health or an alternative body designated by the Department of Health may request sight of these logs in order to facilitate or aid audit or investigations.

3. The approved N3 link recipient is responsible for their compliance with IG policies and procedures and may request authorisation by the Department of Health to monitor and enforce the compliance and conduct of subsidiary connected organisations and suppliers to ensure that all key information governance requirements are met.

4. The use of HSCIC Services should be conducted to support NHS business activities that contribute to the care of patients. Usage of individual services must be conducted inline with those individual services requirements and acceptable use policies. The use of HSCIC provided infrastructure or services for unauthorised advertising or other non-healthcare related activity is expressly forbidden.

5. All threats or security events affecting or potentially affecting the security of HSCIC provided infrastructure or services must be immediately reported via the HSCIC incident reporting arrangements or via local security incident procedures where applicable.

6. All infrastructure and connections to other systems and networks which are not covered by an approved Information Governance Toolkit Assessment and agreement to this IG Assurance Statement must be segregated or isolated from IGT covered infrastructure and connections such that IGT covered infrastructure and connections, or HSCIC Services are not put at risk. A Logical Connection Architecture diagram must be maintained by network managers in accordance with HSCIC guidance and must be provided for Department of Health review on request.

7. Organisations with access to HSCIC Services shall ensure that they meet the requirements of the Department of Health policy on person identifiable data leaving England, or being viewed from overseas. A copy of the Information Governance Offshore Support Requirements applicable to those accessing HSCIC Services is available on request or can be downloaded from http://systems.hscic.gov.uk/infogov/igsoc/links/index_html. The agreement of the Department to this limited support or exceptionally to more extensive processing must be explicitly obtained.

[1] HSCIC Services include the N3 network and other applications or services provided by HSCIC, e.g. the NHS Spine Service, NHSmail, Choose and Book (and in future the NHS e-Referral Service).
[2] Access to the N3 network or HSCIC Services via another organisation or gateway

8. Where another network is connected to N3, only services that have been previously considered and approved by the Department of Health as appropriate for that network are permissible. Requests for new or changed services must be provided to the Department for consideration.

9. Organisations may not create or establish any onward connections to the N3 Network or HSCIC provided services from systems and networks which are not covered by an approved Information Governance Toolkit Assessment and agreement to this IG Assurance Statement.

10. The approved organisation shall allow the Department of Health, or its representatives, to carry out ad-hoc on-site audits, and to review any/all evidence that supports the Information Governance Toolkit Assessment, as necessary to confirm compliance with these terms and conditions and with the standards set out in the Information Governance Toolkit.

Information Governance Assurance Statement

I confirm that I have read, understood and agree to comply with the additional terms and conditions that apply to organisations that have access to HSCIC services and acknowledge that failure to maintain compliance may result in the withdrawal of HSCIC services.

MAIN BOARD MARCH 2016

COMPLAINTS AND CONCERNS
QUARTER 3 OCTOBER TO DECEMBER 2015

1. Introduction

The aim of this report is to provide information on the complaints and concerns reported to the Trust during Quarter 3 2015/16.

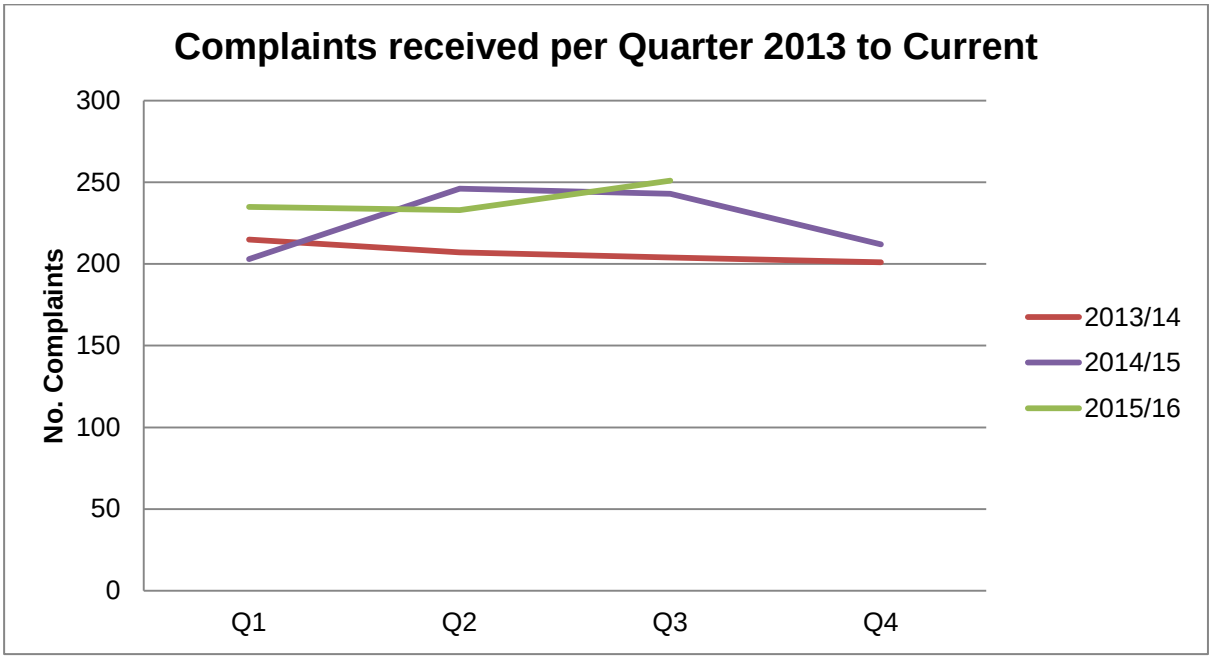
2. Complaints Received during Quarter 3 2015-16

2.1 Number of Complaints Received

During Quarter 3, 2015-16, the Trust received a total number of 250 complaints which equates to an average of approximately 19 complaints per week, which is slightly higher than the number of complaints received during the previous quarter.

This figure equates to 5.45 complaints per 1000 inpatient spells or 1 complaint per 1000 total episodes of care (includes all inpatients, outpatients and ED attendances). During the same period, the Trust received a total of 2292 compliments as notified by all hospital areas.

