GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

The next meeting of the Gloucestershire Hospitals NHS Foundation Trust Main Board will be held on Friday 29 April 2016 in the Board Room, 1 College Lawn Cheltenham commencing at 9.00 a.m. with tea and coffee. **(PLEASE NOTE VENUE FOR THIS MEETING)**

Professor Clair Chilvers
Chair

22 April 2016

AGENDA

				Approximate Timings
1.	Welcome and Apologies			09:00
2.	Declarations of Interest			
	WELL LED			
	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 24 March 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 to be held on 27 April 2016	**PAPER (To follow)** (Mr Gordon Mitchell)	**To note**	09:05
6.	Minutes of the meeting of the Finance and Performance Committee held on 23 March 2016	**PAPER** (Mr Gordon Mitchell)	**To note**	09:08
7.	Minutes of the meeting of the Health and Wellbeing Committee held on 5 April 2016	**PAPER** (Mr Tony Foster)	**To note**	09:09
8.	Summary of the meeting of the Sustainability Committee to be held on 22 April 2016	**PAPER (To follow)** (Mrs Maria Bond)	**To note**	09:12
9.	Minutes of the meeting of the Quality Committee held on 15 April 2016	**PAPER** (Mrs Helen Munro)	**To note**	09:15
10.	Minutes of the meeting of the Equality Committee held on 14 March 2016	**PAPER** (Mr Clive Lewis)	**To note**	09:18
	Chief Executive's Report and Environmental Scan			
11.	April 2016	**PAPER** (Dr Frank Harsent)	**To note**	09:20
	EFFECTIVE			
12.	Integrated Performance Framework Report	**PAPER** (Mrs Helen Simpson)	**To endorse**	09:30
13.	Financial Performance Report	**PAPER** (Mrs Helen Simpson)	**To endorse**	09:45
14.	Emergency Pathway Report	**PAPER** (Mr Eric Gatling)	**To endorse**	10:00
15.	Nurse and Midwifery Staffing	**PAPER** (Mrs Maggie Arnold)	**To approve**	10:10
16.	Board Statements	**PAPER** (Mrs Helen Simpson)	**To approve**	10:15
17.	Workforce Race Equality Standard	**PAPER** (Mr Dave Smith)	**To endorse**	10:25
	SAFE			
18.	Seven Day Services Update	**PAPER** (Dr Sean Elyan)	**To note**	10:35
19.	Institute for Healthcare Improvement – Lessons Learnt	**PRESENTATION** (Mrs Maggie Arnold)	**To note**	10:40

	Next Meeting			
20.	Items for the next meeting and Any Other Business	**DISCUSSION (All)**	**To Discuss**	10:50
	Staff Questions			
21.	A period of 10 minutes will be provided to respond to questions submitted by members of staff		**To Discuss**	10:55
	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**	11:05 11:15
	Break			

Date of the next meeting: The next meeting of the Main Board will take place at on **Friday 20 May 2016** in the **Gallery Room, Gloucestershire Royal Hospital** at 9.00 am. **(PLEASE NOTE VENUE FOR THIS MEETING)**

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 GALLERY ROOM, GLOUCESTERSHIRE ROYAL HOSPITAL ON THURSDAY 24 MARCH 2016 AT 9.00 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
	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
	Ms Anne Marie Millar	Non-Executive Director
	Mrs Helen Munro	Non-Executive Director
APOLOGIES	Mrs Maggie Arnold	Director of Nursing
	Mr Clive Lewis	Non-Executive Director
IN ATTENDANCE	Mr Martin Wood	Trust Secretary
	Mrs Deborah Lee	Chief Executive Designate
	Mr Bob Pearce	Deputy Director of Service Delivery
	Dr Frank Jewell	Chief of Service – Diagnostics and Specialties
	Ms Sue Barnett	Improvement Director
	Ms Rebecca Wassell	Associate Director of Transformation
	Mr Craig Macfarlane	Head of Communications
PUBLIC/PRESS	Mrs Chrissie Johnson	Public Governor
	Mr Alan Thomas	Public Governor
	Mr Matt Discombe	Citizen

The Chair welcomed all to the meeting. In particular she welcomed Mrs Deborah Lee, Chief Executive designate, who was attending the meeting as an observer.

ACTION

069/16 DECLARATIONS OF INTEREST

There were none.

070/16 MINUTES OF THE MEETING HELD ON 26 FEBRUARY 2016

RESOLVED: That the minutes of the meeting held on 26 February 2016 were agreed as a correct record and signed by the Chair.

071/16 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 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. *The Director of Service Delivery reported that work continues with service areas and the situation is reviewed weekly. The numbers referred to in the Performance Management Framework Report are correct with day cases removed. A series of actions are being undertaken to improve performance. 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 at a meeting of the Forum taking place during the week following the February 2016 Board meeting. *The Chair reported that this issue is being raised at every opportunity and will be raised again at the Gloucestershire Strategic Form on 29 March 2016. Completed for minutes.*

041/16 Integrated Performance Framework Report: The Chair suggested that the Trust should aspire to improving the target for 90% of stroke patients 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 be achieved. *The Director of Service Delivery reported that a root cause analysis is being undertaken to understand why the Trust is not achieving a 100% target and to identify actions to move towards this aspiration. Ongoing.*

042/16 Financial Performance Report: In response to a question from Mr Foster, the Finance Director undertook, in conjunction with the Medical Director, to provide details of the £7m spent on Locum Doctors. *The Medical Director reported that a breakdown of the data is being undertaken which will be reported to the April 2016 meeting of the Finance and Performance Committee. Completed.*

SE/HS
(MW to note for Agenda)

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 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. *The Director of Human Resources and Organisational Development reported that a straw poll had been undertaken of colleagues which indicated that their organisations are not experiencing the same recruitment issues largely because they are not recruiting on such an extensive basis. The Chair commented that the test papers are hard and questioned why it is necessary for the Nursing and Midwifery Council to sub-contract the tests. She invited the Director of Human Resources and Organisational Development and the Nursing Director to meet with her to discuss the position further. Ongoing*

CC/DS/MA

045/16 Cultural Change Programme: 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 Non-Executive Directors engaging in a session with PALS to get a good feel (and a direct feel) for what is happening in the Trust. *The Chair reported that she and Mr Foster have accepted the offer to attend an engagement session with PALS following the circulation of the invitation to all Non-Executive Directors. Completed.*

049/16 Appointment of an Additional Non-Executive Director – proposed amendment to the constitution: The Trust Secretary was invited to look at the arrangement in place in other areas where there are similar links with Universities for inclusion in the constitution. *The Trust Secretary reported that he had looked at how other Trusts had incorporated this into their constitutions which was treated the same as other Non-Executive Director and the information was included in a report being presented to the Governance and Nominations Committee on 30 March 2016. Completed.*

048/16 2015 Staff Survey Results: The Director of Human Resources and Organisational Development reported that the Divisional Engagement Group are meeting just before the April 2016 Board meeting which may impact on the action plan. He therefore suggested that the Group presentation be deferred to the May 2016 Board meeting or at the June 2016 Board Seminar. [0907]

DS
(MW to note for Agenda)

072/16 SUMMARY OF THE MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE HELD ON 23 MARCH 2016

The Chair of the Committee, Mr Gordon Mitchell, reported on the meeting of the Finance and Performance Committee held on 23 March 2016. Following the Board Governance Review the Committee's approach is now to balance assurance with reports highlighting areas upon which to focus. The Committee considered six reports. The outturn position should be positive and there are no specific issues for the Board. In considering the Performance Management Framework Report the Committee sought information to understand the C Difficile position and a description on the way forward with performance on Acute Kidney Infection (AKI) ant VTE. The performance in not meeting the recovery trajectory for the 62 day cancer standard in January 2016 is an issue for the Board. The Emergency Pathway Report is to be considered later in the Board agenda. The Budget, Capital Programme and Operational Plan for 2016/17 were reviewed. The focus of the discussion was on the impact of the Sustainability and Transformation Programme, and how cash and the control total plays into the Budget and to achieving the surplus. There are budget pressures from the increase in cancer referrals and Emergency Department attendances and admissions. Lastly, the Committee received a presentation on a different approach to Service Line Management with a pilot being undertaken in Surgery Division.

Mr Foster added that the Committee had considered cash management and what an ideal cash position might be. The cash

position will now be incorporated into future Finance reports.

The Chair thanked Mr Mitchell for his report.

RESOLVED: That the report be noted. [0912]

073/16 MINUTES OF THE MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE HELD ON 24 FEBRUARY 2016

RESOLVED: That the minutes of the meeting of the Finance and Performance Committee held on 24 February 2016 be noted. [0912]

074/16 MINUTES OF THE MEETING OF THE AUDIT COMMITTEE HELD ON 8 MARCH 2016

The Chair of the Committee, Ms Anne Marie Millar, presented the minutes of the meeting of the Audit Committee held on 8 March 2016. She highlighted that the Committee had considered the External Auditors' Plans with a focus on income recognition and an overview of key performance indicators. The Internal Auditors draft Annual Report for 2015/16 placed the Trust in the second highest category in terms of opinion. Some specific audit reports had reserved judgements.

The Chair thanked Ms Millar for her report.

RESOLVED: That the report be noted. [0915]

075/16 MINUTES OF THE MEETING OF THE QUALITY COMMITTEE HELD ON 11 MARCH 2016

The Chair of the Committee, Mrs Helen Munro, presented the minutes of the meeting of the Quality Committee held on 11 March 2016. She said that the Committee had considered the draft Quality Report and CQINS. A presentation was made on clinical coding which is critical to improving patient care as well as for financial reasons. Diagnostics and Specialties Division had presented a positive report although radiographer recruitment remains a challenge despite an improvement. Dr Kate Hellier gave a presentation on her work in connection with Board Rounds and the redesign of stroke services. A feedback form has been used for Divisional attendance which is to be extended to cover all reports. The Chair of the Committee will speak to the Associate Director of Transformation to develop behaviours. **HM**

The Chair thanked Mrs Munro for her report.

RESOLVED: That the report be noted. [0918]

076/16 MINUTES OF THE MEETING OF THE EQUALITY COMMITTEE HELD ON 14 MARCH 2016

In the absence of the Chair of the Committee, the Director of Human Resources and Organisational Development reported on the meeting of the Equality Committee held on 14 March 2016. He highlighted that the Committee considered the equality system with the Workforce Race Equality report being presented to the Board in April 2016. The Committee focused on the Black and Minority Ethnic

position and staff with disabilities particularly working with agencies to improve opportunities for those with disabilities. The Head of Patient Experience is a member of the County Diversity Inclusion Group. The Committee discussed the implications of the proposed establishment of a Workforce Committee for which the Director of Human Resources and Organisational Development is to prepare suggested terms of reference for further discussion.

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

RESOLVED: That the report be noted. [0920]

077/16 CHIEF EXECUTIVE'S REPORT AND ENVIRONMENTAL SCAN

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

- **National:** Our Trust has accepted the financial control total set by Monitor for 2016/17 amounting to £12.9m requiring our Trust to achieve a surplus of £5.3m. A communications strategy is required for staff and the wider health community. Approximately two thirds of Trusts nationally have accepted their control total. The Chief Executive believed that the control total is achievable provided that expenditure on agency staff is reduced. The Sustainable and Transformation Programme monies will be withheld if the control total is not met.
- **Regulators:** Monitor has issued their analysis of Quarter 3 performance. Our Trust has been given a rating of 3 for financial sustainability and for Governance Monitor has decided to open an investigation because of the ongoing poor performance on the 4 hour A&E target.
- **Our Trust:** The industrial action by Junior Doctors is being escalated and on 26 and 27 April 2016 all services are being withdrawn. The Director of Service Delivery commented that to date the industrial action has had no significant impact on our Trust. When the dates for industrial action have been announced our Trust has under booked appointments resulting in few cancellations, although some appointments are inevitably delayed. Doctors work differently during the periods of industrial action with high quality patient care being maintained. The situation at the end of April 2016 will be different with all out industrial action. Part of the planning process for the end of April 2016 will involve messages being published advising people not to attend ED on those dates. The Director of Human Resources and Organisational Development added that details of the Junior Doctors contract was expected shortly.
- A formal Go/No decision for SmartCare will be taken by the Programme Board at the beginning of April 2016 following a review of Phase 1. Pathology and Pharmacy Stock Control will no longer be part of Phase 1 but will be scheduled for later in the year.

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

- M1c (which now incorporates C13 and C8) relating to the hospital at full capacity – noted that the risk score rating had increased to 25.
- F7 – Delay in providing follow up appointment in a number of specialities - is still an issue and needs to remain on the Register.
- S100 – Continued failure to meet 62 day cancer standard – risk rating score of 20 is appropriate when pathways are taken overall.
- New Risk – Palliative Care team unable to provide the necessary responsive and comprehensive service due to staff shortages. The Chief of Service for Diagnostics and Specialities said that a business case is being prepared for submission to the next meeting of the Efficiency and Improvement Board for additional staff resources. Locums are covering two staff sickness absences. Fast track for end of life care and seven day service is impacting on palliative care. He expressed confidence in being able to fill the posts if the business case is approved. The Director Service Delivery added that there has been a dramatic increase in workload. The Chair invited the Chief of Service to provide an update for the May 2016 Board meeting.

FJ
(MW to note for agenda)

The Chair thanked the Chief Executive for his report.

RESOLVED: That the report be noted. [0935]

078/16 OPERATIONAL PLAN 2016/17

The Director of Clinical Strategy presented the report setting out that as part of the national planning guidance every NHS provider Trust is required to submit an Operational Plan by 11 April 2016 covering activity, capacity and finance for 2016/17 and setting out the relationship to the emerging system-wide Sustainability and Transformational Programme. There are no material changes from the draft version of the Plan presented to the Board in February 2016 and Monitor had made no changes on the submitted draft. The presentation of our objectives for 2016/17 now includes milestones at six and twelve months to facilitate a more robust approach to tracking progress as identified in the Board Governance Review. The final Plan is to be submitted to Monitor by 11 April 2016 which gave time for changes to be made to the final Plan prior to submission.

ALL

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

- The Chair referred to the top three risks and the plans for mitigation and asked if partner organisations had agreed to those risks and mitigation plans. In response, the Director of Clinical Strategy said that the risks and mitigation plans had been shared informally with partners which they would recognise.
- The Director of Service Delivery said that the QIPP plans for emergency and elective care should be expanded in the relevant sections of the Plan.

SP

- The Chair commended the layout of our priorities.

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

RESOLVED: That the Operational Plan be approved subject to any further changes and the Director of Clinical Strategy be authorised to submit the final Plan to Monitor. [0942]

079/16 DRAFT REVENUE BUDGET 2016/17

The Finance Director presented the report on the key points of the budget setting process and agreement of revenue budgets for the 2016/17 financial year. The content of the budget will be updated as necessary to ensure that it is in line with the Monitor templates and is coherent with other Trust strategies and policies.

Negotiations are continuing with the Clinical Commissioning Group and the expectation remains that contract signing should be achieved by the end of March 2016. When negotiations are concluded the budgets will be updated to reflect the agreed contract settlement. The proposed budget also took account of the national tariff changes introduced for 2016/17, Divisional budget review meetings and the current assessment of our asset base and the budget may change to reflect the outcome of the asset valuation. The budget was based on delivering the Sustainability and Transformation Programme. The key risks are around reducing expenditure on agency staff. The contingency reserve is £4m to cover risk. Our cash balances are forecast to be between the levels required to maintain a Continuity of Service Rating (COSR) of 3. The Cost Improvement Plan target is currently £18.2m derived using the internal efficiency requirement of 4.8% to reflect the additional funding needed to be generated to support the capital programme to deliver the control total linked to the Sustainability and Transformation Programme. The budget booklet is currently being produced within the overall budget strategy as outlined in the report.

During the course of the discussion, the Finance Director responded to a question from Ms Millar that costs associated with the industrial action by Junior Doctors have been built into the budget.

The Chair thanked the Finance Director for the report.

RESOLVED: That the the current contracting position be noted and that the annual financial plan described within this report be approved. The budgets, pending contract agreement with our main commissioner reflects:-

1. Revenue surplus of £18.2m to support investment of our capital programme, COSR of 3 (rising to 4) and delivery of Sustainability and Transformation funding control total
2. Delivery of cost improvement programme of £18.6m, as well as any unachieved Cost Improvement Programme from 2015/16. [0942]

080/16 CAPITAL PROGRAMME 2016/17

The Finance Director presented the report outlining the Capital Programme for 2016/17. The funds available for investment amounted to £11m which is lower than previous years. The priority schemes related to SmartCare and SmartCare devices, network replacement, telephony, building and infrastructure schemes and the Medical Equipment Fund. The indicative Capital Programme is

consistent with the draft Monitor plan.

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

- In response to a question from Mr Foster, the Finance Director explained that surpluses from the current financial year can be used to support the Capital Programme in 2016/17 and it is hoped that any surpluses in 2016/17 can be used to support a Capital Programme in 2017/18. Confirmation of this is awaited. The Director of Clinical Strategy added that any reinvestment in 2017/18 is dependent upon a robust Sustainability and Transformation Plan which is a system-wide plan. The bulk of the monies from that Plan are available to Acute Trusts but the detailed criteria have yet to be made available.

The Chair thanked the Finance Director for the report.

RESOLVED: That the outline Capital Programme for 2016/17 be approved. [0942]

081/16 INTEGRATED PERFORMANCE FRAMEWORK REPORT

The Finance Director presented the report in the agreed revised format summarising the key highlights and exceptions in the Trust up to the end of February 2016 for the financial year 2015/16. 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 said that performance of no breaches of the mixed sex accommodation standard during February 2016 is cause for congratulation.
- The Chair sought an explanation for the reason why our Trust did not meet the recovery trajectory for the 62 day cancer standard in January 2016. In response, the Director of Service Delivery said that there are ongoing capacity issues in urology where the recovery plan is based on availability of additional consultants. Our Trust has lost the benefit of the additional staff as two consultants are on sick leave and the loss of consultants from Hereford. There is a re-focus on cancer patients at the expense of those on the 18 week pathway. Other options are being explored to increase capacity. Urology currently accounts for 50% of breaches. The Medical Director added that it is a challenge to manage demand.
- Mr Mitchell sought an explanation to the cancer 14 days to first appointment following GP referral which is currently red risk-rated. In response, the Director of Service Delivery said that demand has increased and the issues are in urology where there are now between 20 and 30 additional patients seen every month. The position is monitored daily.
- In response to a question from Mr Mitchell about plans to return to meeting performance standards, the Director of Service Delivery said that the 2 week wait cancer

performance standard should be met in March 2016 and the 62 day cancer performance standard by September 2016.

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. [1002]

082/16 FINANCIAL PERFORMANCE REPORT

The Finance Director presented the Financial Performance Report stating that the financial position of the Trust at the end of February 2016 is a surplus of £0.7m on income and expenditure which is £0.2m higher than the position reported in January 2016.

In response to a question from the Chair, the Finance Director said that the revised report format will be introduced in May 2016. **HS**

The Chair thanked the Finance Director for the report.

RESOLVED: That:-

1. The financial position of the Trust at the end of month 11, a surplus of £0.7m on income and expenditure be noted. This is £0.2m higher than the position reported at Month 10.
2. 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.
3. The Monitor risk assessment framework shows a Financial Sustainability Risk Rating of 3.
4. 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. [1004]

083/16 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 February 2016 with Trustwide performance reported as 76.43%. He acknowledged that this level of performance was not acceptable, either for patients and staff.
- The precise detail of the Monitor investigation into Emergency Department performance is being determined.
- There is to be a step change approach to delivering improved performance. A new Improvement Director, Sue Barnett, has been appointed with experience in other organisations; latterly with the Sherwood Forest Trust in Nottinghamshire where improvements were made and sustained since November 2015 when her appointment finished. She will work with the Director of Service Delivery and the Executive Team. Our Trust has too many operational plans which will be revised. There is a six week plan focusing on three areas; namely firstly, to ensure patients are assessed and treated in our

Emergency Departments in a timely manner in line with best practice; secondly, to provide senior clinical onsite presence and support seven days a week to optimise patient allocation to the correct ward; and thirdly, to review all patients who have been in our Trust for 14 days or more. Each area will be led by an Executive Director with weekly reporting.

- The Director of Service Delivery assured the Board that robust plans are in place for the Easter period which have been challenged with partners.

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

- The Chair said that it is important that safety and quality aspects of Emergency Department performance are reviewed by the Quality Committee. **CC/MW**
- The Medical Director commented on the benefits which the Improvement Director could give our Trust enabling it to focus on smaller issues. For example she had experience of reducing the number of patients over 14 days and our Trust has begun that process with a small reduction to 196 (from 207).
- Mr Mitchell commented that the increase in both attendances and admissions is not a unique situation. He accepted that this situation required a different approach, but expressed concern for patient safety in dealing with these high levels of demand. Currently Emergency Department performance is reported to the Finance and Performance Committee and he wanted the Board to be clear who in our Trust addresses patient safety issues and is there a risk to patient safety. Mrs Munro, as Chair of the Quality Committee, said that the Quality Committee needs to be assured that there is no risk to patient safety or to the quality of care provided. The Director of Service Delivery said that there is no evidence that there are any significant safety issues. The Medical Director added that Band 8 nurses are working out of hours to provide enhanced input into patient flow.
- In response to a question from Ms Millar, the Chief Executive said that re-admission data are quality measures for the whole Trust and it is not possible to draw conclusions that patients are being discharged from the Emergency Department too soon.
- The Chief Executive said the Emergency Department at Cheltenham General Hospital has introduced on a pilot basis the checklist developed in Bristol providing a series of quality checks on individual patients to ensure that important detail is not missed. The pilot will be extended to Gloucestershire Royal Hospital.
- The Chair invited the Director of Service Delivery to revise the Emergency Pathway report to focus on quality, safety and performance metrics to enable the Board to obtain assurance on all issues after prior consideration by both the Finance and Performance and the Quality Committees. The Director of Service Delivery said that this will be developed over the next couple of months. **EG**

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. [1018]

084/16 NURSE AND MIDWIFERY STAFFING

The Chief Executive presented the report updating the Board on the exception report made regarding compliance with the 'Hard Truths' – Safer Staffing Commitments for February 2016. In line with the set parameters for the safer staffing guidance there were no outlying exceptions for February 2016. 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.

Our Trust is undertaking activity to ensure preparedness to meet the new nurses and midwives revalidation. A recruitment campaign to recruit the next cohort of overseas nurses has begun. The greater number of overseas nurses recruited will reduce the reliance on agency staff.

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

- The Director of Human Resources and Organisational Development said in response to a question from the Chair that the overseas nurses will be required to pass the International English Language Testing System (IELTS) examination. Our Trust has employed a former IELTS inspector which will assist staff in passing the examination.
- The Chief Executive commented that due to the IELTS requirement the 2014 campaign to recruit nurses from the Philippines had not resulted in a great return on the efforts to recruit as only 24 had been appointed from 100 offered posts. The Director of Human Resources and Organisational Development added that the 2014 recruitment campaign was undertaken through an agency whereas more recently our Trust is managing the process to fill posts in our Trust.
- In response to a question from Mr Foster, the Chief Executive said that the Nursing Director is to attend the Nursing and Midwifery Council to seek a better position on the IELTS requirement.

(Ms Barnet, Improvement Director, joined the meeting)

- The Chair informed the Board that she had approached the County MPs seeking their support to an extension for nursing on the Home Office shortage occupation list. She would thank Mr Alex Chalk MP for his representations.
- The Chair expressed her appreciation for all the efforts being undertaken to improve recruitment.

The Chair thanked the Chief Executive for the report.

RESOLVED: That the report be endorsed. [1024]

085/16 INFORMATION GOVERNANCE TOOLKIT STANDARDS FINAL ASSESSMENT

The Director of Clinical Strategy presented the report informing the Board of the proposed final scores for our Trust's 2015/16 Information Governance (IG) Toolkit Assessment. Version 13 of the IG Toolkit was released in its current form in May 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 Standards Contract including changes to certain requirement statements, descriptions, attainment level criteria and evidence required. Each standard has to be rated on a scale of 0-3, with Level 0 representing non-compliance and Level 3 representing full compliance. The NHS Operating Framework requires Trusts to achieve Level 2 in the IG Toolkit equivalent to substantial compliance. The IG Toolkit requirements are related to the ISO27001 standards which defines a systematic approach to the management of information security risks. Monitor does not formally consider our Trust's performance against the IG Toolkit, but does consider this to be a contractual matter for our commissioners. SmartCare should enable future IG improvements by delivering enhanced security and audit functionality. Final evidence demonstrates that our Trust's score will reach the required 75% compliance. To achieve level 3 will require investment and our Trust's performance at level 2 is solid. The Audit Committee had noted that the Internal Audit report classified Information Governance as low risk.

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

RESOLVED: That:-

1. Publication of the final Information Governance Toolkit (IGT) assessment described in the report and detailed in Appendix 1 be approved.
2. Authority be delegated 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.
3. The Information Governance Assurance Statement be endorsed. 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. [1024]

086/16 COMPLAINTS AND CONCERNS Q3

The Chief Executive presented the report providing information on the complaints and concerns reported to our Trust during Quarter 3 of 2015/16 stating that he had no areas which he wished to highlight.

The Chair thanked the Chief Executive for the report.

RESOLVED: That the Quarter 3 2015/16 Complaints and Concerns report be noted. [1029]

087/16 MINUTES OF THE MEETING OF THE COUNCIL OF GOVERNORS HELD ON 24 FEBRUARY 2016

The Chair presented the minutes of the meeting of the Council of Governors held on 24 February 2016.

Mr Mitchell updated the Board on the work of the Governor Task Group to take forward the recommendations in the Board Governance Review relating to Governor Effectiveness upon which he and Mr Foster are represented. Work has moved on quickly following a briefing session open to all Governors and attended by a majority. The Task Group had then met to narrow the actions for consideration at a second meeting to take place on 6 April 2016 to which all Non-Executive Directors are invited to attend where the notes of the Governor session will be provided as background.

The Chair expressed her appreciation to Messrs Mitchell, Foster and the Lead Governor, Mr Thomas, for moving quickly on this work.

RESOLVED: That the minutes be noted. [1031]

088/16 ITEMS FOR THE NEXT MEETING AND ANY OTHER BUSINESS

Items for the next meeting: The Workforce Race Equality Standard was identified as an item for the next Board meeting. **DS (MW to note for Agenda)**

Any other business:

<u>High Sheriff Awards</u>

The Chair reported that as part of the High Sheriff's award to people in the community three members of our Trust staff are to receive award. The staff are Mary Lee, Michele Lucarotti and Moira Montague.

RESOLVED: That the Board's congratulation to these staff on their award be recorded.

<u>Appointment of An Additional Non-Executive Director – Proposed Amendment to the Constitution</u>

The Chair reminded the Board of their decision in February 2016 to recommend to the Council of Governors 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 accordingly. Subsequently, Prof Chris Dunn, one of the Public Governors, had suggested that 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 is 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 our Trust, it seems rather invidious to limit the choice to the University of Gloucestershire.

The Chair invited the Board to form a view on this suggestion which could then be presented to the Governance and Nominations

Committee on 30 March 2016 to inform their consideration of the suggestion. The Chief Executive said that teaching hospitals in other areas have a link with a specific university and based on the scale of involvement the link for our Trust should be the University of Gloucestershire. He was not aware of any reciprocal arrangements between a University and a Trust. This view was supported by the Board.

RESOLVED: That the Board's decision for the appointment of one additional Non-executive Director from the University of Gloucestershire remain unchanged and the Governance and Nominations Committee be informed accordingly. [1037]

089/16 STAFF QUESTIONS

There were none.

090/16 PUBLIC QUESTIONS

There were none.

091/16 DATE OF NEXT MEETING

The next **Public** meeting of the **Main Board** will take place at **9.00 am** on **Friday 29 April 2016** in the **Boardroom, 1 College Lawn, Cheltenham**

092/16 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 10.38 am.

Chair
29 April 2016

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – APRIL 2016

MATTERS ARISING

CURRENT TARGETS

Target Date	Month/Minute/Item	Action with	Detail & Response
April 2016	December 2015 Minute 376/15 Integrated Performance Framework Report	**SE/EG**	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. *The Director of Service Delivery reported that work continues with service areas and the situation is reviewed weekly. The numbers referred to in the Performance Management Framework Report are correct with day cases removed. A series of actions are being undertaken to improve performance. Ongoing.*
		CC	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 at a meeting of the Forum taking place during the week following the February 2016 Board meeting. *The Chair reported that this issue is being raised at every opportunity and will be raised again at the Gloucestershire Strategic Form on 29 March 2016. Completed for minutes.*
April 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 patients 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 be achieved. *The Director of Service Delivery reported that a root cause analysis is being undertaken to understand why the Trust is not*

			achieving a 100% target and to identify actions to move towards this aspiration. Ongoing.
April 2016	February 2016 Minute 044/16 Nursing and Midwifery Staffing	**CC/DS/MA**	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. *The Director of Human Resources and Organisational Development reported that a straw poll had been undertaken of colleagues which indicated that their organisations are not experiencing the same recruitment issues largely because they are not recruiting on such an extensive basis. The Chair commented that the test papers are hard and questioned why it is necessary for the Nursing and Midwifery Council to sub-contract the tests. She invited the Director of Human Resources and Organisational Development and the Nursing Director to meet with her to discuss the position further. Ongoing*
April 2016	March 2016 Minute 075/16 Minutes of the Meeting of the Quality Committee held on 11 March 2016	**HM**	A feedback form has been used for Divisional attendance which is to be extended to cover all reports. The Chair of the Committee will speak to the Associate Director of Transformation to develop behaviours. *Ongoing*
April 2016	March 2016 Minute 078/16 Operational Plan 2016/17	**ALL** **SP**	The final Plan is to be submitted to Monitor by 11 April 2016 which gave time for changes to be made to the final Plan and submitted to the Director of Clinical Strategy prior to submission. *Ongoing.* The Director of Service Delivery said that the QIPP plans for emergency and elective care should be expanded in the relevant sections of the Plan. *Ongoing.*
April 2016	March 2016 Minute 088/16 Items for the Next Meeting and Any Other Business	**DS**	The Workforce Race Equality Standard was identified as an item for the next Board meeting. *This item appears later in the Agenda. Completed.*

April 2016	March 2016 Minute 083 Emergency Pathway Report	**CC/MW**	The Chair said that it is important that safety and quality aspects of Emergency Department performance are reviewed by the Quality Committee. *Ongoing.*

FUTURE TARGETS

Target Date	Month/Minute/Item	Action with	Detail & Response
May 2016	February 2016 Minute 048/16 2015 Staff Survey Results	**DS**	The Director of Human Resources and Organisational Development reported that the Divisional Engagement Group are meeting just before the April 2016 Board meeting which may impact on the action plan. He therefore suggested that the Group presentation be deferred to the May 2016 Board meeting or at the June 2016 Board Seminar. *Ongoing.* The Director of Human Resources and Organisational Development said that the action plan is to be presented to the Board in May 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	March 2016 Minute 077/16 Chief Executive's Report and Environmental Scan – Trust Risk Register	**FJ**	New Risk – Palliative Care team unable to provide the necessary responsive and comprehensive service due to staff shortages. The Chief of Service for Diagnostics and Specialities said that a business case is being prepared for submission to the next meeting of the Efficiency and Improvement Board for additional staff resources. He expressed confidence in being able to fill the posts if the business case is approved. The Chair invited the Chief of Service to provide an update for the May 2016 Board meeting. *Ongoing.*
May 2016	March 2016 Minute 082/16 Financial Performance Report	**HS**	In response to a question from the Chair, the Finance Director said that the revised report format will be introduced in May 2016. *Ongoing.*
April 2016	March 2016 Minute 083/16 Emergency Pathway Report	**EG**	The Chair invited the Director of Service Delivery to revise the Emergency Pathway report to focus on quality, safety and performance metrics to enable the Board to obtain assurance on all issues after prior consideration by both the Finance and Performance and the Quality Committees. The Director of Service Delivery said that this will be developed over the next couple of months.

			Ongoing.

COMPLETED TARGETS

Target Date	Month/Minute/Item	Action with	Detail & Response
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 spent on Locum Doctors. *The Medical Director reported that a breakdown of the data is being undertaken which will be reported to the April 2016 meeting of the Finance and Performance Committee. Completed.*
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 Non-Executive Directors engaging in a session with PALS to get a good feel (and a direct feel) for what is happening in the Trust. *The Chair reported that she and Mr Foster have accepted the offer to attend an engagement session with PALS following the circulation of the invitation to all Non-Executive Directors. Completed.*
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 areas where there are similar links with Universities for inclusion in the constitution. *The Trust Secretary reported that he had looked at how other Trusts had incorporated this into their constitutions which was treated the same as other Non-Executive Director and the information was included in a report being presented to the Governance and Nominations Committee on 30 March 2016. 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

SUMMARY OF THE MINUTES OF THE MEETING OF THE TRUST FINANCE AND PERFORMANCE COMMITTEE HELD ON WEDNESDAY 27 APRIL 2016

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

052/16 FINANCIAL PERFORMANCE REPORT

The financial position of the Trust at the end of the 2015/16 financial year is an operating surplus of income over expenditure of £0.9m representing a negative variance of £3.1m from the original planned position of a £4m surplus of income over expenditure at the end of the financial year. Subsequent to the closing of the accounts, agreement has been reached with the Clinical Commissioning Group of an additional funding which will improve the Trust's cash position in 2016/17.

053/15 INTEGRATED PERFORMANCE MANAGEMENT FRAMEWORK

The Committee has considered the Performance Management Framework and wish to draw to the Board's attention the areas of exception on performance in the Emergency Department and the 62 day cancer standard. The Committee also wish to draw the Board's attention to ambulance handover delays.

054/15 EMERGENCY PATHWAY REPORT

The Improvement Director updated the Committee on the work being undertaken in the three priority areas. The focus is on areas within the Trust's gift to improve within a short timescale, but it is recognised that assistance of partner organisations will be required to achieve a final and sustained improvement in performance. The Board is to be provided with timeframes when it is expected that trajectories will be met.

055/15 BOARD STATEMENTS

RESOLVED TO RECOMMEND: that:-

1. The Board has maintained a Financial Sustainability Risk Rating of 3 for the 2015/16 financial year.

2. An exception report is made to NHS Improvement on the A&E 4 hour standard and Cancer 62 day standard. The Trust will continue working with NHS Improvement and partners across the health system to design and deliver performance improvement plans to deliver theatres agreed with Commissioners and NHS Improvement.

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

056/16 STAFF RECRUITMENT AND RETENTION

The Committee received a presentation from the Director of Human Resources and Organisational Development and the Divisional Nursing Director for Medicine on the work undertaken in the Division to better understand the reasons for the challenges in recruiting and retaining nursing staff. Based on the themes emerging from exit interviews a programme of next steps is being implemented to improve recruitment and retention rates.

057/15 TEMPORARY MEDICAL STAFFING

The Committee noted the summary of the financial analysis and the key financial points of the Trust's temporary medical staffing costs. Actions plans are under development and the Committee has invited the Medical Director and the Operational Finance Director to provide an update to the July 2016 Committee meeting.

058/16 OVERVIEW OF LORD CARTER REVIEW

The Committee received a presentation from the Cost Improvement Manager and the Head of Shared Services setting out the background to this review and how it will impact upon the Trust. The 15 recommendations from the review will form cross-cutting themes for the Cost Improvement Programme where the focus will be on those recommendations which will provide the greatest financial benefit. The targets for implementation of the review are set nationally.

059/16 PROGRESS UPDATE CONTRACTING PROCESS

The year-end settlements for 2015/16 have been agreed with the Clinical Commissioning Group and Specialised Services. The position continues to be negotiated with Gloucestershire Care Services. Negotiations continue with each organisation on the 2016/17 contracting process. It is concerning that the Clinical Commissioning Group has decided not to commission seven day services for 2016/17. The Trust is explicit with Gloucestershire Care Services that the legacy recharge arrangement will no longer be tolerated and that it will insist on clear contracts with clear specifications.

060/16 ANNUAL APPRAISAL

The incoming Chair and the Trust Secretary are to develop the terms of reference approach for a more wide ranging appraisal template for completion by the Committee.

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 23 MARCH 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.

ACTION

032/16 DECLARATIONS OF INTEREST

There were none.

033/16 MINUTES OF THE FINANCE AND PERFORMANCE COMMITTEE HELD ON 24 FEBRUARY 2016

RESOLVED: That the minutes of the meeting of the Finance and Performance Committee held on 24 February 2016 were agreed as a correct record and signed by the Chair.

034/16 MATTERS ARISING

155/15 Service Line Reporting Update: Work is continuing on embedding service line reporting into every day operations, and there will be a focus on visibility of cost to create a greater appreciation of what individual services cost. A paper will be produced jointly by the Finance Director and the Director of Service Delivery on the future of Service Line Management. *This item appeared later in the Agenda. Completed.*

023/16 Readmission Analysis: This item was deferred to the meeting in March 2016. *This item appeared later in the agenda. Completed.*

025/16 Cost Improvement Programme Update: Mrs Bond said that the Committee should seek the risk status for the 2016/17 Cost Improvement Programme before the start of the financial year. *Mrs Bond clarified that the Committee should receive an overview of the risk at the start of the 2016/17 financial year and how that compared to the previous year. Ongoing.*

035/16 FINANCIAL PERFORMANCE REPORT

The Finance Director presented the Financial Performance Report stating that the financial position of the Trust at the end of February 2016 is a surplus of £0.7m on income and expenditure which is £0.2m

higher than the position reported in January 2016. The contract position with commissioners has yet to be concluded and there are two main risks to delivering the financial surplus. Firstly, the outcome of the agreement with specialised commissioners and, secondly, the level of agency spend in Medicine Division where there is a need for a strong focus to manage.

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

- The Chair asked for information on the financial gap between specialised commissioners and our Trust. In response, the Finance Director said that the gap is now £0.5m. An offer had been made to our Trust earlier in the week which is being examined. The Chief Executive added that it is hoped that an agreement can be reached with specialised commissioners who are in special measures with NHS England. The deadline for agreement is 24 April 2016 and the matter can be referred to arbitration if no agreement is reached.
- The Finance Director said that Gloucester Care Services (GCS) have offered a reasonable financial settlement which contains caveats. The Trust has given notice to decommission some services next year, for example support services to community services. GCS are forecast to have a financial surplus of £2.5m at year-end.
- The Chief Executive added that the financial controls next year will be more challenging with Clinical Commissioning Groups required to achieve a 1% contingency.

The Finance Director tabled her report providing an update on the debtors and creditors position for our Trust for February 2016. Overall outstanding debt has reduced by £5.8m from January 2016 across all categories with the exception of 91 – 120 days. It is evident that the additional measures put in place to reduce outstanding debt are taking effect. Debts owing from Gloucestershire Clinical Commissioning Group relate to over performance against contracted activity. Debts owing from GCS are broadly matched by the amounts that our Trust owes to GCS. The working capital facility with Barclays will be used in 2016/17 on a monthly cash settlement basis.

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

- The Chair enquired as to the arrangements for the working capital facility. The Finance Director said in response that our Trust has received preferential rates and Barclays are working with the Trust on a flexible amount between £5 and £6m. Mr Foster asked how long it will take for the Trust to return to a normal cash position and what a good cash position might look like. In response, the Finance Director said that a reduction in 120 day debt from GCS would be of benefit to our Trust. To reduce this to zero would take a number of years. The 91 -120 day debt has reduced considerably. The Chief Executive advised that the cash position would remain challenging in view of the overall NHS financial position and pressure on Trusts throughout the Country. Mr Foster observed that if the creditor position improved the working capital facility could be used to pay suppliers. The Chair invited the Finance Director to **HS**

report to the Committee in May 2016 with a view of the action which the Trust should be working towards. **(MW to note for Agenda)**

- Mrs Bond referred to the system that suppliers will not receive payment unless there a prior purchase order has been raised. Suppliers have been notified of this process and some are not comfortable with it. She asked if staff are aware of the process. In response, the Finance Director said that the majority of staff are aware of the process and understand the reasons for it but there is a cultural issue to ensure that the process is followed throughout our Trust.
- In response to a question from the Chair, the Finance Director said that there is a concerted effort in the remaining days of the current financial year to achieve 80% of the Cost Improvement Programme.

The Chair thanked the Finance Director for the report.

RESOLVED: That:-

1. The financial position of the Trust at the end of month 11 is a surplus of £0.7m on income and expenditure be noted. This is £0.2m higher than the position reported at Month 10. Significant risks remain to be monitored particularly in respect of agency expenditure and year-end settlement particularly with Specialised Commissioners.
2. The Trust needs to improve its controls on the use of agency staff and discretionary expenditure improve the financial position as soon as possible.
3. The Monitor risk assessment framework shows a Financial Sustainability Risk Rating of 3.
4. 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.

036/16 INTEGRATED PERFORMANCE MANAGEMENT FRAMEWORK

The Finance Director presented the report in the agreed revised format summarising the key highlights and exceptions in our Trust up to the end of February 2016 for the financial year 2015/16. 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:-

- In response to a question from Mr Foster, the Chief Executive said that Clostridium Difficile infection performance is reconciled on a quarterly basis.
- The Chief Executive said in response to a question from Mr Foster that the main reason why our Trust did not meet the recovery trajectory for the 62 day cancer standard in January 2016 was in urology. A new urologist has started and our Trust is beginning to get the full effect of that appointment. The recovery plan has been agreed with the Clinical Commissioning Group and Monitor. However, national cancer campaigns place the service under severe pressure.
- In response to a question from the Chair relating to VTE

performance which remains re risk rated, the Finance Director said that this is caused by not being able to record those patients who spend such a short period of time in the Ambulatory Care Unit. There is a requirement to capture this data and a prompt is on the drug chart but some patients leave the Unit not requiring drugs.

- Acute Kidney Infection performance remains red risk rated and the Chair asked for the reasons. In response, the Chief Executive said that the process has been reformed by junior doctors with a two stage process where some elements can be included in the discharge summary. The introduction of SmartCare will assist. The Finance Director undertook in response to a question from Mrs Bond to check the impact of performance on coding. **HS**
- In response to a question from Mr Foster, the Finance Director said that the breaches in mixed sex accommodation were as a result of bed pressures relating to high demand.

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.

037/16 EMERGENCY PATHWAY REPORT INCLUDING READMISSION ANALYSIS

The Chief Executive presented the Emergency Pathway Report and highlighted that the 95% four hour target for Emergency Department performance was not successfully met in February 2016 with Trust-wide performance reported as 76.43%.

He then referred to the Monitor investigation. The Improvement Director has been appointed focusing on three areas; namely firstly, to ensure patients are assessed and treated in our Emergency Departments in a timely manner in line with best practice; secondly, to provide senior clinical onsite presence and support seven days a week to optimise patients allocation to the correct ward; and thirdly, to review all patients who have been in our Trust for 14 days or more. The Improvement Director has commented on the quality of staff and their attitude to make improvements. The approach is to achieve 80% performance, high 80% performance and then 90% performance. There are challenges with partner organisations to delivering improved performance, particularly Social Services and Gloucestershire Care Services. There is internal work to be undertaken to improve performance which is also receiving a strong focus. The focus on the day of the meeting is at Gloucestershire Royal Hospital which is experiencing significant demand pressures. The Clinical Commissioning Group has been put into contact with the Nottinghamshire Clinical Commissioning Group to learn from lessons when the Improvement Director worked in that County.

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

- Mr Foster asked if there are any safety issues due to the current level in meeting the 95% performance standard. In response, the Chief Executive said that the Clinical

Commissioning Group has said that there are no safety issues but it is not a good patient experience. Concerns have been expressed over the size of the Emergency Department at Gloucestershire Royal Hospital where all physical areas are being utilised. The Chair asked how safety issues will be handled should there be external concerns raised. The Chief Executive drew attention in the report to the Safety and Experience and Quality Metrics, the introduction of the Emergency Department checklist and the Root Cause Analysis which addressed patient safety during the period of increased operational pressures in the Emergency Departments in December 2015 and January 2016 which had been presented to the Quality Committee. He added that digital communications would act as a check on patient safety and he was not aware of any safety concerns raised through this medium.