The graph below illustrates the number of written complaints received over time since 2013/14.

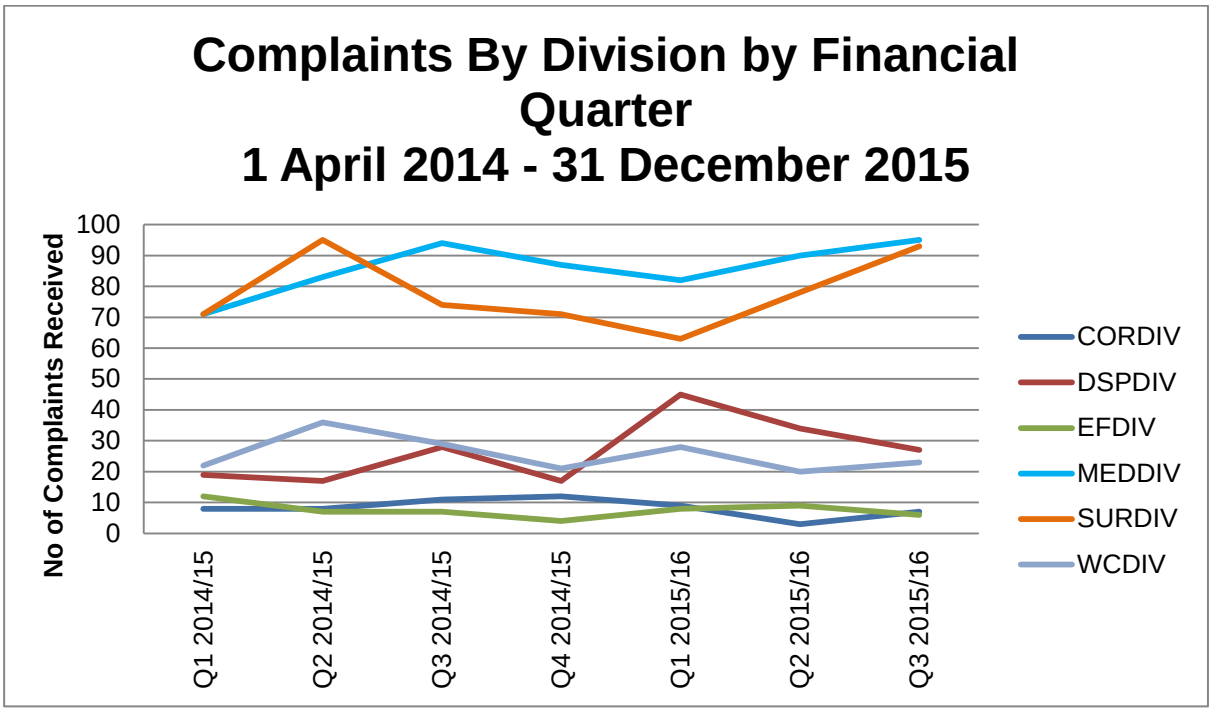


2.2 Upheld Complaints

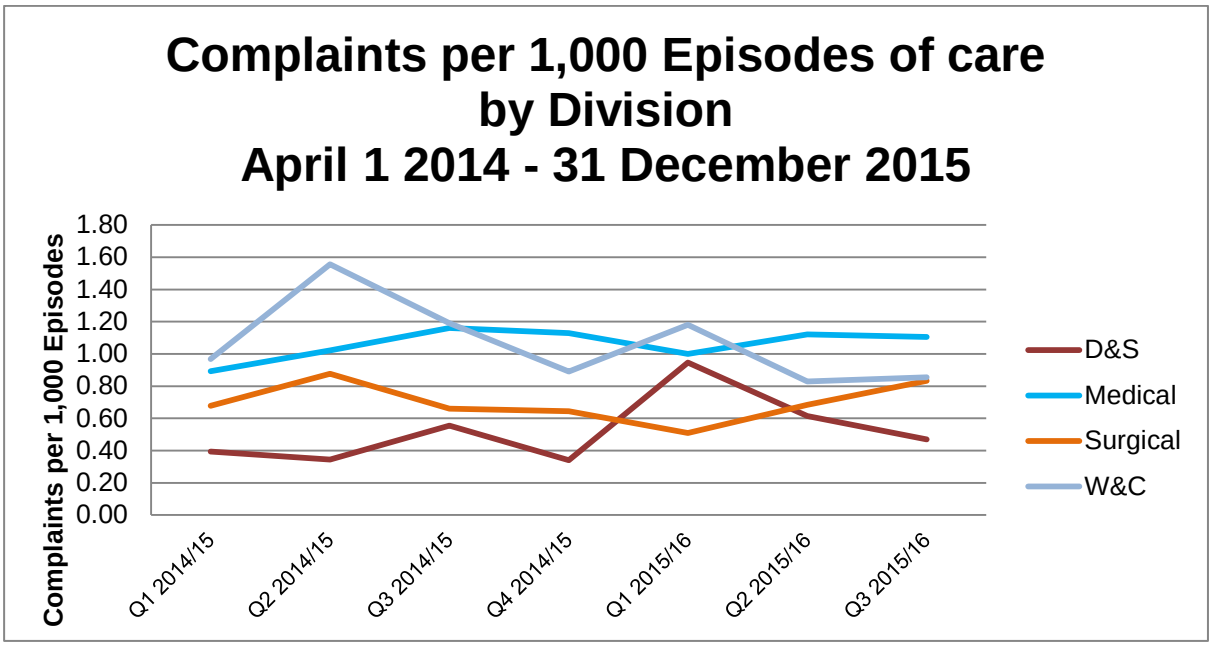
Of the 251 complaints received in Quarter 3, 157 had been closed by the end of January 2016. 54% (79) were upheld either fully or partly.

2.3 Complaints reported by Division

The graphs below show by Division the number and rate of complaints reported since 1 April 2014.



In Quarter 3 2015/16 there was an increase in the number of complaints received within all clinical divisions apart from Diagnostics and Specialities. A proportion of the increase in Medicine Division relates to time to see a doctor in Emergency Department and Acute Assessment Units. Within the Surgical Division there has been an increase across all areas whilst Women's and Children's Division saw an increase in complaints relating to non-communication about parking exemptions.



2.4 What do people complain about?

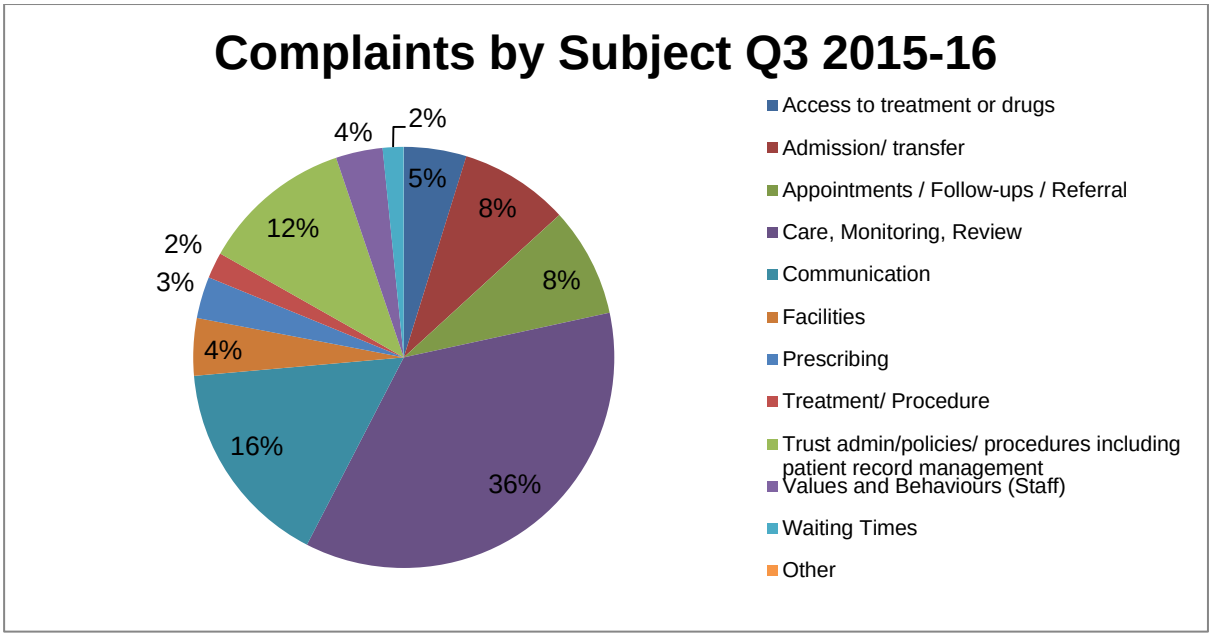
During Quarter 3, we received complaints about the following issues:

Category	Q1 15/16	Q2 15/16	Q3 15/16	% of total received Q3	2014-15 Trust average
Access to treatment or drugs	2	12	12	5%	*
Admissions/transfers/ discharge	23	25	21	8%	6%
Appointments/Follow ups/Referral	26	30	21	8%	10%
Care, Monitoring, Review	76	66	90	36%	54%
Communication	40	33	40	16%	10%
Diagnosis and Assessment	1	-	-	-	*
End of Life Care	2	-	-	-	*
Facilities	14	7	11	4%	*
Prescribing	6	6	8	3%	*
Treatment/Procedure	-	1	-	-	
Trust Admin, policies and procedures	3	8	5	2%	*
Values and behaviours (staff attitude)	25	31	29	12%	14%
Waiting times	9	7	9	4%	*
Other:	8	7	4	2%	6 %

* no comparative data with previous years

"Other" includes complaints relating to damage to personal property, commissioning, privacy, dignity and wellbeing, staff numbers and transport.

The chart below illustrates the category of the complaint.



The most frequent area of complaint to the Trust in Quarter 3 is care, monitoring and review (36%). These mainly relate to failure to diagnose, care needs not adequately met, post treatment complications and delay in treatment or procedure. The second most frequent category is communication (16%) followed by values and behaviours (12%).

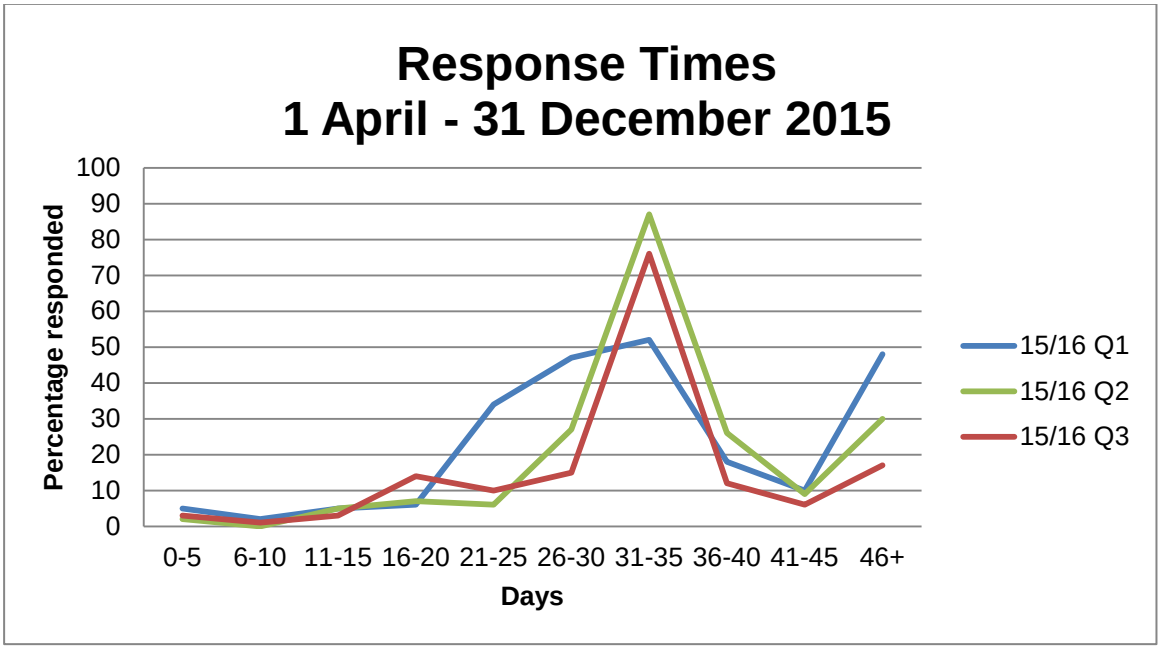
There were no complaints received about the Trust's complaints process during Quarter 3.