- Mr Foster asked if Monitor had invited our Trust to check any other aspects of Emergency Department performance. In response, the Chief Executive said that our Trust is to look at locating ACCU nearer to the Emergency Department to allow cases to be diverted there.
- The Chair expressed concern for out Trust in managing the relationship with Monitor commenting on how to handle the soft and hard data into clear statements to provide clear evidence of performance noting that performance has dipped to 76% from 80%. He enquired as to the dip in this performance. In response, the Chief Executive said that the Improvement Director will help in reporting the position particularly with the soft data. There was no one explanation for the dip in performance but a combination of increasing demand, the medical fit list running at between 70 and 80 patients, patient flow, gaps in junior doctor rotas with doctors not turning up, staff sickness due to flu, increased ambulance demand and severe difficulties in primary care in coping with demand.
- The Chief Executive drew attention to the readmission analysis in the report which demonstrated that the rate had only marginally changed which is a quality measure for discharged patients.

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.

038/16 DRAFT REVENUE BUDGET 2016/17

The Finance Director presented the report on the key points of the budget setting process and agreement of revenue budgets for the 2016/17 financial year. She also referred to the Operational Plan for 2016/17. The content of the budget will be updated as necessary to ensure that it is in line with the Monitor templates and is coherent with other Trust strategies, policies and contract settlements. The draft budget included the tariff uplift which had been confirmed at 1.8% and the Sustainability and Transformation Fund which our Trust had agreed to. The short term challenges are managing capacity, improving quality, meeting performance targets, financial performance, meeting the annual efficiency requirement and the

recruitment of nurses and middle grade doctors and agency costs. The Clinical Commissioning Group will not meet the costs associated with seven day working.

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

- The Chief Executive explained that the payment of monies under the Sustainability and Transformation Plan (STP) is dependent upon performance milestones being achieved and if missed there will be no payment. The challenge for our Trust in meeting the STP target is the recruitment of nurses and doctors to reduce agency spend. If this can be reduced our Trust could achieve the targets. The STP monies are £12.9m with a requirement to achieve a net £5.3m surplus which will be the focus of attention. There is also an issue nationally to ensure that there are sufficient funds to deliver the STP.
- The Chair said there needs to be a clear communications strategy, particularly to staff, and that the emphasis should be on the surplus requirement which is achievable with a substantial reduction in agency spend.

The Chair thanked the Finance Director for the report.

RESOLVED TO RECOMMEND: That the current contracting position be noted and that the annual financial plan described within this report be approved. The budgets, pending contract agreement with our main commissioner reflects:-

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

039/16 CAPITAL PROGRAMME 2016/17

The Finance Director presented the report outlining the Capital Programme for 2016/17. The funds available for investment amounted to £11m which is lower than previous years. The priority schemes related to SmartCare and SmartCare devices, network replacement, telephony, building and infrastructure schemes and the Medical Equipment Fund. The indicative Capital Programme is consistent with the draft Monitor plan which is being updated for final submission and will include contract updates. The contribution from Charitable Funds is lower than previously as the Trustees' focus is on the oncology appeal. The capital receipt for the sale of the College Lawn properties may be lower than anticipated.

During the course of the discussion, Mr Foster noted that the Capital Programme for 2016/17 was lower than previous years and asked if there schemes which our Trust is not able to undertake. As last year we will need to carefully manage schemes. The Finance Director responded saying that she was not aware of any priority schemes which could not be included in the Programme. Any works required at Gloucestershire Royal Hospital as the result Emergency Department programme will be addressed at the appropriate time.

The Chair thanked the Finance Director for the report.

RESOLVED TO RECOMMEND: That the outline Capital Programme for 2016/17 be approved.

040/16 OPERATIONAL PLAN 2016/17

This was considered as part of the Draft revenue Budget in minute no 038/16 above.

041/16 FUTURE OF SERVICE LINE MANAGEMENT

The Finance Director gave a presentation on a proposal to take forward Service Line Management (SLM) within our Trust. The current position is that SLM was introduced to devolve decision-making closer to the point of service delivery, operationally. Our Trust remains committed to the aim of management decisions being taken at the closest point to the delivery of services. A revised regime is now proposed which aims to adjust organisation and the ways of working to support current good practice.

On organisation the proposal is to investigate, through a pilot approach, the merits of devolving down from Divisions to clinical teams. On ways of working the proposal is to investigate, again through a pilot, approaches to making the management control of service lines more robust. The benefits are to use the pilots to determine the extent to which devolution can be pursued and the structure which will best deliver both the objectives of devolved accountability as well as deliverables of a Foundation Trust. It will serve to influence any potential areas for improvement, to determine how Divisions may operate on a more strategic level looking further ahead and to provide significant opportunity for increasing the engagement of our staff and therefore the performance of our Trust.

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

- In response to a question from Mr Foster, the Finance Director clarified that the devolution would be from the Divisional Tris to clinical teams. Speciality Directors would remain. The proposal will not create more work but will provide opportunities for information sharing.
- The Chair enquired whether the outcome of the pilot will be a better system or to refresh behaviours. The Finance Director, in response, said that the pilot is to improve performance to achieve our objectives.
- The Chief Executive explained in response to a question from Mr Foster that not all services, due to the tariff, make a profit and therefore it would be difficult to identify individual service contributions to the financial surplus target.
- The Finance Director said that the pilot will be in Surgery Division initially for three months.
- The consensus was that the pilot be supported.

The Chair thanked the Finance Director for the presentation.

RESOLVED: That the presentation be noted.

042/16 PROGRESS UPDATE ON 2015/16 AND 2016/17 CONTRACTING PROCESS

This was considered as part of the Financial Performance Report in minute no 035/16 above.

043/16 NOTES OF THE EFFICIENCY AND SERVICE IMPROVEMENT BOARD MEETING HELD ON 9 MARCH 2016

The Finance Director presented the notes of the meeting of the Efficiency and Service Improvement Board held on 9 March 2016.

Mrs Bond asked if the Efficiency and Service Improvement Board had considered proposals to reduce staff turnover and also to make the workforce savings. In response, the Finance Director said that this does feature as part of the discussions and work is ongoing particularly in General and Old Age Medicine (GOAM) wards.

The Chair thanked the Finance Director for the notes.

RESOLVED: That the notes be noted.

044/16 FINANCE AND PERFORMANCE COMMITTEE WORK PLAN

There were no changes to the Committee's workplan.

045/16 WASHUP SESSION TO ENHANCE THE TRANSPARENT FLOW OF ASSURANCE AND RISKS

The Committee asked questions to seek assurance on the financial plan, had concentrated on the red risk areas in the Performance Management Framework report seeking reasons for the poor performance, were concerned in relation to ED performance and safety and our Trust's relationship with Monitor and would keep in mind opportunities to focus on large projects.

046/16 COMMITTEE REFLECTION

The Committee's focus had been more forward looking.

047/16 ANY OTHER BUSINESS

There were no further items of business.

048/16 DATE OF NEXT MEETING

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

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

The meeting ended at 12.10 pm.

Chair
27 April 2016

GLOUCESTERSHIRE HOSPITALS NHS TRUST

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

PRESENT:

Tony Foster	TF	Non-Executive Director (Chair)
Kate Jeal	KJ	Communications Specialist
Catherine Boyce	CB	Clinical Strategy Manager
Carol MacIndoe	CM	Trust Governor (Staff)
Jane Evans	JE	Associate Director of Facilities
Jenny Bowker	JW	Associate Director of Strategic Planning (GCCG)
Elaine Watson	EW	Interim Manager Countywide Services/Head of Health Improvement (GCS)
Julie Shepherd	JS	Physiotherapy Manager CGH
Karen Tomasino	KT	Lead Nurse, Paediatrics
Kay Davis	KD	Senior Midwifery Manager
Sue Maxwell	SM	Infant Feeding Specialist Midwife
Sarah Scott	SS	Director of Public Health (GCC)
Lisa Riddington	LR	Library Services Manager
Fiona Brown	FB	Senior Dietician
Den Powell	DP	Trust Governor (Public)
Karina Stallard	KS	Human Resource Advisor (for D Smith)
Philip Lort	PL	Practice Development Nurse, Surgery (for P Garrett)

APOLOGIES:

Sally Pearson	SP	Director of Clinical Strategy
Dave Smith	DS	Director of HR and Organisational Development
Paul Garrett	PG	Deputy Nursing Director
Jane Hadlington	JH	Staff side, Chair Staff H&WB Group
Coral Hollywood	CH	Heptology Consultant
Emma Ralston	ER	Staff side representative
Heather Beer	HB	Head of Patient Experience
Joanna Glasscock	JG	Service Manager/Specialist Advisor Smoking Cessation (GSSS)
Tanya Richardson	TR	Locum Consultant Special Education Needs & Disabilities Provision

ACTION

15/16 APOLOGIES – noted as above.

16/16 MINUTES OF PREVIOUS MEETING HELD ON 5 JANUARY 2016
Agreed subject to minor amendment – K Harrison to be amended to Sue Maxwell (9/16)

17/16 MATTERS ARISING (where not covered elsewhere on the agenda)

- ***Smokefree signage –*** this was now to be funded through estates budgets.
- ***Medical Student placement –*** a 5th year student would be coming to the Trust for a month's H&WB focussed placement in July and a programme was being developed.

18/16 COMMITTEE REFLECTIONS
TF explained that members of the Board Committees were being encouraged to reflect on their meetings and to identify learning or points of action which they would take away as individuals or for their wider Division. Colleagues were invited to capture thoughts on the proforma which had been circulated and to pass this to CB at the end of the meeting. **All→ CB**

PATIENTS' HEALTH AND WELLBEING

19/16 BREASTFEEDING ACTION PLAN
Sue Maxwell, the Infant Feeding Specialist Midwife, presented the latest quarterly report. It was noted that around 77.5% of women initiated breastfeeding or the use of breast milk - a figure only very slightly below the 78% target. However, at discharge the figure had reduced by almost 17%. SM explained the challenge of the very short length of time women spent in the unit and the limited staffing resources dedicated to supporting breastfeeding, although a small number of additional hours of infant feeding support had recently been agreed. The Committee noted the Action Plan which had been developed, which contained a range of elements, including training, a review of policies, information and pathways, a review of the frenulotomy service. The Trust was also working towards reaccreditation under the Baby Friendly Initiative later in the year. The role of the Breastfeeding Peer Support Network was noted, although it was acknowledged that, without capacity to undertake home visits, it was difficult for some

women to access the support available after discharge, when living without transport in rural areas or unable to drive following a caesarean section.

20/16 SMOKING CESSATION MONITORING REPORT

The latest quarterly report was noted. EW highlighted a number of points:

- 4% decrease in secondary care referrals in comparison with the previous year (in line with national trends), but with a more recent increase in the rate of referrals.
- The opt out schemes, where GSSS colleagues worked particularly closely with specific departments, had worked well.
- Further work was to start soon to develop more robust SB4op pathways in secondary care, recognising that primary care also had a role to play in this initiative.
- 14% decrease in maternity referrals over the past year. It was also of concern that in Q3 only 57% of those who were recorded as smoking at booking were referred to GSSS, although the numbers had risen again during Q4. At present only 61% of mothers of mothers referred had a CO reading, although the standard was 100%.

KD and GSSS and Divisional colleagues had reviewed the position and had updated the Maternity smoking cessation action plan to address the issues raised above. The Committee noted the action plan and acknowledged the progress made to date.

TF queried why there was no universal opt out system across the Trust and proposed that this should be raised with SP. CB explained that currently, without electronic capture of smoking status and electronic referral mechanisms, the most effective approach at present was to target key areas and specialties.

21/16 DEVELOPMENT OF THE TRUST'S PATIENT H&WB STRATEGY

CB/KJ presented a draft version of the Trust's *"Patients' H&WB Strategy"*, based on the storyboard shared at the previous meeting. As agreed, relevant service leads had been approached to assist in the development of sections on each of the areas, which largely reflected the Gloucestershire's Countywide H&WB priorities. Each of the main sections included patient stories to provide a more accessible and personal approach. Other cross cutting enabling activities had also been identified e.g. training, media and communications etc. The Strategy would be underpinned by a more detailed work programme for implementation in the year ahead and beyond.

Members of the Committee were asked to forward comments on the draft by 22 April. The Strategy would be taken to the Trust Board in May. **All → CB**

22/16 TRAINING FOR MAKING EVERY CONTACT COUNT (MECC)

TF mentioned that he had had a further discussion with colleagues who had made the presentations on overweight and obesity at the previous meeting. He, himself, had also completed the smoking cessation and the obesity e learning modules – the latter of which had further reinforced for him the complexities associated with obesity and the need for a sensitive approach. As well as the MECC training sessions run by GCC, it was recognised that e-learning was another important means of raising awareness of staff and of training them to feel more confident to raise health and lifestyle issues with patients. At present, because of the significant volume of clinical and other mandatory training required, neither the smoking cessation nor the obesity e-learning modules were included in mandatory list. KJ undertook to raise this with DS and the Education, Learning and Development Committee. KJ

HEALTH AND WELLBEING OF THE WIDER COMMUNITY

23/16 COUNTYWIDE H&WB BOARD AND HEALTHY WEIGHT WORKSTREAM UPDATE

SS reported that the current Healthy Weight Action Plan was designed to draw together work required across the whole system. This had now been agreed by the H&WB Board and drew on feedback from a multi-agency workshop held at the end of 2015. The four proposed outcomes for this countywide priority area were:

- A joined up approach to the healthy weight agenda is delivered through effective partnerships;
- People live, work and play in places that make it easier to eat well and be physically active;
- Individuals & communities are encouraged to adopt healthier lifestyles (eat well, move more);
- Effective weight management is in place for those at greatest risk.

A series of further events were scheduled including meetings to start to look more closely at the adult and children's weight management pathways - recognising that the National Childhood Obesity Strategy was still awaited. The need for a Steering Group for the Healthy Weight card had also been identified.

It was noted that Gloucestershire had been selected to take part in a 3-year project with

Leeds Becket University, to develop a systems approach to addressing obesity and overweight. A high level exploratory workshop with key stakeholders was planned.

SS also reported on a number of other current activities:

- Proposals to establish a "Prevention Board" to drive and oversee the delivery of all the priority H&WB areas. This would also involve key providers, who were not currently part of the membership of the H&WB Board.
- "The Gloucestershire Pledge" – a challenge to GCC staff to make a small change to improve their health and wellbeing – eat less, move more, stress less etc. This would be evaluated with a view to rolling out the initiative more widely.
- Action Plans for the other Countywide Priority areas had been agreed by the H&WB Board, with the exception of the Healthier Ageing Plan, due to be agreed in June.

24/16 REDUCING OBESITY IN THE TRUST

It was recognised that there was still further work to do in the Trust to encourage staff to make healthy choices. It was suggested that a questionnaire could be used to elicit ideas from staff on the activities or actions which they felt would help them.

It was agreed that JE and her colleague from catering would make a presentation to the next meeting of the Committee about some of the ideas which were being considered.

LR offered explore the possibility of drawing together a series of resources which staff could borrow from the libraries to learn more about H&WB and improve their own H&WB – for example exercise videos etc. LR

25/16 HEALTHY INDIVIDUALS PROGRAMME GROUP

JB reported briefly on the recent meeting and would forward a e-bulletin which would update the Committee on the various projects connected with the Programme Group. **JB → CB to circulate**

Work continued on the Sustainability and Transformation Plan for the County, due for submission in June. Key areas included self-care and prevention, diabetes and obesity.

A business case was being developed for health coaching cascade training for staff and means of developing capacity for personalised health planning were also be explored.

It was noted that a small number of national H&WB CQUINS had been published very late in the day. It was not yet certain if or how these would be adopted locally.

STAFF AND HEALTH AND WELLBEING

26/16 MEETING OF STAFF HEALTH AND WELLBEING GROUP – 17 MARCH 2016

KS reported on the March meeting of the staff H&WB group. Four main work streams had been agreed - weight management and healthy eating; the ageing workforce; mental wellbeing; clubs and physical activities

KS highlighted a number of current and potential initiatives.

- Quick wins - signposting screensavers, encouraging staff to do the "One You" individual survey, yoga classes- very well received, but staff limited to 2 sessions.
- Middle cost - additional resilience training was to be funded by the Diagnostic and Specialties Directorate: the potential for dietetic support for staff was being explored.
- Higher cost - Mental Health First Aid, coaching and motivational interview training.
- Challenges – walking, running, cycling, rowing etc.

27/16 Staff survey

KS drew attention to a number of elements.

- Flexible working - staff positive about the opportunities.
- Extra hours - similar to previous year.
- Stress - down by 2%
- Pressure to attend work when unwell - increase
- Organisational interest in H&WB - indication of staff starting to recognise this interest, being taken by the organisation. However, a need to raise awareness of initiatives and engage more actively with staff was recognised.

28/16 Britain's Healthiest Workplace initiative

The Trust had been invited to join this initiative, which offered staff the opportunity to complete a confidential H&WB questionnaire. An organisational self-assessment and aggregated results of the individual surveys would assist in identifying areas for action.

JB reported that local organisations were also being encouraged to sign up to the Wellbeing Charter.

ACTION

29/17 COMMUNICATIONS UPDATE

KJ shared examples of recent initiatives including "Dry January", Smoking Cessation and "Time to Talk", promoted under the "Better for You" branding. At present, initiatives were publicised in Outline, Involve, through the internet and websites, on the occasional screensaver and through social media. The recently introduced electronic briefing "The Week" was attracting fewer hits than the former individual global e mail system and was proving less effective in raising awareness of H&WB initiatives.

The new meditation sessions had been very popular, but had been limited to 2 sessions per member of staff. Those attending were mainly from non clinical staff groups. JS reported that physiotherapy colleagues had run some lunchtime classes. If further funding could be identified, these could be maintained. It was recognised that a lack of funding remained a barrier to the continuation of a number of popular initiatives which had been introduced on a trial basis.

FB informed colleagues that 6-10 June was British Dietetic Association Week and she would liaise with KJ about publicity. **FB**

30/16 NICE PUBLIC HEALTH RELATED GUIDANCE

The report was noted

31/16 ANY OTHER BUSINESS

- **Staff with disabilities or long-term health conditions**

CMc expressed continuing concern that although a not insignificant percentage of respondents classified themselves as having a disability in the staff survey and appeared to have a worse experience than other groups, only a very small proportion of these staff were known to the Trust. It was important to find a means of enabling staff to feel comfortable in revealing their conditions and to feel safe from any possible adverse attitudes from co-workers or managers.

CMc outlined briefly the Lloyds Banking Group's initiative, a *"One Stop Hub for reasonable adjustments"*, which enabled staff to self-refer, be allocated a personal case manager to work with them to identify and facilitate any necessary reasonable adjustments. Such adjustments were funded centrally, which removed the onus from individual departments. The Lloyd's scheme had been shown to be effective in reducing sickness levels, whilst increasing productivity and morale. The possibility of training a small number of staff to set up an embryonic "hub" at the Trust was being explored at present. Members of the Committee expressed the view that central funding of the reasonable adjustments would be key to the success of such a scheme as departmental budgets were generally unable to meet these costs. On occasions this led to the staff member having to be redeployed.

- **Kings Fund Seminar on H&WB**

EW reported on a recent seminar, which included examples of good practice from some of the organisations leading in this field. Examples included the appointment of a dedicated H&WB coordinator, evening gym and other sessions and GPs being commissioned to undertake staff health checks in the hospital.

32/16 FORMAT AND TIMING OF FUTURE MEETINGS

TF reported that the Chairs of the Board Committees had been asked to consider the potential for video or telephone conferencing and paperless meetings. Following discussion, it was agreed to retain the face to face meeting at present, but, subject to the availability of rooms, to hold alternate meetings in Gloucester and to delay the start time until 9.30 to fit with the shuttle bus timetables. It was also agreed to try to make the meeting paperless. Papers would be projected onto the screen at the next meeting or could be downloaded onto electronic personal devices, although it was recognised that few had access to these at work. **CB(+MW)**

- Potential items for a presentation at the next meeting or future meetings.
    - Making healthy choices easier – catering and related initiatives
    - Staff support, resilience training, mindfulness
    - Reducing alcohol harm
    - Mental wellbeing

33/16 FUTURE MEETINGS

Tuesday 5 July, Tuesday 4 October – please note possible later start time of 9.30 TBC Boardroom, Trust Headquarters, Cheltenham, until otherwise notified.

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

SUMMARY OF THE MINUTES OF THE MEETING OF THE TRUST SUSTAINABILITY COMMITTEE HELD ON FRIDAY 22ND APRIL 2016

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

CHANGES TO COMMITTEE STRUCTURE FROM MAY 2016

This was the final meeting of the Committee in this structure as it is to become an executive function. There will be a Non-Executive Director lead but the chair and vice chair roles will be rotated between Estates & Facilities, Procurement and HR / Education. The Terms of Reference will be revised.

CATERING AND FOOD MILES - PRESENTATION BY THE CATERING TEAM

Members of the Catering Team gave a presentation about local food purchasing. They described four existing suppliers who are all local to Gloucestershire and the South-West. These suppliers are all on the NHS Framework for Food which ensures that the suppliers conform to the Government Buying Standards, rules around food safety etc. If the Trust is to use local suppliers who are not on the framework then there would need to be more local policies, arrangements made for food hygiene audits, processes agreed with Procurement and potentially more funding. The team also identified opportunities including expanding the Farm Shop stall, developing more seasonal local products e.g. summer salads, and exploring the options around home baked cakes.

MONITORING REPORTS: PROCUREMENT

Level 1 of the Procuring for Carbon Reduction framework has been completed. In their annual report B Braun highlighted the water savings resulting from their new water plant at the Cotswold Unit and waste savings from a change in disposal method for filters.

MONITORING REPORTS: CARBON AND ENERGY – CARBON EMISSIONS

The current carbon emission forecast for 2015-16 is to be very close to the target i.e. to reduce emissions by 10% from the 2007 baseline. A graduate placement student on a two-month project will help develop strategies and initiatives to improve the energy performance of plant and equipment around the Trust. There is a need for a focus on behavioural change by asking staff to do their bit to reduce energy consumption.

MONITORING REPORTS: COMMUNICATIONS

The Chair congratulated Kate Jeal on her work in raising the profile of sustainability issues, as there have been a large number of articles in Outline, This Week etc. focusing on waste costs, reduction in consumption etc. The articles will continue and a reminder issued to staff to turn off equipment ahead of the bank holiday weekends.

TRANSPORT AND CAR EMISSIONS

The Committee agreed a maximum limit of 120g/km CO2 emissions for all new lease cars and for the cars offered under the new salary sacrifice scheme. The 120g limit will be reduced to 100g at regular intervals during the next three years.

GOOD CORPORATE CITIZENSHIP MODEL

This tool assists organisations to assess their contribution and progress towards a range of activities associated with Sustainable Development and Corporate Social Responsibility. The Trust score for 2016 is 60%, a slight improvement from 2015. The Trust has made improvements in the areas of Procurement, Workforce and Travel.

THANK YOU TO MARIA BOND

This was Maria's last meeting as NED. On behalf of Helen Simpson, Alex Gent offered thanks to Maria for her work in chairing the Sustainability Committee.

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE TRUST QUALITY COMMITTEE HELD IN THE BOARDROOM, 1 COLLEGE LAWN, CHELTENHAM ON FRIDAY 15 APRIL 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
	Mrs M Arnold	Nursing Director
	Mr A Seaton	Director of Safety
	Mrs H Beer	Head of Patient Experience
	Mrs K Haughton	CCG Quality Lead
	Mrs P Adams	Governor – Staff, AHPs
	Dr P Jackson	Governor – Forest of Dean District Council Area
	Mrs C Johnson	Governor – Forest of Dean District Council Area
	Mrs A Lewis	Governor – Tewkesbury District Council Area
	Ms F Storr	Governor – Gloucester City Council Area
IN ATTENDANCE	Mr M Wood	Trust Secretary
APOLOGIES	None	

The Chair welcomed all to the meeting.

ACTION

046/16 DECLARATIONS OF INTEREST

There were none.

047/16 MINUTES OF THE QUALITY COMMITTEE MEETING HELD ON 11 MARCH 2016

RESOLVED: That the minutes of the meeting of the Quality Committee held on 11 March 2016 were agreed as a correct record and signed by the Chair.

048/16 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 and an update will be provided in the next report. *Ongoing.*

018/16 Committee Reflection and Development: The Chair and the Trust Secretary to design a feedback form to be completed after Divisional attendances. The Committee agreed that the form be amended to reflect feedback on the whole meeting and that the form will be used from the April 2016 meeting. *Completed.*

025/16 Quality Framework 2016: 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. *The Director of Safety reported that the new template incorporating the above will be introduced when the Divisions report to the Committee on the first occasion in 2016/ 17. Completed.*

049/16 DRAFT QUALITY REPORT

The Director of Clinical Strategy presented the final draft of the Quality Report 2015/16. This was the last opportunity which the Committee would have to consider the Quality Report before submission to the Board and Monitor. The Report this year contained more graphs and trend data, for example, dementia and more examples of patient experience. The deadline for the submission of the draft Report to Stakeholders was 20 April 2016 and if Committee members had any further minor textural comments they should be submitted to the Director of Clinical Strategy before that deadline. **ALL**

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

- Mrs Lewis asked what impact the delay in introducing SmartCare will have on implementation of the priorities identified in the Quality Report, in particular with regard to improving care for patients with dementia and delirium. In response, the Director of Clinical Strategy said that the delay in the introduction of SmartCare will not have a substantial impact on delivering the priorities in the document. Improving care for patients with dementia and delirium was a separate issue. The benefits realisation from SmartCare are to be recognised at Phase 2 regarding electronic prescribing and there needs to be an understanding of what the impact of the delay will have. The same benefits will be reprofiled at that time and there is nothing fundamental in the Quality Report which is dependent on SmartCare. The Chief Executive added that his introduction to the Quality Report reflected the current position with SmartCare.
- In response to a question from Mr Foster, the Director of Clinical Strategy said that she would clarify in the Quality Report a commentary to explain the graphs on pages 16 to 18. **SP**
- Ms Storr commented on the improvement in the photographs.
- Mrs Adams asked if the CQUINs are yet final. The Director of Clinical Strategy said in response that negotiations are continuing with the Commissioners and will be added to the report when those negotiations are concluded. She and the CCG Quality Lead stressed that the CQUINs reflect this years' Quality Priorities.
- The CCG Quality Lead said that in some incidents national data was available later than 2012 as indicated in the Quality Account which the Director of Clinical Strategy said that she would look at. **SP**

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

RESOLVED: That the draft Quality Report 2015/16 be approved subject to the above amendments.

050/16 DIVISIONAL ATTENDANCE – SURGERY

(Mr Paul Garrett, Divisional Nursing Director, Surgery Division, attended the meeting for the presentation of this and the following item).

The Divisional Nursing Director gave a presentation to support the Division's Quality Report for the period October to December 2015. The presentation covered the following topics:-

Self-assessment – Governance arrangements

- All Divisional specialities present to the monthly Quality Group and are challenged on compliance. An additional ten audits are undertaken to ensure compliance. He acknowledged that insufficient time has been available to consider the quarterly review of the Divisional Risk Register and this is a learning for future meetings. However, there are substantial areas showing a green rating on compliance.

Dashboard

- Medication errors continue to represent the third highest trend within the Division. The Division is piloting a national medication safety thermometer to capture missed doses and other indicators. Pharmacy are involved in this work.
- Violence and aggression incidents highlighted as red on quality dashboard – This was mainly caused by two patients with repeated incidents. A review of all incidents identified no other concerns.
- In-patient falls incidents highlighted as amber on quality dashboard in November and December 2015. Considerable work has been undertaken on Guiting Ward to identify the issues where environmental factors are involved. The SWARM forms completed pending analysis.
- Percentage of orange incidents closed – additional resources provided to reduce length of time for investigators to complete investigations and for Clinical Governance Groups to review and close.
- SSIS – hip and knee replacement surgery. Meetings are held with infection control and microbiology and monthly meetings set up in trauma and orthopaedic theatres for SSIS from April 2016. Trauma and orthopaedics are concerned over the figures and are looking at organisations with low infection rates to learn lessons. The Chief Executive referred to the change from 0.5 to 6.1 in the report and sought reasons to this big variation. In response, the Divisional Nursing Director said that the same data reporting needs to be used and this will be addressed in the Infection Control Committee.
- PROMs – the concern in the percentage of questionnaires given out in varicose vein and groin hernia and a review is being undertaken of the process for giving out forms.

Nursing Metrics

- All Ward areas were classified as green risk-rated. Mrs Lewis referred to the grade 2 pressure ulcers and the greater awareness that is to be provided to staff to look after those patients and enquired as to the progress with the introduction of that awareness. In response, the Divisional Nursing Director said that training is in place with HCA's. It is a red risk area for two nursing patient groups difficult to manage – Vascular and

Intensive Care. He gave an example changes to face masks for those who have pressure ulcers on their face.
- TARN – Trauma Audit and Research Network – improvement in data completeness for our Trust at 81.3% from the high teens in earlier years.
- CQC must do's – all actions completed with authority for administration of eye drops. For consent in Urology proforma piloted and agreed pending final approval and printing.

CQC 'Should Do' Action Plan – highlights
- Review how staff perceive the feedback they get from incident reporting and the level of detail received.
- Serious untoward incidents reported to Divisional Boards and the feedback is then referred to speciality groups.
- Reduce the number of patients who have their operation cancelled on the day and reduce the number of patients not rebooked within 28 days.
- Cancellation of day cases at both sites due to medical outliers and emergency admissions.
- There are issues in meeting the cancer 2 week wait performance target due to capacity issues where locums are supporting existing staff.

Fractured Neck of Femur Action Plan – highlights
- The review from the Royal College of Surgeons was considered in minute number 051/16 below. Mr Foster commented that some of the actions were dependent on funding agreed which had not been made available. In response, the Chief Executive explained that it is a matter for the Trust to determine at what point in the financial year funding issues are addressed where they are not funded by the CCG. Our Trust has to form a list of priorities.

First hour priorities
- Paperwork awaiting approval by documentation group prior to roll out.

NATSSIPs
- List of invasive procedures completed with a pilot of debrief documentation.

Risk Register
- The Divisional Nursing Director explained that those risks with a score of 15 and above are considered for inclusion on the Trust Risk Register. Some risks identified were straightforward to address; for example S2257 where inadequate lighting levels were identified in DCC at Cheltenham General Hospital where a solution was readily found.

Serious Incidents
- Wrong side knee surgery – concerns that this was the second event over the last few years and actions had been taken to improve the situation.
- Patient developed haemorrhage inside right inferior turbinate with tracking towards right lower lid and right orbit – no care or service delivery problems identified during the investigation which has been presented to all ENT Consultants and an external report requested.

- Naso Gastric tube inserted into critical care patient on arrival on the unit for feeding purposes. Placement confirmed by x-ray in the absence of aspirated gastric fluid. Change of practice introduced. The Chief Executive explained that in these incidents it is better to undertake a pH test and not an x-ray. The CCG Quality Lead said that the interpretation of x-rays should be given to Radiologists and not Junior Doctors. The Nursing Director said that this incident had to be put into perspective as there are many tubes inserted every day. The team have been open and honest to get procedures right a very fine tube can be used but it is difficult to aspirate which is the challenge.

Speciality Outcomes

- Ophthalmology age related macular degeneration primary RRD failure rate and Oral maxillofacial skin cancer margins.

Complaints and PALS

- The Chair of the Trust observed that the current overall Divisional complaint response rate is currently red risk-rated and she sought an explanation. In response, the Divisional Nursing Director said that the majority of complaints related to the use of day surgery and cancelled operations and some other cases were complex. The Chair of the Trust said that an early response is better for the patient.

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

- The Chair observed that the presentation referred to a number of external reports where only a summary is presented to the Committee and not the actual report. In response, the Director of Clinical Strategy said that an annex can be provided to the Directors' Statement providing details of all reports, the key findings and actions taken. This will then provide assurance and an audit trail. In this regard the Director of Safety referred to the NCEPOD report into lower limb amputation and would have expected to see more detail in the Divisional Quality Report. He also questioned the action required around the wound infection rates and whether it is on the appropriate risk register, a more detailed response with actions should be provided by Surgery Division. **SP** **PG**
- The Chair of the Trust said that the CQC 'should do' action plan should have dates incorporated.
- In response to a question from the Chair of the Trust, the Divisional Nursing Director said that it was a resource issue in not processing the SSI actions sooner.
- The CCG Quality Lead referred to the serious untoward incident in November 2015 which was a shared incident with the Medicine Division where Endoscopy staff observed a rust coloured residue on the base of a drying cabinet at the end of the cycle for a flexible cystoscope on 18 July 2015 and enquired as to the delay in reporting this as a serious untoward incident. In response, the Divisional Nursing Director said that this was not noticed until November and a check was made when the cystoscope was last used.

The Chair thanked the Divisional Nursing Director for the report and his open and honest presentation which showed good performance and identified areas for improvement.

RESOLVED: That the report be noted.

(The meeting adjourned from 10.42 to 10.50am)

051/16 FRACTURED NECK OF FEMUR

The Medical Director presented the report updating the Committee on the current position and future work relating to the high reported mortality for patients treated in our Trust with fractured neck of femur. Over the last 18 months there have been two alerts from Dr Foster Intelligence relating to mortality rates for patients treated with fractured neck of femur at our Trust. A notes audit was conducted as a consequence of the first alert showed cared for patients who died was within acceptable standards. This process was repeated in response to the second alert and on this occasion the care of some could have been improved. In response, our Trust commissioned an external visit from the Royal College of Surgeons (RCS) to review the fractured neck of femur pathway. The review sought recommendations to improve care that would reduce mortality rates. The report which was published in September 2015 has been reviewed by our Trust and the team providing care of these patients. An action plan has been developed in response to the report. Additional information has been used to enhance the action plan. Two internal audits conducted by the team providing care have resonated with some of the RCS findings but additional observations regarding consistent anaesthetic and surgical practice across the County. A joint workshop with colleagues in the Clinical Commissioning Group has enabled aspects of out of hospital care to be considered and the findings from these audits and the workshops have been added to the overarching action plan. Data from the national hip and knee audit confirms the findings of our Trust as a mortality outlier for this group of patients.

The findings of the internal work, the RCS review and the workshop confirm that there is no single factor contributing to the mortality figures. The action plan is being managed through the fractured neck of femur group which was already established but has been enhanced since the RCS visit with the addition of the Medical Director to the attendees and cross speciality and profession representation. There is also management support to the group. This group is also responsible for audit data relating to the action plan and reviewing the notes of patients who have died in the period between meetings. There are a number of areas of practice that require review and possible improvements with the main themes being admission process, ward care, care in theatre and community support/ rehabilitation and follow up.

Almost all of the patients are brought into the Trust through the Emergency Department and to ensure standardisation of care an Emergency Department admissions proforma has been developed which follows patients from ED to the Ward to provide a continuous record. This group of patients are generally older patients with multiple comorbidities. It is recognised that minimising time from admission to undertaking surgery is an important determinant of outcome. It is equally important to stabilise the patient medically before surgery. The RCS report suggested that at Gloucestershire Royal Hospital, where the time to theatre is shorter than at Cheltenham General Hospital whilst having a higher mortality, the speed with which patients were going to theatre may be contributing to the excess mortality. Best practice is to admit these patients to a speciality Ortho-geriatric ward run by experienced

Geriatricians. Whilst there are areas on both sites, obtaining Consultant level staffing has been challenging. The job plan of one Consultant has changed to focus exclusively on this area but needs to do so without putting other areas of General and Old Age Medicine (GOAM) at risk. A review of anaesthetic practice has been undertaken and discussions are underway to ensure a consistent approach across the County. The RCS visit and internal audit have highlighted variability in surgical practice. The main issues being reviewed and tackled are the cementing of hip prostheses and the use of intramedullary nailing. National guidance now states that best practice is to cement hip prostheses. However, case review within the County suggests that cementing may be a risk factor contributing to morbidity and mortality. The importance of both cementing technique and review of anticipated patient outcome to ensure realistic goals are set for patients are under review. Working with community colleagues aspects of safe discharge, continued rehabilitation and future falls prevention are included within the action plan.

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

- The Medical Director commented on the conclusions reached by the RCS in their review given the Trust's understanding of the situation.
- The Chair of the Trust asked for information on the monthly mortality trends per month. In response, the Medical Director said that the numbers are small, approximately 3 to 4 per month, but emphasised that one mortality can change the mortality rate significantly. Mr Foster asked how long it would take to make the changes identified in the report. In response, the Medical Director said that a reduction in the relative risk of 12% would be a move in the right direction. Mr Foster asked whether a second external review by Dr Foster Intelligence is planned to be undertaken. In response, the Medical Director said that the data from the RCS report is continuing to be checked and it is too early at this stage to suggest whether a second external review should be undertaken.
- The Chair of the Trust asked if a record on a case by case basis is undertaken which might offer an explanation to the mortality rates. The Medical Director said in response that there is good clinical involvement in the recording process.
- The Director of Safety referred to the increase in mortality in 2014 and asked whether there were any organisational changes such as changes to coding which impacted on the position. The Medical Director said in response that the review had not looked at comorbidity coding for fractured neck of femur which might offer an explanation. The Director of Safety added that the data might be affected in that the Trust operate on less high risk patients as they are operating on the right patients.
- The CCG Quality Lead referred to the minutes of the meeting of the Neck of Femur Mortality on 11 March 2016 which indicated that for January and February 2016 the mortality figures showed a reduction at Gloucestershire Royal Hospital but an increase in Cheltenham General Hospital. She stressed that fractured neck of femur is the concern. In response, the Medical Director said that there were concerns regarding just one patient which should not detract from the focus of the wider picture.
- In response to questions from Ms Storr, the Medical Director confirmed that the action in 4.7 of the action plan regarding nurse

to patient ratio on ward 4A has been completed.

- The Medical Director stressed that the proforma following patients from ED to the Ward will guide the timing of patients to surgery. He undertook to provide a key to the staff in the action plan. **SE**
- The Nursing Director commented that research has concluded that patients are admitted to surgery for pain relief as they may not tolerate drugs even if the outcome is death.
- In response to a question from Mrs Lewis, the Medical Director said that the peaks in mortality needed further investigation to understand the reasons.
- The Chair observed on the completeness of the action plan on the basis of 'we do not know what we do not know'.

The Chair thanked the Medical Director for the report.

RESOLVED: That the report be noted and following an external review and internal audit findings a comprehensive service review is underway leading to considerable change in practice be endorsed.

(The Divisional Nursing Director, Surgery Division, left the meeting)

052/16 SERIOUS UNTOWARD INCIDENTS

The Director of Safety briefed the Committee on current serious untoward incidents (SUIs), never events, high level reviews and RIDDOR reportable incidents. He said that there has been an increase in serious untoward incidents during the last six weeks which were not connected. He drew attention to the following open serious incidents:-

- Re-admission of 13 day old baby with severe jaundice – this is a particularly distressing incident for staff which was avoidable and is being investigated.
- Inoperative complications during surgery – misidentification of anatomy – this was not classified as a never event but a misidentification of anatomy.
- Transfer of unit of blood intended for another patient – no ill effects were noted based on compatibility of blood group of the unit and recipient. The CCG Quality Lead confirmed that this was not a never event but is being investigated.
- Catastrophic intraoperative haemorrhage during elective surgery – this was a difficult technical operation.
- Still birth of baby following complicated delivery (shoulder dystocia) – this has raised an issue for out Trust.
- Delay to act on severe sepsis – there was an incomplete clinical plan.
- Delays to diagnostic investigations contributing to progression of prostatic cancers – this was a missed opportunity.
- Impact of patient with behavioural difficulties following acute brain injury is also the same incident as the RIDDOR reported incidents relating to violence and aggression against a nurse.

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

- Mr Foster referred to the number of serious incidents reported to the Executive Team/ Commissioners by month and asked if there was any external comparison. In response, the Director of Safety said that our Trust is in the lower end of reported incidents nationally. Reported incidents are a measure of culture not of

harm and our Trust encouraged reporting.

- The Chair of the Trust referred to the delay to act on severe sepsis and asked if this was avoidable if the patient had been seen within 15 minutes of arrival in the Emergency Department. In response, the Director of Safety said that this was a potential consequence.

The Chair thanked the Director of Safety for the report.

RESOLVED: That the report be noted.

053/16 DUTY OF CANDOUR UPDATE

The Director of Safety presented the report providing an update on the current position and the plans for ongoing management of the duty of candour process. The long-term objective for managing the statutory duty of candour is to achieve a Trust wide process which is consistent across all Divisions. Our current process requires that patients and carers are informed of the incident having occurred both verbally and in writing. The Safety Department are endeavouring to ensure that notification letters are sent to patients within the required 10 day deadline; however, initial cases have demonstrated that adhering to this 10 day timescale is often not possible when patient notes are required for dual purposes, such as inquest, complaints or patient meetings. In Women and Children's and Diagnostic and Specialties Divisions, local arrangements for reporting and investigating are effective and efficient although in Women and Children's Division the recent resignation of the Divisional Risk Manager has added further pressure to the Governance Team. In Medicine Division the Divisional Risk Manager is endeavouring to review all reported incidents and ensure that the incident has been appropriately graded through the risk management matrix. Whilst it is intended that investigations are undertaken and documented by Ward level staff, this is not common practice. In Surgery Division the Divisional Risk Manager is endeavouring to review all reported incidents and as often as possible will chase lead investigators to produce a completed investigation document. Again, whilst it is intended that investigations are undertaken and documented by ward level staff, this is not common practice.

Trust staff report between 20 and 30 moderate harm incidents per week. It is necessary for each incident to be reviewed and consideration given to whether this has been correctly reported and whether on initial review it is considered that the patient has or may in the future suffer moderate harm or above. This exercise is extremely time consuming and is currently being undertaken by members of the safety department team in the absence of the duty of candour coordinator. Of those 20 to 30 incidents, it is estimated that between 2 and 3 cases per week fulfil the criteria for duty of candour. To assist with this work load the post of duty of candour coordinator has been re-advertised with the closing date on the date of the Committee meeting. The further action for Medicine and Surgery Divisions is to provide a band 7 Divisional Investigator for duty of candour incidents for a dual reporting line to the Corporate Department and the duty of candour lead was approved by the Trust Management Team. The trajectory of Surgery and Medicine Divisions in a timely completion of orange incident investigations is to be monitored and the impact upon the legal services team of drafting summary letters is to be reviewed in June 2016.

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

- The Chair of the Trust commented that from the outset of the introduction of the legislation the duty of candour was going to place a big burden on our Trust and she was not surprised at the issues raised. She asked about the appointment of the duty of candour coordinator which the Director of Safety confirmed had been readvertised on a permanent basis. The Chief Executive echoed the Chair's comments in the burden which duty of candour places upon our Trust. He said that given the nature of the work, the Coordinator will require support.

The Chair thanked the Director of Safety for the report.

RESOLVED: That the report be noted.

054/16 SAFEGUARDING ADULTS UPDATE

The Nursing Director presented the report updating the Committee on progress made by our Trust Safeguarding Adult Strategic Board against its defined 2015/16 work plan and the key priorities for our 2016/17 action plan. She highlighted the concerns raised by our Trust in relation to care or harm by another provider or family which did not relate to our Trust care experience and those which did relate to our care experience. All referrals are forwarded to the CQC and to Social Services. Some referrals are not substantiated. The number of DoLS applications is impacting on patient discharge as care homes are reluctant to take those patients as it is more challenging to manage them. Domestic abuse is a worry in this County. Midwives need to understand the history of partners in potential domestic abuse cases. The Nursing Director expressed her appreciation of the work undertaken by her team in challenging circumstances.