2.5 Complaint Acknowledgement and Response Times

There is a requirement under the current NHS Complaints regulations to respond within three working days to a written complaint with an acknowledgement letter. During Quarter 3 this requirement was met in 99% (248) of cases. 1 of the other 3 cases (0.5%) was acknowledged within 4 working days and 1 within 5 (0.5%) working days.

Our internal standard of written response within 35 working days in 95% of cases was met in 87% of cases during Quarter 3 to date. This is a slight improvement in performance compared to the Trust average for 2014-15 (86%). Response time is affected by a number of issues including complexity of complaint but also is affected by unavailability of health records, staff availability and delay in receiving consent. Discussions are in progress with the Trust's Information Governance committee as to the processes of sharing complaint-related information.

The graph below displays Trust-level responses sent during Quarters 1 to 3 and demonstrates that a high proportion of complaints are responded to within our internal standard.



The table below shows response rates by Division during Quarters 1 to 3.

	Corp	D&S	E&F	Med	Surg	W&C	Trust Response
2014/15	65%	80%	93%	90%	85%	68%	86%
Q1 2015/16	78%	69%	63%	78%	79%	65%	75%
Q2 2015/16	100%	80%	100%	71%	71%	65%	78%
Q3 2015/16	67%	78%	100%	84%	90%	100%	87%
Total YTD 2015/16	**78% 11/14**	**74% 59/80**	**79% 15/18**	**82% 146/178**	**79% 145/184**	**71% 39/55**	**78% 415/529**

2.6 Local Resolution Meetings

During Quarter 3, six local resolution meetings were held with complainants and Trust staff. The aim of local resolution meetings is to provide an opportunity for the complainant to explain what they are unhappy or unclear about and gives them and us the time to listen, discuss the complaint and provide information. We offer face to face meetings for complex or serious complaints or when the complainant specifically requests a meeting. Those held during quarter 3 related to lack of care, medication provision, care on the ward, availability of transport following emergency care, delay in diagnosis and premature discharge.

3. Parliamentary and Health Service Ombudsman Reviews (PHSO)

During Quarter 3, ten new cases were referred by complainants to the Ombudsman for second stage resolution. Following investigation, decisions were received on seven cases during the quarter, five of which were partly upheld and two not upheld.

Division	PHSO information	Summary of Original Complaint	Recommendation from PHSO
Surgery – Upper GI	Complaint received July 2012. PHSO Investigation commenced November 2014	Clinicians' attitudes to terminal patients and the use of TPN	**Partly Upheld** Trust was asked to send letter of apology and action plan to learn from failings identified in terms of nutritional care – nursing metrics provided as evidence of improved practice and monitoring.
Medicine – Respiratory	Complaint received November 2013. PHSO investigation commenced January 2015	Inadequate pressure area care	**Partly Upheld** Trust was asked to send letter of apology and show where improvements have been made to the way in which pressure ulcers are prevented and cared for
W&C – Gynaecology	Complaint received November 2014. PHSO investigation commenced March 2014	Refusal to fund IVF treatment and the information provided	**Partly Upheld** The Trust was asked to apologise, provide financial payment for redress and further amount for costs incurred of IVF treatment and review the mechanisms for communicating information about IVF treatment
W&C – Maternity	Complaint received May 2014. PHSO investigation commenced May 2015	Lack of reassurance re care and treatment. Information not translated as it should have been and outcome of appointment not sent to GP	**Partly Upheld** The Trust was asked to apologise for loss of confidence, distress and anxiety and financial payment.
Surgical – Lower GI	Complaint received May 2013. PHSO investigation commenced July 2015	Failure to diagnose and treat bowel problems	**Partly Upheld** The Trust was asked to apologise, financial payment and carry out a multi-disciplinary review and root cause analysis re inappropriate discharge.

Medicine – ED	Complaint received August 2014. PHSO investigation commenced May 2015	Lack of x-ray at time of injury	**Not Upheld**
Surgery – Urology	Complaint received May 2015. PHSO investigation commenced September 2015	Surgery not offered for prostate cancer and patient died as a result	**Not Upheld**

The outcome of 18 cases currently held by the Ombudsman is still awaited at the end of Quarter 3.

4. Referrals from SEAP (Support. Empower. Advocate. Promote)

SEAP act as an independent complaints, advocacy and advice service and in Gloucestershire are hosted by Healthwatch. They support complainants through the process of making a complaint which will include attending any local resolution meetings.

The Trust received two referrals from SEAP during Quarter 3 both of which have not been upheld following investigation. Of the four outstanding cases for Quarter 2, one has not yet been completed, two were partly upheld and one was not upheld.

5. Concerns

During Quarter 3, our PALS team dealt with 484 concerns of which the top three themes were:

- Communication between Trust and patients/carers
- Appointments/Follow-ups/Referral
- Access to treatment or drugs

All concerns are also reviewed by the Divisions and feed into the consideration of improvement. Actions resulting from addressing of concerns include many individual level actions but some broader actions. These include discussions within the various ward teams, appointments made with clinical staff to discuss specific concerns, appointments brought forward.

6. Learning from Complaints and Concerns

The table below provides an update of lessons learned during the past quarter.