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

- The Chief Executive confirmed the defensive approach being taken by care homes when our Trust approaches them with successful DoLS applications.
- The Chair of the Trust expressed her appreciation of the achievements during the last year and was impressed by the amount of work undertaken and she asked the Nursing Director to pass on to the team her appreciation.
- The Chair commented on the cancellation of a meeting of the Safeguarding Adult Strategic Board which the Nursing Director commented was as a result of operational pressures. Nonetheless, the work of the team continued.

The Chair thanked the Nursing Director for the report.

RESOLVED: That the volume of work being undertaken by the Unscheduled Care Safeguarding team in relation to safeguarding victims of domestic abuse and their children and progress that has been made in refining Trust policy, processes and procedures in the light of recommendations coming out of domestic homicide reviews be noted.

055/16 MINUTES OF THE PATIENT SAFETY FORUM MEETING HELD ON 9 MARCH 2016

The Director of Safety presented the minutes of the meeting of the Patient Safety Forum held on 9 March 2016. He highlighted the implementation of Safety Alert involving an improvement collaborative approach with the National Standards for invasive procedures. A checklist, similar to a World Health Organisation checklist, is being introduced outlining the safety of invasive procedures. It is a tried and tested methodology which has been used in the South West of England.

The Chair thanked the Director of Safety for the minutes.

RESOLVED: That the minutes be noted.

056/16 MINUTES OF THE MEDICINE OPTIMISATION COMMITTEE MEETING HELD ON 16 MARCH 2016

The Medical Director presented the minutes of the meeting of the Medicine Optimisation Committee held on 16 March 2016. He highlighted the number of apologies presented to the meeting which is being addressed. Nevertheless, he assured the Committee that appropriate Divisional representation is present for the items under consideration. The focus of the meeting had been on patient safety.

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

- The Chair of the Trust referred to the concern expressed that trainee/ junior doctors have only achieved 56% of their eLearning training requirement. In response, the Medical Director said that there have been changes to the mandatory training requirement with prescribing now excluded as it was undertaken elsewhere. Kim Benstead is looking to provide a better process on induction.
- The Chief Executive referred to the charts depicting total antibiotic expenditure which had a dip in 2012/13 which was not replicated on the chart depicting the percentage of patients on antibiotics. In response, the Medical Director said that the Trust is a high user of antibiotics and arrangements are being made to reduce their reliance.

The Chair thanked the Medical Director for the minutes.

RESOLVED: That the minutes be noted.

057/16 MINUTES OF THE SCREENING PROGRAMME GOVERNANCE COMMITTEE MEETING HELD ON 11 MARCH 2016

The Director of Clinical Strategy presented the minutes of the meeting of the Screening Programme Governance Committee held on 11 March 2016. She highlighted that our Trust is not as robust as it should be on the capital replacement in the screening programme which is an issue to be addressed. The position is complicated by the fact that NHS England is not legally able to give our Trust a capital allocation and the capital element is recognised in the block contract.

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

RESOLVED: That the minutes be noted.

058/16 ANY OTHER BUSINESS

Mrs Helen Munro

The Chair of the Trust said that this would be the last meeting of the Committee which Mrs Helen Munro would be attending following a reshuffle of the Non-Executive Directors on Committees. She thanked Helen for her guidance and for taking forward the work of the Committee. Mr Gordon Mitchell will be taking over as Chair.

Dr Frank Harsent

The Committee noted that this would be the last meeting which Dr Harsent would be attending before his retirement.

059/16 QUALITY COMMITTEE WORK PLAN

The Committee invited the Trust Secretary to update the Work Plan as follows:-

- June 2016 – add prevention of pressure ulcers annual plan and lessons learnt from investigations (which was not presented in March 2016)

060/16 ANNUAL APPRAISAL 2015/16 AND FREQUENCY OF COMMITTEE MEETINGS

The Chair tabled a format for the annual appraisal 2015/16 based on the Committee's terms of reference with suggestions in the form of 'positives', 'requires development' and 'comments' in meeting those terms of reference. She invited the Committee to provide feedback on form.

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

- She invited the Medical Director, Nursing and Director and the Director of Clinical Strategy to consider a mechanism to sign off standards for example triangulation of royal college and patient experience standards. **SE/ MA/ SP**
- The Director of Safety suggested that a programme on risk or quality priorities could form deep dives. Visits to our Trust were not considered appropriate, especially in the current circumstances.

The Chair thanked Committee members for their suggestions and any further suggestions should be submitted to the Trust Secretary. **ALL**

The Committee considered the frequency of meetings and whether there should be an increase from the current 8 to 11. The consensus was that it should remain at 8 with the possibility of a work shop to consider a topic in detail.

The Committee considered whether the reporting of the quality aspects of the work of the Improvement Director should be presented to the Quality Committee. The conclusion was that this should remain the consideration of the Finance and Performance Committee and the suggestion was made whether this should be renamed 'Performance Committee'. Reports of the outcome of the Monitor investigation in to the Emergency Department would be presented to the Committee.

061/16 WASH UP SESSION TO ENHANCE THE TRANSPARENT FLOW OF ASSURANCE AND RISK

This was considered in minute number 060/16 above.

062/16 COMMITTEE REFLECTION

This was considered in minute number 060/16 above.

063/16 DATE OF NEXT MEETING

The next meeting of the **Quality Committee** will be held on **Friday 10 June 2016** in the **Boardroom, 1 College Lawn, Cheltenham** commencing at **9.30am**.

The meeting ended at 12.06pm.

Chair
10 June 2016

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE EQUALITY STEERING COMMITTEE HELD ON MONDAY 14th MARCH 2016 IN HR MEETING ROOM, BEACON HOUSE, GRH

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

PRESENT

Dave Smith	DS	Director of Human Resources/OD (Chair)
Sally Pearson	SP	Director of Clinical Strategy
Mike Seeley	MS	Associate Director of HR
Richard Giles	RG	Medical Staffing Manager
Mark Read	MR	Chaplain
Brian Oosthyusen	BO	Governor
Kate Jeal	KJ	Communications Specialist
Heather Beer	HB	Head of Patient Experience
Carol McIndoe	CM	Disability Equality Officer

APOLOGIES

Clive Lewis	CL	Non-Executive Director
Judi Brown	JB	Lay Member
Rayna Kibble	RK	Staff Side Representative

Item	Details	Action
01/16	The minutes of the last meeting were agreed to be a correct record of the meeting.	
02/16	**Matters Arising**	
	Enquiry from public via Facebook regarding hoist facilities was discussed and that this should be picked up under the role of the Disability Equality Officer. There was clear indication from committee that this needed to be resolved. CL/DS would follow up.	**CL/DS**
	An Equality Calendar of events based on previous years has been put together which can be used as a diary for forthcoming events to focus on.	**KJ**
	Equality Policy is still in progress and will need to be put to the committee for final agreement on wording before putting through the Policy Group.	**RG**
	The forthcoming NHS Employers Equality & Diversity Week will be used to focus attentions on recruiting Personal Fair and Diverse (PFD) Champions into our Trust.	**RG**
03/16	**Equality Committee Objectives 2015/16**	
	Update on objectives provided by each lead. The main highlights were: - Ongoing Sustainability and Transformation Plan will help to meet the health needs of local communities. - Higher number of BME staff attending training, full data awaited from L&D - Evaluations to be undertaken on staff who take up the Equality, Diversity & Inclusion (EDI) training. All EDI training now suspended until September and will be relaunched with article in Outline.	

- Bullying increased by 2% in Staff Survey
- Flexible working options for staff is shown in the Staff Survey not to be a problem but there are still known issues

04/16 Setting Equality Committee Objectives 2016/17

Discussion was held to formalise objectives for this coming year. No final decision made but strong consideration was to look at BME staff and those who have reported having a disability.

05/16 NHS Staff Survey Results

Not a significant change to last year. More engagement is needed with disabled staff to understand issues; there has been minimal activity in this area. Discussion held on whether the EDI Training is focussing on the Staff Survey outcomes and whether this should be adapted to accommodate. It was considered whether the training should include education on workplace adjustments where staff have a disability, possible options were to use case studies as examples of what can be done. EDI training is a resource that should be promoted through Cultural Change Group and with HR Business Partners through Divisional meetings. The use of PFD Champions to engage on these issues is critical to support the efforts of the committee.

06/16 Workforce Race Equality Standards (WRES)

DS reviewed the WRES scores from the latest Staff Survey. It was suggested that engagement with BME staff in our Trust could be achieved by setting up a BME Network to gain the perceptions of their experience. RG stated that the Equality and Diversity Council of NHS England has commenced an engagement campaign to prepare the wider NHS for a probable introduction of a Workforce Disability Equality Standard (WDES) in April 2017.

07/16 Gender Pay Gap & Audits

Preliminary work has been undertaken by DS, but will bring more detail to future meeting once full analysis has been undertaken **DS**

08/16 Employing People with Learning Disabilities

CM updated the group on an action plan that has been put together to consider how the Trust can employ more people with learning disabilities. This needs careful thinking to get it right and at this stage engagement is being made with organisations who can help us develop a strategy. **DS/CM/ RG**

09/16 Equality Impact Assessment (EIA)

CM provided a revised/updated EIA tool that would be used in our Trust. SP stated that there were issues when completing the business case template and it was requested that CM review this to develop a simpler option that could be used but still ensured we met our responsibilities. **CM**

10/16 Accessible Information Standards Update

CM reported that by 31 July 2016 all organisations that provide NHS or publicly funded adult social care must have fully implemented and conform to the

Accessible information Standard. The Accessible Information Standard aims to make sure that disabled people have access to information that they can understand and any communication support they might need. It was considered that the Smartcare front screen can highlight concerns/needs of a patient so that this is followed through the whole process of the patient life

CM

11/16 Establishment of Cross-County Diversity and Inclusion Group

HB updated the committee that a meeting was arranged for the 23rd March 2016 at the Gloucestershire CCG to discuss the possibility of setting this group up regarding the common themes that all organisations face. Consideration should be made on how this will work with the Sustainability and Transformation Service if this evolves.

HB

12/16 Future Position of Group

DS provided details on the future of the committee and whether it will stand as a sub-committee of the board with aster into the Workforce Group. Further discussion is needed on this

DS

13/16 Any Other Business

This year's annual Equality Report will be available in draft at the next meeting for the committee to review.

RG

14/16 Date of next meeting

The following meeting will take place on **Monday 6th June 2016 in the HR meeting room, Beacon House, GRH, 14.30 – 16.30.**

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – APRIL 2016
REPORT OF THE CHIEF EXECUTIVE

1. National

1.1 NHS England have published CCG Improvement and Assessment Framework 2016/17. Attached at Annex A is the set of indicators that will be used.

1.2 NHS England and NHS Improvement have published a national Whistleblowing Policy which is at Annex B. We will need to examine our Raising Concerns approach to see if it needs amendment.

2. Regional

2.1 The West of England Academic Health Science Network (AHSN) has published its 2016/17 business plan. At Annex C is the plan on a page.

3. Regulators

3.1 As from 1 April 2016 NHS Improvement came into effect. It brings together oversight of foundation Trusts previously undertaken by Monitor and non-foundation Trusts by the Trust Development Authority.

4. Our Trust

4.1 Attendances remain high with March 2016 seeing 11,510 patients compared to 10,394 in March 2015. The difference is actually even greater as over the past year there has been a GP in the Emergency Department at Gloucestershire Royal Hospital which has reduced the overall March 2016 figure.

4.2 A visit was undertaken to the University Technical College at West Bromwich which has a healthcare focus. This has given impetus to the bid that is being created for submission in October 2016 and is led by the University of Gloucestershire. Our Trust is well represented in this work.

4.3 At the end of March we hosted a visit from Dame Gill Morgan who is the Chair of NHS Providers.

4.4 The health and social care partners have agreed a process by which Gloucestershire will submit its Sustainability and Transformation Plan in June 2016. The first stage was to submit its early high level view of a draft plan which was required in a set format. This document is at Annex D.

4.5 April will have seen two separate episodes of industrial action by Junior Doctors. Arrangement were put in place to maintain safe services.

4.6 The following consultants have been appointed

Respiratory	-	Markus Gutsche
Histopathology	-	Jill Farmer

4.7 The Risk Register is at Annex E.

Dr Frank Harsent
Chief Executive

April 2016

Annex A – Indicator summary

31. The CCG Improvement and Assessment Framework includes a set of 57 indicators across 29 areas. It is intended that the indicators will be reported quarterly. Not all indicators will be based on data available each quarter: some indicators will be refreshed quarterly, some will use moving averages to provide a more up to date view, and some will only be refreshed annually.

32. The Table below provides a one line summary of each of the 57 indicators. A detailed technical document that describes the definition, rationale, data source and construction of each of the indicators will be issued shortly to help CCGs understand the purpose and construction of the indicators in the Framework.

Area	Indicator Name
Better Health	
Smoking	Maternal smoking at delivery
Child obesity	Percentage of children aged 10-11 classified as overweight or obese
Diabetes	Diabetes patients that have achieved all the NICE-recommended treatment targets: Three (HbA1c, cholesterol and blood pressure) for adults and one (HbA1c) for children
	People with diabetes diagnosed less than a year who attend a structured education course
Falls	Injuries from falls in people aged 65 and over
Personalisation and choice	Utilisation of the NHS e-referral service to enable choice at first routine elective referral
	Personal health budgets
	Percentage of deaths which take place in hospital
	People with a long-term condition feeling supported to manage their condition(s)
Health inequalities	Inequality in avoidable emergency admissions
Anti-microbial resistance	Anti-microbial resistance: Appropriate prescribing of antibiotics in primary care
	Anti-microbial resistance: Appropriate prescribing of broad spectrum antibiotics in primary care

Carers	Quality of life of carers
Better Care	
Care ratings	Use of high quality providers
Cancer	Cancers diagnosed at early stage
	People with urgent GP referral having first definitive treatment for cancer within 62 days of referral
	One-year survival from all cancers
	Cancer patient experience
Mental Health	Improving Access to Psychological Therapies recovery rate
	People with first episode of psychosis starting treatment with a NICE-recommended package of care treated within 2 weeks of referral
	Children and young people's mental health services transformation
	Crisis care and liaison mental health services transformation
	Out of area placements for acute mental health inpatient care - transformation
Learning disability	Reliance on specialist inpatient care for people with a learning disability and/or autism
	Proportion of people with a learning disability on the GP register receiving an annual health check
Maternity	Neonatal mortality and stillbirths
	Women's experience of maternity services
	Choices in maternity services
Dementia	Estimated diagnosis rate for people with dementia
	Dementia care planning and post-diagnostic support
Urgent and emergency care	Achievement of milestones in the delivery of an integrated urgent care service
	Emergency admissions for urgent care sensitive conditions

	Percentage of patients admitted, transferred or discharged from A&E within 4 hours
	Ambulance waits
	Delayed transfers of care attributable to the NHS per 100,000 population
	Population use of hospital beds following emergency admission
Primary medical care	Management of long term conditions
	Patient experience of GP services
	Primary care access
	Primary care workforce
Elective access	Patients waiting 18 weeks or less from referral to hospital treatment
7 day services	Achievement of clinical standards in the delivery of 7 day services
NHS Continuing Healthcare	People eligible for standard NHS Continuing Healthcare
Sustainability	
Financial sustainability	Financial plan
	In-year financial performance
Allocative efficiency	Outcomes in areas with identified scope for improvement
	Expenditure in areas with identified scope for improvement
New models of care	Adoption of new models of care
Paper-free at the point of care	Local digital roadmap in place
	Digital interactions between primary and secondary care
Estates strategy	Local strategic estates plan (SEP) in place
Leadership	
Sustainability and Transformation Plan	Sustainability and Transformation Plan

Probity and corporate governance	Probity and corporate governance
Workforce engagement	Staff engagement index
	Progress against workforce race equality standard
CCGs' local relationships	Effectiveness of working relationships in the local system
Quality of leadership	Quality of CCG leadership

NHS Improvement
NHS England

Freedom to speak up: raising concerns (whistleblowing) policy for the NHS

April 2016

Contents

Speak up – we will listen

Speaking up about any concern you have at work is really important. In fact, it's vital because it will help us to keep improving our services for all patients and the working environment for our staff.

You may feel worried about raising a concern, and we understand this. But please don't be put off. In accordance with our duty of candour, our senior leaders and entire board are committed to an open and honest culture. We will look into what you say and you will always have access to the support you need.

This policy

This 'standard integrated policy' was one of a number of recommendations of the review by Sir Robert Francis into whistleblowing in the NHS, aimed at improving the experience of whistleblowing in the NHS. It is expected that this policy (produced by NHS Improvement and NHS England) will be adopted by all NHS organisations in England as a minimum standard to help to normalise the raising of concerns for the benefit of all patients.

Our local process has been integrated into the policy/adheres to the principles of this policy and provides more detail about how we will look into a concern *[insert link].*

What concerns can I raise?

You can raise a concern about **risk, malpractice or wrongdoing** you think is harming the service we *deliver/commission* [delete as appropriate]. Just a few examples of this might include (but are by no means restricted to):

- unsafe patient care
- unsafe working conditions
- inadequate induction or training for staff
- lack of, or poor, response to a reported patient safety incident
- suspicions of fraud (which can also be reported to our local counter-fraud team *[insert contact details])*
- a bullying culture (across a team or organisation rather than individual instances of bullying).

For further examples, please see the Health Education England video.

Remember that if you are a healthcare professional you may have a professional duty to report a concern. **If in doubt, please raise it.**

Don't wait for proof. We would like you to raise the matter while it is still a concern. It doesn't matter if you turn out to be mistaken as long as you are genuinely troubled.

This policy is not for people with concerns about their employment that affect only them – that type of concern is better suited to our grievance policy *[insert link].*

Feel safe to raise your concern

If you raise a genuine concern under this policy, you will not be at risk of losing your job or suffering any form of reprisal as a result. We will not tolerate the harassment or victimisation of anyone raising a concern. Nor will we tolerate any attempt to bully you into not raising any such concern. Any such behaviour is a breach of our values as an organisation and, if upheld following investigation, could result in disciplinary action.

Provided you are acting honestly, it does not matter if you are mistaken or if there is an innocent explanation for your concerns.

Confidentiality

We hope you will feel comfortable raising your concern openly, but we also appreciate that you may want to raise it confidentially. This means that while you are willing for your identity to be known to the person you report your concern to, you do not want anyone else to know your identity. Therefore, we will keep your identity confidential, if that is what

you want, unless required to disclose it by law (for example, by the police). You can choose to raise your concern anonymously, without giving anyone your name, but that may make it more difficult for us to investigate thoroughly and give you feedback on the outcome.

Who can raise concerns?

Anyone who works (or has worked) in the NHS, or for an independent organisation that provides NHS services can raise concerns. This includes agency workers, temporary workers, students, volunteers and governors.

Who should I raise my concern with?

In many circumstances the easiest way to get your concern resolved will be to raise it formally or informally with your line manager (or lead clinician or tutor).[1] But where you don't think it is appropriate to do this, you can use any of the options set out below in the first instance.

If raising it with your line manager (or lead clinician or tutor) does not resolve matters, or you do not feel able to raise it with them, you can contact one of the following people:[2]

- our Freedom to Speak Up Guardian (or equivalent designated person) *[insert name(s) and contacts details]* – this is an important role identified in the Freedom to Speak Up review to act as an independent and impartial source of advice to staff at any stage of raising a concern, with access to anyone in the organisation, including the chief executive, or if necessary, outside the organisation

- our risk management team *[insert contact details].*

If you still remain concerned after this, you can contact:

- our executive director with responsibility for whistleblowing *[insert name and contact details]*

- our non-executive director with responsibility for whistleblowing *[insert name and contact details]*.

All these people have been trained in receiving concerns and will give you information about where you can go for more support.

If for any reason you do not feel comfortable raising your concern internally, you can raise concerns with external bodies, listed on page 8.

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[1] The difference between raising your concern formally and informally is explained in our local process. In due course NHS England and NHS Improvement will consider how recording could be consistent nationally, with a view to a national reporting system.

[2] Annex A sets out an example of how a local process might demonstrate how a concern might be escalated.

Advice and support

Details on the local support available to you can be found here *[link to organisation intranet]*. However, you can also contact the Whistleblowing Helpline for the NHS and social care, your professional body or trade union representative.

How should I raise my concern?

You can raise your concerns with any of the people listed above in person, by phone or in writing (including email).

Whichever route you choose, please be ready to explain as fully as you can the information and circumstances that gave rise to your concern.

What will we do?

We are committed to the principles of the Freedom to Speak Up review and its vision for raising concerns, and will respond in line with them (see Annex B).

We are committed to listening to our staff, learning lessons and improving patient care. On receipt the concern will be recorded and you will receive an acknowledgement within two working days. The central record will record the date the concern was received, whether you have requested confidentiality, a summary of the concerns and dates when we have given you updates or feedback.

Investigation

Where you have been unable to resolve the matter quickly (usually within a few days) with your line manager, we will carry out a proportionate investigation – using someone suitably independent (usually from a different part of the organisation) and properly trained – and we will reach a conclusion within a reasonable timescale (which we will notify you of). Wherever possible we will carry out a single investigation (so, for example, where a concern is raised about a patient safety incident, we will usually undertake a single investigation that looks at your concern and the wider circumstances of the incident[3]). The investigation will be objective and evidence-based, and will produce a report that focuses on identifying and rectifying any issues, and learning lessons to prevent problems recurring.

We may decide that your concern would be better looked at under another process; for example, our process for dealing with bullying and harassment. If so, we will discuss that with you.

[3] If your concern suggests a Serious Incident has occurred, an investigation will be carried out in accordance with the Serious Incident Framework.

Any employment issues (that affect only you and not others) identified during the investigation will be considered separately.

Communicating with you

We will treat you with respect at all times and will thank you for raising your concerns. We will discuss your concerns with you to ensure we understand exactly what you are worried about. We will tell you how long we expect the investigation to take and keep you up to date with its progress. Wherever possible, we will share the full investigation report with you (while respecting the confidentiality of others).

How will we learn from your concern?

The focus of the investigation will be on improving the service we provide for patients. Where it identifies improvements that can be made, we will track them to ensure necessary changes are made, and are working effectively. Lessons will be shared with teams across the organisation, or more widely, as appropriate.

Board oversight

The board will be given high level information about all concerns raised by our staff through this policy and what we are doing to address any problems. We will include similar high level information in our annual report. The board supports staff raising concerns and wants you to feel free to speak up.

Review

We will review the effectiveness of this policy and local process at least annually, with the outcome published and changes made as appropriate.

Raising your concern with an outside body

Alternatively, you can raise your concern outside the organisation with:

- NHS Improvement for concerns about:
    - how NHS trusts and foundation trusts are being run
    - other providers with an NHS provider licence
    - NHS procurement, choice and competition
    - the national tariff
- Care Quality Commission for quality and safety concerns
- NHS England for concerns about:
    - primary medical services (general practice)
    - primary dental services
    - primary ophthalmic services
    - local pharmaceutical services
- Health Education England for education and training in the NHS
- NHS Protect for concerns about fraud and corruption.

Making a ‘protected disclosure’

There are very specific criteria that need to be met for an individual to be covered by whistleblowing law when they raise a concern (to be able to claim the protection that accompanies it). There is also a defined list of ‘prescribed persons’, similar to the list of outside bodies on page 8, who you can make a protected disclosure to. To help you consider whether you might meet these criteria, please seek independent advice from the Whistleblowing Helpline for the NHS and social care, Public Concern at Work or a legal representative.

National Guardian Freedom to Speak Up

The new National Guardian (once fully operational) can independently review how staff have been treated having raised concerns where NHS trusts and foundation trusts may have failed to follow good practice, working with some of the bodies listed above to take action where needed.

Annex A: Example process for raising and escalating a concern

Step one

If you have a concern about a risk, malpractice or wrongdoing at work, we hope you will feel able to raise it first with your line manager, lead clinician or tutor (for students). This may be done orally or in writing.

Step two

If you feel unable to raise the matter with your line manager, lead clinician or tutor, for whatever reason, please raise the matter with our local Freedom to Speak Up Guardian(s):

[Name]

[Contact details]

This person has been given special responsibility and training in dealing with whistleblowing concerns. They will:

- treat your concern confidentially unless otherwise agreed
- ensure you receive timely support to progress your concern
- escalate to the board any indications that you are being subjected to detriment for raising your concern
- remind the organisation of the need to give you timely feedback on how your concern is being dealt with
- ensure you have access to personal support since raising your concern may be stressful.

If you want to raise the matter in confidence, please say so at the outset so that appropriate arrangements can be made.

Step three

If these channels have been followed and you still have concerns, or if you feel that the matter is so serious that you cannot discuss it with any of the above, please contact *[chief executive, medical director, responsible officer, nursing director, nominated non-executive director].*

Step four

You can raise concerns formally with external bodies *[relevant list of prescribed bodies to be provided, similar to that on page 8].*

Annex B: A vision for raising concerns in the NHS

Source: Sir Robert Francis QC (2015) *Freedom to Speak Up: an independent report into creating an open and honest reporting culture in the NHS*.

NHS Improvement
NHS England

Contact us

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Wellington House
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E: nhsi.enquiries@nhs.net
W: improvement.nhs.uk

NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change Team and the Intensive Support Teams.

This publication can be made available in a number of other formats on request.

NHS Improvement (April 2016) Publication code: Policy 01/16
Publications Gateway Reference: 04877

ANNEX C

Patient Safety Collaborative

Plan on a Page 2016/17

West of England Academic Health Science Network

	Primary Care	Secondary Care	Community Care	Home
The deteriorating patient. Emergency management of the deteriorating patient, identifying patients at risk and avoiding patient deterioration	**National Early Warning Scores (NEWS)** Standardising GP referrals | Ambulance Trust Electronic Patient Record (ePCR) | Sepsis			
		Emergency Laparotomy (ELC)		
		Emergency Department (ED) Checklist		
	Involving our patients and the public Human factors with patients and carers | Public contributors | NEWS with patients and carers			
Primary care and **medicines safety collaboratives.** Supporting a culture of safety and collaborating to reduce variation in practice		**Improving medicines safety at transfers of care** PharmOutcomes system | Medicine reviews by community pharmacists		
		Improving insulin safety Sharing lessons learned | Patient's own drugs scheme | Shared formulary		
			Supporting patient safety in the community Sharing learning and use of incident reports	
	Pilot GP practices		**Building capability in human factors** Human factors toolkit and train the trainer	
	Incident reporting in primary care		Community Forum	

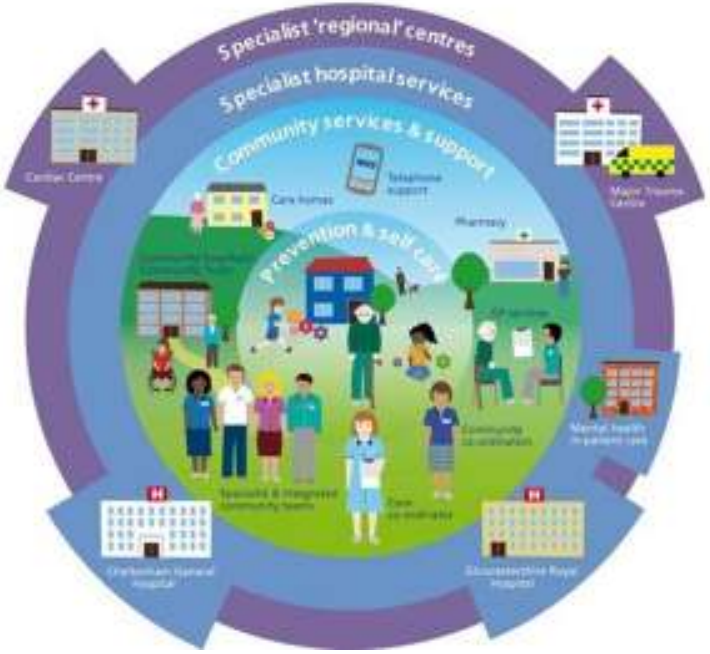
Enablers to support the overarching aim that by March 2019 everyone in the West of England can be confident that care is safer for patients based on a culture of openness, collaboration, continual learning and improvement

Measurement. We will promote understanding and use of measurement, agree shared metrics for safety and use data (e.g. NELA) to drive improvement. Outputs include the Life system, aggregate chart reporting and measurement knowledge resources.	**Learning.** We will develop relationships between stakeholders encouraging network development and collaboration to share learning and commitment to action. Outputs include effective networks in place, with learning shared through reports, posters and presentations.
Capability building. We will develop capability through our Academy programme for Improvement Coaches and masterclasses, and create a virtual network through Q asset mapping. Outputs include asset mapping database, QI toolkit and project life cycle resources.	**Leadership**. We will increase awareness and promotion at all levels of patient safety as a priority so that all organisations have a shared understanding of common purpose of patient safety. We will support Sign Up to Safety priorities through workshops for members e.g. falls, pressure ulcers, etc.
Culture. We will promote a culture of openness, person-centredness and clinical effectiveness. Outputs include the pilot GP practices, supporting incident reporting in primary care, and Patient Safety Culture survey (SCORE).	**Innovation.** We will create an infrastructure for innovation, sharing, adoption and spread. Innovations we are supporting include the ED checklist, NEWS toolkit, ePCR in ambulance service, PharmOutcomes, connecting care, and diabetes test bed.

Support, collaborate, adopt and spread	**Mental health collaborative** | **Link into other AHSN clusters** (sepsis, medicines, transfers of care)			
		Mortality reviews		

Gloucestershire STP: Joining Up Your Care

ANNEX D



FOOTPRINT INFORMATION

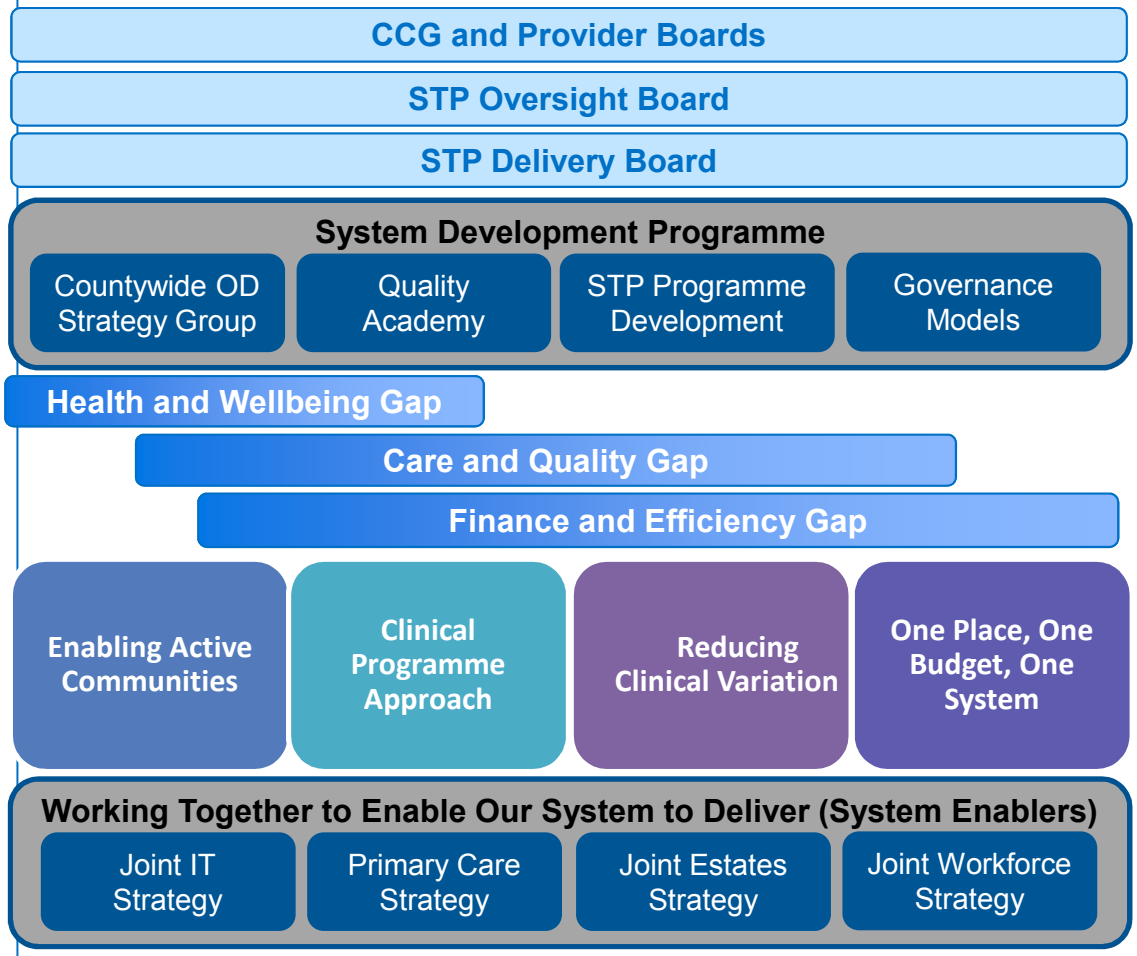
Name of footprint and no: Gloucestershire, 43 **Region:** South
Nominated lead of the footprint including organisation/function: Mary Hutton, Accountable Officer GCCG
Contact details (email and phone): Mary Hutton, mary.hutton1@nhs.net,Tel: 0300 421 1415
Organisations within footprints: Gloucestershire Clinical Commissioning Group, Gloucestershire Hospitals NHS Foundation Trust, 2Gether NHS Foundation Trust, Gloucestershire Care Services NHS Trust, Gloucestershire County Council, South Western Ambulance Service NHS Foundation Trust

NHS Gloucestershire Clinical Commissioning Group
Gloucestershire Hospitals NHS Foundation Trust
Gloucestershire Care Services NHS Trust
South Western Ambulance Service NHS Foundation Trust
2gether NHS Foundation Trust
Gloucestershire County Council

Leadership, Governance and Collaboration:

Progress Made:

- We have a long and positive history of working together in Gloucestershire through our joint strategic forum. Building on this, Our system has agreed a **collaborative leadership approach for our STP,** with system leaders taking ownership of key STP work programmes on behalf of partners across Gloucestershire.

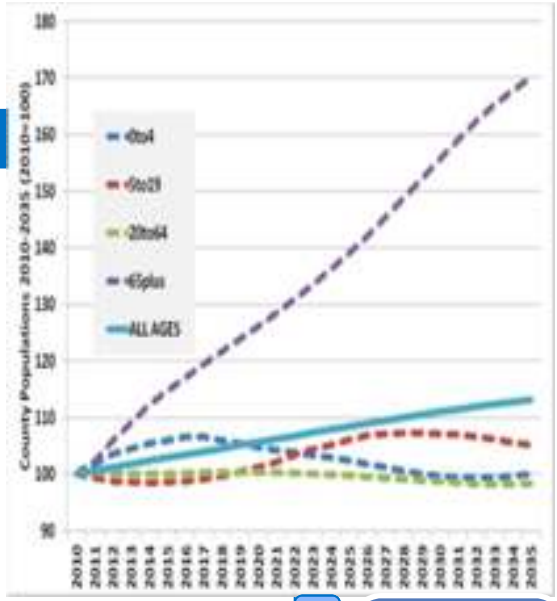


- **Local government partners** are fully engaged partners in our STP, evidenced through our **joint coterminous Devolution proposal** and our extensive joint commissioning portfolio. Our **Health and Wellbeing Board** will take a key role in supporting our prevention and self care strategy and the Enabling Active Communities STP programme
- The **nominated lead for our STP is supported by a programme office working group,** We are in the process of appointing additional posts to support the STP work programme at programme and project levels.
- Our shared system vision for our Health and Care Community, Joining Up Your Care, **was built from extensive community and staff engagement**. Where relevant, our delivery groups **all include lay , Healthwatch and / or patient representation** and where any change is planned we undertake extensive patient engagement to support the development of new ways of working.
- Clinicians are **active participants in all of our STP working groups**. Our STP board to date has been clinically chaired (this may change in future as the recommendation from NHS England is that we should have an independent chair and process underway). We are developing a health community wide organisational development approach including **health coaching and behaviour change for clinicians.** Furthermore, we are working in partnership with the ASHN around innovation and developing a system wide **quality academy.**

Section 2a: Improving the health of people in your area

Areas of focus for improving health and wellbeing

Three leading causes of death for our population: cancer (27.9%), cardiovascular disease (26.8%) and respiratory disease (14.2%)



Age is the leading risk factor for the majority of chronic health conditions but lifestyle plays a key part. WHO data indicates almost half of diseases such as the above are associated with four risk factors: **poor diet, physical inactivity, smoking, and excess alcohol** consumption Poor mental and emotional wellbeing also have a key part to play.

Gloucestershire is broadly in line with national and regional benchmarks for alcohol related admissions to hospital, levels of physical activity and adult excess weight, although some districts have worse outcomes than the county as a whole, notably in the west of the county in the Forest of Dean, Gloucester and Tewkesbury. Smoking rates in Gloucestershire are steadily declining and are lower than comparators, Work is underway to capture the impact of loneliness and social isolation as both are factors in worse health outcomes. Healthy life expectancy for women is almost two years better than for their regional counterparts, the average for Gloucestershire men is lower than for the South West as a whole.

Our ageing population, changing patterns of disease (more people living with multiple long-term conditions) and rising public and patient expectations mean that fundamental changes are required to the way in which care is delivered in our county. We will support our vision to deliver joined up care with a **radical shift to more fully involve individuals in their own health and care**. This will include making **shared decision-making** a reality by intensively training our clinicians to work in a new way with people they care for, giving people the support and information they need for effective self-management and involving their families and carers to support them in making the changes needed to keep healthy. Evidence is clear **that most people want to be more involved in their own health**, and that when they are, decisions are better, **health and health outcomes improve**, and resources are allocated more efficiently.

To deliver change we will build on **our existing collaborations** between the NHS, local government, the third sector, employers and others – evidenced in our delivery of social prescribing across our county as a partnership between all of these partners and our new initiatives to tackle workplace health with our local LEP being developed for delivery in 2016/17. Some of the high level details of our work is set out on the following slide:

Health and Wellbeing Gap

- Enabling Active Communities
- Clinical Programme Approach
- Reducing Clinical Variation
- One Place, One Budget, One System

Section 2a: Improving the health of people in your area

Areas of focus for improving health and wellbeing

Our STP approach is to **work in partnership to radically upgrade prevention and self care by**:

Radically upgrading prevention through the following actions:

- Deliver county-wide action plan on obesity including Leeds Beckett national pilot: system plan to tackle obesity
- Diabetes programme developing community based model with prevention and self care as key, Digital test bed with AHSN using technology to support self management and remote monitoring, Bid for roll out of diabetes prevention programme
- Development of Social Investment Bond to support physical activity in Gloucestershire

Mobilising Healthy Behaviours for our population by:

- Delivering new programme of Health coaching to train staff in supporting people to set their own health goals, supported by development of personalised care planning and adoption of House of Care approach
- Recommissioning of Healthy Lifestyle services to support self management, with target 1:1 support for those with greatest need such as alcohol dependence
- Enabling Active Communities Policy agreed with joint action plan with council and other partners to develop system wide approach to commissioning community navigator/connector roles and shared information/ directory platforms

All partners including Local Government working together to deliver **Prevention and Public Health Improvements:**

- Multi-agency Self Care and Prevention group established to deliver system wide leadership and direction as part of STP governance structure. £1.7 million non-recurrent funds in 2016/17 to pump prime agenda

We are working to improve the **Health and Wellbeing of staff** through:

- Working with Active Gloucestershire to roll out Health and Wellbeing Workplace Charter for key employer groups and to facilitate spread of Mile a Day initiative in schools
- Healthy workplaces a key strand of Self Care and Prevention Group with Local Authority working in partnership with the LEP

Health and Wellbeing Gap

Enabling Active Communities

Clinical Programme Approach

Reducing Clinical Variation

One Place, One Budget, One System

Section 2b: Improving care and quality of services

Areas of focus for improving care and quality

The NHS faces unprecedented operational challenges with targets for waiting times being missed; and in all areas of the NHS staff are under pressure from rising demand alongside constrained resources. Locally Gloucestershire is failing key constitution standards for A&E 4 hour waiting times, and other waiting time targets such as for cancer and diagnostics. **To improve care and quality to deliver better health outcomes** for our population our developing STP programmes are:

Clinical Programmes Approach	Reducing Clinical Variation	One Place, One Budget, One System
To challenge our system to go further through our STP we will use **Respiratory** in 2016/17 to test our delivery of truly integrated care pathways. In line with our system challenges assessed through local intelligence, performance issues, benchmarking and right care we will also run clinical programmes for Cancer, Circulatory, Eye Health, MSK, Mental Health, **Dementia, End of Life,** Diabetes and Head and Neck (ENT). We will deliver 'cross cutting' improvement programmes for **Urgent Care** (with a particular focus on delivery of the 4 hr standard and improved discharge), planned care and community services ensuring a joined up care approach for people who experience **multiple co-morbidities**	Using our **clinical programmes approach** (left) we will focus on **better value**, improving productivity across our system by engaging clinical teams in reducing variations through our **Reducing Clinical Variation programme**. Through this work stream we will also deliver a **Choosing Wisely programme** for Gloucestershire, that will consider medicines optimisation and roll out right care approach	Through our One Place, One Budget, One System programme we will take a **place based approach ,** pooling our available resources and breaking down barriers. We will deliver integrated care for older people through our **30,000 place based model of care** and scale up of our **End of Life strategy** to support people to die in the place of their choice. We will set out a plan for 7 day services and expand our roll out of personal health budgets.

Care and Quality Gap

- Enabling Active Communities
- Clinical Programme Approach
- Reducing Clinical Variation
- One Place, One Budget, One System

To identify our areas of focus to reduce the care and quality gap we have **reviewed a comprehensive range of indicators** to support the development of our programmes. Our outcomes indicator data highlights our most challenged outcomes are for patients admitted to hospital with **fractured hips**, people who need **IAPT**, and for **Acute Stroke Care** pathways. These issues are being addressed through our clinical programmes for **MSK, Circulatory and Mental Health**

Local Bench-marking dataset comparing data from SAR, Right Care, CfV, and Internal Analysis:

OP Elective							IP & DC Elective								Non Elective						
T&O / MSK	Ophthalmology	Respiratory	Circulatory	ENT	Dermatology	Cancer	Womens & Children	T&O / MSK	Respiratory	Circulatory	Gastro	Neurology	ENT	Cancer	Womens & Children	Respiratory	Gen Med	T&O / MSK	Circulatory	Neurology	Cancer
●	●	●						●	●		●				●	●	●	●			
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This table highlights rationale for improvement in Respiratory programme in STP (MSK programme is already in delivery phase)

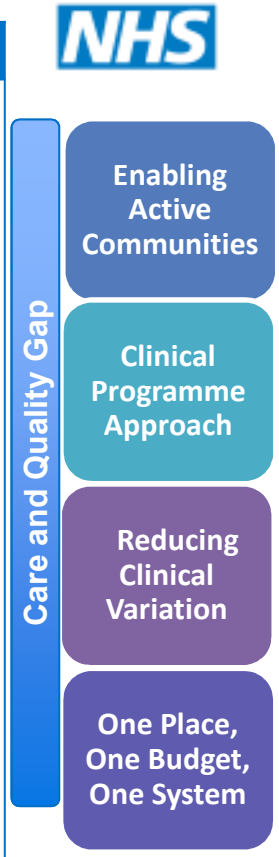
Section 2b: Improving care and quality of services

Areas of focus for improving care and quality

- In addition to our transformational change programmes we will focus on the **delivery of core constitution standards, particularly performance of urgent care** and deliver quality improvement **in line with CQC recommendations from recent inspection reports.** The top three risks for our main in county providers are set out below.
- In line with the **Mental Health FYFV** we will focus on improved parity for mental health, using our STP to spark new focus on improving outcomes for people with **Dementia** and people with **Personality Disorders**
- Providers in our system will continue with the implementation of their action plans in line with the recommendations around patient safety from the **Francis Report, Keogh Reviews, Berwick Report and the findings from Winterbourne View.**
- To ensure the sustainability of **Primary Care** we will focus on scaling up 5 key areas of work: **Premises**, **Workforce** 40% of all practices are carrying GP vacancies, 75% are partners. 56% have impending GP retirements,. **Quality, IT** and **Transformational Change:** improving access at evening and weekends, more on-the-day urgent appointments

System Enablers:

- Developing a joint plan to deliver **7 day services** across Gloucestershire
- We have a shared approach to digital road map and **local digital roadmap footprint** (Gloucestershire) aligned to STP boundary. As a system we have a shared records implementation plan**: Joining up Your Information** (JUYI)
- Workforce is a huge challenge for all parts of our system and we are working to develop a **system wide workforce strategy**, includes work in **partnership with the LEP** and an **innovative technical college proposal** (new roles). Workforce strategy reviewing opportunities for skill mix and increased role of technology in supporting staff to deliver
- We are working to develop **a system wide approach to quality improvement** through the development of a countywide quality academy in partnership with the academic health sciences network.
- A **countywide OD group** is being instigated to support the scale of ambition and change required by our STP
- We have a **'one Gloucestershire' estates group** working together on a joint estates strategy



Gloucestershire Hospitals Foundation Trust	Gloucestershire Care Services	2gether Foundation Trust	Gloucestershire County Council
•Increasing levels of demand and discharge flow issues for hospital services leading to operational delivery pressures •Workforce - availability, resilience and skill mix challenges •Premises and site configuration challenges arising from two site model	•Workforce – availability, resilience and skill mix challenges. •Variation – of services and service delivery across localities •Financial challenge and sustainability	•Workforce – availability, resilience and skill mix challenges •Financial challenge and sustainability •Managing rising demand and maintaining service quality	•Workforce – availability, resilience and skill mix challenges. •Financial context and sustainability of services, especially for public health •Rising demand for social care in context of finance and workforce

Section 2c: Improving productivity and closing the local financial gap

Emerging thinking on the finance and quality gap

Our system is currently in **financial balance**, but we recognise the potential scale of the challenge for our system looking forward to the pressures arising from future funding not keeping pace with demographic change and other drivers of demand. Our collective challenge is estimated at circa **£200 million over five years** (excluding local government) and we are working together to agree how each of our programmes will contribute to delivering savings at this level. In addition, we need to recognise that there will be **costs inherent in delivering change**, not just in terms of costs to support service change but also in terms of the capacity needed to design and deliver an STP programme at scale.

We intend to work together as partners across the health and **social care system through the following principles** (currently draft, to be further developed and underpinned by a formal MOU):

- We will ensure commitment to a risk share approach aligned to our priorities. This should be underpinned by an open, transparent approach to the development of opportunities for change
- We will commit to the principles of 'One Place, One Budget, One System' to improve services and outcomes for our population, whilst working to ensure financial stability across our system
- We will develop our clinical programme groups to the point where they are working with full visibility of programme budgets in 2016/17 to prioritise resources across programmes; starting with our priority pathway Respiratory
- We will work to the principle of moving care 'upstream', and will be aiming to prioritise resources within our care pathways towards primary care and prevention where possible
- We will work to the principle of commissioning through a care pathways approach, and within commissioned pathways we will work together to identify opportunities for increased cost effectiveness, minimising the number of steps and driving greater efficiency
- We will consider whether the pilot(s) of innovative organisational forms in line with the five year forward view new models for delivery of care will require us to develop any new and innovative approaches to contracting
- We will not commission or provide services that are deemed by evidence to not be cost or clinically effective

Section 2c: Improving productivity and closing the local financial gap

Emerging thinking on the finance and quality gap

- Our modelling suggests that **our prevention and self care model improvement plans** should deliver a reduction in anticipated levels of demand to provide an allocative efficiency saving against projected demand of approximately **£20million over five years.**
- Our high level ambitions for **how our work on care and quality and new care model plans will impact on technical and operational efficiencies** across our system is set out in the table below. It should be recognised that this is currently work in progress, and will be revised as work progresses towards our June submission. We are clear that although our system is **currently in aggregate financial balance**, longer term sustainability requires that as a health and care system we deliver around **£200 million efficiencies over 5 years** and as yet not all the work has been completed to identify how the gap can be closed.
- As set out on slide 11, **our big decision will be which new model of care** we wish to implement across our system. We intend to use our work in 2016/17 to test some prioritised approaches to agree a way forward for implementation from April 2017. It is clear that **a new model of care will need to also realise resource efficiencies** for our system

Organisation	Draft Totals
One Place, One Budget, One System	29.3m
Enabling Active Communities	20m
Clinical Programmes Approach	29.4m
Person Centred Care	10.9m

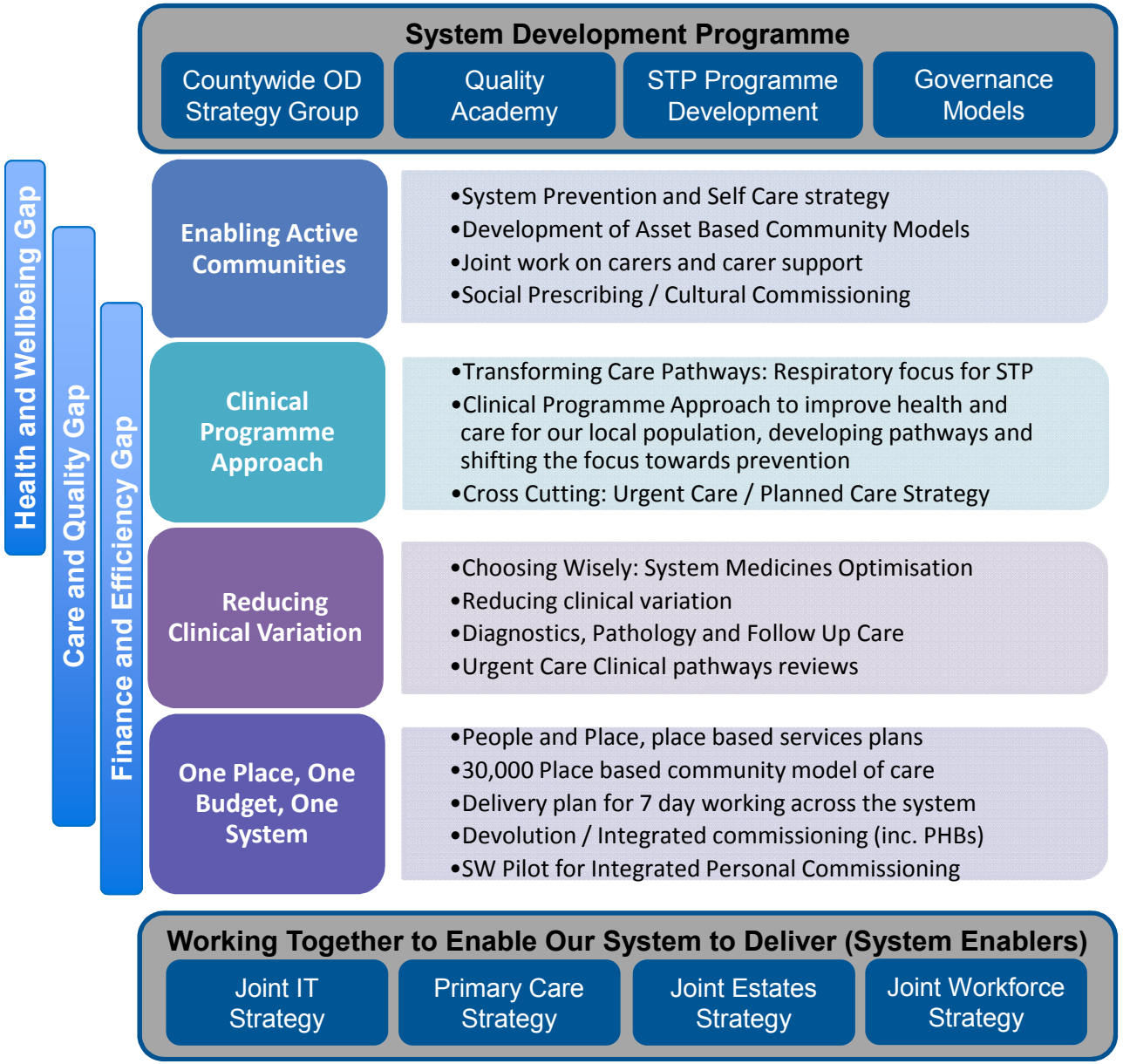
These draft savings are estimated against allocative efficiency and demographic growth

We are working to develop Shared Programme Level Savings Assumptions over the 5 year timeframe of STP being developed, Please note - this is still work in progress and provider efficiency assumptions to be added in following work on impact of new tariffs, Carter review local assessment etc. plus currently still working on social care savings impact

Finance and Efficiency Gap

- Enabling Active Communities
- Clinical Programme Approach
- Reducing Clinical Variation
- One Place, One Budget, One System

Section 3: Our emerging priorities:



Gloucestershire STP builds on the strategic commitments set out in our joint strategy: Joining Up Your Care and responds to the three gaps in the Five Year Forward View.

Our shared transformation work programme will sets clear ambitions for radical improvement informed by national and local benchmarking, to ensure we have a sustainable health and care system for Gloucestershire – for now and for the future.

Our STP work programme priorities are local priorities identified from the outcomes framework, NHS right care, our population health priorities and a range of other local and national data sources.

Our **big decision that we will need to make as a system to drive transformation will be which new model of care** we wish to adopt for Gloucestershire. We have prioritised two key pilots to deliver in the first half of 2016/17 – our system wide Respiratory programme and our 30,000 integrated care model to test principles and delivery. Our programme timeline proposes the agreed new model for implementation from April 2017.In addition EOL, Dementia and Clinical variation will be priority projects.

These work programmes represent a significant scaling up of ambition, as well as building on track record of successful delivery

Section 4: Support you would like

Emerging thinking on support needs

Support Needs

- We have identified **our main support need as being activity and finance modelling support** for our finance and efficiency gap, ensuring **triangulation of plans** across our system and setting up a realistic and informative reporting system to track our delivery of a range of system efficiency metrics
- We also require additional capacity to support our **programme office and backfill for senior level support and clinical engagement** across our system
- We have made an application for financial support for both of these needs. For the activity and financial support we wish to commission an external provider to help us with this work. We have proposed a further amount to support our programme office and senior backfill.

Best Practice

- Areas we can share: Enabling Active Communities, Social Prescribing, Cultural Commissioning (national pilot), Integrated Community teams model and clinical programmes approach
- We would be happy to share further work that would be considered as **best practice** and happy to receive any other examples that are identified as such

National Barriers or actions to support STP

- Political support for difficult decisions taken to resolve operational and financial efficiency challenges, including potential changes to service and / or site solutions
- Support from national bodies to develop new roles to support workforce gaps

Key risks

- Political risks associated with strategic change
- Capacity to deliver change at scale and pace alongside business as usual
- Financial risk – challenge of maintaining financial balance vs. allocations positions and demand on services

ANNEX E

TRUST RISK REGISTER –April 2016

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

M1
Inability of the local health and social care system to manage demand within the current capacity leading to significant fluctuation of attendances in ED
	• Weekly Emergency Care Board
	• Emergency Care Plan
	  ○ Addressing three main areas of concern
	  ▪ Demand
	  ▪ Staffing (Medical & Nursing)
	  ▪ Beds and capacity
	• Monthly Emergency Care Board report
	• Delivery of relevant QIPP plans & CQuINs
	• Monthly County System Resilience group
	• Improvement Director
		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	5	25
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 Divisional Board	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 and not part of licenced activity.	• 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 Ambulances	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 Finance Director of CITS	IM&T Board	Monthly	4	4	16
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

INTEGRATED PERFORMANCE MANAGEMENT FRAMEWORK

EXECUTIVE SUMMARY

TRUST BOARD – APRIL 2016

1. INTRODUCTION

This report summarises the key highlights and exceptions in Trust performance up until the end of March 2016 for the financial year 2015/16.

2. KEY HIGHLIGHTS ON PERFORMANCE

- GP referrals have continued to run at higher levels than last year and were 4.2% over last year at the end of March. However the Trust has met the 18 Week RTT standard in overall terms at Trust level for incomplete pathways as it has done each month in 2015/16.

- The Trust met the standard for a maximum 14 day wait for patients urgently referred by their GP. It also achieved the standard for 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 up to February, noting that this is reported one month in arrears.

- The Trust had no occurrences of MRSA post 48 hours during March.

- The Trust continues exceed its target for the completion of mandatory training.

- The Trust continues to achieve its carbon utilisation reduction target.

3. AREAS OF EXCEPTION ON PERFORMANCE

- Emergency admissions continue to run at levels over the plan for the year, ending as 7.5% over plan at the end of March, a significant increase over the 6.9% reported in February. The percentage of patients spending less than 4 hours in the Emergency Department has made a small improvement compared 76.4% for February. A recovery plan is in place with support from NHS Improvement. This has also had a consequential impact on the number of ambulance handovers delayed over 30 minutes which exceeded last year's level in March.

- There was only one case of Clostridium Difficile (C-Diff) infection - post 48 hours in March, taking the Trust total to 41 for the year. Following the NHS England guidance which allows Trust to appeal cases that are found to be unavoidable after lockdown of the monthly data, 6 of the 41 cases have been appealed with the Commissioners. If these six are all agreed then the year-end for cases that were avoidable would be 35 compared with the target of 37. This compared with the agreed trajectory for C-Diff for 2014-15 was set at 55 trust-attributable episodes. The Trust achieved this target and reported 37 cases.

- 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 February. The trajectory is under review, due to ongoing capacity issues in Urology, with support from Executive Directors.

- The numbers of medically fit patients remaining in a hospital bed continues to run at high levels and significantly above agreed system wide standards. This inability to discharge medically fit patients has impacted on our performance.

4. 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: **Philip Hopwood, Interim Head of Business Intelligence**

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

Date: **April 2016**

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	Q4	Jan	Feb	Mar	Monitor weighting	Current position for 4
C-Diff Toxin Detection (post 48 hour annual target)	37/yr	9	6	8	13	8	10	10	13	6	6	1	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%	92.1%	92.2%	92.2%	92.0%	1.0	
A&E 4 Hour Wait	95%	93.3%	94.3%	89.5%	82.7%	93.4%	89.7%	85.6%	78.5%	80.2%	76.4%	77.7%	1.0	1.0
Cancer 31 Days for all subsequent drugs	98%	100%	100%	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%	99.5%	94.1%	100.0%			
31 days to Radiotherapy	94%	100%	98.6%	99.8%	100%	100%	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%	95.6%	84.0%	100%		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%	75.2%			
14 Days to First Appt	93%	90.5%	94.1%	94.3%	88.8%	91.5%	90.9%	92.4%		88.0%	93.2%		1.0	1.0
14 days symptomatic breast (cancer not initially suspected)	93%	66.1%	93.6%	96.6%	94.9%	95.2%	91.8%	93.4%	93.4%	94.1%	95.2%			
31 Days from Diagnosis to Treatment	96%	99.6%	99.8%	99.5%	100%	99.5%	99.7%	100%	100%	100%	100%		1.0	
		2.0	1.0	2.0	3.0	3.0	3.0	4.0	4.0					4.0

KEY: Actual Provisional

Gloucestershire Hospitals NHS
NHS Foundation Trust

PERFORMANCE MANAGEMENT FRAMEWORK 2015-16

April 2016

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TRUST PERFORMANCE - as at end March 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	Mar	Year end position	Basis of year / quarter end assessment
Monitor Financial Risk Rating	level 3	Monitor	M	Mar	3	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	Feb	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%	6.3%	6.4%		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%	4.3%		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%	6.6%		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%	6.9%		year end cumulative
LOS for general and acute non elective spells	Q1 /Q2 <5.4days , Q3 /Q4 <5.8days	Trust	M	Mar	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	5.8		year end cumulative
LOS for general and acute elective IP spells	≤ 3.4 days	Trust	M	Mar	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	3.7		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%	0.2%		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%	100%	100.0%			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%	99.8%	99.0%			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 March 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	Mar	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	Mar	9	6	8	13	8	10	10	4	4	0	4	4	2	3	4	3	6	6	1		year end cumulative
Number of Methicillin-Resistant Staphylococcus Aureus (MRSA) infections - post 48 hours	0	GCCG	M	Mar	0	0	1	1	0	0	2	0	0	0	0	0	0	0	1*	1	0	1	0		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	Mar	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%	1.4%		year end cumulative
SAFETY																									
Number of Never Events	0	GCCG	M	Mar	0	1	0	2	0	1	1	0	0	0	1	0	0	0	0	1	0	0	0		year end cumulative
% women seen by midwife by 12 weeks	90%	GCCG	M	Mar	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%	90.6%	88.8%	91.0%		year end cumulative
% stroke patients spending 90% of time on stroke ward	80%	GCCG	M	Feb	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%	91.0%			year end cumulative
% of eligible patients with VTE risk assessment	95%	GCCG	M	Mar	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%	94.1%	93.2%		year end cumulative
ED																									
% patients spending 4 hours or less in ED	≥ 95%	Monitor	M	Mar	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%	77.8%		current quarter end
Number of ambulance handovers delayed over 30 minutes	< previous year	GCCG	M	Mar	283	184	248	324	192	191	213	52	88	52	37	87	67	66	68	79	93	105	195		year end cumulative
Number of ambulance handovers delayed over 60 minutes	< previous year	GCCG	M	Mar	37	26	27	51	13	21	28	3	7	3	3	11	7	6	2	20	5	16	12		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 March 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	Mar	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%	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**	**91**	**90**	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%		90.0%	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		Report May	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		Report May	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		Report May	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		Report May	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%	84.80%	
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%	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%	100.0%	
Delerium	Q1 - Develop Assessment tool, Q2 Roll out to selected w ards Q3 Further w ards rollout, Q4 Further w ard 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	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	Mar	Year End Target
Planned Process for the Transition from Child to Adult Services	Q1 - Develop Policy, Q2 Implement Q3 & Q4 test and audit - 2 year plan	0.250%	Q	Q																	
Frailty	Q1 - Develop Assessment tool, Q2 Implement Q3 Audit & locally agree baseline improvement Q4 agreed target with sliding scale	0.187%	M	Q																	
Configuring Emergency Surgical Services	Q1-Q2 - baseline, Q3 &Q4 agreed target from baseline	0.187%	M	Q		G					Report and baselines			REPORT			TARGET TBC			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			TARGET TBC	Q4 TARGET
Cancer Survivourship	Q1-Q3 Implementation Q4 Outcome measure	0.500%	M	M							REPORT			REPORT			REPORT			TARGET TBC	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	Mar	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 - Softw are 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 softw are & interface methodology.																					
1d) Appropriate information flow s established, datasets and a schedule of regular reports are agreed with commissioners.																					
1e) Softw are 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) Softw are & 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 March 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	Mar	Year end position	Basis of year / quarter end assessment
18 WEEKS																									
Incomplete pathways - % waited under 18 weeks	≥ 92%	Monitor	M	Mar	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%	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	Mar	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%	2.7%	7.1%		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	Mar	60	138	2	79	400	206	142	219	353	400	455	505	206	83	79	142	190	184	225		year end snapshot
CANCER																									
Max 2 week wait for patients urgently referred by GP	≥ 93%	Monitor	M	Feb	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%	93.2%			current quarter end
Max 2 week wait for patients referred with non cancer breast symptoms	≥ 93%	Monitor	M	Feb	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%	95.2%			current quarter end
Max wait 31 days decision to treat to treatment	≥ 96%	Monitor	M	Feb	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%	100%			current quarter end
Max wait 31 days decision to treat to subsequent treatment : surgery	≥ 94%	Monitor	M	Feb	99.0%	100%	100%	98.8%	100%	100%	99.5%	100%	100%	100%	100%	100%	100%	98.8%	100%	100%	94.1%	100%			current quarter end
Max wait 31 days decision to treat to subsequent treatment : drugs	≥ 98%	Monitor	M	Feb	100%	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	Feb	100%	98.6%	99.8%	100%	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	Feb	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%	75.2%			current quarter end
Max wait 62 days from national screening programme to 1st treatment ***	≥ 90%	Monitor	M	Feb	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%	100.0%			current quarter end
Max wait 62 days from consultant upgrade to 1st treatment	≥ 90%	GCCG	M	Feb	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	Mar	9	5	14	13	11	13	19	8	8	11	11	16	13	8	26	19	16	16	10		year end snapshot
No. of medically fit patients - over/day	≤ 40	Trust	M	Mar	55	60	57	66	40	56	51	67	55	52	64	51	56	40	54	51	54	63	51		Total days
Bed days occupied by medically fit patients		Trust	M	Mar	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	1526	17,582	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%	88.1%			current quarter end
Number of Breaches of Mixed sex accommodation	0	GCCG	M	Mar	0	0	0	0	0	0	17	0	0	0	0	0	0	9	0	8	11	0	19		year end snapshot
CANCELLATIONS																									
Elective Patients cancelled on day of surgery for a non medical reason	≤ 0.8%	Trust	M	Mar	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%	1.6%		year end cumulative
Patients cancelled and not rebooked in 28 days	0	GCCG	M	Mar	9	9	19	41	17	18	15	6	6	5	2	8	8	8	4	3	1	11	15		year end cumulative

NO LONGER A NATIONAL TARGET - UNVALIDATED INFORMATION

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	Mar	Year end position	Basis of year / quarter end assessment
18 WEEKS																									
Admitted pathways - % treated in 18 weeks *	≥ 90%	Trust	M	Mar	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%	83.2%	77.6%		current quarter end
Non-admitted pathways - % treated in 18 weeks *	≥ 95%	Trust	M	Mar	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%	90.2%	91.2%		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 March 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	Mar	Year end position	Basis of year / quarter end assessment
Total PayBill spend £'000	target + 0.5%	Trust	M	Mar	£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	£23,800	£24,900		year end cumulative
Total worked FTE	target + 0.5%	Trust	M	Mar	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	6,657.0	6,677.0		year end cumulative
Annual sickness absence rate *	<3.5	Trust	M in arrears	Feb	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%	3.78%	3.77%			year end cumulative
Staff who have annual appraisal	90%	Trust	M	Mat	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%	83.0%	83.0%		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	Mar	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%*	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##	3.71%##	3.71%##		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%##	34%##		annual
Turnover rate (FTE)	7.5 -9.5%	Trust	M in arrears	Feb	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%	11.63%	11.71%			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 March 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%	Feb-16	6.3%	R

What is driving the reported overperformance

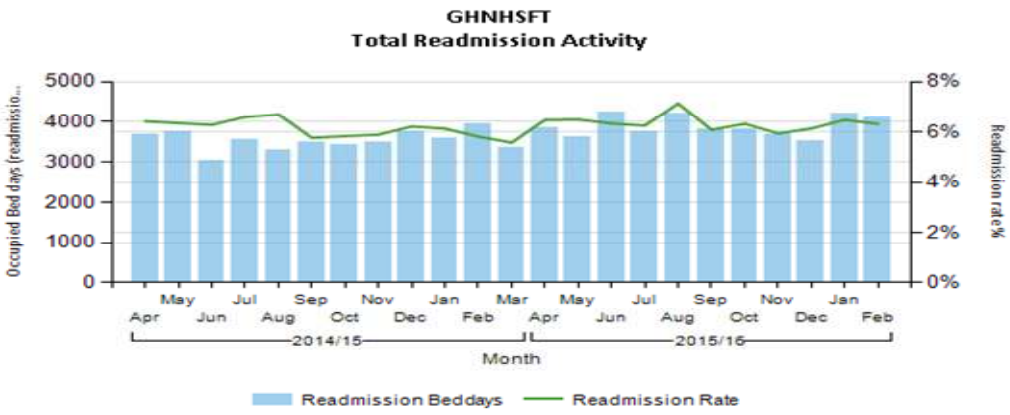
The emergency re-admission rate has been relatively constant this financial year.

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

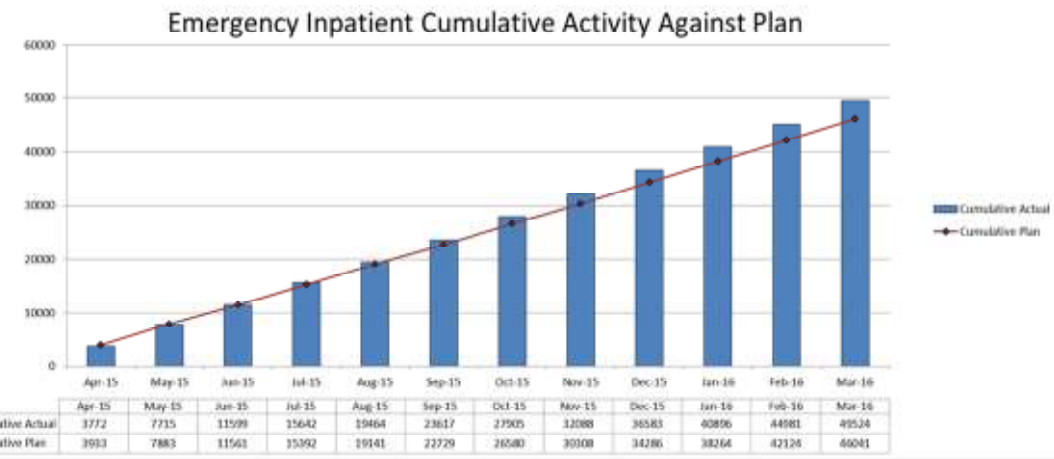
Emergency spells have increased in the winter months.

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



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	Mar-16	3.7	R

What is driving the reported over performance

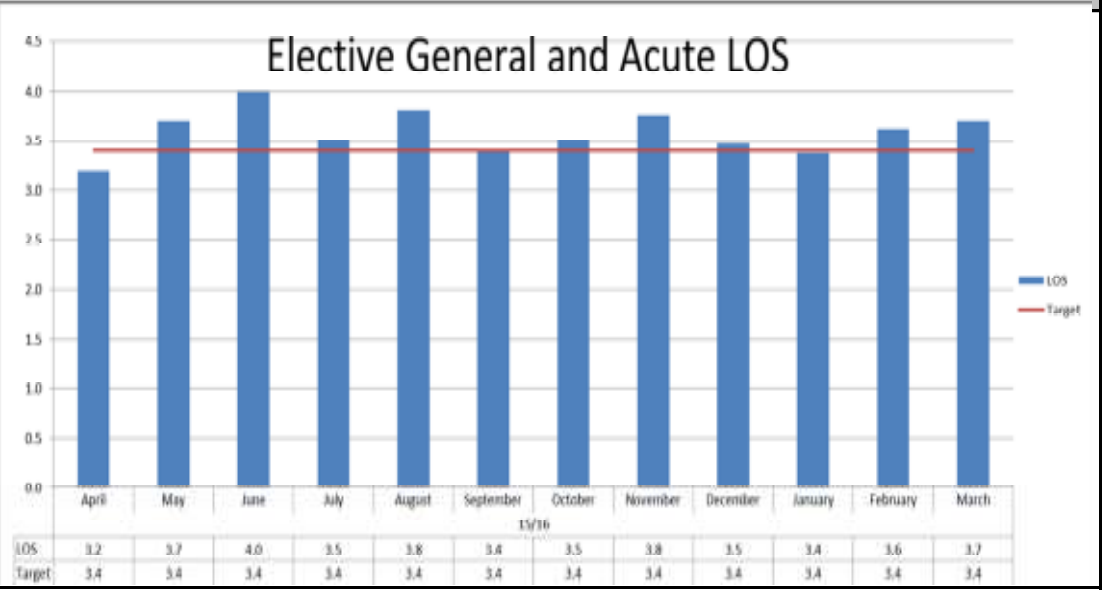
Elective length of stay has fluctuated close to the Trust's target in 2015-16

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



% 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%	Mar-16	93.2%	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.

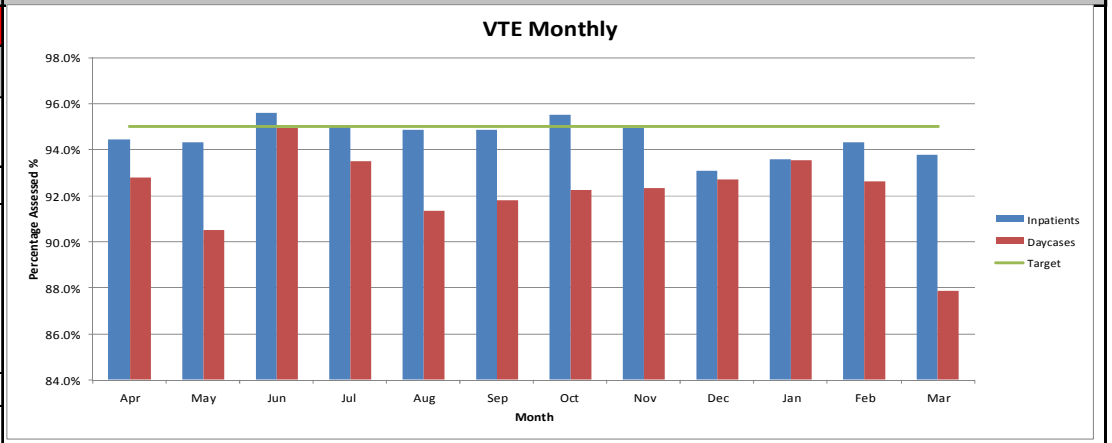
Actions taken to improve performance

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%	Mar-16	77.8%	R

What is driving the reported underperformance

Please refer to Emergency Pathway Report

Actions taken to improve performance

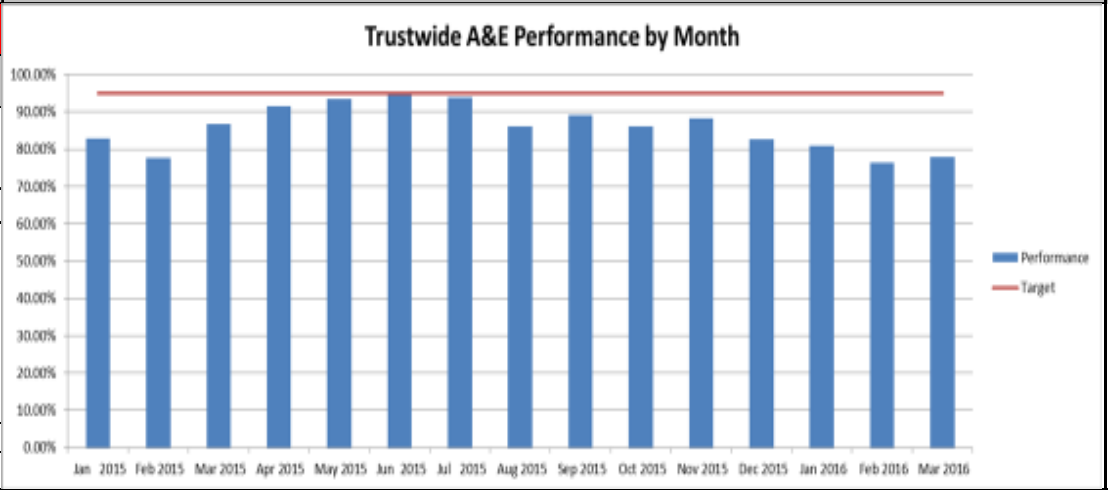
Recovery plan in with Monitor support focusing on: internal flow ; ED Department ; Admission avoidance.

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



AMBULANCE HANDOVERS DELAYED OVER 30 MINUTES

GCCG Standard
Financial Penalty

Number of ambulance handovers to ED over 30 minutes

Standard	Month	Actual	RAG for current month
< previous year	Mar-16	195	R

What is driving the reported underperformance

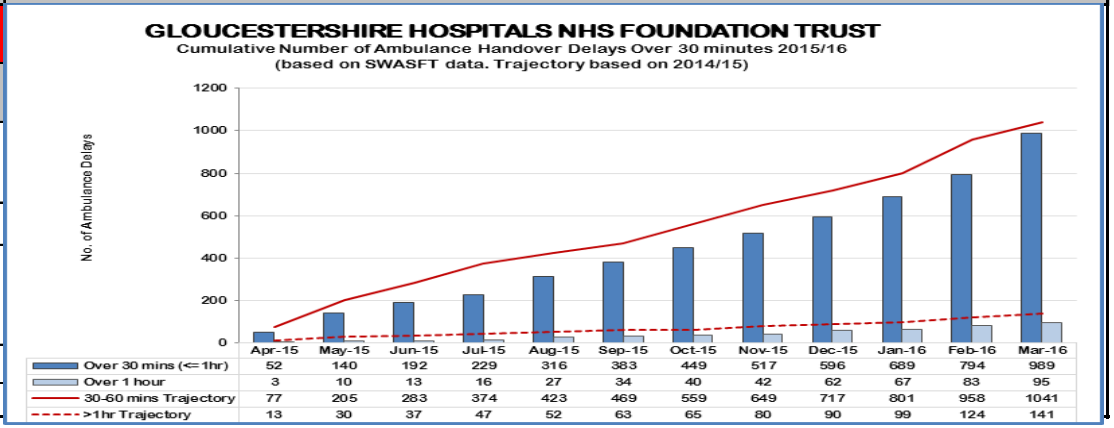
Please refer to Emergency Pathway Report

Actions taken to improve performance

Please refer to Emergency Pathway Report

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

Activity



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Over 30 mins (<=1hr)	52	140	192	229	316	383	449	517	596	689	794	989
Over 1 hour	3	10	13	16	27	34	40	42	62	67	83	95
30-60 mins Trajectory	77	205	283	374	423	469	559	649	717	801	958	1041
>1hr Trajectory	13	30	37	47	52	63	65	80	90	99	124	141

AMBULANCE HANDOVERS DELAYED OVER 60 MINUTES

GCCG Standard
Financial Penalty

Number of ambulance handovers to ED over 60 minutes

Standard	Month	Actual	RAG for current month
< previous year	Mar-16	12	R

What is driving the reported underperformance

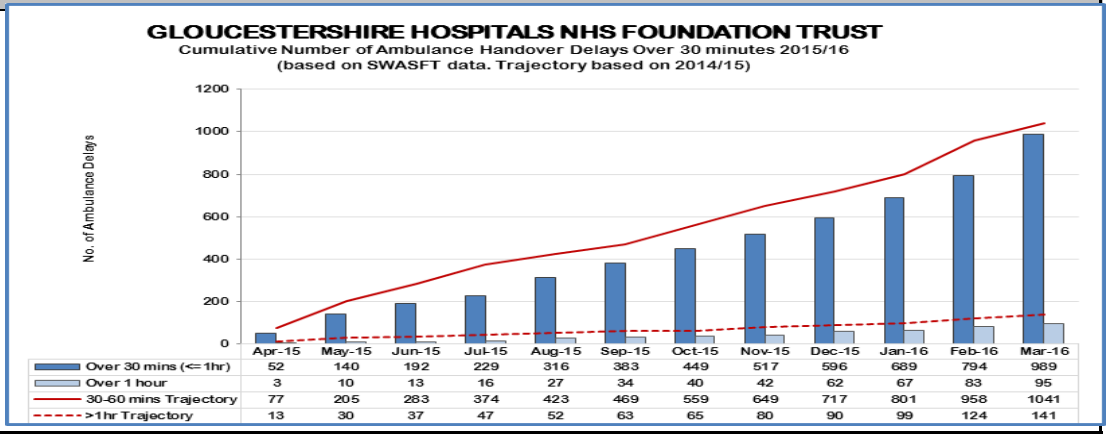
Please refer to Emergency Pathway Report

Actions taken to improve performance

Please refer to Emergency Pathway Report

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

Activity



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Over 30 mins (<=1hr)	52	140	192	229	316	383	449	517	596	689	794	989
Over 1 hour	3	10	13	16	27	34	40	42	62	67	83	95
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

DIAGNOSTIC WAITS OVER 6 WEEKS

GCCG Standard Financial Penalty

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

Standard	Month	Actual	RAG for current month
<1% of nos waiting at month end	Mar-16	7.2%	R

What is driving the reported underperformance

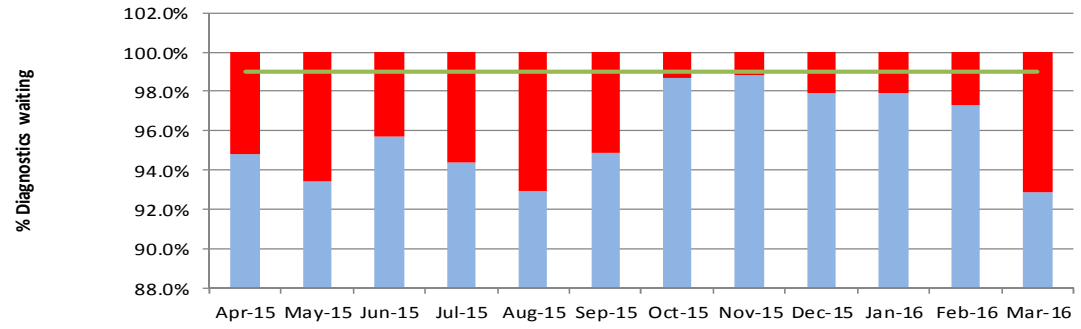
455 patients of which Neurophysiology 83, Urodynamics 29, Echos 32, MRI 134, Audiology 154, other imaging 13, Cystoscopy 9, respiratory physiology 1.

Actions taken to improve performance

Recovery plans in place with Divisions. Discussions with Commissioners to limit demand pressures.

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

Activity



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
% Breaches	5.2%	6.6%	4.3%	5.6%	7.1%	5.1%	1.3%	1.2%	2.1%	2.1%	2.7%	7.2%
% Non Breaches	94.8%	93.4%	95.7%	94.4%	92.9%	94.9%	98.7%	98.8%	97.9%	97.9%	97.3%	92.8%
Target	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%

PLANNED SURVEILLANCE ENDOSCOPY PATIENTS

GCCG Standard Financial Penalty

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

Standard	Month	Actual	RAG for current month
<1% of nos waiting at month end	Mar-16	225	R

What is driving the reported underperformance

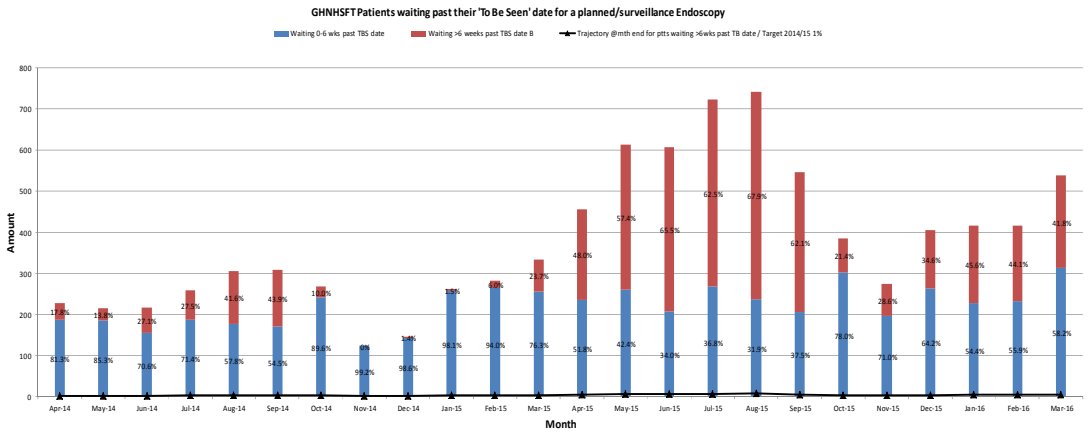
Demand has increased, particularly for 2ww Endoscopy, which has impacted on capacity available.

Actions taken to improve performance

Additional activity is being undertaken.