Issue	Actions taken/planned
Cleanliness	• Monitoring leads in cardiology dismantled and cleaned after each patient use
End of life care	• Advanced care plan drawn up for patient in case of readmission

Communication	• Patients whose procedures are cancelled to be telephoned as well as written communication • Withington Suite answer machine message changed allowing messages to be left • Ward 3A has started a book to log calls so all staff are aware of who has contacted them
Staffing	• Cardiology administrative support increased
Policies and Procedures	• Policies revised for preparing patients on ACU for theatre • Clear instructions on prophylactic fragmin to be included in Junior doctors induction
Care of Patients	• Reflections by staff where identified in complaint and reviews at team meetings • Printed signs placed at each TV in Ward 7A bays to keep sound at low level. • Rare complication to be discussed at Audit meeting for specialty and mortality & morbidity meeting • Respiratory clinic template scheduling changed • Additional education re completion of food and fluid charts • Check list written for patients being transferred from ED to another ward to wait for transport • Timings of cardioversions changed to a day and location where it is less likely that they will have to be cancelled. Patients asked to call hospital on day of procedure to check whether bed available.

7. Recommendations

The Quality Committee is asked to note the Quarter 3 2015-16 Complaints and Concerns report.

Author: Heather Beer, Head of Patient Experience

Presenting Director: Maggie Arnold, Nursing Director

Date: March 2016

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE COUNCIL OF GOVERNORS HELD IN THE LECTURE HALL, SANDFORD EDUCATION CENTRE, KEYNSHAM ROAD, CHELTENHAM ON WEDNESDAY 24 FEBRUARY 2016 AT 5.30 PM

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 P Adams	Staff, AHPs
Governors/	Mrs S Attwood	Staff, Nursing and Midwifery
Constituency	Dr D Beard	Public, Tewkesbury
	Mr A Cieciura	Public, Stroud
	Prof C Dunn	Public, Stroud
	Dr C Feehily	Appointed, Healthwatch
	Mrs J Harley	Patient Governor
	Dr P Jackson	Public, Forest of Dean
	Mrs C Johnson	Public, Forest of Dean
	Mrs A Lewis	Public, Tewkesbury
	Dr T Llewellyn	Staff, Medical and Dental
	Ms C McIndoe	Staff, other/ non-clinical
	Mr J Marstrand	Public, Cheltenham
	Cllr B Oosthuysen	Appointed, Gloucestershire County Council
	Mr M Pittaway	Staff, other/ non-clinical
	Mrs D Powell	Public, Gloucester
	Dr A Seymour	Appointed, Clinical Commissioning Group
	Ms F Storr	Public, Gloucester
	Mr A Thomas	Public, Cheltenham (Lead Governor)
Directors	Prof C Chilvers	Chair
	Dr F Harsent	Chief Executive
	Mr E Gatling	Director of Service Delivery
	Dr S Pearson	Director of Clinical Strategy
	Mrs H Simpson	Finance Director and Deputy Chief Executive
	Mr D Smith	Director of Human Resources and Organisational Development
	Mr G Mitchell	Senior Independent Director/ Vice Chair
	Mrs M Bond	Non-Executive Director
	Ms A M Millar	Non-Executive Director
Public/ Press/ Observers	None	
IN ATTENDANCE	Mr M Wood	Trust Secretary
APOLOGIES	Mrs J Hincks	Public, Cotswold
	Dr S Elyan	Medical Director
	Mrs M Arnold	Nursing Director
	Mr T Foster	Non-Executive Director
	Mr C Lewis	Non-Executive Director
	Mrs H Munro	Non-Executive Director

The Chair welcomed members of the Council and thanked Governors for attending.

ACTION

001/16 DECLARATIONS OF INTEREST

There were none.

002/16 MINUTES OF THE MEETING HELD ON 4 NOVEMBER 2015 AND THE EXTRAORDINARY MEETING HELD ON 9 DECEMBER 2015

RESOLVED: That the minutes of the meeting held on 4 November 2015 and the extraordinary meeting held on 9 December 2015 were agreed as a correct record and signed by the Chair.

003/16 MATTERS ARISING

112/15 Governor attendance at Council of Governor meetings: In response to a question from Ms Storr, the Trust Secretary undertook to check the attendance details of Mrs Powell at Council of Governors meetings. *The Trust Secretary reported that the attendance record has been revisited and Mrs Powell attended two (and not three) of the three meetings listed having submitted apologies for the meeting in September 2015. Ms Storr and Mrs Powell have been informed of the outcome. Completed.*

105/15 Q2 Performance: The Lead Governor referred to the bad debtors position reported nationally and asked if the Trust was in that category to which the Finance Director responded that the Trust was not and is honouring liabilities.

004/16 MINUTES OF THE MEETING OF THE GOVERNANCE AND NOMINATIONS COMMITTEE HELD ON 27 JANUARY 2016

The Chair presented the minutes of the meeting of the Governance and Nominations Committee held on 27 January 2016.

RESOLVED: That the minutes be noted.

005/16 APPOINTMENT OF NEW CHIEF EXECUTIVE

In presenting the report, the Chair reminded the Council of Governors that in December 2015, for the process of the appointment of a new Chief Executive authority was delegated to the Chair, if the interview panel was in agreement, to offer the successful candidate the post of Chief Executive. The Chair was delighted to report that Mrs Deborah Lee has been appointed as the new Chief Executive. No start date had yet been agreed, but she hoped that this would be in June 2016.

RESOLVED: That the report be noted.

006/16 REPORT OF THE CHIEF EXECUTIVE

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

- The Trust is performing well with one exception which is in meeting the four hour Emergency Department (ED) standard of 95%. This has been a challenge for the Trust for some time and the Trust is not alone in experiencing these challenges. There is increased scrutiny from Monitor and others over ED performance

and the Trust, along with a number of other Trusts, has been requested to attend a meeting on London on 1 March 2016 specifically to discuss ED performance. This level of increased scrutiny led the Chief Executive to believe that at some point Monitor may decide to take some form of formal action against the Trust. The measures which the Trust is taking to improve its position are firstly, with the support of Monitor an Improvement Director has been identified who will start with the Trust on 1 March 2016. That person has experience of improving ED performance in a large Foundation Trust and that performance is continuing after the end of the appointment period. Secondly, the Trust is looking at what can be undertaken differently to quickly make a positive impact. It has concluded that an increase in the number of routine discharges should also take place at weekends to assist with admissions which continue at the same rate as weekdays. The Chief Executive stressed that this will not apply to complex discharges. From last weekend additional senior nurses will progress chase discharges. Monitor is clear that A & E performance is the only issue of concern which it has with the Trust.