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

Activity



OUR PATIENTS

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%	Feb-16	75.2%	R

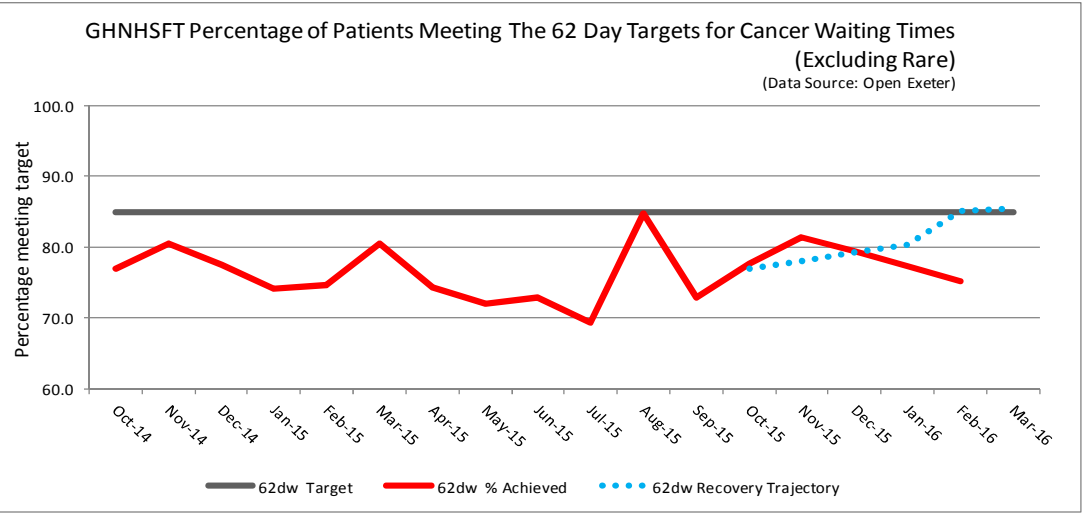
What is driving the reported underperformance

Actions taken to improve performance

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

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

Activity



MEDICALLY FIT PATIENTS

Trust Standard

Average per day in month

Standard	Month	Actual	RAG for current month
≤ 40	Mar-16	51	R

What is driving the reported underperformance

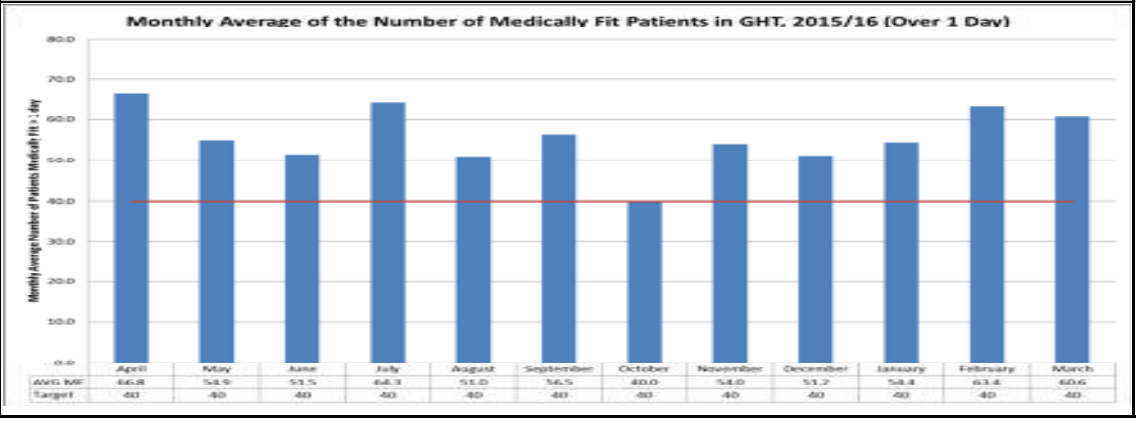
Please refer to Emergency Care Report

Actions taken to improve performance

Please refer to Emergency Care Report

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

Activity



OUR PATIENTS

BREACHES OF MIXED SEX ACCOMMODATION

GCCG Standard
Financial Penalty

Numbers of patients breaching same sex accommodation

Standard	Month	Actual	RAG for current month
0	Mar-16	19	R

What is driving the reported underperformance

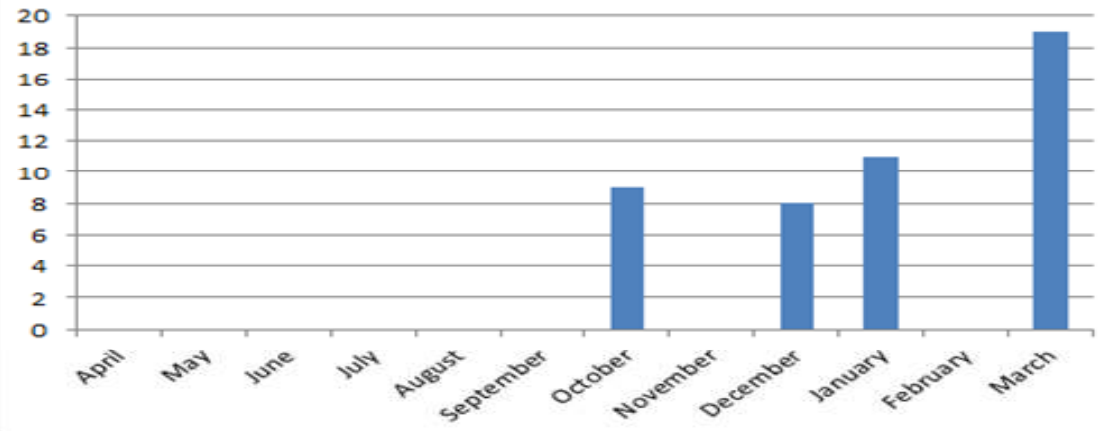
All breaches occurred in the Acute Care Units except 1, this is an ongoing trend and may be related to the actions taken to improve the Emergency Department performance

Actions taken to improve performance

Review of patient flow in the Acute Care Unit

Expected date to meet standard	Feb-16
Lead Director	Maggie Arnold

Activity



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%	Mar-16	1.6%	R

What is driving the reported underperformance

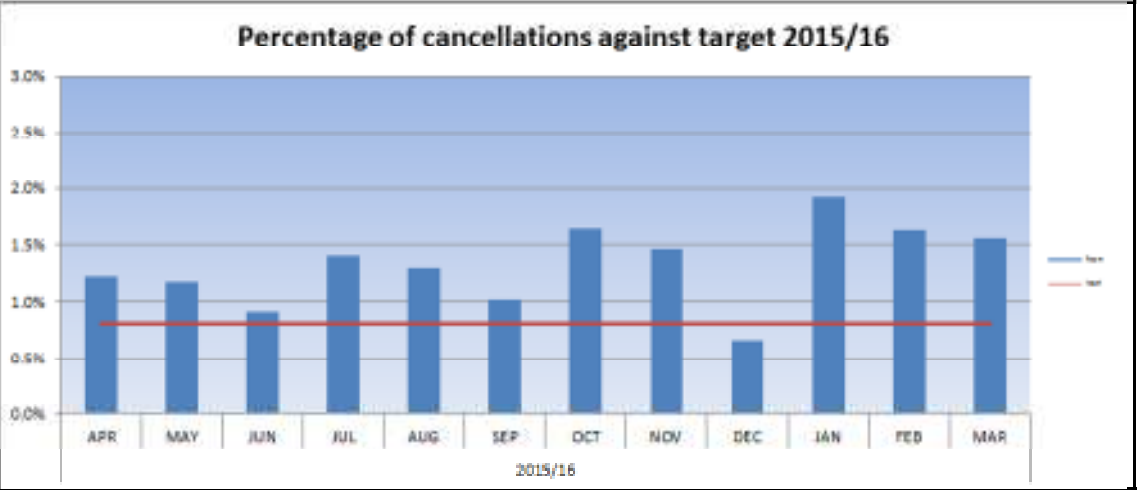
The increase in the numnber of medically fit patients and level of emergency admissions inpacted on this measure.

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	Mar-16	15	R

What is driving the reported underperformance

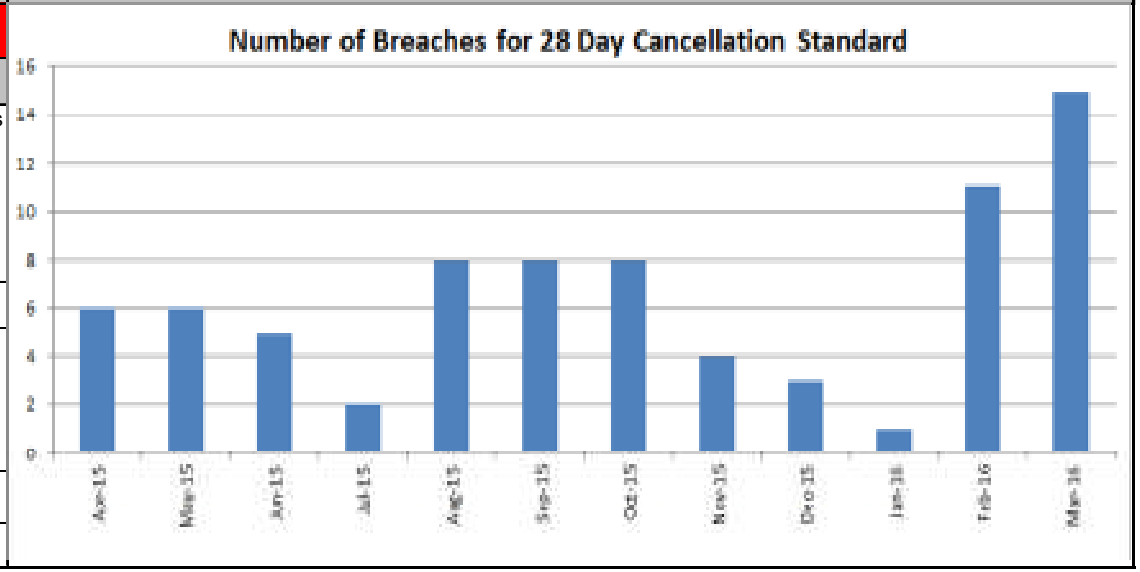
The increase in the numnber of medically fit patients and level of emergency admissions inpacted on our ability to rebook patients in 28 days.

Actions taken to improve performance

Focus by Surgical Division.

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

Activity



TOTAL PAYBILL

Trust Standard

Total Paybill spend £'000

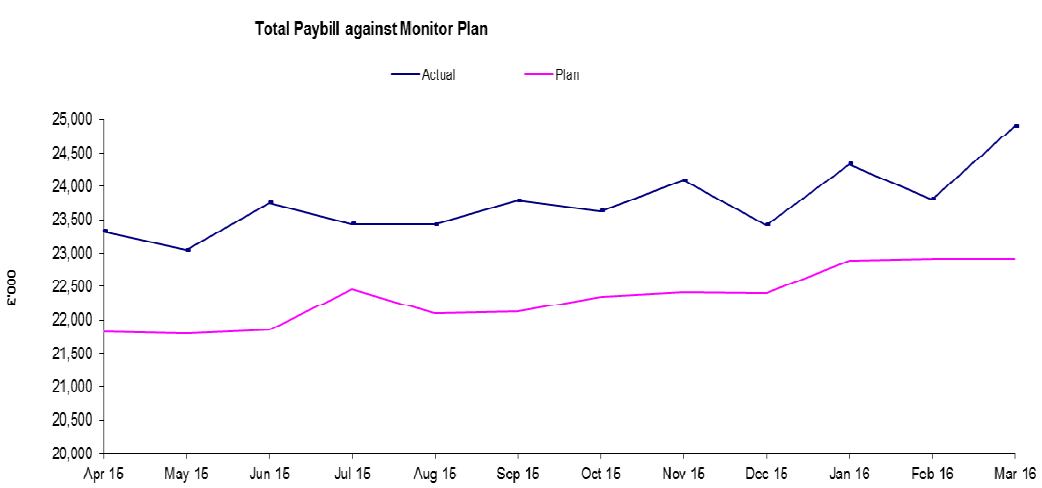
Standard	Month	Actual	RAG for current month
target + 0.5%	**Mar-16**	**£24,900**	**R**

What is driving the reported underperformance

Actions taken to improve performance

Expected date to meet standard	2016-17
Lead Director	Director of HR and OD

Activity



TOTAL WORKED

Trust Standard

Total worked fte

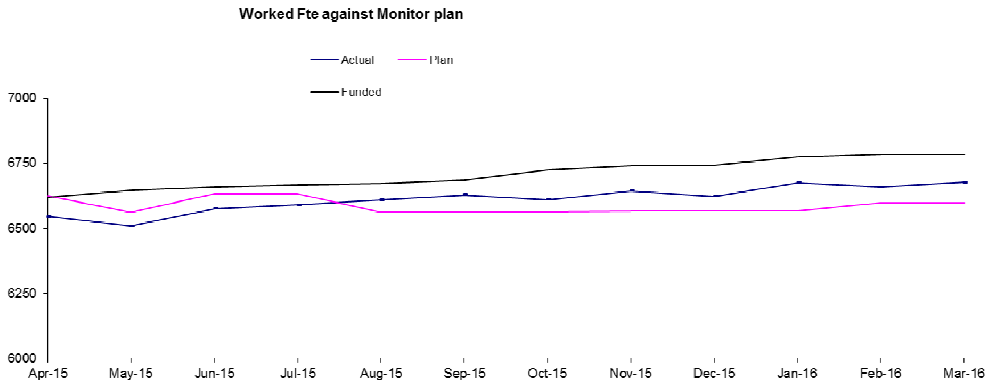
Standard	Month	Actual	RAG for current month
On Target	**Mar-16**	**6677**	**R**

What is driving the reported underperformance

Actions taken to improve performance

Expected date to meet standard	2016-17
Lead Director	Director of HR and OD

Activity



TURNOVER RATE (FTE)

Trust Standard

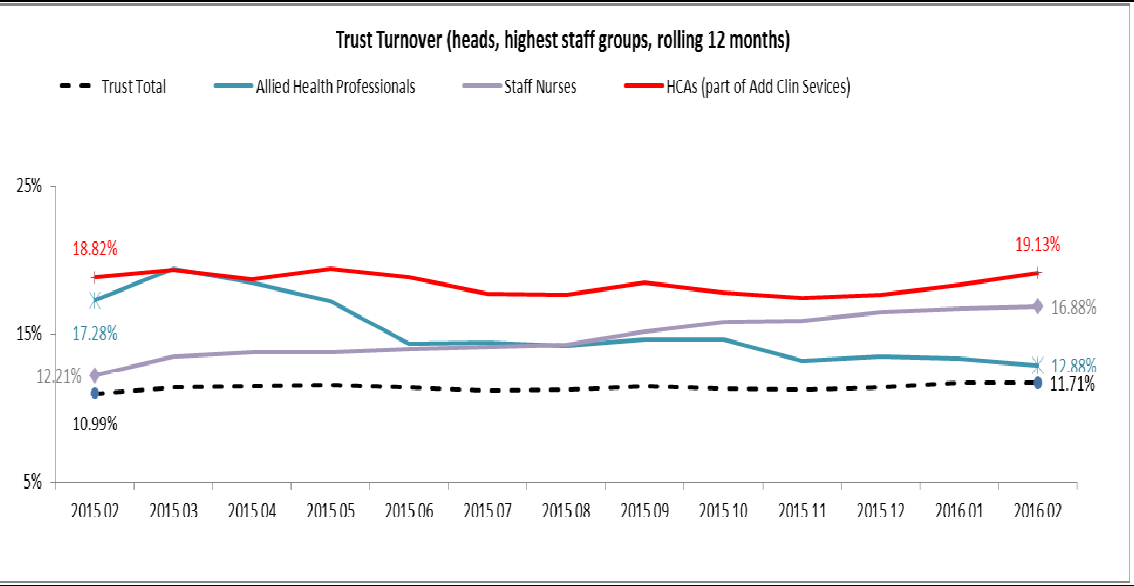
Standard	Month	Actual	RAG for current month
9.50%	Feb-16	11.70%	R

What is driving the reported underperformance

Actions taken to improve performance

Expected date to meet standard	2016-17
Lead Director	Director of HR and OD

Activity



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

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

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

REPORT OF THE FINANCE DIRECTOR

FINANCIAL PERFORMANCE FOR THE PERIOD TO 31ST MARCH 2016

1. Executive Summary

Due to the timing of the production of the Trust Annual Accounts, the financial performance report has been shortened. The position presented is consistent with the draft accounts which are subject to audit.

The table below summarises the performance for the year to 31 March 2016 against key elements of the Trust's plan and financial duties.

	Month 12 YTD actual	Month 12 YTD plan	Variance	Full Year Plan
Delivering planned surplus	£0.9m	£4.0m	(£3.1m)	£4.0m
Monitor Financial Sustainability Risk Rating (provisional)	3	3	(0)	3
Better Payment Practice Code - provisional	67%	95%	(28%)	95%

Key Issues:

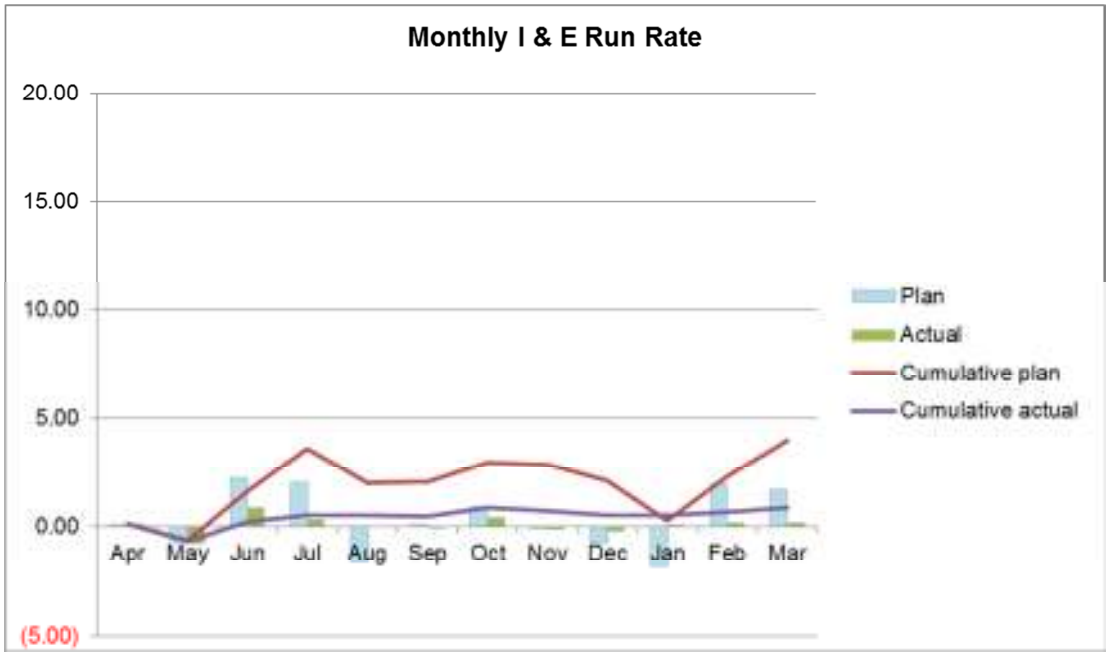
- The financial position of the Trust at the end of the 2015/16 financial year is an operating surplus of income over expenditure of £0.9m.
- This represents a negative variance of £3.1m from the original planned position of a £4.0m surplus of income over expenditure at the end of the financial year.
- Temporary staffing expenditure in Month 12 was £0.2m higher than previous month. This includes expenditure on bank staff.
- The impact of the emergency cap cumulative to Month 12 was £1.7m.

2. Financial Position to 31st March 2016

The position at the end of the 2015/16 financial year is a surplus of £0.9m on income and expenditure, which represents an adverse variance of £3.1m 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	414,441	423,144	8,703
PP, Overseas and RTA Income	5,557	5,557	5,607	50
Operating Income	62,785	62,785	64,898	2,113
Total Income	**482,783**	482,783	**493,649**	**10,866**
Pay	294,713	294,713	310,474	(15,761)
Non-Pay	160,180	160,180	161,497	(1,317)
Total Expenditure	**454,893**	**454,893**	**471,971**	**(17,078)**
EBITDA	**27,890**	**27,891**	**21,678**	**(6,212)**
EBITDA %age	**5.8%**	**5.8%**	**4.4%**	**-1.4%**
Depreciation	12,391	12,391	9,847	2,544
Public Dividend Capital Payable	7,028	7,028	7,447	(419)
Interest Receivable / Payable	4,491	4,491	3,507	984
Funds Available for Investment	**3,980**	**3,981**	**878**	**(3,103)**

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



The income and expenditure position at the end of March has improved by £0.2m in the month to £0.9m surplus. Although this is a small improvement on February's position, this is still below the original plan set at the start of the financial year.

Income from contracts is £8.7m above plan, however the increased use of agency staff is having a negative impact on the Trusts savings plans and the overall pay expenditure. As the Board is aware there is a national supply issue for trained nursing and medical staff in hard to recruit specialties. The Trust continues to work hard to mitigate this risk without impacting on the quality of care provided. This is an ongoing risk that needs to be managed in the new financial year.

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

3. Final Accounts 2015/16

As part of the normal asset valuation requirements, the Trust has undertaken a desktop revaluation of its asset base as at 31st March 2016. This has resulted in a net impairment reversal of £3.8m which has the effect of moving the reported operational surplus of £0.9m to £4.7m. This represents a technical adjustment in the accounts that NHS Improvement disregards when assessing a Foundation Trusts Performance.

4. Income

Total income for the 2015/16 financial year was £10.9m above the planned level. This includes an over performance of income from contracts of £8.7m. This reflects the significant increase in demand for services in excess of original plans set by commissioners at the start of the financial year.

The table below shows the commissioner income position to the end of Month 12 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	12,264	11,365	(899)	39,769	38,576	(1,194)
Daycase Spells	47,211	52,345	5,134	36,217	39,093	2,876
Non-elective Spells	1,428	1,350	(78)	2,510	2,181	(329)
Emergency Spells	46,043	49,480	3,437	85,767	91,149	5,382
Outpatient Attendances	457,021	451,393	(5,628)	50,934	51,515	581
Outpatient Procedures	120,865	127,524	6,659	17,853	18,137	284
A&E Attendances	126,309	127,201	892	15,108	15,536	428
Radiology Direct Access	40,746	37,580	(3,166)	2,798	2,333	(464)
Radiology Unbundled	15,178	19,307	4,129	1,704	2,017	313
Renal Dialysis	48,340	59,921	11,581	5,933	6,849	916
Excluded Drugs				43,526	47,445	3,918
Other Non-PbR				112,322	108,314	(4,009)
Grand Total				414,441	423,144	8,702

Key issues to note include:

- **Referrals**
  Referrals are 3.9% higher than the 12 months of 2014/15. Within this GP referrals are 4.2% ahead 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 7.2% above plan on activity and 3.8% above plan on income. When separated out, elective activity is 7.3% below plan on activity and 3.0% below plan on income whilst daycase activity is 7.6% above plan with income 5.0% above plan on the same comparative basis as last month.

- **Emergency Activity**
  The Emergency spells position is 7.5% above plan in activity terms, and income is above plan by 6.3%.

  The impact on income of the Emergency Cap at month 12 was £1.7m, which is £500k in excess of the planned level of £1.2m 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 2.8% 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 0.2% and 1.3% respectively.

- **Radiology Direct Access**
  Radiology Direct Access activity and income are below plan by 7.8% and 16.6% respectively.

- **Unbundled Radiology**
  Activity and income levels are above plan by 27% and 18% respectively.

- **Excluded Drugs**
  Excluded drugs ended the year at 9% ahead of plan.

5. Expenditure

Expenditure against plan for the 2015/16 financial year represents an overspending of £17.1m against approved budgets.

Pay Expenditure

At Trust level for the year ending March 2016 pay expenditure was above plan by £15.8m.

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

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

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	49,424	51,371	(1,947)	-3.94%
Junior Medical	28,229	28,219	31,928	(3,709)	-13.14%
Nursing	100,067	100,067	106,110	(6,043)	-6.04%
Admin & Clerical and Management	32,383	32,392	34,639	(2,245)	-6.93%
Clinical Support Services	42,631	42,631	43,803	(1,172)	-2.75%
Other Non Clinical	9,518	9,518	9,831	(313)	-3.29%
Other staff (includes CIP target)	866	866	583	282	32.53%
Divisional Pay sub total	**263,118**	**263,118**	**278,265**	**(15,147)**	-5.76%
Hosted Services Pay	25,974	25,974	26,543	(569)	-2.19%
Shared Services and Other Pay	5,620	5,620	5,666	(46)	-0.82%
Total	**294,713**	**294,713**	**310,474**	**(15,761)**	-5.35%

Key issues to note for the month include:

- Total Pay expenditure for March was £26.0m, which is £0.1m lower than February.
- Total temporary staffing expenditure during the month was £3.0m, which was £0.2m higher than previous month and £1.1m above the monthly average for 2014/15.
- The level of Pay overspend against plan (5.3%) is not in line with the total income over-recovery of 2.2%.
- Cumulative Divisional pay overspends were most significant within Medicine/USC (£9.5m overspent, an increase of £0.9m in the month) and Surgery (£7.2m overspent) which relates to both Nursing and Medical staff.
- Whilst Nursing is still showing the highest financial variance against plan at £6.0m (6.04%), the largest variance in terms of percentage from plan is Junior Medical staffing at 13.14% (£3.7m).
- 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 work additional sessions to cover these gaps.
- Unachieved pay savings are in part linked to the use of agency staff to cover hard to fill middle grade 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 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 March expenditure at £0.2m higher than February's expenditure, which in turn was £0.4m higher than January.

Temporary Staffing Expenditure – Analysis by Staff Group	Expenditure to date £000's
Medical Agency & Locum	9,439
Nursing Agency	7,171
Nursing Bank	6,627
Other Clinical staff	1,289
Non Clinical staff	4,463
Total	**28,989**

NHS Improvement 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

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

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	51,851	53,901	(2,050)	-3.95%
Medical and Surgical Equipment (MSE)	40,527	40,527	40,936	(409)	-1.01%
Contract Services and Service received	20,126	20,126	21,967	(1,841)	-9.15%
Energy / Utilities	5,602	5,602	5,633	(31)	-0.55%
Building and other Estate expenses	5,916	5,916	5,608	308	5.2%
Establishment expenses	11,618	11,618	11,290	328	2.82%
Other Non-Pay (includes CIP target)	23,032	23,032	23,222	(190)	-0.82%
Total Divisional Non Pay	158,671	158,671	162,556	(3,885)	-2.45%
Hosted Services Non Pay	344	344	496	(153)	-44.43%
Shared Services & Other Non Pay	1,165	1,165	(1,556)	2,721	233.52%
Total	160,180	160,180	161,497	(1,317)	-0.82%

Key issues to note for the month include

- Overall Non-pay expenditure overspent in comparison to plan by £0.7m (excluding the effect of impairments).
- Drug expenditure overspent in comparison with plan in month 12 by £1.4m with a year to date position showing a £2.0m overspending.
- Medical & Surgical Equipment expenditure in month 12 overspent in comparison to plan by £1.0m and stands at £0.4m above plan for the year to date.

6. Savings Plans

Due to the completion of the annual accounts, a verbal update will be given on the year-end position.

7. Statement of Financial Position 2015/16

Due to the preparation and completion of the annual accounts, a verbal update will be provided on this section.

8. Recommendation

The Board are asked to note:

- The financial position of the Trust at the end of the financial year 2015/16 is an operational surplus of £0.9m on income and expenditure. This is £0.2m higher than the position reported at Month 11.
- The Trust needs to improve its controls on the use of agency staff and discretionary expenditure during the new financial year.
- 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: **April 2016**

Appendices

A Divisional budget positions
B Healthcare Contract Income by Commissioner

DIVISIONAL POSITION AS AT THE END OF MONTH 12 - MARCH 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	414,441	423,144	8,703	4,110	2,232	2,807	1,987	3,099	0	(5,532)
Operating income	68,342	70,505	2,163	(2,068)	(3,385)	183	(376)	817	(871)	7,864
Pay expenditure	294,713	310,474	(15,761)	(9,480)	(7,170)	(1,027)	(947)	(622)	(833)	4,316
Non pay expenditure	160,180	161,497	(1,317)	(3,336)	(470)	(1,494)	(506)	(520)	2,362	2,647
Non Operating Costs	23,910	20,801	3,109	0	0	0	0	0	0	3,109
Total	**3,981**	**878**	**(3,103)**	**(10,774)**	**(8,794)**	**470**	**158**	**2,775**	**658**	**12,404**
Last Month Variance	**2,279**	**671**	**(1,608)**	**(9,919)**	**(7,346)**	**(394)**	**39**	**2,879**	**(21)**	**13,155**
Movement	**1,702**	**206**	**(1,495)**	**(855)**	**(1,448)**	**864**	**119**	**(105)**	**679**	**(750)**

HEALTHCARE CONTRACT INCOME POSITION AS AT MONTH 12

2015/16 Healthcare contracts position as at Month 12	2015/16 Full year plan £000	Month 12 Plan £000	Month 12 Actuals £000	Variance £000
NHS Gloucestershire CCG	292,592	292,592	301,922	9,330
Worcestershire Health Community	10,828	10,828	10,815	(13)
NHS Hereford CCG	3,748	3,748	4,180	432
Wiltshire Health Community	2,979	2,979	2,670	(309)
NHS South Warwickshire CCG	250	250	210	(41)
Oxfordshire CCG	386	386	494	108
Specialist Commissioning Group	74,180	74,180	78,111	3,931
Welsh Commissioners	3,435	3,435	4,110	675
Other Commissioner Income	22,026	22,026	16,705	(5,322)
Non Contractual Agreements (NCAs)	4,017	4,017	3,928	(89)
NHS CLINICAL REVENUE	**414,441**	**414,441**	**423,144**	**8,703**

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

1. Executive Summary

Key Messages

- The 95% 4 hour target for Emergency Department performance was not successfully met in March 2016, with Trustwide performance reported as 77.77%. Neither site achieved the 95% standard in March.

- The daily average number of Emergency Department attendances in March 2016 was 371 patients (11,510 for the month), compared to March 2015 (335 per day) and February 2016 (366 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 March 2016 was 123 patients (3,827 for the month), compared to March 2015 (109 per day) and February 2016 (119 per day).

- The target of 5.8 days for General and Acute average length of stay for non-elective admissions was met in March 2016.

- The number of patients on the medically fit list for one day and over has been at an average of 61 throughout March 2016. This is 2 patients less than the previous month, but remains above the system-wide plan of no more than 40 patients.

Key Risks

- Demand exceeding both the contractual plan and historical levels.

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

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

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

- **Report Purpose**

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

- **Emergency Pathway Metrics**

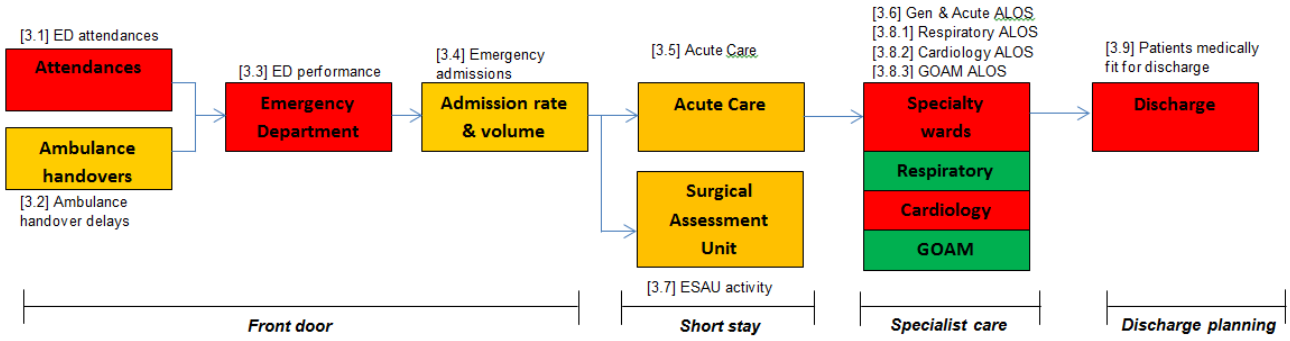
  The diagram below shows the key processes within the emergency pathway.

  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 Improvement Director commenced in March 2016. They have worked with the Executive to identify three priority workstreams for immediate improvements, they are:

1. Emergency Department – with specific focus on the safety metrics for Time to Initial Assessment within 15 minutes and Time to Treatment within 60 minutes.
2. Site Management – to increase the presence of senior co-ordination of both hospitals 24/7, to ensure patients are in the right place, first time.
3. >=14 Day Length of Stay patients – to reduce the number of these patients who currently occupy 65% of total bed days across the Trust.

3.1 Emergency Department Attendances

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

How: Work with:-

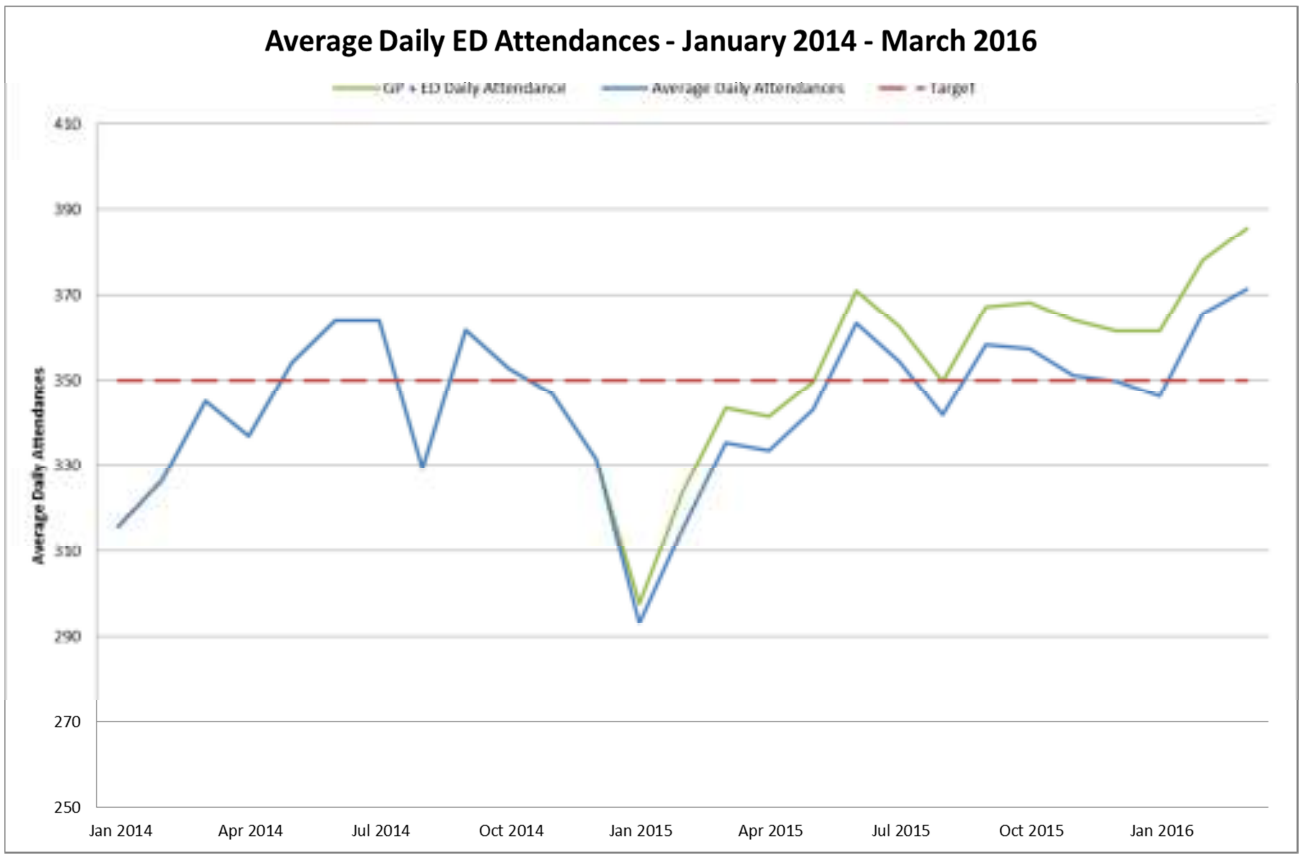
- South Western Ambulance Service NHS Foundation Trust (SWAST) to 'Smooth' emergency demand in the system;
- Integrated Discharge Team (IDT) within Emergency Department to increase direct admissions to community hospitals from Emergency Department;
- Develop the Older Person's Assessment and Liaison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

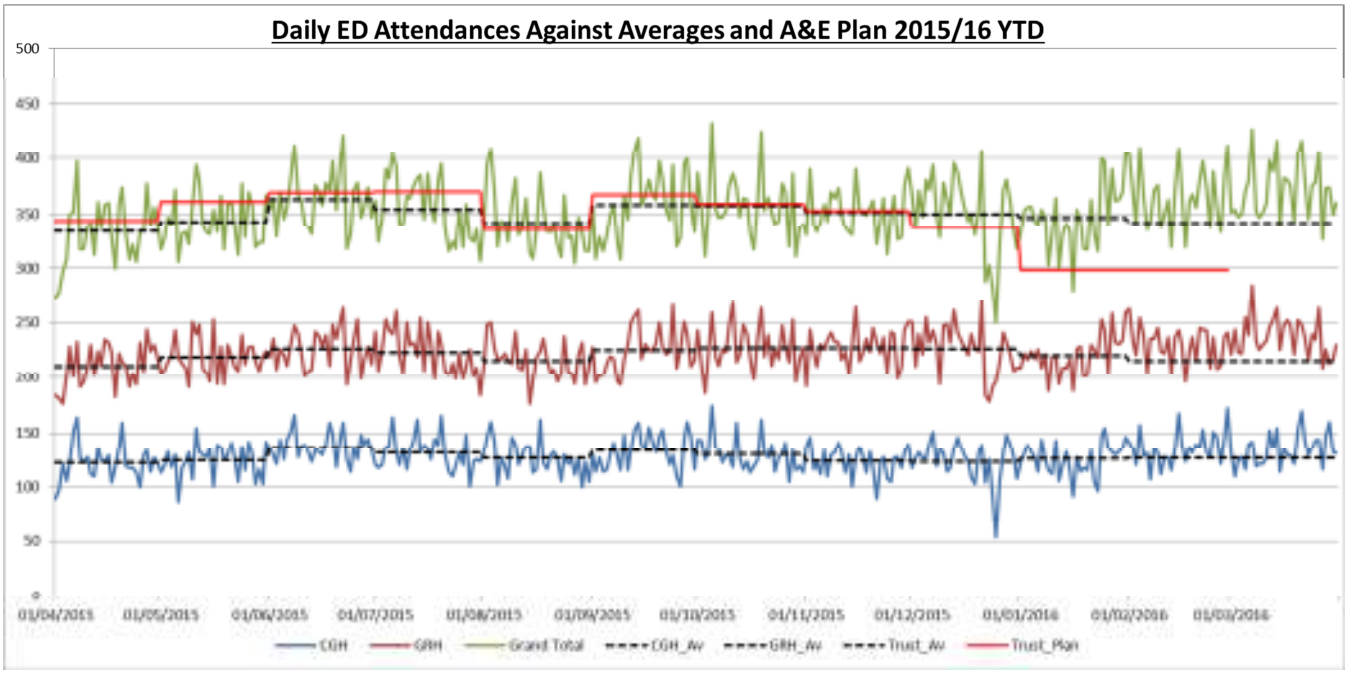
Narrative: There were 11,510 attendances in March 2016 (average of 371 per day) which is 5 higher than February 2016 and 21 above the plan of 350 per day.

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
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%
March 2016	11510	2559	77.77%	443	78.59%

Actions to be taken

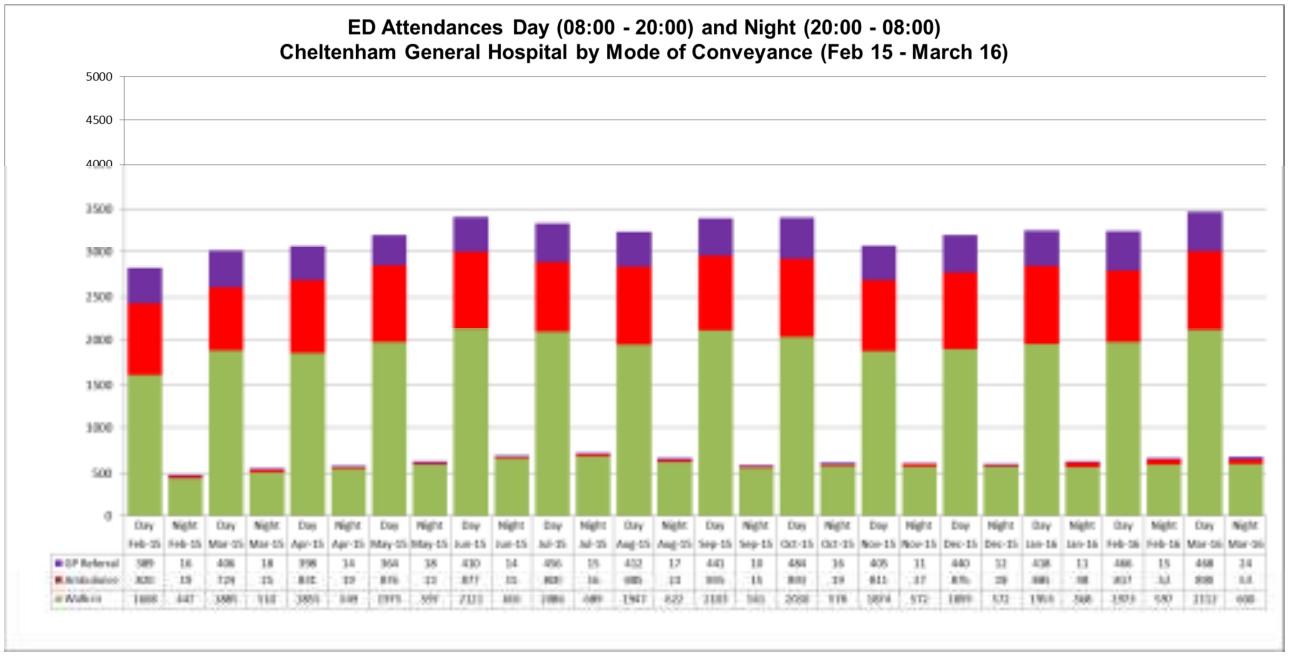
- Continue with Primary Care in Emergency Department pilot (now extended to July 2016) and managed by South West Ambulance Trust. The service is provided from a dedicated room near to Gloucestershire Royal Emergency Department reception (since September 2015). This has freed up the cubicle in the minors area;

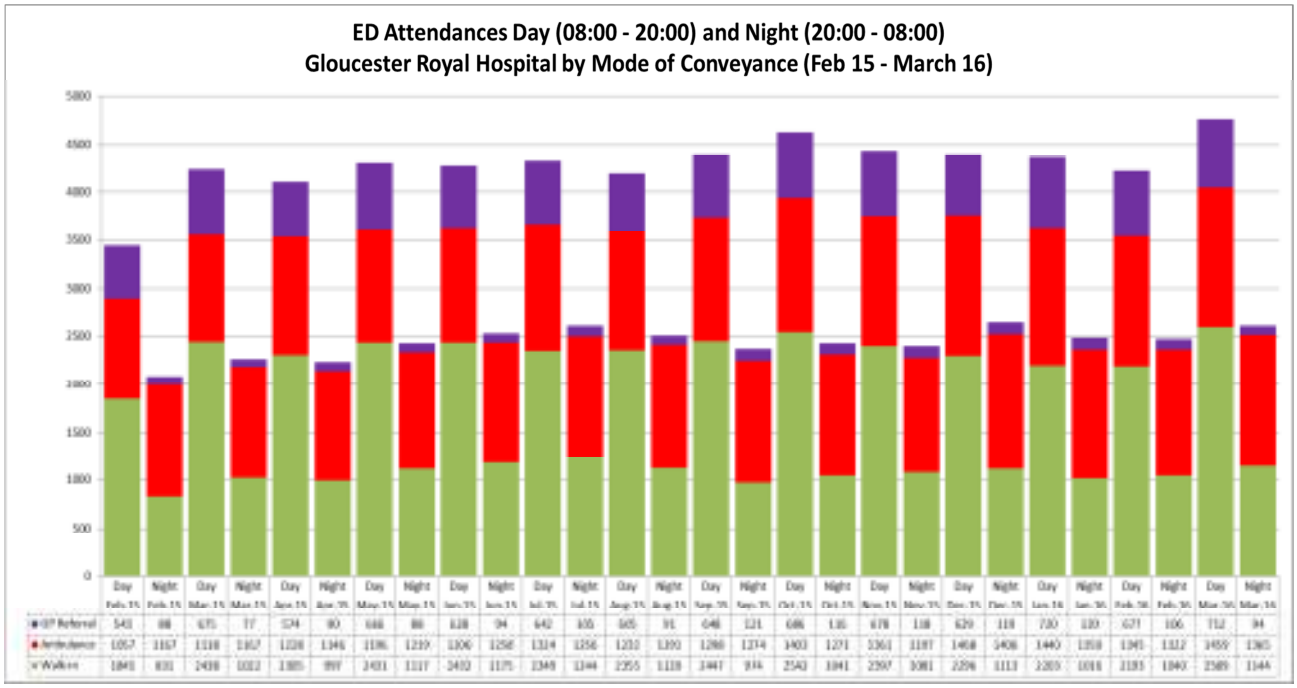
- Streamlining Urgent Care Programme: the 'Streaming' function and pathways have been revised, and a pilot that tested the role of a Clinical Navigator took place over two days w/c 12th October. This proved successful and Gloucestershire Clinical Commissioning Group has agreed to fund the post until the end of July 2016. 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.

Emergency Department Attendances by Mode of Conveyance Charts





Narrative: In March 2016 there were 3,767 ambulance arrivals across both sites (average 122 per day). This is an increase of 24% on the same period last year, when there were 3,034 ambulance arrivals (average 98 per day). However, it is in line with the daily average in February 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.

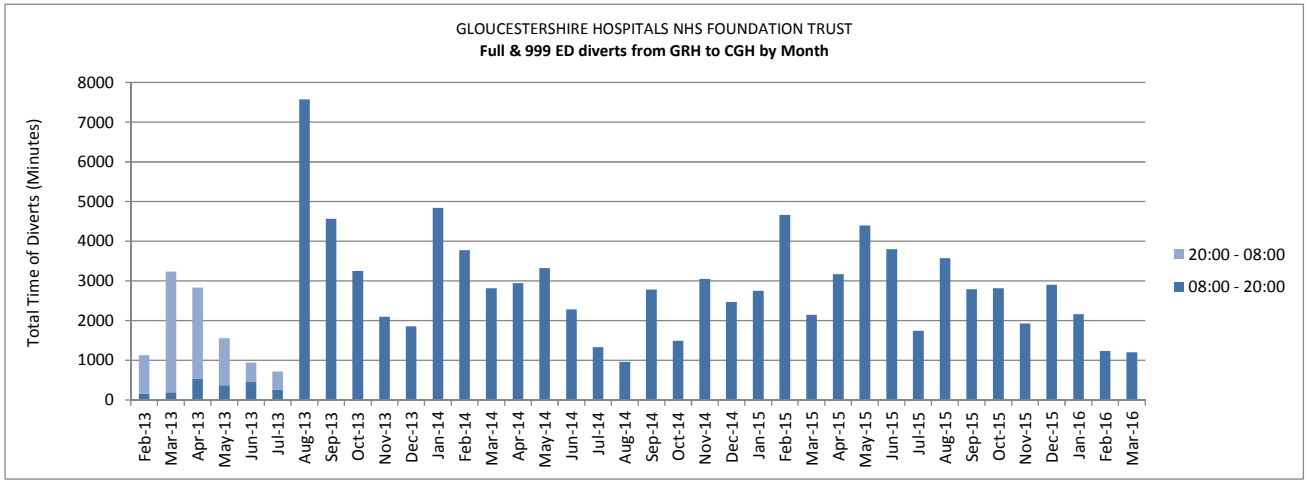
Diverts Between Gloucestershire Royal Hospital & Cheltenham General Hospital

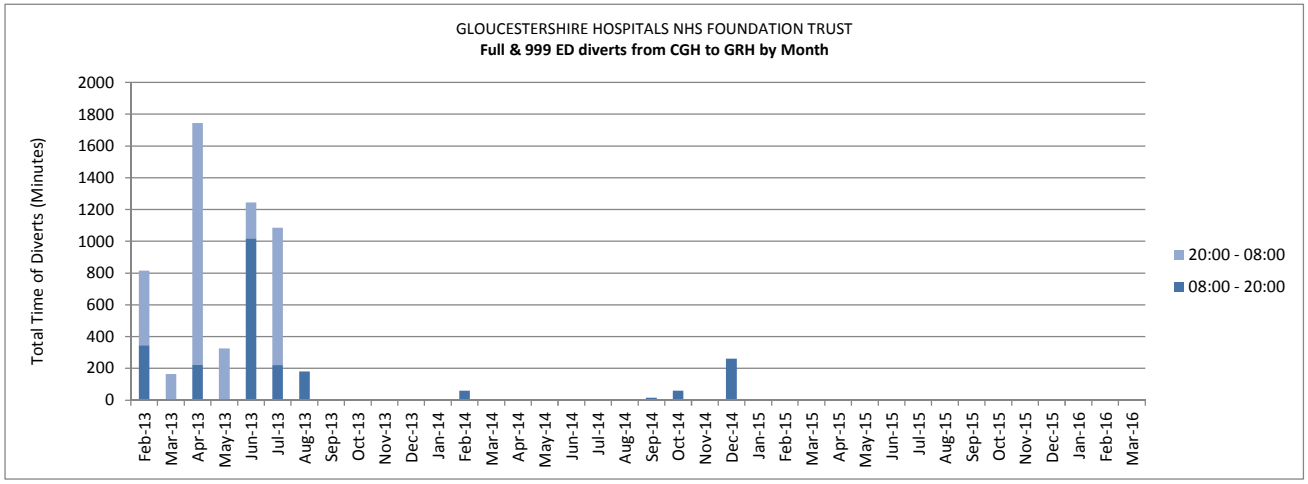
Aim: To reduce the number of across site diverts.

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 5 occasions when a Full/999 divert took place in March 2016 compared to 6 last month. Although the total duration of diverts reduced slightly from 20.6 hours in February 2016, to 20 hours in March 2016, the average number of hours per divert increased to 4 hours in March, compared to 3.4 hours in February.





3.2 Ambulance Handover Delays

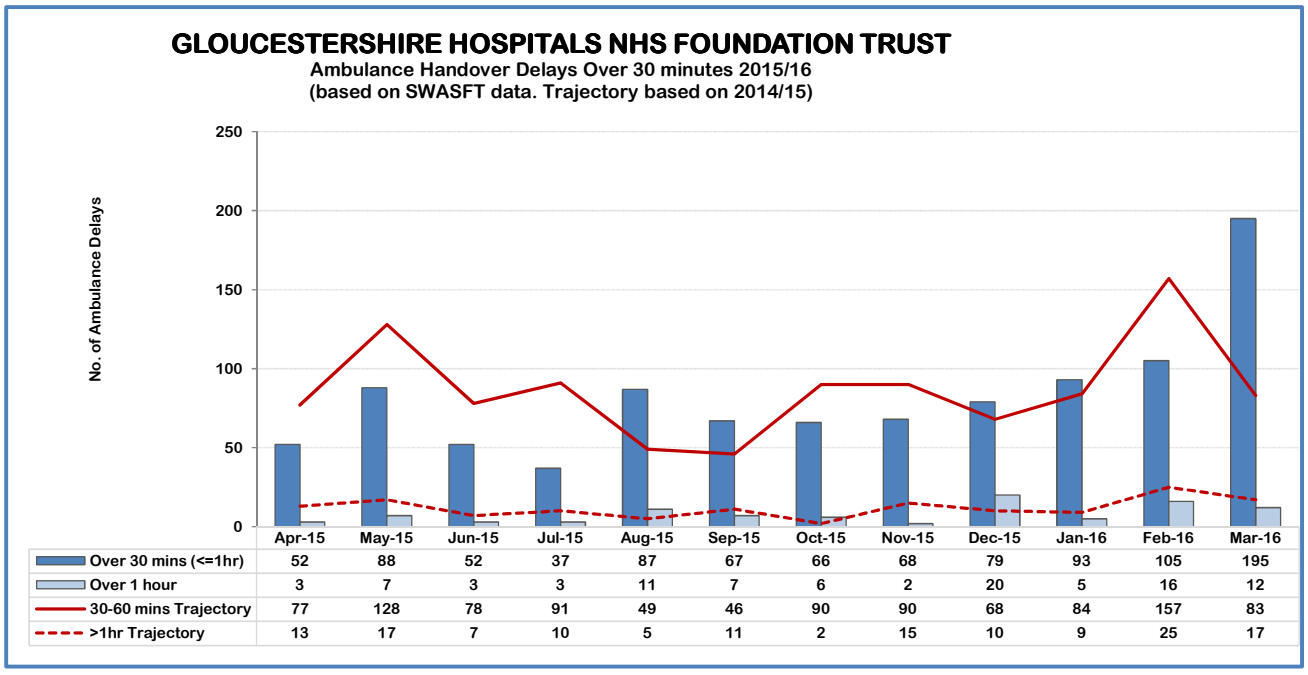
Aim: To reduce the number and time associated with ambulance handover delays.

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.

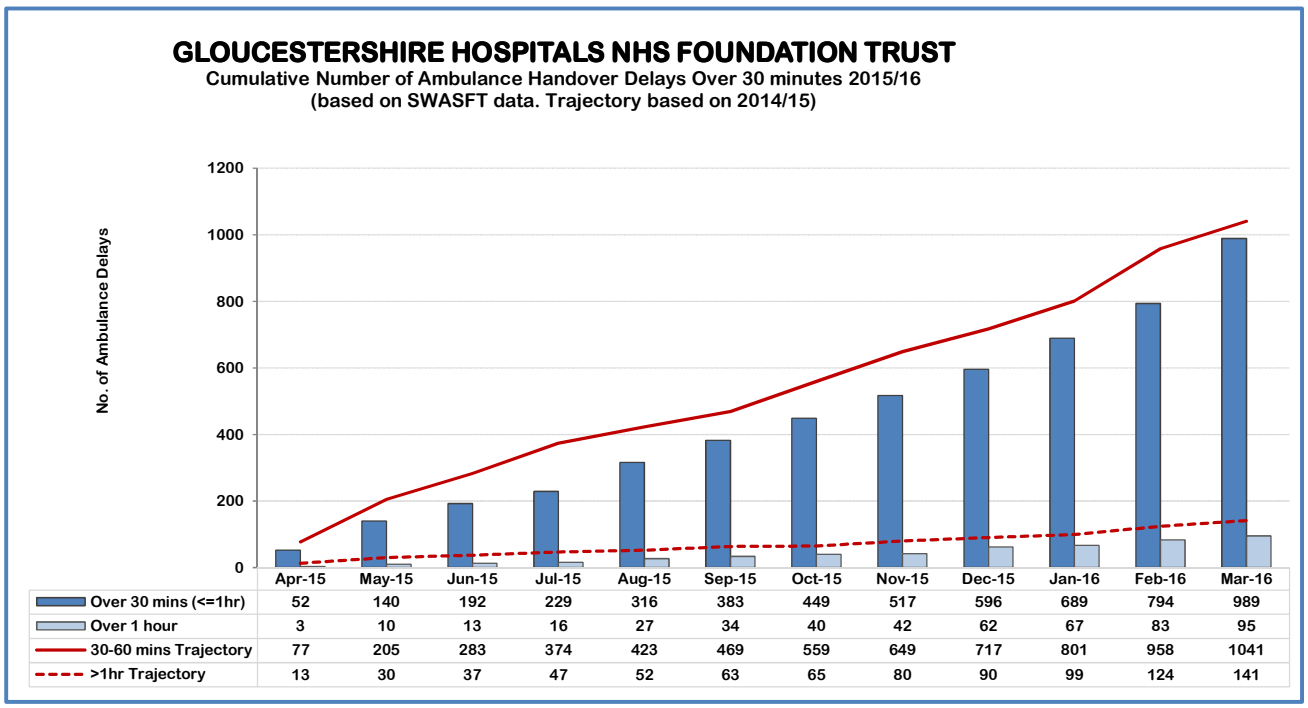
Narrative: There were 207 ambulance handover delays in March 2016; of which 12 were over one hour. This is a significant increase from last month; however there were slightly fewer over one hour delays.

To note: A difference exists between this figure and the 46 quoted on the ED Dashboard for 'Black Ambulance 60min delays' for March. The ED dashboard is based on Patient First data, whereas these charts are based on SWASFT data. There has always been a discrepancy and SWASFT figures are deemed more accurate, hence reported within this report. However, Patient First figures on the ED dashboard are now highlighting the discrepancy as SWASFT data does not currently provide daily or weekly figures and hence the use of Patient First data.

There is an overall improvement compared to 2014/15 trajectory compared to the March actuals as shown in the cumulative graph below. However, in the monthly actuals, the number of 30-60 minute handover delays is above the 2014/15 trajectory.



	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	195
Over 1 hour	3	7	3	3	11	7	6	2	20	5	16	12
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



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. March 2016 data shows that neither site successfully met the 95% standard. The overall Trust performance in March was 77.77%.

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%	87.85%
GRH actual	89.50%	92.27%	93.70%	92.41%	82.40%	85.61%	83.27%	85.86%	79.06%	76.08%	69.13%	72.09%
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%	77.77%

NHS England (Type 1) Emergency Department performance for Quarter 4 2015/16 have not yet been published. The Trust's performance for this period was 78.1% and 86.7% for 2015/16.

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 March 2016 is outlined in the following table:

March 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	504	28	330	54	13	79
GRH	2055	423	967	135	287	243
Total	2559	451	1297	189	300	322
%		17.62%	50.68%	7.39%	11.72%	12.58%

*'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.

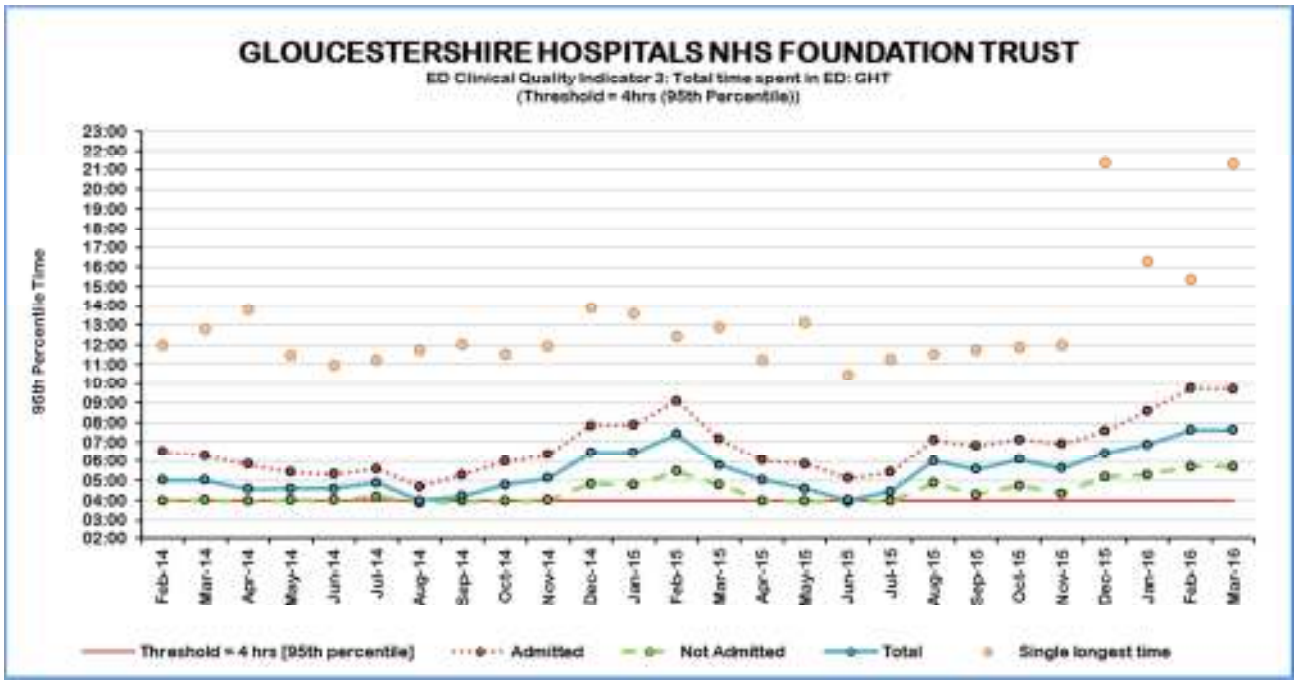
National Quality Indicators

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	Mar-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%	1.50%
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	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%	1.90%
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	01:12
Avg time to Triage	*<15 mins*	14.7	17.8	17.4	11.2	14.8	15.7	15.7	16.4	17.0	18.0	16.4	18.6	18.2	21.3	19.1

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 March was 7 hours 37 minutes, compared to 5 hours 49 minutes the previous year. The single longest wait was circa 21 hours within the department.


GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST
ED Clinical Quality Indicator 3: Total time spent in ED: GHT
(Threshold = 4hrs (95th Percentile))
95th Percentile Time
23:00
22:00
21:00
20:00
19:00
18:00
17:00
16:00
15:00
14:00
13:00
12:00
11:00
10:00
09:00
08:00
07:00
06:00
05:00
04:00
03:00
02:00
Feb-14
Mar-14
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
Mar-16
Threshold = 4 hrs (95th percentile)
Admitted
Not Admitted
Total
Single longest time

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 and is now reported to ECB on a weekly basis and to the monthly Quality committee.

3.4 Emergency Admissions

3.4.1 Emergency Admission Rate

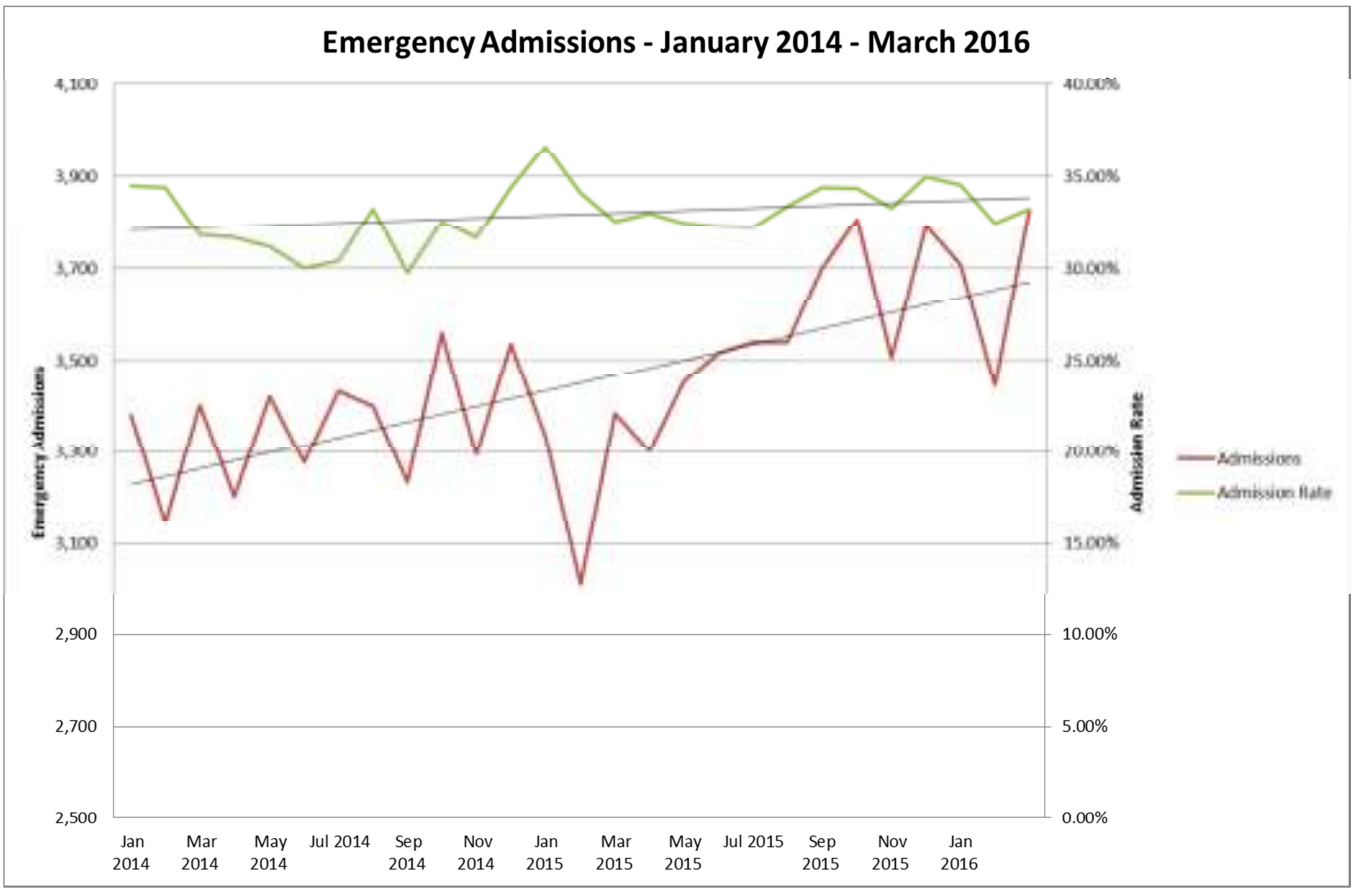
Aim: To ensure the admission rate from the Emergency Department remains in control.

How: By avoiding admissions through alternatives as appropriate.

Narrative: The Emergency admission rate in March 2016 was 33.25% compared to March 2015, when the admission rate was 32.56%. In March 2016 there were 11,510 Emergency Department attendances and 3,827 patients were admitted (average 123 per day), compared to March 2015 when there were 10,395 attendances but 3,385 patients were admitted (average 109 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.

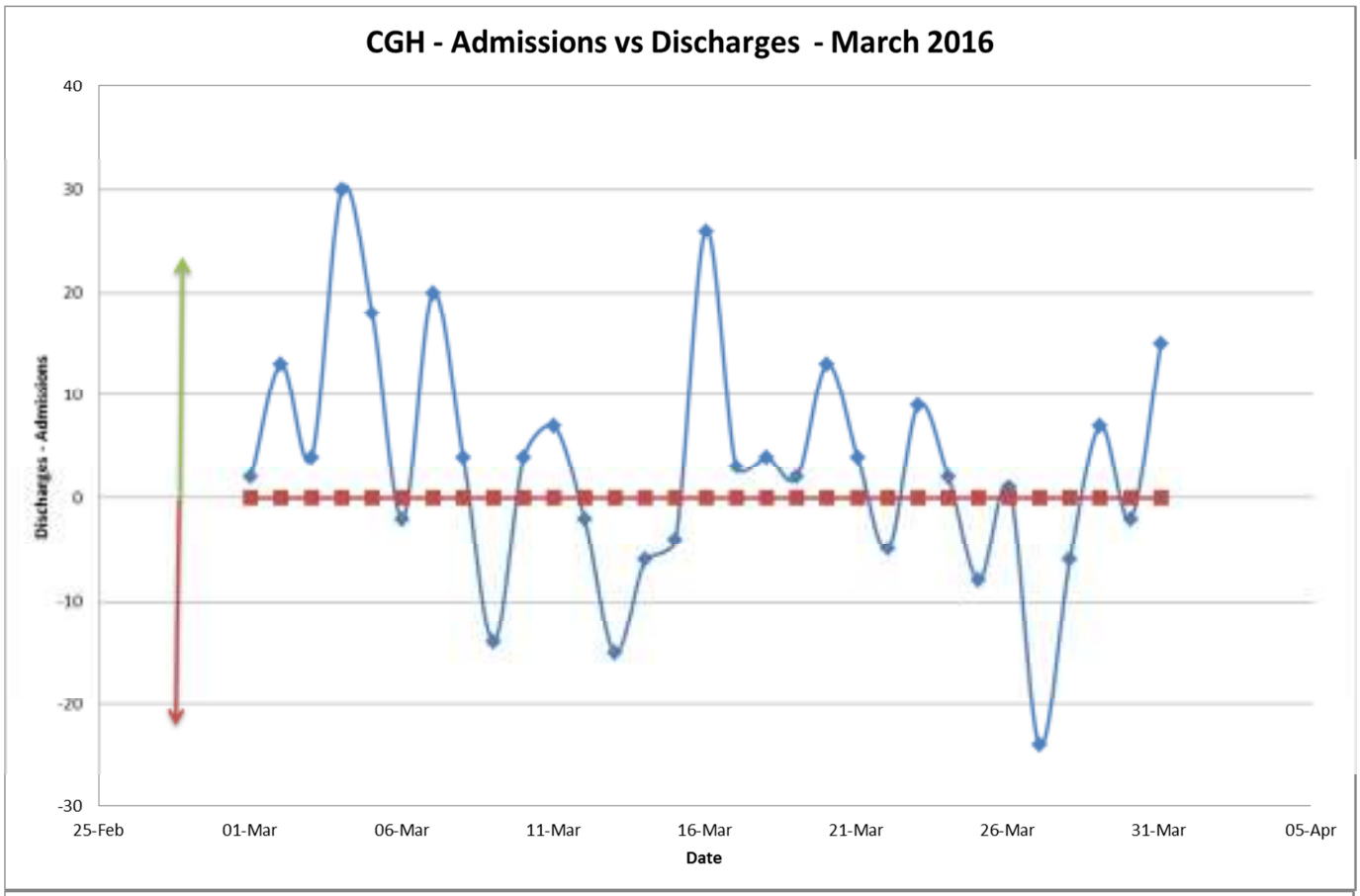


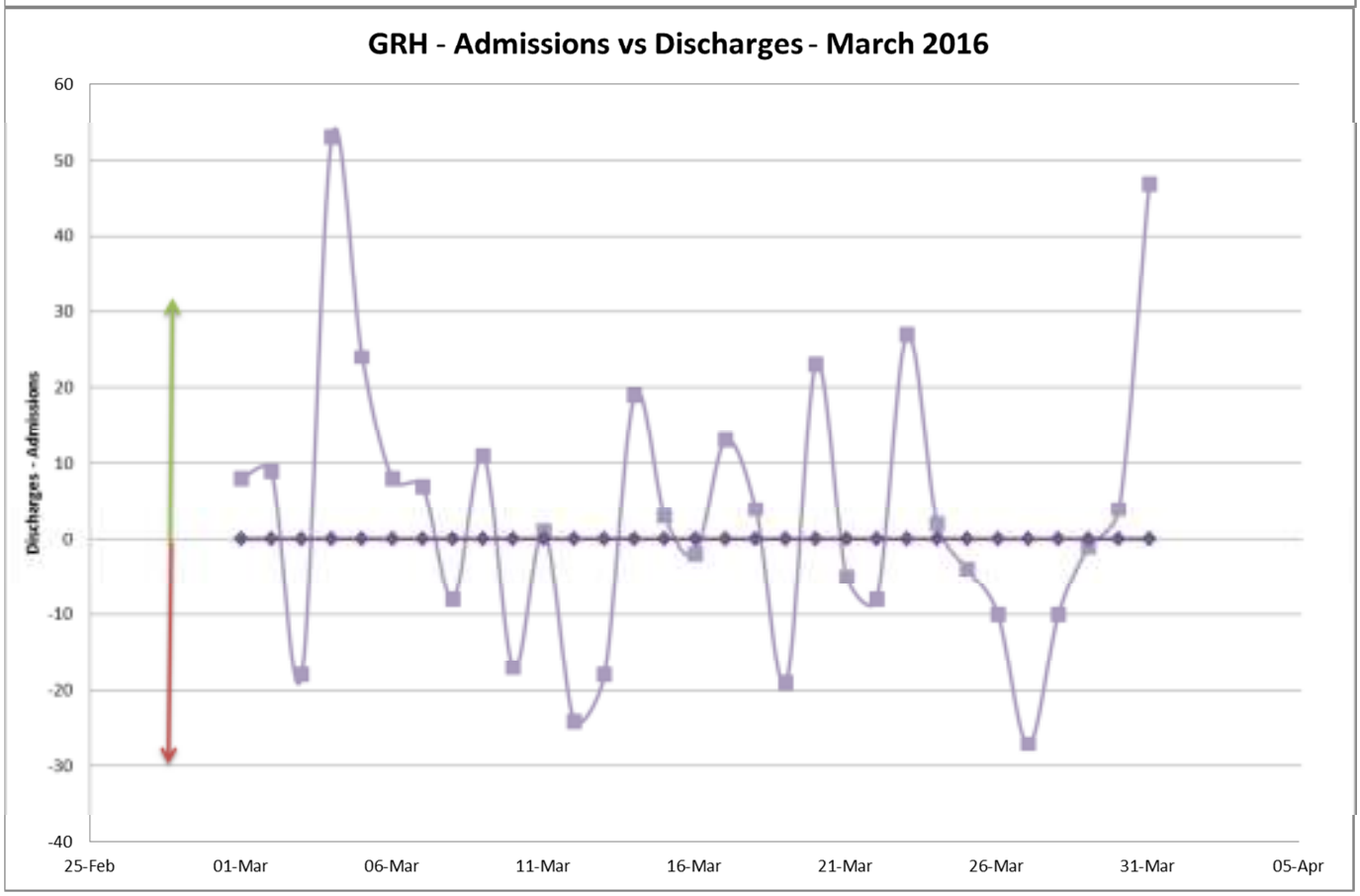
3.4.2 Admissions vs Discharges

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.


CGH - Admissions vs Discharges - March 2016
Discharges - Admissions
40
30
20
10
0
-10
-20
-30
25-Feb
01-Mar
06-Mar
11-Mar
16-Mar
21-Mar
26-Mar
31-Mar
05-Apr
Date


GRH - Admissions vs Discharges - March 2016
Discharges - Admissions
60
50
40
30
20
10
0
-10
-20
-30
-40
25-Feb
01-Mar
06-Mar
11-Mar
16-Mar
21-Mar
26-Mar
31-Mar
05-Apr

3.5 Ambulatory Emergency Care Attendances

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

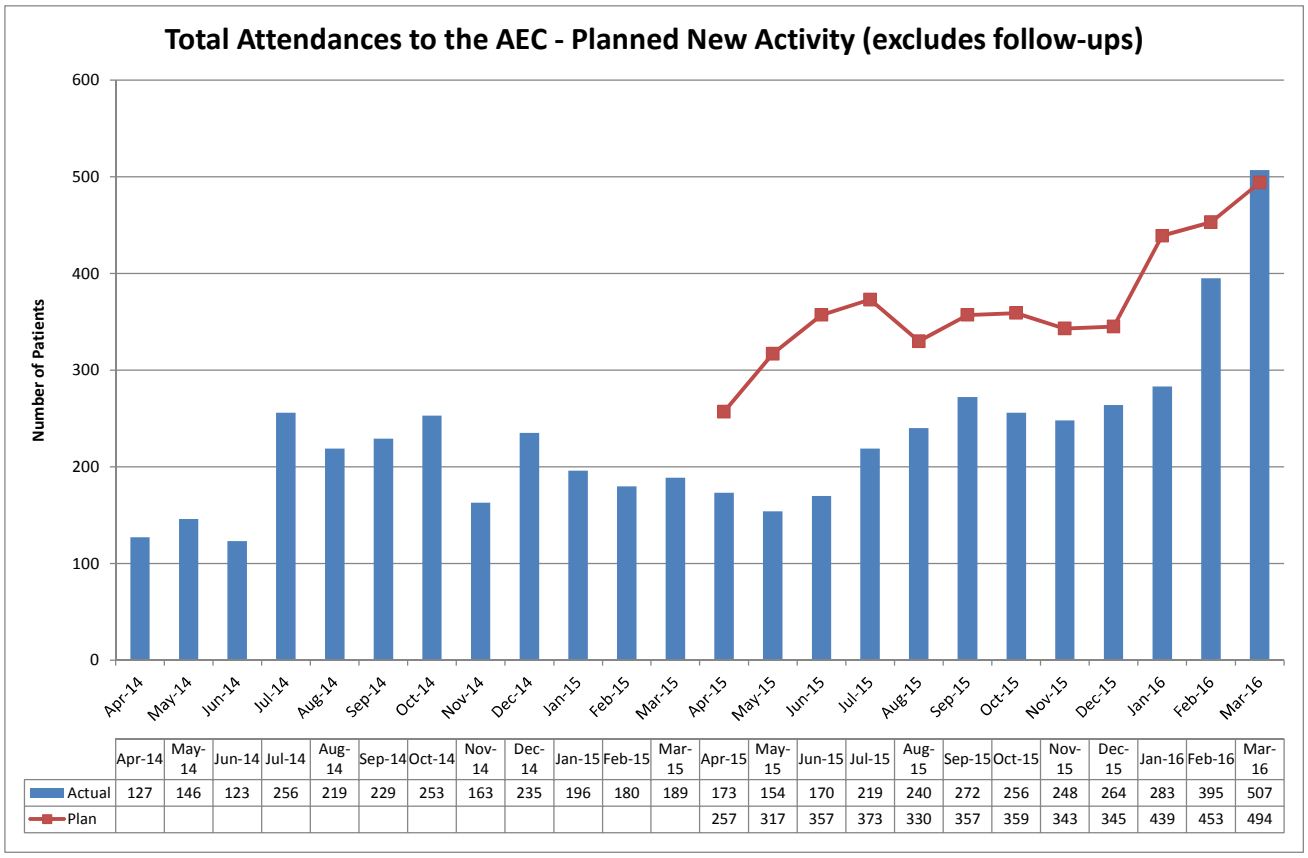
How: Expand pathways and remodel ambulatory services.

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 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 average for March 2016 was 24 compared to an average of 19 last month.

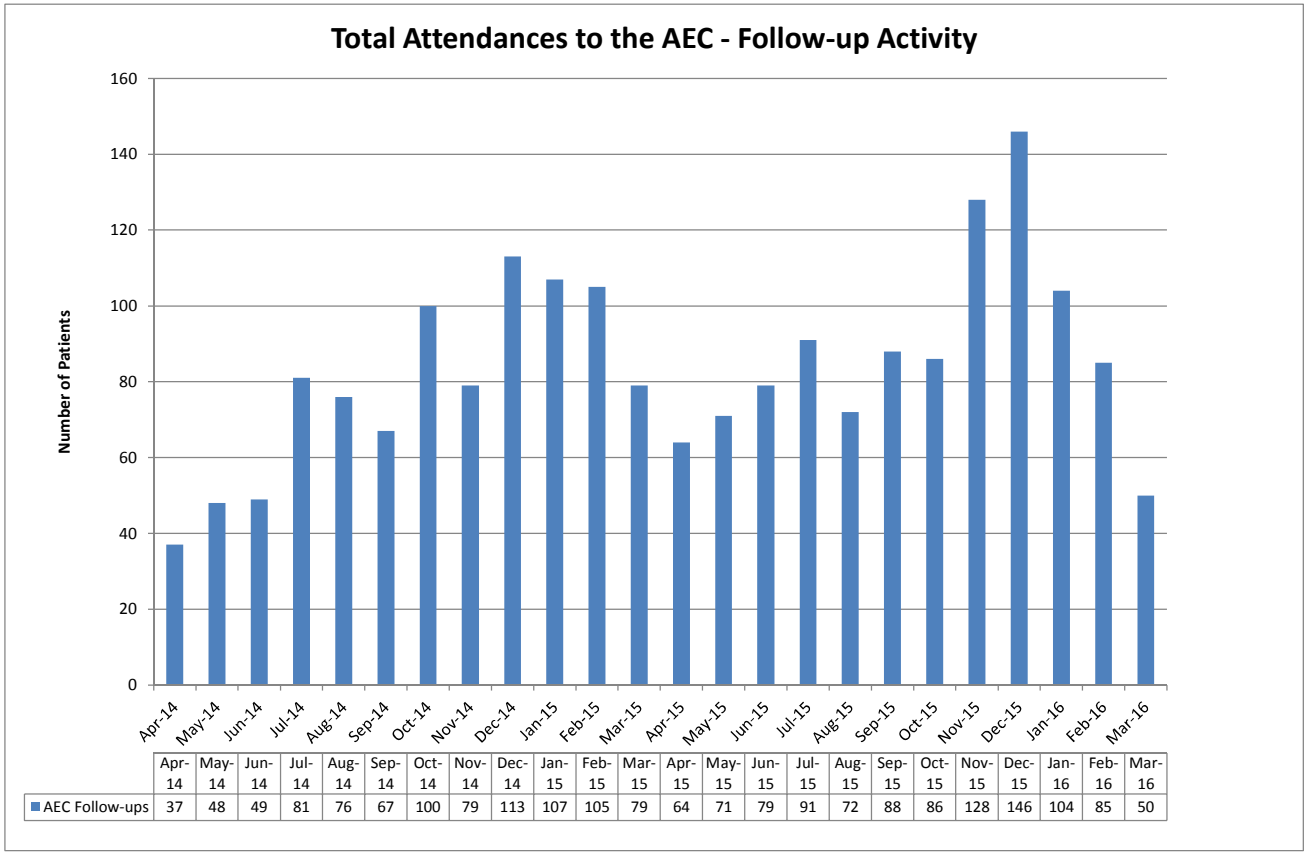
This is the first time in 2015/6 that activity has matched and exceeded the trajectory predictions.

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.



	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	Mar-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	507
Plan													257	317	357	373	330	357	359	343	345	439	453	494

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



	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
AEC Follow-ups	37	48	49	81	76	67	100	79	113	107	105	79	64	71	79	91	72	88	86	128	146	104	85	50

The number of follow-ups in March was 50, which is the lowest they have been since June 2014. This would have enabled the service to see more new patients, as there would be more physical capacity within the units.

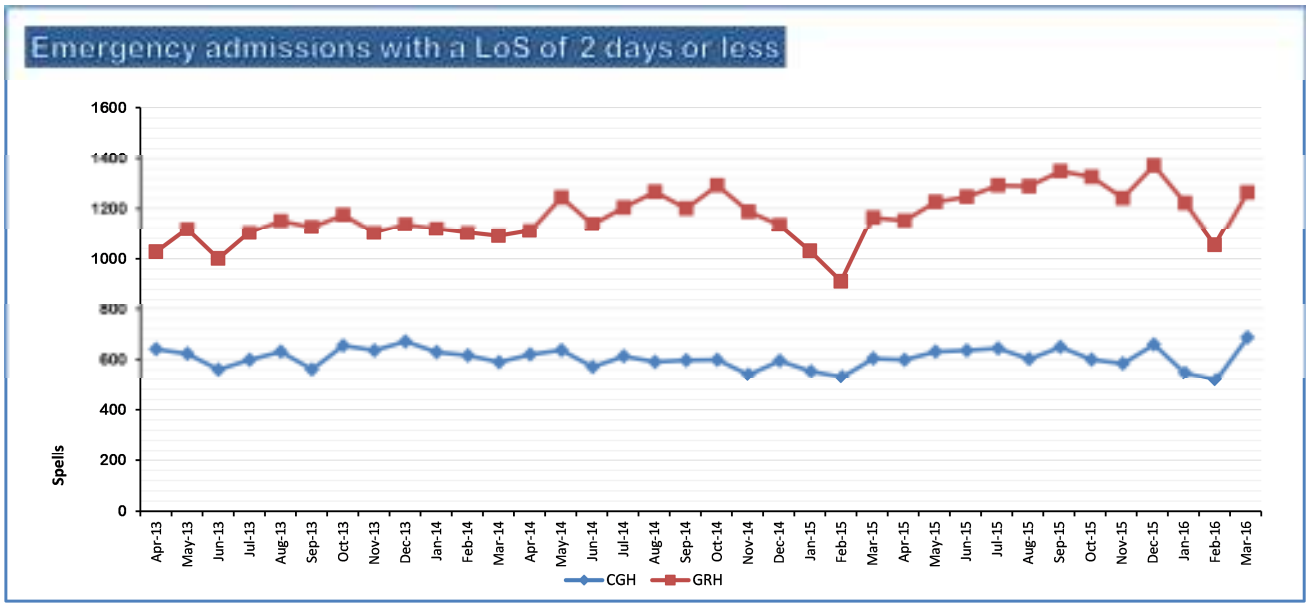
Ambulatory Emergency Care is a key strand of the High-Level Priorities Plan agreed with Monitor.

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

Aim: To increase the number of short stay discharges.

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

Narratives March 2016 showed 1,952 patients with a length of stay of 2 days or less Trustwide (average 63 discharges per day); compared to February which showed 1,574 patients (average 54 per day). The average per day for 2015/16 was 61.



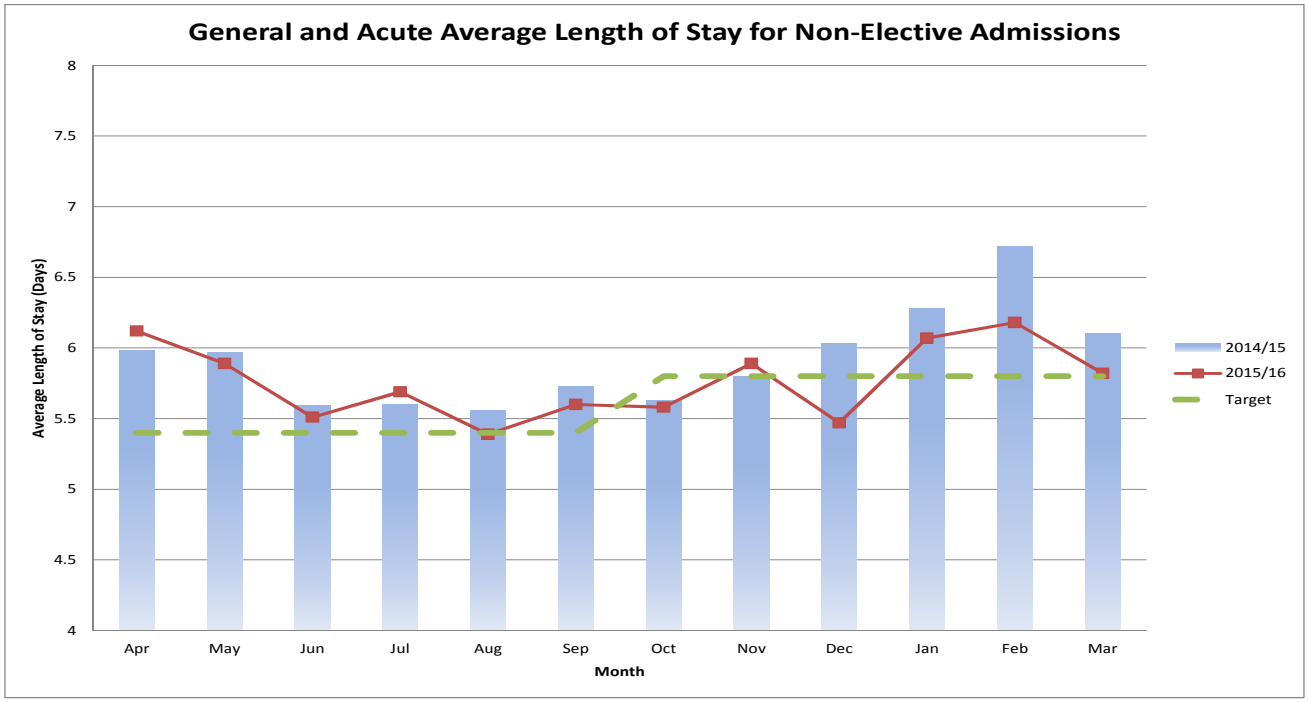
3.6 General & Acute Emergency Admissions Average Length of Stay

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. March 2016 shows an Average Length of Stay of 5.82 days which is in line with the target.

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.

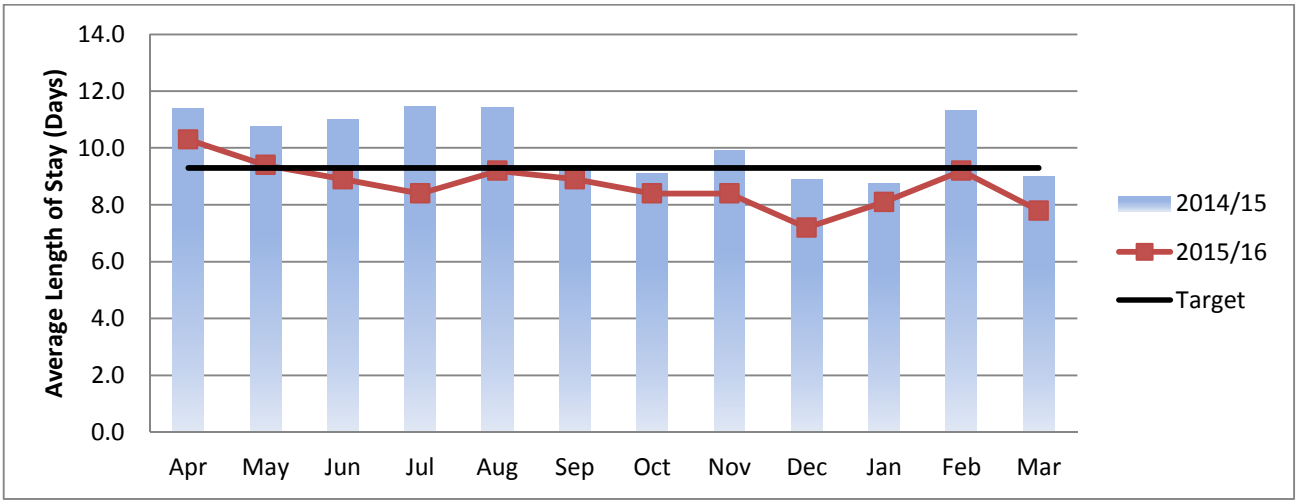
3.7 Average Length of Stay of Targeted Specialties

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

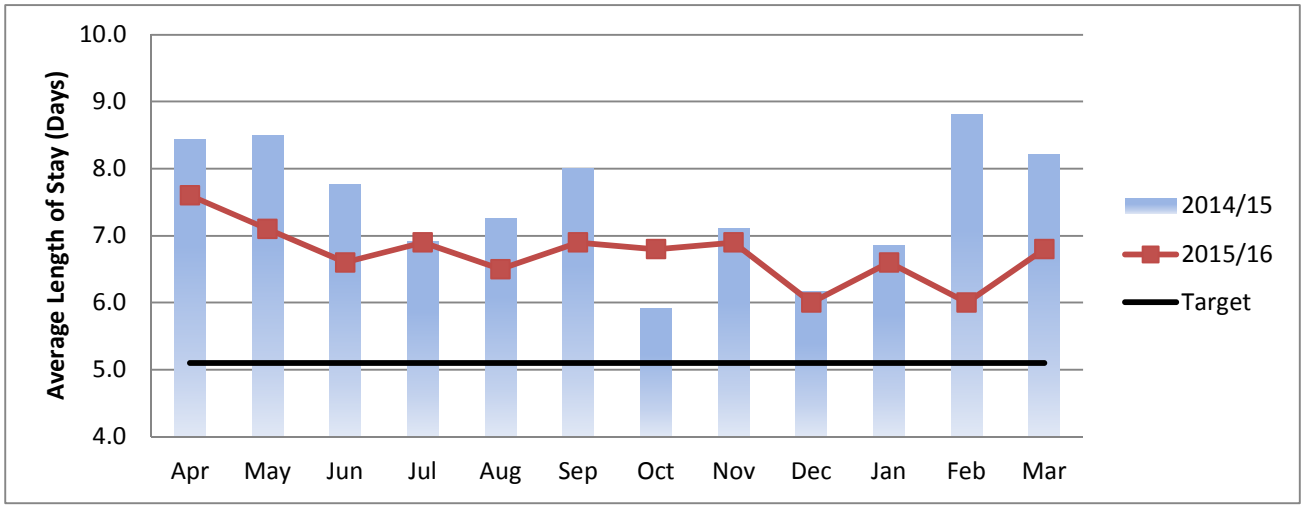
Narrative: The internal target is set at 9.3 days for 2015/16**.** The Average Length of Stay reduced to 7.8 days in March 2016; and is well within the target.