- With regard to finance, approximately 95% of Acute Foundation Trusts are in deficit.
- The Trust is delivering the 18 week Referral to Treatment (RTT) target for incomplete pathways.
- On integration the organisations in the County health and social care community are discussing in principle an approach on Place and Pathways and it is anticipated that a pilot will start for the next financial year. The Director of Clinical Strategy is representing the Trust in these discussions.
- The implementation date for SmartCare remains at 2 May 2016 for Phase 1 although Pathology may not commence then.

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

- In response to a question from Mrs Lewis about the Place element of integration, the Chief Executive explained that the proposal for the pilots is to identify two or three geographical areas. Each will be based on populations of about 30,000 and based on GP practices. The aim is to bring together in one team district nurses from Gloucestershire Care Services, social workers from Gloucestershire County Council and mental health staff from the 2gether Trust. The goal is to provide more integrated services and keep more people in their homes. In addition Pathways will be developed around conditions, for example, respiratory disease and will see this centred across Trusts. Organisational changes will be for future consideration. Cllr Oosthuysen expressed the view that this approach is a good way forward. Dr Beard asked if the implementation of the Five Year Forward View will lead to a mini organisational restructure. In response, the Chief Executive said that the view of the Secretary of State is that there will be different levels of autonomy based upon different criteria, for example, the outcome of CQC inspections. The integration work in the County will assist in developing the right relationships. The Foundation Trust model is unlike to survive.
- In response to a question from Prof Chris Dunn, the Director of Clinical Strategy explained that an Emergency Department

safety checklist is being introduced initially at Cheltenham General Hospital following the Emergency Department safety intervention work carried out at University Hospitals Bristol. The Chief Executive added that the Trust is keen to learn from this piece of work. The Trust already uses the NEWS system and will work with the ambulance service to explain their ability to upload patient information when the patient arrives in hospital. This system will also fit in well with SmartCare.

- Cllr Oosthuysen sought an assurance as to the level of confidence that Phase 1 of SmartCare can be introduced on 2 May 2016 as planned. In response, the Chief Executive said that an update was provided to him at the beginning of the week of the meeting which stated that the software has been released and tested. A problem has been identified with the pathology element and it is likely that this element will take effect in July 2016. The remainder of Phase 1 is to be introduced on 2 May 2016 as planned.
- Mrs Johnson referred to the improved cancer performance where, subject to validation of the December 2015 figures, it appeared that six of the eight targets will be met. The Chief Executive, in response, explained that two new urology consultants have been appointed and the Trust is on trajectory with the target agreed with Monitor and the Clinical Commissioning Group.
- Dr Feehily referred to the arrangements for weekend discharges and enquired whether they are reliable and robust given that there is a reliance on partner organisations and that the risk to patients is not being increased. In response, the Chief Executive explained that patients are admitted seven days a week and patients should also be discharged seven days a week. Patients will be discharged only when clinical staff say that it is safe to do so. Most patients do not require other services as they go home. Mr Marstrand said that discharging patients relies on the availability of district nurses and he understood that there is a shortage of such staff provided by Gloucestershire Care Services. In response, the Chief Executive stressed that approximately 95% of patients discharged do not require further services and go home. The focus will not be on patients with complex as our experience is that it is difficult to discharge them at weekends.
- The Lead Governor asked if the Trust has received assurance on the “must do” actions in the CQC Inspection Report. In response, the Chief Executive said that PriceCoopersWaterhouse will undertake starting with an internal audit of this matter.

The Chair thanked the Chief Executive for his report.

RESOLVED: That the report be noted.

007/16 Q3 PERFORMANCE

The Finance Director presented the report summarising the key highlights and exceptions in Trust performance for the third quarter of the 2015/16 financial year. She drew attention to each of the highlights and exceptions on performance as set out in the report.

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

- Dr Jackson observed that GP referrals are running at higher levels than last year and at the end of the quarter they are 2.9% higher than at the same time last year. He had raised this issue then and again commented that the actions in place are not having the desired effect. In response, the Finance Director said that the Trust is working with the Clinical Commissioning Group to reduce demand; however patients are being referred and need to be treated. There is little else within the Trust's gift to reduce demand.
- Dr Feehily referred to the delayed transfer of patients and observed that the Trust has the number of patients as an issue whereas Gloucestershire County Council, which is described as one of the best performing organisations in this regard, considers it not to be an issue. The Chief Executive said in response that the term "delayed discharge" has a narrow definition and the definition used by the Trust and the Clinical Commissioning Group is "medically fit". There are currently 75 medically fit patients in the hospitals against an agreed standard of 40. With the exception of one week, the Trust has been well above this standard for the year. Taking into account those patients and patients waiting for social services assessments and end of life care the number is closer to 100.
- Mr Marstrand asked where the outcome of Never Events is presented. In response, the Finance Director said that the outcomes are presented to the Quality Committee and subsequently to the Board.

The Chair thanked the Finance Director for the report.

RESOLVED: That the Integrated Performance Framework report be noted.

008/16 BOARD GOVERNANCE REVIEW

In presenting the report the Vice Chair said that overall the Board Governance Review had not identified any areas as red risk-rated and had made a number of recommendations. The link to the full report and action plan had been made available to Governors. The Council of Governors was invited to establish an ad hoc working group to take forward the review recommendations insofar as they related to Governors. The intention is that the Group should meet on three occasions and report back to the Council of Governors in May 2016. The Lead Governor is seeking expressions of interest from Governors to serve on the Group.

The Lead Governor in supporting the proposal added that the intention is that the first and third meetings of the group will be for group members only but the middle meeting will be open to all Governors and Non-Executive Directors.

The Chair thanked the Vice Chair and the Lead Governor for their report.

RESOLVED: That the establishment of an ad hoc working group and the terms of reference attached to the report be approved.