3.8.2 Cardiology - Average Length of Stay

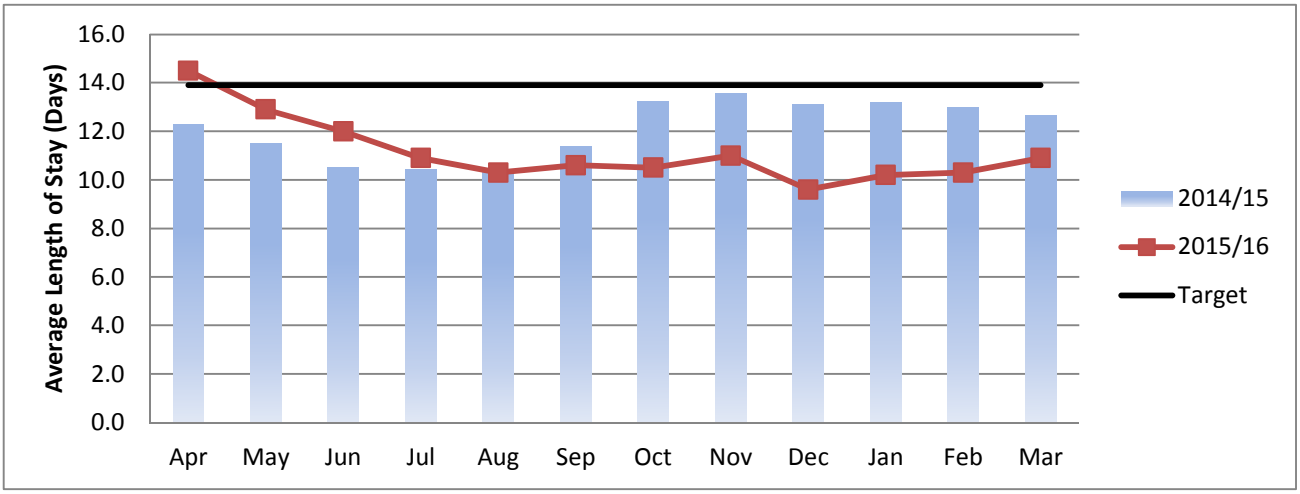
Narrative: The internal target is set at 5.1 days for 2015/16. The Average Length of Stay for non-elective Cardiology discharges increased slightly in March 2016 to 6.8 days.

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 has remained static for several months and is 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.

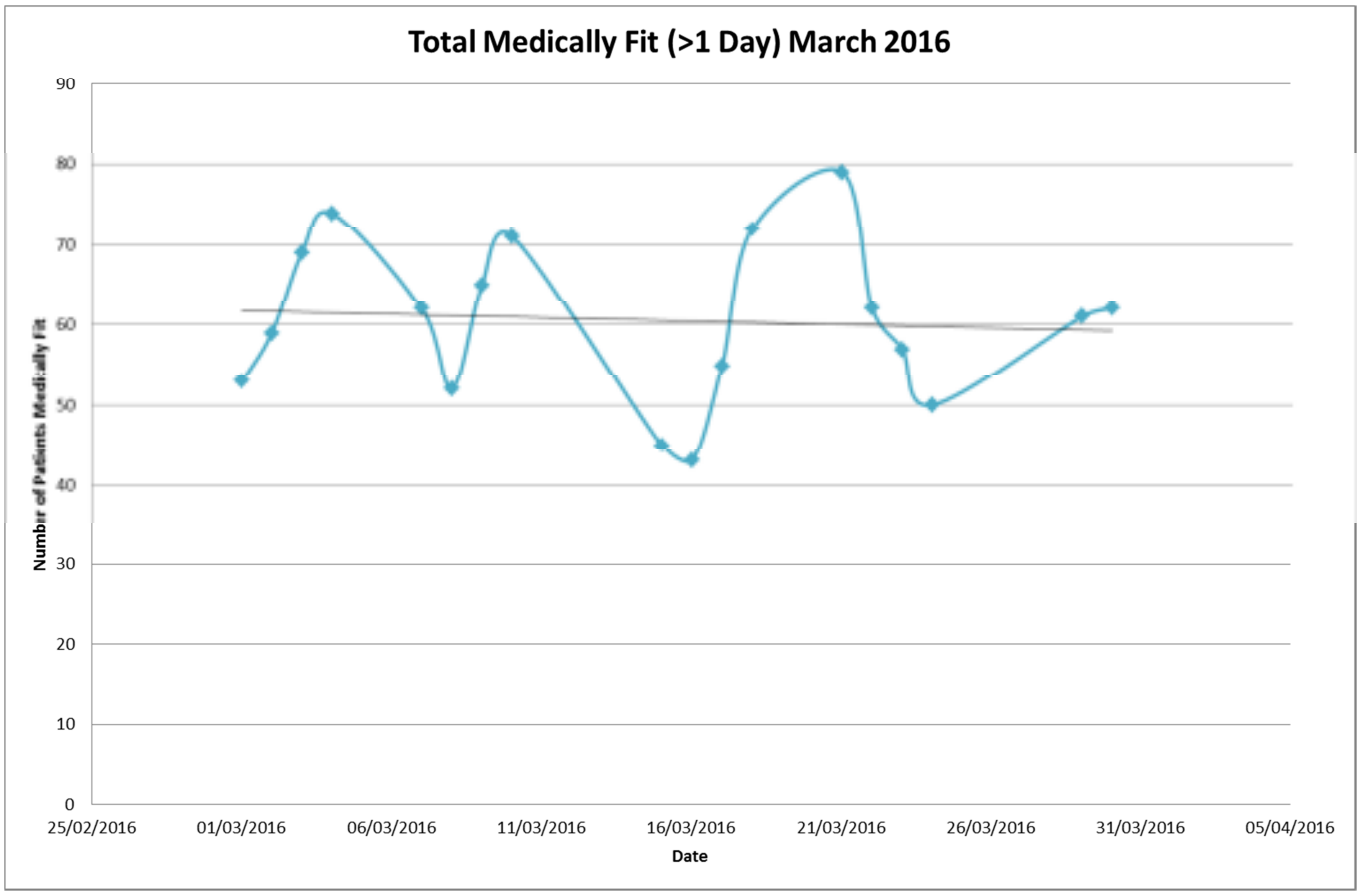
How: Focussing on a range of actions on safe and effective discharge processes. For the Trust and whole heath care system this is one of the key activities to manage.

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 March 2016:

Week 1	64	**Week 2**	63
Week 3	59	**Week 4**	58

In March, there was an average of 43 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 61 for the month, with the number of medically fit patients peaking in March to 64 in week 1. This is on average a slight decrease of 2 medically fit patients, compared to February 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.

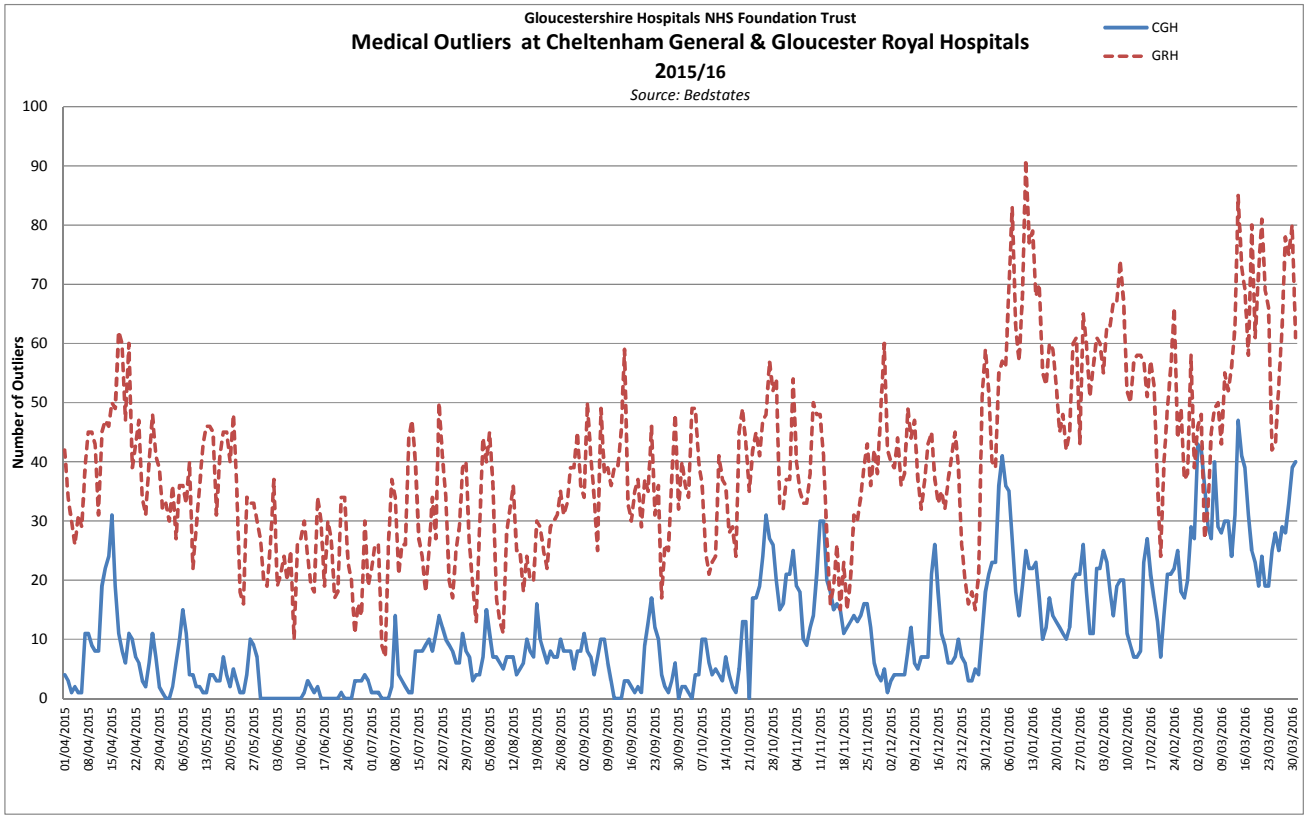
From September 2015, a weekly Senior Executive review of all Medically Fit patients takes place. This is being led by Mrs Arnold, Director of Nursing with her peers from across the system.

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 66 at Gloucestershire Royal and 33 at Cheltenham General in March; an increase from 54 and 18 last month.

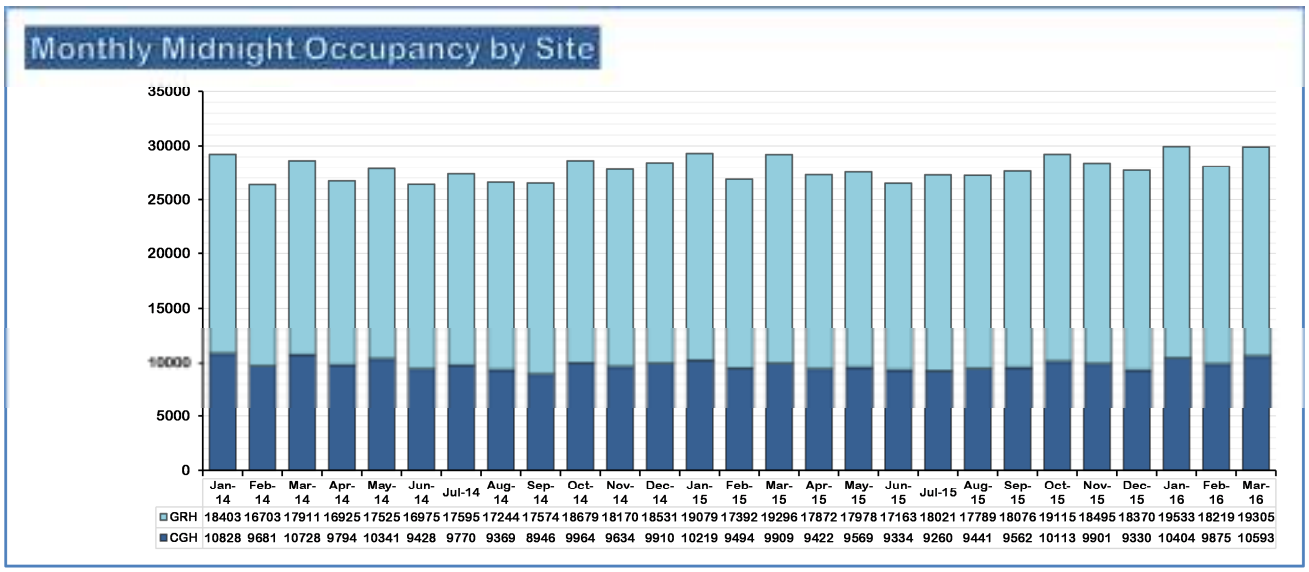


3.9.3 Midnight Bed Occupancy

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 March 2016 were 29,898 (average 964.5 per day). In the same month last year bed occupancies were 29,205 (average 942.1 per day).



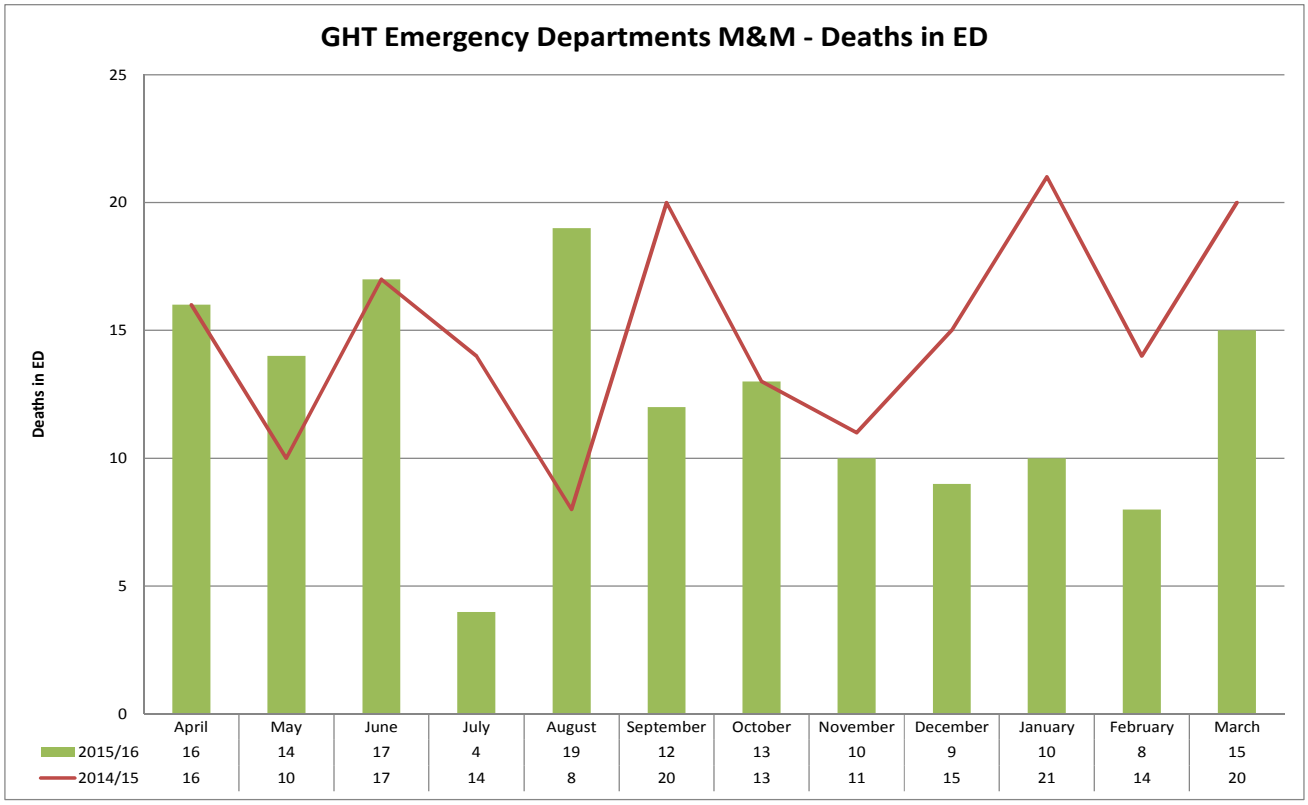
% Bed Occupancy (as at Thursday snapshot)

Week ending:	CGH	GRH	Total
06/03/2016	99.7%	98.9%	**99.2%**
13/03/2016	98.3%	97.8%	**98.0%**
20/03/2016	95.6%	97.8%	**96.9%**
27/03/2016	96.7%	99.6%	**98.5%**
03/04/2016	96.1%	98.7%	**97.6%**

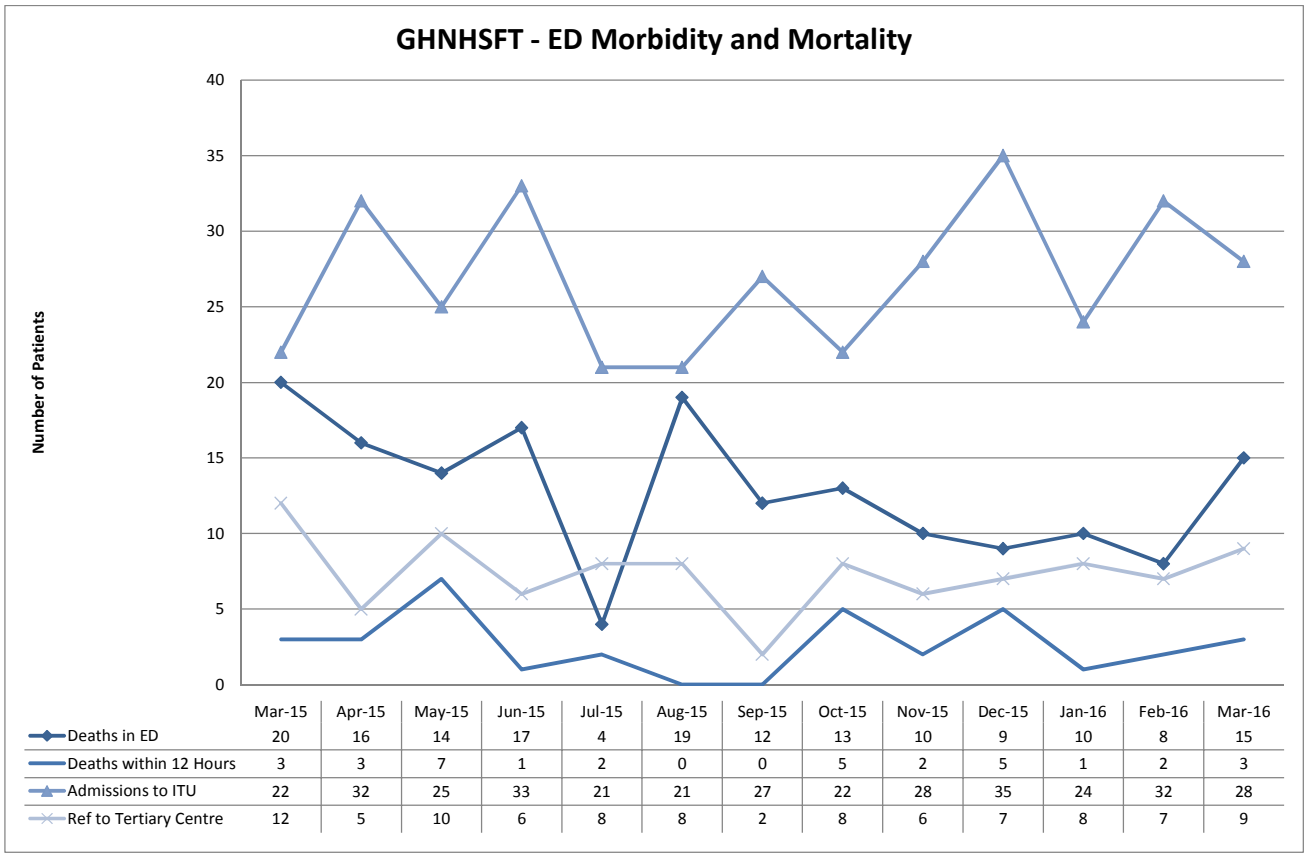
3.10 ED Morbidity and Mortality

Aim: To review the Morbidity and Mortality trend.

Narrative: During March 2016 there were 15 deaths in the Emergency Department, which is lower than March last year (-5). There were 28 admissions to ITU and 9 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	15
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	15
Deaths within 12 Hours	3	3	7	1	2	0	0	5	2	5	1	2	3
Admissions to ITU	22	32	25	33	21	21	27	22	28	35	24	32	28
Ref to Tertiary Centre	12	5	10	6	8	8	2	8	6	7	8	7	9

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 March (wte)	Variance In Post vs. Establishment	Variance vs. in Post in February
Emergency Department	Consultants	18.70	19.60	+0.90	0
	Trainee Doctors	33.52	32.10	-1.40	+2.0
Acute Medicine	Consultants	11.03	8.33	-2.70	0
	Trainee Doctors	86.29	66.36	-19.9	-1.04

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

The primary areas of focus for the Trust in the immediate term are the three priority areas identified by the Executive Team. These are detailed below, including the clinical outcome measures and how these workstreams link to our existing emergency care programme plan.

1. Emergency Department:

With specific focus on the safety metrics for Time to Initial Assessment within 15 minutes and Time to Treatment within 60 minutes. This includes a detailed demand and capacity review of all staff and streams of work to optimise resources.

Clinical Outcomes:

- Improvement in Time to Initial Assessment (15 mins) for 99% of patients;
- Improvement in Time to Treatment (60 mins);
- No one in the department for more than six hours (for anything);
- No patients waiting in the corridor.

Measures:

- % Assessed within 15 minutes;
- Average Time to Initial Assessment;
- % Treated within 60 minutes;
- Average Time to Treatment;
- Number of patients waiting over six hours;
- % of patients waiting over six hours;
- Number of patients waiting in the corridor.

Links to existing plan:

- There are actions relating to workforce (Emergency Care Practitioners and Middle Grade doctors) which aimed to assist in the achievement of the clinical outcomes identified.
- There are also links to the Emergency Department Internal Professional Standards.

2. Site Management:

To increase the presence of senior co-ordination of both hospitals 24/7, to ensure patients are in the right place, first time. An interim rota is being put in place with full implementation planned for June.

Clinical Outcomes:

- 12 hour daytime cover 07:30 – 22:00 7 days a week by a Senior Clinician, with evidence of outliers reduced;
- 12 hour night time cover 17:00 – 08:00 7 days a week by General Managers, with evidence from daily reports that managers come in to tackle issues in line with the Escalation Policy;
- Staff are aware of their role and function in the bed meetings and the information required;
- Have a Stroke, Cardiac and Fractured Neck of Femur bed available for next patient.

Measures:

- Number of Surgical Outliers;
- Number of Medical Outliers;
- Number of days in Black Escalation;
- Number of days in Red Escalation.

Links to existing plan:

- The action relating to additional Senior Nurse / Clinical Lead to work each Saturday and Sunday has a direct correlation to this workstream.
- The refinement of the bed meetings has also been an action identified on the existing plan and is now being prioritised as part of this workstream.

3. >= 14 Day Length of Stay:

To reduce the number of these patients who currently occupy 65% of total bed days across the Trust to improve flow and reduce outliers.

Clinical Outcomes:

- Reduction in bed days occupied;
- Reduction in numbers on the >= 14 days Length of Stay by 20%;
- Standardise SAFER programme;
- Reduction in the use of Day Surgery Units for Inpatients.

Measures:

- Number of >= 14 days on the list;
- Number of bed days occupied by >= 14 day patients;
- Total bed days occupied;
- % of Total bed days occupied by >= 14 day patients;
- Estimated Discharge Date accuracy;
- Bed allocation (from Acute Care Units to ward) within 30 minutes;
- Number of discharges before 12:00;
- Number of weekend discharges;
- Number of Inpatients on Day Surgery Unit overnight.

Links to existing plan:

- The roll-out of the SAFER bundle has been a key area for action throughout 2015/16 and workstream 1 includes the 'R' of SAFER – a 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.

The measures identified for each workstream will be reported in next month's board paper for Quarter 4 of 2015/16 and April 2016.

Executive Directors and Chiefs of Service with their teams are in the process of understanding the root causes of the issues to determine the long-term Emergency Care Plan to provide sustainable improvements with support from the Improvement Director and the Programme Management Office. This will be prepared for discussion at the June board.

NURSE AND MIDWIFERY STAFFING
APRIL 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 March 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 April.

3 Findings

3.1 In line with the set parameters for the Safer Staffing guidance there are no outlying exceptions for March. 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 has been explained in previous Board papers. It is therefore unnecessary to report this in the future.

3.2 On 5th April 2016 CQC requested information regarding staffing in specific areas in Gloucestershire Royal Hospital. Annex A is the response sent to CQC. It is clear that although due to no agency or bank staff being available to fill late requests there is no evidence of harm to patients.

4 Recruitment Update

4.1 UK Pipeline

- There are currently 14 experienced UK-based nurses in the recruitment pipeline due to commence employment in April/May 2016. Advertisements and interviews are ongoing throughout Easter and into the spring, but the number of candidates continues to be poor.
- There are a further 78 newly-qualified nurses due to start at the Trust in summer 2016.
- The Trust will be attending the forthcoming Birmingham City University Nursing Careers Fair on 27th April 2016.

4.2 Overseas-Qualified Nurses

- Following a successful advertising campaign for overseas-qualified nurses, the first cohort of 100 candidates was invited for assessment and interview on 19th March 2016. A revised assessment process with a new scoring matrix was used to ensure candidates appointed would be able to satisfy the English language requirements of the NMC. In total, 18 candidates were offered employment on the day.
- Another recruitment day for the second cohort of overseas-qualified nurses is currently being finalised by Professional Education and Recruitment.
- A separate fast-track interview day is being held on 31st March 2016 for candidates that have already completed the IELTS English language exam. Ten candidates have been identified for fast-tracking.

- A new advertisement specifically targeting candidates with the requisite IELTS examination result has been added to NHS Jobs to target nurses that can be fast-tracked onto the programme.

4.3 EU Recruitment

- Two EU nurses are due to join the Trust in early April, and a further five candidates are being processed to start shortly.
- Four EU nurses are scheduled for interview on 30th March 2016, and further candidates are currently being shortlisted by senior nursing staff.
- The Trust will attend a recruitment event hosted by the British Council in Thessaloniki and Athens on 4th and 5th June 2016.

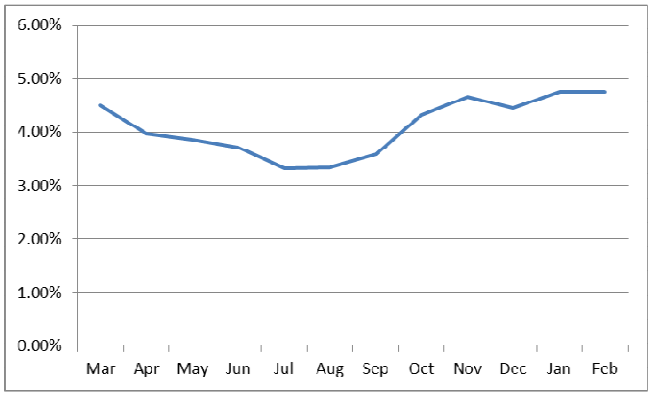
4.4 Philippines Recruitment

- The Migration Advisory Committee has recommended for nurses to remain on the Shortage Occupation List until 2019. There will be an annual cap of 3000-5000 visas made available for nurses, in line with anticipated demand. It is expected that this annual cap will be reached before the end of each year (possibly around Month 9), and therefore the Trust will plan recruitment events accordingly.
- 2015 Campaign: The first two nurses from the November 2015 campaign will join the Trust in April 2016. A further nine candidates are waiting for paperwork from the NMC before they can obtain their visas, and a further eight have passed the IELTS examination and are waiting to take the NMC Test of Competence (the Computer Based Test (CBT)).

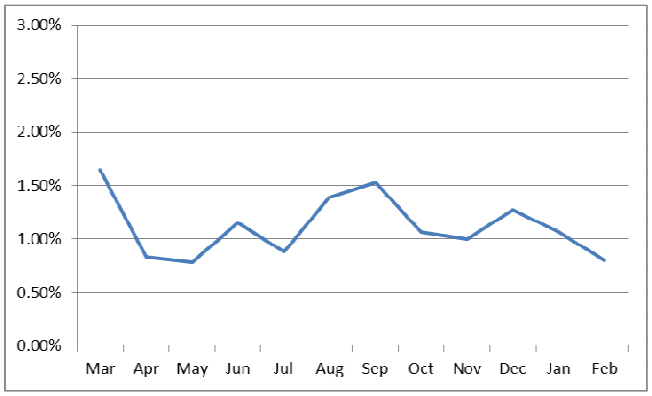
Status	Numbers
Passed the IELTS and CBT exams, accepted by the NMC, waiting for visa application	2
Passed the IELTS and CBT exams, waiting for NMC decision letter	9
Passed the IELTS examination, waiting for CBT examination	8
Not passed the IELTS examination	105
Not yet accepted the offer	9
Withdrawn	4
Total (minus withdrawn candidates)	**133**

4.5 Nursing Workforce Metrics

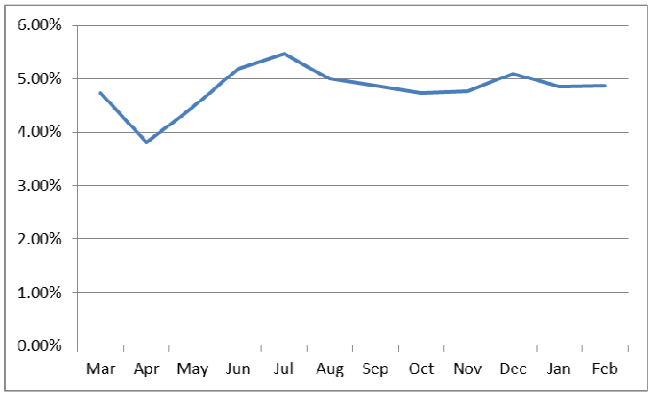
Division	Band 5 Vacancies	Sickness		Turnover		Maternity	
		RGNs	HCAs	RGNs	HCAs	RGNs	HCAs
Diagnostic & Specialist	0	3.89%	5.12%	11.24%	10.39%	3.40%	1.31%
Medicine	95.87	3.96%	5.52%	19.45%	23.60%	3.20%	3.14%
Surgery	25.79	4.11%	4.54%	10.47%	18.77%	4.05%	2.35%
Women & Children	0	4.17%	3.36%	12.76%	13.21%	3.77%	5.76%



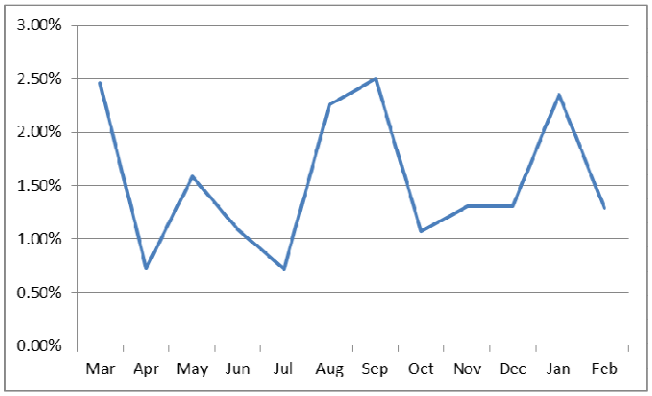
RGN: Sickness Absence by Month (Mar 15 – Feb 16)



RGN: Turnover by Month (Mar 15 – Feb 16)



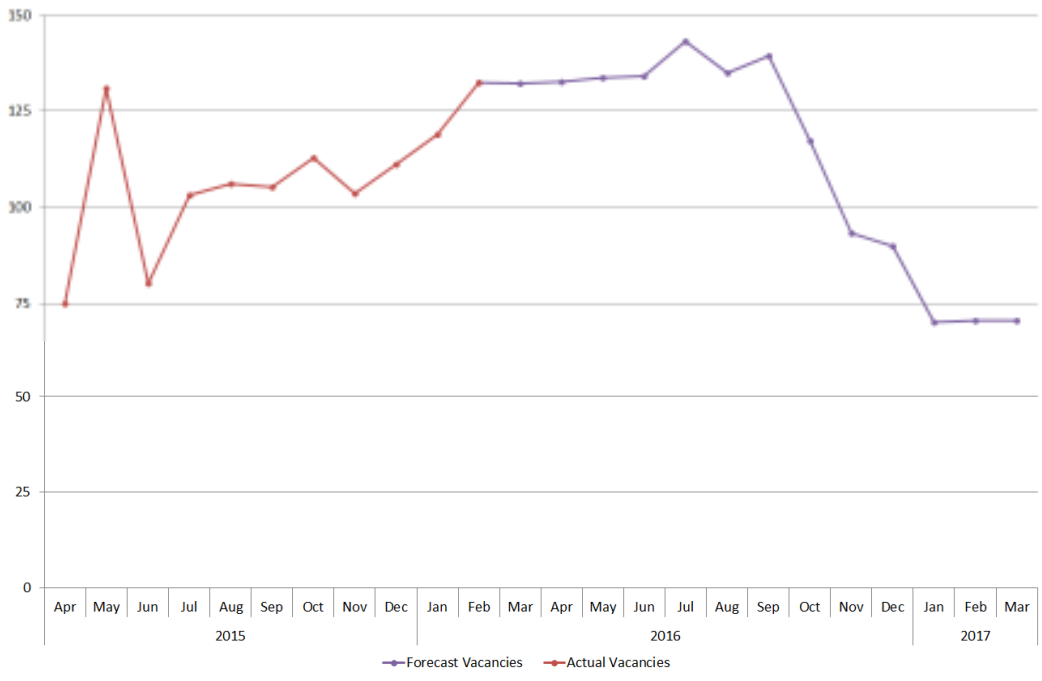
HCA: Sickness Absence by Month (Mar 15 – Feb 16)



HCA: Turnover by Month (Mar 15 – Feb 16)

4.6 **Vacancy Forecast**

The data from February 2015 shows an increase in the vacancy rate for the third successive month, in line with forecasted predictions of reduced recruitment activity after the January intake of newly-qualified nurses. The anticipated vacancy rate between February and June is unlikely to change significantly, due to the number of starters in the organisation equalling the number of staff leaving. In addition to continued recruitment of registered nurses, the current focus is to recruit sufficient numbers of healthcare assistants and apprentice healthcare assistants to ensure there are no additional vacancies on the wards, and to provide additional cover to wards with high staff nurse vacancy rates.



5 Next Steps and Communication

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

6 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**

ANNEX A

Care Quality Commission Request for staffing information for Wards 3b, 6a and 9a Gloucestershire Royal Hospital

April 2016

1. Introduction

Our Trust received a request from Mr Gary Latham, Inspector, Hospital Directorate on 5th April, 2016. The request asked for information for staffing for the three wards, at Gloucestershire Royal Hospital as above, and detailed below:-

1) The planned nurse and health care assistant cover for day and night shifts for wards 9A, 6A and 3B. For the period 01 February 2016 to 04 April 2016.

2) The actual nurse and health care assistant cover for the same shifts and periods.

3) Details of any staff movements from the ward to which they were assigned to any other ward following the start of shift, including details of the cover on those wards as a result of the movements. This needs to be for the same shifts and time period, please.

4) Any incident reports arising from staff shortfalls or skill mix over the same period.

2. Nursing Staffing Methodology clarification

The Trust uses twice yearly the Keith Hurst Safer Staffing Benchmarking tool. This allows all wards to be compared to the ward data by speciality contained. There is also a professional judgement discussion on the stated outcomes. The recommended staffing is compared with the funded establishment for the ward under analysis and changes recommended. The exercise assists the Trust in producing both funded shift by shift recommendations for both RGNs and HCAs, and the then professional judgement discussions also assists in setting an agreed 'minimum shift cover' for each staff group, which should be considered in times of shortfall. As the staffing benchmark changes centrally by Hurst, and the exercise is completed twice yearly there is the opportunity to also reset the shift cover totals, if required.

3. Data sets

The data has been extracted from the Safer Staffing Returns for the month's February and March. April's Safer Staffing period is currently in collection, therefore the staffing for the first four days in April have been extracted from the wards themselves for that period.

4. Overview of findings

The actual shift returns in detail are shown in appendix A for all wards requested.

The set minimum staffing for the wards requests are as follows:-

Ward	AM Shift (RGN/HCA)	PM Shift (RGN/HCA)	Night Shift RGN/HCA)
3b (35 beds)	4/4	3/3	3/2
6a (28 beds)	4/4	3/3	3/2
9a (13 beds)	2/2	2/2	2/1

Where any component of staffing (RGN or HCA) fell below this level, then the following provides detail of that by ward, and covers whether there was any reported patient incident or harm for that period.

Ward 3b 35 beds

Date	Shortfall	Datix Reported Patient incident/Harm
2/2/16 Night	Night by 1 RGN though Twilight RGN provided 19.30 to 00.30. Agency could not fill.	None
10/2/16 PM	PM 1 HCA although 5 HCAs on morning shift so ward should have moved HCA from AM shift. 1 RGN stayed from AM shift to cover to 18.00pm	None
16/3/16 PM	PM 1 RGN though 5 RGNs on AM shift so ward could have moved AM RGN.	None
17/3/16 PM	PM 1 RGN – Ward 3a down to 1 RGN on PM shift. RGN moved from ward 3b to cover. No agency available.	DATIX received reporting 'Moderate short turn harm' but no other DATIX received and stated harm level needs further review for supporting evidence.
18/3/16 AM/PM	AM 1 RGN. Late sickness. No agency available. Though 5 HCAs on shift. PM 1 RGN – Ward 3a down to 1 RGN on PM shift. RGN moved from ward 3b to cover. No agency available.	None
19/3/16 Night	Late sickness of Night RGN. No Agency available.	None
20/3/16 Night	Night RGN required emergency leave. No agency available.	DATIX received reporting 'Moderate short turn harm' but no other DATIX received and stated harm level needs further review for supporting evidence

Ward 6a 28 beds

Date	Shortfall	Datix Reported Patient incident/Harm
1/2/16 AM	1 RGN. 5 HCAs so staff number available whilst skill mix out.	1 patient fall. But 5 HCAs on duty
12/2/16 AM	1 HCA. Bank/Agency could not cover.	None for shift
13/2/16 AM	1 HCA. Bank/Agency could not cover	None
14/2/16 AM	1RGN agency nurse went sick mid shift. 5 HCAs so staff number available whilst skill mix out	None
15/2/16 AM	1 RGN – Agency nurse booked but refused to stay. 1 HCA Bank/Agency could not cover.	None
16/2/18 AM	1 RGN. 5 HCAs so staff number available whilst skill mix out.	None
18/2/16 AM	1 RGN. 5 HCAs so staff number available whilst skill mix out.	Non3
21/2/16 AM	1 RGN Booked Agency Nurse did not attend shift	None
22/2/16 AM	1 RGN Agency nurse booked, but moved to ward 6b due to 2 RGN on duty (min	None

	4/4 for AM shift there).	
26/2/16 AM	1 HCA no bank or agency available	None
29/2/16 AM	1 RGN. Ward could have moved RGN from PM shift to cover.	None
2/3/16 AM	1 RGN. Ward could have moved RGN from PM shift to cover.	None
4/3/16 Night	1 HCA. Bank HCA did not attend shift	None
6/3/16 AM	1 HCA Bank/Agency could not cover	None
21/3/16 AM	1 RGN & 1 HCA, Bank/Agency could not cover	None
23/3/16 AM	1 RGN. Bank/Agency could not cover	None
27/3/16 AM	1 HCA. Bank/Agency could not cover	None
31/3/16 AM	1 RGN. Bank/Agency could not cover	None
2/4/16 AM	2 RGN. Agency Nurse did not attend. 1 RGN sickness	None
4/4/16 Night	1 RGN – Sickness. No Bank or Agency available	None

Ward 9a 13 beds

Date	Shortfall	Reported Patient incident/Harm
2/2/16 Night	1 HCA moved to ward 2b (no HCA and 22 beds)	None
8/2/16 Night	1 HCA moved to ward 9b (No HCA and 28 beds)	DATIX received but no harm stated
18/2/16 AM	1 HCA Did not attend	None
20/2/16 Pm	1 HCA did not arrive for PM shift	None
22/2/16 AM	1 HCA bank/agency could not cover	None
25/2/16 Night	1 HCA did not arrive for night shift	None
28/2/16 Night	1 HCA moved to cover shortfall (ward location not given)	None
12/3/16 Night	1 HCA moved to cover shortfall (ward location not given)	None
19/3/16 Night	1 HCA did not attend	None
20/3/16 AM	1 HCA. Bank/Agency could not cover	None
28/3/16 Night	1 HCA did not attend	None
29/2/16 Night	1 HCA. Bank/Agency could not cover.	None
1/4/16 Night	1 HCA Bank/Agency could not cover	None.

5. Datix reported incidents of patient harm

Our Trust uses Datix as an electronic reporting system for incidents. There were five Datix reported incidents concerning staffing during the period under review. Two have been removed as they relate to difficulties in getting both medical staff to prescribe, and other staff to cannulate a patient. Of the remaining, one cited 'no harm caused' and two were reported as 'moderate short term harm' although this was concerning delay to medication rounds (but no medication omissions) or patient falls or any other measurable consequence of shortage in nursing staffing. The definition of harm level with these Datix reports are still under investigation as the Trust has 28 days to review the submitted data for agreement of harm level.

6. Conclusion

There is evidence that some shift shortfalls were due to a late notice staff sickness issue, where, no short notice Bank or Agency staff were available. There are also on a number of shifts, when compared to other shifts, an opportunity for staff to be moved from other shifts, where, on occasions there was a slight surplus.

Whilst one area mentions 'moderate short term harm' there appears to be no other incidents received to quantify whether this was a true reflection of the risk stated, e.g. no falls, or omitted medications.

The Trust continues to explore all opportunities for substantive nurse recruitment, whilst attempting to comply with the challenge non-framework and percentage cap issued by Monitor for Agency spend.

Author
Paul Garrett
Deputy Nursing Director

8th April 2016

Ward 3b

Safer Nursing & Midwifery Staffing					*You must complete the **green** boxes*	
Ward	**3B**	**Filled in by**	**DEANNA ROONEY**		*Save the file, then click the button to the right*	
Month	**Feb-16**				Email for support	

Day	Staff type	AM*	PM*	Night*	Reason for shortfall**	Did patient harm occur? If yes what?***
1	RM/RN	5	3	3	Late shift bd 7 did long day to cover for band 5	
	HCA	3	3	3	sickness	
2	RM/RN	5	3	2	Twi Rgn 19.30-00.30 bd 5 late sick	
	HCA	5	3	3	Night RGN not cov by agency RGN Twi in at 19.30 -00.30	
3	RM/RN	5	3	3	RGN LONG DAY SICKNESS. Covered by own staff	
	HCA	5	3	3	HCA SICK LATE	
4	RM/RN	5	4	3	HCA SICK EARLY	
	HCA	5	3	3		
5	RM/RN	5	4	3	TW RGN 1930-0030hrs	
	HCA	4	2	3		
6	RM/RN	5	3	3		
	HCA	4	3	3		
7	RM/RN	5	3	3		
	HCA	4	3	3		
8	RM/RN	5	3	3	HCA SICK LATE	
	HCA	4	3	3		
9	RM/RN	5	3	3	HCA SICK EARLY	
	HCA	3	3	3		
10	RM/RN	4	3	3	RGN SICK LATE	
	HCA	5	2	3	Early shift RGN stayed til 6p.m- TW SHIFT RGN--	
11	RM/RN	5	3	3	RGN SICK EARLY	
	HCA	3	3	3		
12	RM/RN	5	3	3	RGN SICK EARLY SHIFT	
	HCA	3	3	3		
13	RM/RN	5	3	3	RGN SICK LATE	
	HCA	3	3	3		
14	RM/RN	5	3	3	HCA SICK NIGHT	
	HCA	3	3	3		
15	RM/RN	4	3	3	RGN sent to DSU replaced with agency RGN	
	HCA	4	3	3	HCA SICK NIGHT	
16	RM/RN	5	3	3		
	HCA	4	3	3		
17	RM/RN	4	3	3		
	HCA	5	3	3		
18	RM/RN	5	3	3		
	HCA	4	3	3		
19	RM/RN	4	3	3		
	HCA	5	3	3		
20	RM/RN	4	3	3		
	HCA	5	3	3		

21	RM/RN	4	3	3		
	HCA	5	3	3		
22	RM/RN	4	3	3		
	HCA	5	3	4		
23	RM/RN	5	4	3		
	HCA	4	3	4		
24	RM/RN	5	3	3	x 5 patients requiring very close observation	
	HCA	6	3	4		
25	RM/RN	4	4	3	"	
	HCA	6	3	4		
26	RM/RN	4	3	3	"	
	HCA	5	3	4		
27	RM/RN	4	3	3	"	
	HCA	5	3	5		
28	RM/RN	4	3	3	"	
	HCA	7	4	5		
29	RM/RN	4	3	3	"	
	HCA	5	3	3		
30	RM/RN					
	HCA					
31	RM/RN					
	HCA					

Rationale:

Safer Nursing & Midwifery Staffing				*You must complete the* ***green*** *boxes*	
Ward	**3B**	**Filled in by**	**DEANNA ROONEY**	*Save the file, then click the button to the right*	
Month	**Mar-16**			Email for support	

Day	Staff type	AM*	PM*	Night*	Reason for shortfall**	Did patient harm occur? If yes what?***
1	RM/RN	5	4	3	RGN early and late shift on duty following mat	
	HCA	4	2	3	leave. Supernumery	
2	RM/RN	4	4	3		
	HCA	4	2	4		
3	RM/RN	4	3	3		
	HCA	6	4	3		
4	RM/RN	4	3	3		
	HCA	4	3	3		
5	RM/RN	4	3	3	RGN early and late shift on duty following mat	
	HCA	5	3	3	leave. Supernumery	
6	RM/RN	4	3	3		
	HCA	5	4	3		
7	RM/RN	5	4	3		
	HCA	5	2	3		
8	RM/RN	5	4	3		
	HCA	4	2	3		
9	RM/RN	4	3	3		
	HCA	5	3	3		

10	RM/RN	5	3	3		
	HCA	4	2	3		
11	RM/RN	5	4	3	HCA emergency annual leave taken long day	
	HCA	3	2	3		
12	RM/RN	4	3	3	emergency annual leave HCA late shift	
	HCA	4	3	3		
13	RM/RN	5	3	3		
	HCA	4	3	3		
14	RM/RN	5	4	3		
	HCA	5	3	3		
15	RM/RN	5	3	3		
	HCA	4	3	3		
16	RM/RN	5	2	3	HCA Late shift off sick	
	HCA	3	3	3		
17	RM/RN	4	**2**	3	RGN sent to ward 3A late shift to cover	
	HCA	4	4	3		
18	RM/RN	3	**2**	3	RGN sent to ward 3A late shift to cover	
	HCA	5	4	3		
19	RM/RN	4	3	2	RGN went off duty sick night duty	
	HCA	5	3	3		
20	RM/RN	4	3	2	RGN required emergency annual leave	
	HCA	5	3	3		
21	RM/RN	5	4	3		
	HCA	4	3	3		
22	RM/RN	5	4	3		
	HCA	4	3	3		
23	RM/RN	5	4	3		
	HCA	4	2	3		
24	RM/RN	5	3	3		
	HCA	4	3	3		
25	RM/RN	4	3	3	HCA Late shift off sick	
	HCA	4	2	3		
26	RM/RN	4	3	3		
	HCA	5	3	3		
27	RM/RN	4	3	3		
	HCA	5	3	3		
28	RM/RN	5	4	3		
	HCA	5	2	3		
29	RM/RN	5	3	3		
	HCA	4	3	3		
30	RM/RN	5	4	3		
	HCA	4	3	3		
31	RM/RN	5	3	3		
	HCA	4	3	3		

Safer Nursing & Midwifery Staffing				*You must complete the **green** boxes Save the file, then click the button to the right* [Email for support]
Ward	**3b**			
Month	**April**			

Day	Staff type	AM*	PM*	Night*	Reason for shortfall**	Did patient harm occur? If yes what?***
1	RM/RN	5	4	3		
	HCA	4	3	3		
2	RM/RN	4	3	3		
	HCA	5	3	3		
3	RM/RN	4	3	3		
	HCA	3	4	3		
4	RM/RN	5	3	3		
	HCA	3	3	3		

Ward 6a

Safer Nursing & Midwifery Staffing Report

Ward	**6A**
Month	**Feb**

Day	Staff type	AM*	PM*	Night*	Reason for shortfall**	Did patient harm occur? If yes what?***
1	RM/RN	3	3	3	1xE Agency, 1X E uncovered backfilled by HCA	
	HCA	5	2+Twi	2	1x bank Twi (18-24)	
2	RM/RN	4	4	3	One RGN x1 covered LD	
	HCA	4	3	2		
3	RM/RN	4	4	3	1xBank RGN E, 1xAgency RGN L, 1xAgency RGN ND	
	HCA	4	3	2		
4	RM/RN	4	4	3	1XAgency RGN LD	
	HCA	3	2	2	Bank HCA sick uncovered E&L	
5	RM/RN	4	4	3	1xBank RGN L	
	HCA	4	2	2	HCA L gap uncovered	
6	RM/RN	4	4	3	Own staff completing bank	
	HCA	4	3	2		
7	RM/RN	4	4	3	own staff completing bank	
	HCA	4	3	2		
8	RM/RN	4	4	3	2 x staff covering E, 1x agency RGN L, 1x agency RGN ND	
	HCA	4	3	2	2x staff covering E due to sickness	
9	RM/RN	4	3	3	L RGN uncovered, 1xAgency RGN ND	
	HCA	4	3	2	2xown staff bank E, 1x HCA	

					bank E	
10	RM/RN	4	4	3	Own staff covered RGN E&ND	
	HCA	4	3	2	Own HCA covered E	
11	RM/RN	4	4	3	own RGN covered E, 1x agency RGN ND	
	HCA	4	3	2	2x bank HCA E	
12	RM/RN	4	4	3	1xbank RGN L, 2xRGN Agency L, 1x RGN Agency ND	
	HCA	3	2	2	1xHCA E uncovered,1HCA L uncovered	
13	RM/RN	4	3	3	1xRGN Agency LD,1xRGN agecny L, 1xRGN agecny	
	HCA	3	3	2	1x HCA uncovered E & 1x RGN L uncovered	
14	RM/RN	3	4	3	1x Agency RGN E, 1xAgency L ,1x Agency ND	
	HCA	5	3	2	HCA covered RGN gap E HCA sent at 10.00 when agency nurse went home sick	
15	RM/RN	3	3	3	1X Agency E refused to stay, Agency on every shift	
	HCA	3	3+Twi	2	E x1 HCA uncovered, Special E uncovered,Twi used to special	
16	RM/RN	3	2+1	2	1xRGN Agency E, nurse unable to do drugs awaiting PIN L	
	HCA	5	3	2	HCA to backfill E RGN gap, 1xHCA E&L to special used	
17	RM/RN	3+1	4	3	Own staff bank, Agency x1 RGN ND, nurse unable to do drugs awaiting PIN	
	HCA	3+1	3+1	2	1X HCA LG used to special	
18	RM/RN	3	3+1	3	1xRGN uncovered E, nurse awaiting PIN unable to do drugs	
	HCA	4+1	3	2	1xHCA E used to special, stepped down after am shift	
19	RM/RN	3+1	4	3	nurse awaiting PIN unable to do drugs, 1xagency ND, 1xAgency LD	
	HCA	3	3	2	1xHCA E uncovered following sickness	
20	RM/RN	3	4	3	1xRGN E uncovered, 3xRGN agency L shift1X agency RGN ND	
	HCA	4	3	2		
21	RM/RN	3	3	3	1xRGN Agecny LD did not turn up no cover available	
	HCA	4	3	2	1xRGN agency swapped with 6B for trust nurse	
22	RM/RN	3	3	3	Agency covered E but staff member given to 6B who were short on E shift	
	HCA	4	3	2	Agency L shift nurse did not turn up	
23	RM/RN	4	3	3	2xAgency RGN E, 1x Bank RGN E,1xAgency RGN L 1xAgency RGN ND	
	HCA	4	4	2	1 x Agency HCA covered L RGN gap	
24	RM/RN	4	4	3	1x Agency RGN LD, 1x RGN help from ward 3B	
	HCA	4	3	2		

25	RM/RN	4	4	3	1xRGN agency E,L,ND. Own staff RGN Bank E	
	HCA	4	3	2		
26	RM/RN	4	4	3	2xAgency RGN E, 1x agency RGN L, 1x RGN agency ND	
	HCA	3	3	2	1xHCA sick no cover E	
27	RM/RN	4	4	3	1xRGN agency E, 2xRGN agency L, 1xBank RGN ND	
	HCA	4	2	2	HCA bank L phoned in sick no cover	
28	RM/RN	4	4	3	2x agency RGN E, 2xRGN agency L, 1xBank RGN ND	
	HCA	4	3	2		
29	RM/RN	3	4	2	1xRGN sick no cover, 1xRGN agency E, 2x RGN agency L, 1x RGN agency ND	
	HCA	4	2	2	HCA L x1 uncovered.	
30	RM/RN					
	HCA					
31	RM/RN					
	HCA					

Rationale

Safer Nursing & Midwifery Staffing Report

Ward	**6A**
Month	**March**

Day	**Staff type**	**AM***	**PM***	**Night***	**Reason for shortfall****	**Did patient harm occur? If yes what?*****
1	RM/RN	4	4		x1 Agency LD	
	HCA	4	3		x2 bank HCA E, X1 bank HCA L	
2	RM/RN					
	HCA					
3	RM/RN	4	4		x1 agency LD	
	HCA	4	3		x2 bank HCA E	
4	RM/RN	4	3		x1 agency E, x1 agency L x1 RGN uncovered	
	HCA	4	3		x1 HCA bank	
5	RM/RN	3	4	3	HCA didn't turn up on nights so had someone from m/nite 2 agency RGN ND	
	HCA	5	3	2	Back filled with HCA	
6	RM/RN	4	3		RGN agency L DNA HCA E+L	
	HCA	3	2		no help given	
7	RM/RN	4	4	3	x1 RGN agency LD	
	HCA	4	2	2	uncovered L shift	
8	RM/RN	3	3	3	agency DNA E 1x agency RGN L	
	HCA	4	3	2		
9	RM/RN	4	4	3	1x agency LD RGN own staff doing bank *Drs strike*	
	HCA	4	2	2		

10	RM/RN	4	4	3	*Drs strike*	
	HCA	4	3	2		
11	RM/RN	4	4	3	x1 agency RGN E + x1 bank RGN *Drs strike*	
	HCA	4	3	2		
12	RM/RN	4	4	3	agency RGN E + late x2 + ND	
	HCA	4	3	2	bank HCA E+L	
13	RM/RN	4	4	3	agency covered 2 shifts + ND	
	HCA	4	3	2		
14	RM/RN	4	4	3		
	HCA	4	2 + Twi	2		
15	RM/RN	4	4	3	x1 agency LD x1 bank ND	
	HCA	4	3	2	x2 bank E x1 bank L	
16	RM/RN	4	4	3	x1 agency E, x2 agency L, x1 agency ND	
	HCA	4	3	2	x3 bank E	
17	RM/RN	4	4	3	x1 bank E, x2 agency L, x1 bank ND	
	HCA	4	3	2	x2 bank E, (HCA moved to 6B 1315-1800)	
18	RM/RN	4	3	3	x2 agency E, Lshift uncovered x1 agency ND	
	HCA	3	3	2	x1 bank L, E shift uncovered	
19	RM/RN	4	4	3	agency RGN covered L + ND	
	HCA	4	3	2		
20	RM/RN	4	4	3	x1 agency E, x1 bank L x1 agency ND	
	HCA	4	3	2	x2 bank hca, x1 bank L	
21	RM/RN	3	4	3	x1 agency LD x1 agency DNA -uncovered x1 agency L x1 bank ND	
	HCA	3	3	2	x1 hca off sick - no relief	
22	RM/RN	4	4		x1 bank E x1 agency LD	
	HCA	4	3	2	x2 bank hca	
23	RM/RN	4	4	3	x2 agency LD	
	HCA	3	3	2+Twi	1x Twi, 2 bank E, 1x bank L, 1x ND	
24	RM/RN	3	3	3	1x bank LD, 1 uncovered E+L	
	HCA	4	3	2	2x bank E, 1x bank ND	
25	RM/RN	4	4	3	1x bank LD, 1x bank L, 1x agency ND	
	HCA	4	3	2	1x bank E	
26	RM/RN	4	4	3	1x agency E, 1x agency L 1x bank LD 1x bank ND	
	HCA	4	2	2	1x bank E, L uncovered	
27	RM/RN	4	4	2	1xbank&agency E, 2xagency L, ND agency moved to 9B	
	HCA	3	3	2	1x bank HCA DNA E	
28	RM/RN	4	4	3	1xbank E, 2xagency L 1x	

					bank ND	
	HCA	4	3	2	1xbank E	
29	RM/RN	3	4	3	1xE RGN uncovered,2xRGNagency L 1xRGN agency ND	
	HCA	4	2	2		
30	RM/RN	4	4	3	2xagency RGN E, 2xRGN agency L, 2xRGN agecny ND	
	HCA	4	3	2		
31	RM/RN	3	3	3	1xagency E 1xagency L 1x agency ND	
	HCA	4	3	2		

Rationale

Safer Nursing & Midwifery Staffing				*You must complete the **green** boxes* *Save the file, then click the button to the right* *Email for support*
Ward	**6a**			
Month	**April**			

Day	Staff type	AM*	PM*	Night*	Reason for shortfall**	Did patient harm occur? If yes what?***
1	RM/RN	2	4	3	Agency nurse DNA	
	HCA	4	3	2		
2	RM/RN	4	4	3		
	HCA	4	3	2		
3	RM/RN	4	3	3		
	HCA	4	3	2		
4	RM/RN	4	4	2	Sickness. No agency available.	
	HCA	4	2	2		

Ward 9a

Safer Nursing & Midwifery Staffing				*You must complete the **green** boxes* *Save the file, then click the button to the right* *Email for support*
Ward	**9A**		**Sr Holly York**	
Month	**February**			

Day	Staff type	AM*	PM*	Night*	Reason for shortfall**	Did patient harm occur? If yes what?***
1	RM/RN	2	2	2		
	HCA	2	2	1		
2	RM/RN	2	2	2		
	HCA	2	2	0	staff moved to 4b and 2b	
3	RM/RN	2	2	2		
	HCA	2	2	0	staff moved to ACU A	
4	RM/RN	2	2	2		
	HCA	2	2	0	Staff moved to A&E and 7A	

5	RM/RN	2	2	2		
	HCA	2	2	1		
6	RM/RN	2	2	2		
	HCA	2	2	1		
7	RM/RN	2	2	2		
	HCA	2	2	1		
8	RM/RN	2	2	2		
	HCA	2	2	0	staff moved to 9b	
9	RM/RN	2	2	2		
	HCA	2	2	1		
10	RM/RN	2	2	2		
	HCA	2	2	1		
11	RM/RN	2	2	2		
	HCA	2	2	1		
12	RM/RN	2	2	2		
	HCA	2	2	1		
13	RM/RN	2	2	2		
	HCA	2	2	1		
14	RM/RN	2	2	2		
	HCA	2	2	1		
15	RM/RN	2	2	2		
	HCA	2	2	1		
16	RM/RN	2	2	2		
	HCA	2	2	1		
17	RM/RN	2	2	2		
	HCA	2	2	1		
18	RM/RN	2	2	2		
	HCA	1	2	1	DNA for early shift	
19	RM/RN	2	2	2		
	HCA	2	2	1		
20	RM/RN	2	2	2		
	HCA	2	1	1	DNA forlate shift	
21	RM/RN	2	2	2		
	HCA	2	2	1		
22	RM/RN	2	2	2		
	HCA	1	2	2	not covered	
23	RM/RN	2	2	2		
	HCA	2	2	2		
24	RM/RN	2	2	2		
	HCA	2	2	2		
25	RM/RN	2	2	2		
	HCA	2	2	0	DNA for night shift	
26	RM/RN	2	2	2		
	HCA	2	2	2		
27	RM/RN	2	2	2		
	HCA	2	2	2		
28	RM/RN	2	2	2		
	HCA	2	2	0	Moved by site services	
29	RM/RN	2	2	2		
	HCA	2	2	2		
30	RM/RN					
	HCA					
31	RM/RN					
	HCA					

Rationale:

Safer Nursing & Midwifery

You must complete the

Staffing				*green boxes* *Save the file, then click the button to the right* *Email for support*
Ward	**9A**		**Sr Holly York**	
Month	**MARCH**			

Day	Staff type	AM*	PM*	Night*	Reason for shortfall**	Did patient harm occur? If yes what?***
1	RM/RN	2	2	2		
	HCA	2	2	1		
2	RM/RN	2	2	2		
	HCA	2	2	1		
3	RM/RN	2	2	2		
	HCA	2	2	1		
4	RM/RN	2	2	2		
	HCA	2	2	1		
5	RM/RN	2	2	2		
	HCA	2	2	1		
6	RM/RN	2	2	2		
	HCA	2	2	1		
7	RM/RN	2	2	2		
	HCA	2	2	1		
8	RM/RN	2	2	2		
	HCA	2	2	1		
9	RM/RN	2	2	2		
	HCA	2	2	1		
10	RM/RN	2	2	2		
	HCA	2	2	1		
11	RM/RN	2	2	2		
	HCA	2	2	1		
12	RM/RN	2	2	2		
	HCA	2	2	0	Moved by site services	
13	RM/RN	2	2	2		
	HCA	2	2	1		
14	RM/RN	2	2	2		
	HCA	2	2	1		
15	RM/RN	2	2	2		
	HCA	2	2	1		
16	RM/RN	2	2	2		
	HCA	2	1	0	moved by site services/not covered.	
17	RM/RN	2	2	2		
	HCA	2	2	1		
18	RM/RN	2	2	2		
	HCA	2	2	1		
19	RM/RN	2	2	2		
	HCA	2	2	0	DNA NIGHT SHIFT	
20	RM/RN	2	2	2		
	HCA	1	2	1	Early not covered	
21	RM/RN	2	2	2		
	HCA	2	2	1		
22	RM/RN	2	2	2		
	HCA	2	2	1		
23	RM/RN	2	2	2		
	HCA	2	2	1		
24	RM/RN	2	2	2		
	HCA	2	2	1		
25	RM/RN	2	2	2		

	HCA	2	2	1		
26	RM/RN	2	2	2		
	HCA	2	2	1		
27	RM/RN	2	2	2		
	HCA	2	2	1		
28	RM/RN	2	2	2		
	HCA	2	2	0	DNA NIGHT SHIFT	
29	RM/RN	2	2	2		
	HCA	1	2	0	Shifts not covered.	
30	RM/RN	2	2	2		
	HCA	2	2	1		
31	RM/RN	2	2	2		
	HCA	2	1	1		

Safer Nursing & Midwifery Staffing				*You must complete the **green** boxes* *Save the file, then click the button to the right* *Email for support*
Ward	**9A**			
Month	**April**			

Day	Staff type	AM*	PM*	Night*	Reason for shortfall**	Did patient harm occur? If yes what?***
1	RM/RN	2	2	2		
	HCA	2	2	0		
2	RM/RN	2	2	2		
	HCA	2	1	1		
3	RM/RN	2	2	2		
	HCA	2	2	1		
4	RM/RN	2	2	2		
	HCA	2	1	1		

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

BOARD STATEMENTS

MAIN BOARD – APRIL 2016

1. Introduction

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

For Finance that:

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

For Governance that:

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

Otherwise:

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

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

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

2. Finance

The Trust consistently delivered a continuity of service rating of 3 throughout the financial year and although the surplus is below plan the Trust continues to achieve FSRR of 3. The Trust continues to experience ongoing demand pressures; this has a consequential impact throughout the financial year.

3. Governance

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

The performance challenges against the compliance framework both of which have been presented to the Finance and Performance Committee and are as follows:

A&E - The A&E 4 hour wait standard has not been achieved to date, and levels of demand to continue to be higher than plan additionally the number of medically fit patients awaiting discharge continues to be significantly higher than the target agreed with Gloucestershire CCG. The Trust is working closely with NHS Improvement on our plans to improve performance in addition to the wider system issues. NHS Improvement are investigating A&E performance and are working with us to improve performance.

Cancer - The Trust did not meet the 62-day target for Q4, however, a recovery plan is in place which includes plans to manage increasing demand. Particular issues relating to capacity within the Urology Service and we have plans in place to address the capacity issues.

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

4. Any other Areas

There are no issues to raise with NHS Improvement under this heading.

5. Conclusion

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

6. Recommendation

The Board is asked to consider that:-

1. The Board has maintained a Financial Sustainability Risk Rating of 3 for the 2015/16 financial year.

2. An exception report is made to NHS Improvement on the A&E 4 hour standard and Cancer 62 day standard. The Trust will continue working with NHS Improvement and partners across the health system to design and deliver performance improvement plans to deliver theatres agreed with Commissioners and NHS Improvement.

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

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

April 2016

Table A1: Indicators and their thresholds

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

Appendix 2

Table 3: Examples of where an exception report is required

	Examples

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

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

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

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

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

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

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

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

MAIN BOARD – APRIL 2016

WORKFORCE RACE EQUALITY STANDARD

1. Aim

To update the Board on progress made in the first year of reporting following the introduction of the Workforce Race Equality Standard (WRES) in 2015.

2. Background

There has been significant research in recent years including West, M (2011) and Dawson, J (2009) linking the experience of staff and the care provided to patients and the cost to both employers and patients of not treating staff well. More recent research, Kline, R (2014) has demonstrated that the treatment and experience of BME staff within the NHS is significantly worse, on average, than that of white staff. In the 'Snowy White Peaks of the NHS' (2014), Kline demonstrated that BME staff were absent from the leadership of many NHS organisations including areas such as London, where organisations provided services to communities with large BME populations. There has also been an absence of BME executive leadership in organisations such as Monitor, CQC, the Trust Development Authority and NHS England. In addition there appeared to be a number of other areas where less favourable treatment was experienced by BME staff including promotions, gradings, disciplinary proceedings and access to non-mandatory training. Parallel research also suggests the likelihood of BME staff being appointed from a shortlist is significantly less than that of white staff (Kline, R, 2013, 'Discrimination by Appointment'), with white staff being 1.74 times more likely to be appointed from a shortlist than BME staff. It has also been demonstrated that BME staff are twice as likely to enter disciplinary processes and more likely to be disciplined for similar offences (Archibong et al, 2010). Clearly this is an unacceptable position for a public service from both a moral and practical perspective. Definitive action needed to be taken and it was felt that a voluntary approach to this issue thus far had not yielded sufficient progress.

3. Workforce Race Equality Standard

This research was considered by the Equality and Diversity Council (EDC) in 2014 who concluded that early and decisive steps needed to be taken to remedy the situation for the benefit of patients and staff. In July 2014 the EDC pledged its commitment to consult on a Workforce Race Equality Standard (WRES) with a view to it being included in the Standard Contract for 2015/16. Following a three month consultation period, the WRES was accepted for implementation and required organisations employing almost all of the 1.4 million strong NHS workforce, to demonstrate progress against a number of indicators of workforce equality, including a specific indicator to address the low levels of BME Board representation. The WRES takes a small number of indicators and requires NHS organisations to close the gap between the comparative experience of white and BME staff for those indicators.

The Standard is made up of a small number of indicators that are already collected from most trusts and in many cases, published. Of the 9 measurements making up the standard, the first 4 relate to workforce data, the next 4 are taken from the annual staff survey and the final metric is linked to the diversity of the Board.

4. Timetable for Implementation

There have been a number of implementation milestones associated with the WRES for NHS organisations;

April 2015 – Prepare baseline data for comparison with April 2016 (presented to the Trust Board in April 2015)

July 1st 2015 – Deadline for publication of baseline data including identification of any essential shortcomings (published as required).

April 2015-March 2016 – Work to start to address any data shortcomings and to understand and address shortfalls identified by the WRES indicators (no particular data shortfalls were identified).

April 2016 – Baseline data for comparison with April 2015 to be completed including steps underway to address key shortcomings in data, or significant gaps between the treatment and experience of white and BME staff.

5. GHFT Workforce Race Equality Standard Performance

Our performance as at April 2016 is presented in detail in Appendix 1 and includes data for comparison from our submission from April 2015.

There has been one area of difficulty in terms of data collation. Indicator 8 relates to discrimination from managers or colleagues and requires staff survey data relating to a single question. BME response data is only readily available in terms of 'key findings' (each key finding is a composite of several individual questions) and this has necessitated a request to survey provider Quality Health to provide the information. There are no other significant issues with our data and our self-reporting of ethnicity is high.

With regards to each of the indicators, very few of the movements in scores have been significant. The highlights are;

- We have improved the percentage of BME staff in Bands 8-9 from 3.78% to 4.7%. Whilst this is a significant result, this has been achieved naturally as opposed to any form of positive selection being adopted.
- The likelihood of white staff being appointed from shortlisting compared to that of BME staff has also dropped and this is a positive trend, albeit small(2.07 times more likely from 2.17).
- In similar vein, there has been a marginal (downward) improvement in the likelihood of BME staff being involved in formal disciplinary processes (1.22 from 1.26).
- There has been a marginal deterioration in the likelihood of BME staff accessing non-mandatory training and CPD as compared to white staff (1.27 from 1.23). This result sits outside of both national indications and the reported experience of staff as expressed through the annual staff survey. This is also reflected in 'indicator 7' (see below).
- We have a slight reduction in all staff experiencing abuse, bullying and harassment from members of the public or patients and relatives in comparison to 2015. In addition there is no real significant difference between white and BME staff (with BME staff reporting slightly lower)
- That situation reverses when we consider the same metric as experienced from managers and staff. There has been a 2% increase for all staff, 23% to 25% (mirroring national trends), however a 3% increase for BME staff (from 24% to 27%.
- As described above, there is a contradiction between our collected data regarding access to non-mandatory training and the feeling that the trust provides equal opportunities for development. There has been a 1% reduction from 90% to 89% for all staff, but a worrying 4% reduction from 79% to 75% for BME staff. Whilst access to training and development beyond mandatory training could be seen as some evidence of equality of opportunity in development, the two findings aren't mutually exclusive. However, the first indicator also points to an increase in the number of senior BME staff which whilst also potentially contradictory, suggests that the problem may exist in the middle bandings.
- There is a continuing clear distinction between the perception of BME staff as expressed in the staff survey, regarding discrimination. The figures have slightly improved over the year with 13% of BME staff reporting discrimination from managers

and other staff, compared to 14% the previous year, however this still sits some wayt above the percentage of white staff reporting in the same category – 5%, compared to 4% in the previous year.

- Whilst we will be reporting an above average representation of BME Board members for the current reporting year, that position will not be held in the next reporting cycle. Senior BME representation at Board level will continue to be provided by the presence of the Chiefs of Service.

6. Summary and Next Steps

The WRES provides useful focus on an important topic and this is enabled by not making the areas of consideration too many or too complex. What is clear is that the data answers nothing by itself and gives rise to more questions. Whilst we have improved on a number of indicators, results suggest that we need to focus on key issues concerning discrimination and career opportunities. Throughout 2015, the Equality Committee were pleased to support the delivery of an awareness workshop which was positively received. It dealt with a cross section of discrimination issues and spent some time focusing on the legislative background, but much of the time stimulating discussion. This is important because it is generally considered that if the WRES is considered a useful tool to improve performance in this area then other Workforce Equality Standards may follow. Notwithstanding this, if we are to improve our performance in terms of discrimination and development it will have to come about as a result of targeted actions.

To date, our attempts to engage with our Personal, Fair and Diverse Champions (PFD) have not taken off and we will need to extend invitations to this group and also to attendees of the training sessions run thus far. We will also be asking some of our current BME senior leaders if they are prepared to engage with colleagues at lower levels and act as 'role models'. Interestingly, when the Leadership Academy offered a programme for Aspiring BME Senior Leaders (with executive/Board membership as the aspiration), there were no takers within the organization. This did not reflect a lack of ambition, more a belief from these individuals that they did not wish to be singled out on the basis of ethnicity, but considered on the basis of ability. This is perfectly understandable from those who do not perceive there to be barriers, but they could still play a very useful role in helping those who may see the issue through a different lens and lack their faith in the meritocratic nature of our promotional and development processes.

In support of the WRES we are also joining a countywide group to consider issues of Equality and Diversity and the Director of Human Resources and Organisational Development will continue to attend both regional and national WRES seminars. We will (subject to Board confirmation) publish our WRES report, continue to monitor our performance through the Equality and Diversity Steering Group (both internally and nationally), reporting on progress made to the Trust Board periodically.

6. Recommendations

The Board is asked to;

- **Agree** that the WRES report can be published in line with our obligations.
- **Agree** that future progress can be relayed to the Board via the minutes from the Equality and Diversity Steering Group.

Author and Presenting Director:
Dave Smith, Director of HR and OD
April 2016

Workforce Race Equality Standard

REPORTING TEMPLATE

Name of provider organisation
Gloucestershire Hospitals NHS Foundation Trust

Name and title of Board lead for the Workforce Race Equality Standard
Dave Smith, Director of Human Resources & Organisational Development

Name and contact details of lead manager compiling this report
Richard Giles, Equality Steering Committee Member, Richard.giles@glos.nhs.uk , 0300 4223144

Names of commissioners this report has been sent to
Gloucestershire Clinical Commissioning Group

Name and contact details of co-ordinating commissioner this report has been sent to
Caroline Smith, Senior Manager Engagement & Inclusion, Gloucestershire Clinical Commissioning Group. Email Caroline.smith37@nhs.net,
Tel 0300 4211514

Unique URL link on which this report will be found (to be added after submission)

This report has been signed off by on behalf of the Board on (insert name and date)
Dave Smith, Director of Human Resources & Organisational Development

Report on the WRES indicators

1. Background narrative

a. Any issues of completeness of data

Obtaining the ethnicity data against a specific staff survey question (17b in 2016, 23 in 2015) for indicator 8 has required dialogue with the survey provider Quality Health as the survey reports only provide comparative BME data on key findings, not the individual questions that make up those key findings.

b. Any matters relating to reliability of comparisons with previous years

N/A

2. Total numbers of staff

a. Employed within this organisation at the date of the report

8120 (including GP Trainees)

b. Proportion of BME staff employed within this organisation at the date of the report

948 BME staff (11.7% of staff total)

3. Self reporting

a. The proportion of total staff who have self–reported their ethnicity

96.9%

b. Have any steps been taken in the last reporting period to improve the level of self-reporting by ethnicity

No due to the high level responses reported

c. Are any steps planned during the current reporting period to improve the level of self reporting by ethnicity

No

4. Workforce data

a. What period does the organisation's workforce data refer to?

1st April 2015 to 31st March 2016

5. Workforce Race Equality Indicators

For ease of analysis, as a guide we suggest a maximum of 150 words per indicator.

	Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
	For each of these four workforce indicators, the Standard compares the metrics for White and BME staff.				
1	Percentage of BME staff in Bands 8-9, VSM (including executive Board members and senior medical staff) compared with the	4.7% / 11.7% 12.9%/11.7% including consultants	3.78%/11% 12.6%/11%	An increase of nearly 1% of BME staff in the senior population and a minor increase in the percentage of BME staff including consultants.	Our objective for 2016 as discussed within our Equality and Diversity Steering Group is to use our senior managers from BME groups as role models.
2	Relative likelihood of BME staff being appointed from shortlisting compared to that of White staff being appointed	White staff are 2.07 times likely to be appointed from shortlisting	White staff are 2.17 times likely to be appointed from shortlisting	Our percentage of BME staff is double that of the population of Gloucestershire, however we have experienced a marginal decrease in appointment rates.	We continue to be more successful at attracting a higher proportion of BME applications for employment and will continue top check for trends on a quarterly basis.
3	Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation*	BME staff 1.22 times more likely to enter formal investigation	BME staff 1.26 times more likely to enter formal investigation	There remains a higher proportion of BME staff in the lower grades and this is matched to higher incidence of disciplinary procedures for lower grade staff.	Continue to monitor this rolling data on a quarterly basis.
4	Relative likelihood of BME staff accessing non-mandatory training and CPD as compared to White staff	BME staff 1.27 times more likely to access	BME staff 1.33 times more likely to access	Superficially it appears that BME staff have more access to more non-mandatory training. This remains a contradictory finding with the staff survey which suggests fewer development opportunities generally for BME staff.	A key objective for this year is to understand and improve the employment experience of BME staff in terms of development.

	Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including eg does the indicator link to EDS2 evidence and/or a corporate Equality objective
	For each of these four staff survey indicators, the Standard compares the metrics for each survey question response for White and BME staff.				
5	KF 18. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White 29% BME 28%	White 30% BME 29%	There appears to be no obvious distinction between BME and non BME staff with a minor improvement on performance over the year.	No action planned
6	KF 19. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White 25% BME 27%	White 23% BME 24%	There has been both a local and national increase in the incidence of bullying with a slightly bigger increase for BME staff.	We will attempt to get behind the data by discussing with our PFD Champions some of the potential reasons as well as continuing to monitor HR data which suggest that BME staff are twice as likely to raise issues of bullying and harassment..
7	KF 27. Percentage believing that trust provides equal opportunities for career progression or promotion	White 89% BME 75%	White 90% BME 79%	There appears to be a clear distinction between the experience of the two groups.	As above. The data from the staff survey is contradicted by the training statistics and will need to be considered against the population of other staff groups who score low on this finding. Again we will need to engage with staff as part of our EDS objective to improve the employment experience of BME staff in terms of discrimination and development.
8	Q23. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	White 5% BME 13%	White 4% BME 14%	There appears to be a clear distinction between the experience of the two groups.	As above, we will need to engage fully with BME staff to understand the reasons and to recommend actions.
	Does the Board meet the requirement on Board membership in 9?				
9	Boards are expected to be broadly representative of the population they serve	4.6% of the Gloucestershire Population is BME, compared to 7.14% of the Trust's Board.	4.6% of the Gloucestershire Population is BME, compared to 7.14% of the Trust's Board.	The board is made up of 15 people of whom 1 is of BME origin. We also have 4 Chiefs of Service who attend board meetings and seminars of whom 2 (50%) are of BME origin.	No immediate action required and we will monitor to ensure appropriate representation.

Note 1. All provider organisations to whom the NHS Standard Contract applies are required to conduct staff surveys though those surveys for organisations that are not NHS Trusts may not follow the format of the NHS Staff Survey

Note 2. Please refer to the Technical Guidance for clarification on the precise means of each indicator.

6. Are there any other factors or data which should be taken into consideration in assessing progress? Please bear in mind any such information, action taken and planned may be subject to scrutiny by the Co-ordinating Commissioner or by regulators when inspecting against the “well led domain.”

WRES will be discussed through our Trusts quarterly Equality Steering Committee and objectives for this committee include developing a greater understanding of the issues given rise to the responses on the staff survey with regards to career opportunities and discrimination experience by BME staff.

7. If the organisation has a more detailed Plan agreed by its Board for addressing these and related issues you are asked to attach it or provide a link to it. Such a plan would normally elaborate on the steps summarised in section 5 above setting out the next steps with milestones for expected progress against the metrics. It may also identify the links with other work streams agreed at Board level such as EDS2.

WRES Board Paper provided to the Trust Board in April 2015 and 2016 describing the introduction of the WRES, including the rationale for introducing it, a description of the WRES indicators, our initial and updated performance against those targets and how they will be used to track progress internally and externally. A copy of the reports can be found here:-

http://www.gloshospitals.nhs.uk/SharePoint2/Board%20Papers/2015/April%202015/Item%2021%20-%20Workforce%20Race%20Equality%20Standard.pdf

Current and previous Trust Annual Equality Reports can be founds here :-
http://www.gloshospitals.nhs.uk/en/Pulications/201314-Publications/

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – APRIL 2016

7 DAY SERVICES PROJECT UPDATE

1 Background

1.1 The Main Board was last updated on the 7 Day Services project in January 2016 and is updated quarterly. This report will provide comment on the pilot in Respiratory and the roll out plan for the remainder of the Trust.

1.2 This note will also provide an update on the County-wide activity.

1.3 The Board is requested to note this update.

2 Update on Pilot

2.1 The pilot in Respiratory has continued to demonstrate positive outcomes, particularly with regard to the reduced Length of Stay (LOS). The intent this year is to develop the pilot into a 'business as usual' approach as part of the Medicine Division priorities for the year.

2.2 The Gloucestershire Respiratory Team is exploring integrated working and will support the Sustainability and Transformation planning across the County.

3 Whole Trust Plan

3.1 Priorities for 2016/17. The Project team has been working with the Divisions to refine the Trust plan and confirm the priorities for this financial year. NHS England has published that we should concentrate on 4 National Standards of the original 10 standards in the first instance (2 – time to first consultant, 5 - Access to Diagnostic Services, 6 - Consultant Directed Interventions (Critical Care, Radiology, Endoscopy) and 8 – Every patient seen every day). Trust priorities have taken this direction into account and Rough Order Costs have been worked up to support the input to the Trust Operational Plan.

- **Emergency Department**
    - Develop the consultant and middle grade cover for the acute medical rota (Emergency Departments and Acute Care Units) to deliver standards 2 and 8.
- **Medicine Division**
    - Progress from pilot status to 'business as usual' for Respiratory to deliver all 10 standards. Embed Ward Round and Board Round processes (with attendance from Multi-Disciplinary Teams (MDT) representatives) 7 days a week. Develop links with community specialist nurses to provide supported discharge and admission prevention.
    - Streamline Emergency Pathway and implement appropriate 7 day consultant, administration, nursing and therapy support in Cardiology to deliver standards 2, 3 and 8. Extend specialist nursing cover in Emergency Department to deliver a 7 day service.
    - Implement 7 day Older People Assessment and Liaison (OPAL) service with appropriate consultant or consultant nurse, administration, nursing and therapy support for General Old Age Medicine (GOAM) to support admission avoidance and enhance standards 2 and 8 for admitted patients.

- **Surgery Division**

    - Trauma & Orthopaedics to provide appropriate consultant, administration, nursing and therapy support to deliver standards 2, 3, 8 and 9.

    - Implement appropriate consultant, administration, nursing and therapy support in Urology to deliver a 7 day service and meet standards 2, 3 and 8.

    - Implement appropriate 7 day consultant, administration, nursing and therapy support in Lower/Upper Gastrointestinal (GI) to deliver standards 2, 3 and 8.

- **Diagnostics and Services Division**

    - Deliver diagnostic services at weekends (including pharmacy) to meet standards 5 and 6 in support of priority area development.

    - Deliver improved Oncology discharge provision and community support (including palliative care) to meet standard 9.

    - Deliver 7 Day physiotherapy support across the Trust to meet standards 3 and 9 in support of Divisional priority area development.

- **Women and Children Division**

    - Deliver appropriate 7 day consultant, administration, nursing and therapy support Obstetrics and Gynaecology to deliver an enhanced and consistent service across both specialties by meeting standards 2 and 8. Recruit specialist clinicians with Mental Health special interest to provide support to the service and deliver Standard 7.

    - Deliver the appropriate consultant, administration, nursing and therapy support in Acute Paediatrics to deliver Board and Ward rounds 7 days a week to meet standards 2 and 8.

    - Improve the internal provision of Speech and Language Therapy (SALT), Integrated Discharge Team (IDT) and bed management support for paediatrics and neonatal services to deliver standard 9.

3.2 The Project Team will coordinate the development of these priorities into business cases to provide a robust case to be presented to the CCG for investment.

3.3 Ward Clerks. We now have an additional 22 ward clerks at weekends and the Ward Clerk Manager has been in post for two months. A ward clerk website has been set up to improve communications and the Manager has also been developing a standardised approach to training. A focus for this initial period has been developing the skills for on-line transport booking in order to support the work being conducted to improve flow through the hospital.

4 County-wide Activity

4.1 The County-wide Steering Group for the end of April has been cancelled but the intent is to hold the next meeting in June. A working Group meeting was held on 18 April to review the NHS England survey, encourage other providers to conduct a detailed gap analysis in the National Priority Standards areas and discuss the impact on other providers of the Acute Trust's priorities for this year.

4.2 NHS England Project update. Following the requirement for all Trusts to conduct a review of 7 Day Services in September 2015, all Acute Trusts have again been asked to conduct another review. This second survey has taken account of the feedback from the first and refined the process, with fewer ambiguities in the data collection and

a more targeted survey. The requirement was to focus again on the 4 National Priority Standards and conduct the review of 280 emergency admissions over a week commencing Wednesday 30 March through to Tuesday 5 April. The review was conducted and the results will be uploaded by the end of the month. A further comparison with other Trusts is likely to be available a month after all Trusts have uploaded their data. These surveys are likely to be called for every six months.

5 Risks

5.1 The risks to the Whole Trust Plan are being reviewed to concentrate on the delivery against the priority areas rather than just focus on the Respiratory Pilot. Contract negotiations to meet the resource requirement will be supported by the Business development work in each of the Divisions.

6 Recommendation

6.1 The Board is requested to note this update on progress towards the introduction of 7 Day Services into the Trust.

Author: **Bob Pearce**

Presenting Director: **Dr Sean Elyan**

Date April 2016

ITEM 19

INSTITUTE FOR HEALTHCARE IMPROVEMENT – LESSONS LEARNT

PRESENTATION

Mrs Maggie Arnold
Nursing Director

ITEM 20

ITEMS FOR THE NEXT MEETING AND ANY OTHER BUSINESS

DISCUSSION

ITEM 21

STAFF QUESTIONS

(One question attached)

Prof Clair Chilvers
Chair

QUESTIONS FROM STAFF

Question from Jonathan Ord, Consultant Urologist

"Why has the business case for Consultant Anaesthetist led preassessment at Cheltenham, which was approved 2 years ago still not been acted upon? Is the board aware that for the last five years 75 % of Urology inpatients are preassessed less than 2 weeks before their surgery date which does not give enough time to correct most of the problems flagged up? And why despite the doubling in numbers in the last 5 years coming through the clinic has an HCA and a band 5 nurse been cut from the clinic in the last 3 years meaning that we now can't even get patients preassessed at all for some lists?"

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