009/16 QUALITY REPORT 2015/16

The Director of Clinical Strategy presented the report setting out the process for the production of and external assurance of the Quality Report 2015/16. The report contained the arrangements including the timetable for producing the Quality Report in the Trust and the external assurance. The quality priorities for 2016/17 were set out in Annex 1 and the Quality Report Indicators 2015/16 in Annex 2 to the report. The Trust is working with the Clinical Commissioning Group to identify CQUINS and the priorities might need adjusting in the light of those conversations but nothing had so far been indicated. The Director of Clinical Strategy thanked Healthwatch for their input where the quality priorities had been strengthened by patient and user feedback. The External Auditors provide assurance on the accuracy of the data against the selected indicators. The mandated indicators for the Trust would be:

(i) referral to treatment within 18 weeks for patients on incomplete pathway (as last year)
(ii) A&E four-hour wait (new this year)
(iii) 62-day cancer treatment wait
(iv) 28-day readmissions.

Two indicators would be tested in this order of preference where relevant for the Trust. In accordance with the requirements Governors were invited to indicate which of the indicators (from those above and in Annex 2) they would wish to see included as a local indicator if required.

(Mrs Attwood left the meeting)

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

- The Lead Governor expressed his disappointment largely from a personal perspective that there was no reference to mental health oversight and issues in the Emergency Department. With regard to mental health oversight, the Director of Clinical Strategy said that this will be a priority for next year and the issue is whether the Trust has the necessary information upon which to base a measure. The Council left it to the Director of Clinical Strategy to see if there is any measure which can be developed this year. **SP**
- The Lead Governor undertook to seek a majority view of Governors for the local indicator based on their first and second preferences and let the Director of Clinical Strategy know by 4 March 2016. **AT**

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

RESOLVED: That:-

1. The process of preparing and publishing the Quality Report 2015/16 be noted;

2. The quality priorities identified for 2016/17 be noted;

3. The Lead Governor confirms the locally selected indicator for sample testing by the external auditors by 4 March 2016.

010/16 MEMBERSHIP STRATEGY UPDATE

(Debra Clark, Senior Patient Experience Manager attended the meeting for the presentation of this item)

The Senior Patient Experience Manager presented the report providing an update on the progress against the Membership Strategy action plan. The objectives for 2015/16 are to provide more opportunities for member engagement, enhance and diversify membership communication channels, maintain our existing membership base and to develop a more representative membership. The progress made against each objective was set out in the report.

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

- Prof Dunn said that said he had received comments from his area over the last few weeks that there were four complaints of cancelled appointments and three or four relating to lost patient notes and he enquired whether this was representative throughout the Trust. The Chief Executive said in response from seeing all complaints that there may be an occasional complaint in these categories but that it is not a general problem.
- Mrs Adams sought information on the approach to staff (who are also members unless they choose not to be) and member engagement wishing to ensure that there is no duplication and that there is a broader input from staff members. The Senior Patient Experience Manager said that she will ask the Head of Patient Experience to respond to the points raised. **HB**
- Mrs Lewis asked how the Trust is planning to engage with younger members. In response, the Senior Patient Experience Manager said that the Annual Meeting on 1 October 2016 is to be preceded by a session to engage with students. Staff have volunteered as career ambassadors. The Chair added in response to a comment from Ms Storr that the aims of the Trust and the Cheltenham Science Festival are different and that is why the Trust is arranging this event around the Annual Meeting. It did not preclude working with the Science Festival in the future.
- Ms McIndoe observed that the Trust is doing well in the proportion of members from the Black and Minority Ethnic community which at 4.2% is double that for the County. The Senior Patient Experience Manager added that the Clinical Commissioning Group has identified areas where they wish to see an improvement in membership and these are being considered.

The Chair thanked the Senior Patient Experience Manager for the report.

RESOLVED: That the progress made to date against the Membership Strategy during 2015/16 be noted.

011/16 APPOINTMENT OF NON-EXECUTIVE DIRECTORS

The Chair invited the Council of Governors to delegate authority to the interview panel to appoint two Non-Executive Directors. The recruitment process has commenced for the appointment of two Non-Executive Directors to replace Mrs Maria Bond and Mr Clive Lewis whose terms of office expire on 30 April and 31 August 2016 respectively. In accordance

with the recruitment process timetable the posts were advertised on 17 January with final interviews taking place on 22 March 2016.

The Governance and Nominations Committee had formally endorsed the recruitment timetable and the advertisement, person specification and job description. The appointment of Non-Executive Directors requires the approval of the Council of Governors. Given that the first appointment is effective on 1 May 2016 and the Council of Governors does not meet until 18 May 2016, the Governance and Nominations Committee recommend to the Council of Governors that authority be delegated to the interview panel to make an offer to the candidates as determined by the panel. This will be formally reported to the Governance and Nominations Committee on 30 March 2016 and the Council of Governors on 18 May.

RESOLVED: That authority be delegated to the interview panel to make an offer to the candidates as determined by the panel; the outcome of which will be formally reported to the Governance and Nominations Committee on 30 March 2016 and the Council of Governors on 18 May.

012/16 CHAIR/ NON-EXECUTIVE DIRECTOR APPRAISALS

The Chair reported that dates for Non-Executive appraisals against their objectives have been scheduled for April 2016. The Vice Chair has scheduled the Chair's appraisal. In both instances Governor feedback will be sought through the Lead Governor. The outcome of the appraisals will be reported to Governors in due course.

013/16 CHAIR/ NON-EXECUTIVE DIRECTOR REMUNERATION

The Chair presented the report providing an opportunity for the Council of Governors to consider the remuneration of the Chair and Non-Executive Directors following the publication by NHS Providers of their Chair and Non-Executive Director Remuneration Survey 2015. In the light of this survey she invited the Council of Governors to consider the following recommendations namely that the Chair's salary should be reconsidered from Jan 2017; the Non-Executive Director salary is slightly above the median and should remain unchanged; and, that the uplifts for Deputy Chair and Audit Committee Chair should be reconsidered. The Chair stressed that her recommendation in respect of the Chair's remuneration would be applicable to her successor.

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

- Mrs Bond said that the remuneration of Non-Executive Directors had remained constant since her appointment six years ago. Mr Marstrand suggested that the remuneration of the Chair and Non-Executive Directors be adjusted in line with the percentage increase paid to staff over the last six years and that there should be different levels of remuneration for different levels of responsibility. The Chair advised against this later approach as it was one not followed nationally and the Trust needed to attract the right people.
- Mrs Powell was of the view that the Chair and Non-Executive Directors should record the hours worked both in terms of transparency and providing information as to whether the time devoted to duties (three days a week for the Chair and five days

a month for Non-Executive Directors) was right. The Chair advised that given the seniority of these Board positions this would not be appropriate.

- The Chair said that it would be helpful if any changes were presented to the Council of Governors on 18 May 2016. To this end it was suggested that at the next available Governor meeting this matter be considered with the Director of Human Resources and Organisational Development who should be approached if any additional information was required for that discussion. **AT/DS**

RESOLVED: That this matter be deferred for further consideration by Governors with a report being presented to the next meeting of the Council of Governors in May 2016.

014/16 UPDATE FROM GOVERNORS ON MEMBER ENGAGEMENT

The Chair invited Governors to report on any member engagement activities which they had undertaken since the last meeting and the following were reported:-

- Prof Dunn undertook to re-send to the Trust Secretary for circulation to Governors the report prepared with Mrs Johnson of the meeting of the South West Governor Exchange Network held in November 2015. He said that that section of the Salisbury Hospital's website is out of date and the Trust Secretary undertook to pursue this with the Secretary of the Network. Prof Dunn reported that, although the government had encouraged patients to seek health advice first from a pharmacy during winter pressure times, it has just announced a 6.1% cut (£170m) in the global sum paid to community pharmacies and expected 2,000-3,000 pharmacies to close as a result. He also invited the Trust Secretary to consider whether Council of Governor meeting papers could be made available electronically to Governors as he was now able to download the papers from the Trust's website. **CD MW** **MW**

(Mr Gatling joined the meeting) **CC/MW**

- Ms Storr referred to the open evening held in February 2016 for prospective Non-Executive Directors and suggested that a similar event be held for prospective Governors in the elections later in the year. **MW**
- Mrs Johnson said that the Forest of Dean Health Forum met the needs of the area and efforts should be made of the Clinical Commissioning Group to see if similar arrangements exist elsewhere in the County. The Trust Secretary was invited to contact Mrs Becky Parish at the Clinical Commissioning Group.

The Chair thanked those Governors for the reports.

015/16 GOVERNOR SUB-COMMITTEE REPORTS

Quality Committee – 4 December 2015 and 15 January 2016: These reports were deferred to the next meeting in May 2016. **MW (To note for Agenda)**

Health and Wellbeing Committee – 5 January 2016: The Director of Clinical Strategy reported that the Committee had adopted a themed approach to its meeting and had considered obesity noting that the pathway for adults was satisfactory but that further work is required on

the pathway for children.

Audit Committee – 22 January 2016: The Chair of the Committee reported that a deep dive had been undertaken into risks in relation to clinical coding and knee replacements noting the importance of clinical coding information to assist the Trust in discussions with the Clinical Commissioning Group. A Sub-Committee is to be established with the 2gether Trust in respect of Shared Services and it is anticipated that this Sub-Committee will operate from the new financial year. Extra time is to be factored into future Committee meetings to allow sufficient time for discussion.

Sustainability Committee – 18 January 2016: The Chair of the Committee reported that the meeting had successfully been held by videoconferencing between the two sites. A presentation had been made on the carbon benefits of the SmartCare Programme and investment may be necessary in charging points so that the Trust can benefit from the purchase of electric vans.

The Chair thanked the presenters for their reports.

016/16 GOVERNOR QUESTIONS

The questions submitted by Mr J Marstrand and the responses provided are set out in an appendix to these minutes. Mr Marstrand was invited to contact the Trust Secretary if he had any queries on the responses provided.

017/16 ANY OTHER BUSINESS

There were no further items of business.

018/16 RETIREMENT OF DR FRANK HARSENT, CHIEF EXECUTIVE

Ms Storr said that this would be the last meeting of the Council of Governors which Dr Harsent would be attending before his retirement in May 2016. On behalf of the Governors she thanked Dr Harsent for all the sterling work he had undertaken for the Trust in his time as Chief Executive which was greatly appreciated by Governors. The Council of Governors applauded Dr Harsent for his work and wished him well for the future.

019/16 DATE OF NEXT MEETING

The next meeting of the Council of Governors will be held in the Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital on Wednesday 18 May 2016 commencing at 5.30pm.

020/16 PUBLIC BODIES (ADMISSION TO MEETINGS) ACT 1960

RESOLVED: That under 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 7.20 pm.

Chair
18 May 2016

ITEM 20

ITEMS FOR THE NEXT MEETING AND ANY OTHER BUSINESS

DISCUSSION

ITEM 21

ANY OTHER BUSINESS

Question from Prof Chris Dunn – Appointment of Additional Non-Executive Director

1. The following question has been received from Prof Chris Dunn, a Public Governor for the Stroud Constituency:-

"I think it is an excellent idea that a senior member of a local university be invited to join the GHNHSFT Board as an NED. But it seems unduly restrictive to limit the choice to the University of Gloucestershire: the University of the West of England, Bristol's School of Nursing in located in Gloucester Docks; the University of Bristol is very highly ranked through its Medical School; and the Trust accepts placements from the University of Worcester. Given all these establishments – plus the University of Gloucestershire – are at least potential sources of staff for the Trust, it seems rather invidious to limit the choice to the University of Gloucestershire."

Prof Dunn Comments that he has no associations with the University of Gloucestershire. UWE awarded me my personal Chair nearly ten years ago and I have had little or no association with UWE for 8+ years. I have just completed two years teaching at the University of Worcester and have declined any continuation of that arrangement. My only association with the University of Bristol was during the RAE 2008 when I worked with one or two members of staff from the Medical School.

Perhaps the proposal could be reworded to express a desire to include a NED from a local university with shared interests with the Trust?

2. The Board is invited to consider this question.

ITEM 21

STAFF QUESTIONS

Prof Clair Chilvers
Chair

ITEM 22

PUBLIC QUESTIONS

(Procedure 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